

# AMY T. COREY, PH.D. Licensed Psychologist

Date: \_\_\_\_\_

How were you referred?  Healthcare Provider  Website  Insurance  Internet   
Other: \_\_\_\_\_

## PERSONAL INFORMATION

Name: \_\_\_\_\_ Gender:  Male  Female  \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

Who do you live with? \_\_\_\_\_

Phone: \_\_\_\_\_ Leave detailed messages?  Yes  No

Email: \_\_\_\_\_ Leave detailed messages?  Yes  No

Preferred Contact Method:  Phone  Email

## EMPLOYMENT

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ How long: \_\_\_\_\_

Employer Address: \_\_\_\_\_

## MILITARY SERVICE

Rank: \_\_\_\_\_ Branch: \_\_\_\_\_

Years Served: \_\_\_\_ Where did you serve? \_\_\_\_\_ Duties: \_\_\_\_\_

## MARITAL STATUS

Single  Married / Domestic Partner (Year: \_\_\_\_\_)  Separated (Year: \_\_\_\_\_)

Divorced (Year: \_\_\_\_\_)  Widowed (Year: \_\_\_\_\_)

Spouse/Partner Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

# CHILDREN / STEPCHILDREN

**Name** \_\_\_\_\_ **M/F** \_\_\_\_\_ **Age** \_\_\_\_\_

## FAMILY HISTORY

Father Name: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation:  
\_\_\_\_\_

If deceased: Year: \_\_\_\_\_ Cause: \_\_\_\_\_

Mother Name: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation:  
\_\_\_\_\_

If deceased: Year: \_\_\_\_\_ Cause: \_\_\_\_\_

Siblings

**Name** \_\_\_\_\_ **M/F** \_\_\_\_\_ **Age** \_\_\_\_\_

Family history of mental illness or substance abuse?  Yes  No If yes, explain:  
\_\_\_\_\_

## EDUCATION

High School / Year Graduated: \_\_\_\_\_

College / Year Graduated: \_\_\_\_\_

Degree(s): \_\_\_\_\_

Other Training: \_\_\_\_\_

## LEGAL ISSUES

List any past or current legal or court issues:

## MEDICAL INFORMATION

Primary Care Provider: \_\_\_\_\_ How long: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Notify your physician about your visit?  Yes  No

Medications:

| <u>Name</u> | <u>Dosage</u> | <u>Purpose</u> | <u>Prescriber</u> |
|-------------|---------------|----------------|-------------------|
|-------------|---------------|----------------|-------------------|

Physical Health Treatment History. List physical conditions, surgeries, serious illnesses, injuries. If hospitalized, name of hospital, dates, and duration of hospital stay:

Family history of serious medical conditions?  Yes  No If yes, explain:

\_\_\_\_\_

Tobacco:  Yes  No Type: \_\_\_\_\_ Frequency: \_\_\_\_\_

Alcohol:  Yes  No Type: \_\_\_\_\_ Frequency: \_\_\_\_\_

Other Drugs:  Yes  No Type: \_\_\_\_\_ Frequency: \_\_\_\_\_

Caffeine:  Yes  No Type: \_\_\_\_\_ Frequency: \_\_\_\_\_

Gambling:  Yes  No If yes, has it caused financial/relationship problems?  Yes  No

## MENTAL HEALTH TREATMENT HISTORY

(List conditions, providers, dates, inpatient/outpatient, hospitalizations, etc.)

**CURRENT ISSUES** Describe the reason for today's appointment:

**RESPONSIBLE PARTY**

Name: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

**FINANCIAL ARRANGEMENTS**

- I will be utilizing my insurance coverage and will make my co-payment at each appointment.
- I will not be utilizing insurance coverage and will make payment in full at each appointment.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**CONSENT**

- I agree to take part in treatment with the psychologist. I understand that treatment is voluntary and may be stopped at any time. I understand that no promises have been made to me regarding the results of treatment or any procedures provided by the psychologist.
- I understand that I am responsible for payment of services I have received. I understand that my insurance company (or other third-party payor) may require information about the type, cost, date, and provider of any services or treatment I receive.

Client/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Psychologist Signature: \_\_\_\_\_ Date: \_\_\_\_\_

