

LIBERTY PSYCHOLOGICAL SERVICES  
REBECCA MORRIS, PH.D.  
LICENSED CLINICAL PSYCHOLOGIST

DATE: \_\_\_\_\_

### PATIENT INFORMATION

\_\_\_\_\_  
First Name MI Last Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Zip

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

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

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

May we leave messages on Home? \_\_\_ Cell? \_\_\_ Work? \_\_\_

Birth date: \_\_\_\_\_ D/L No.: \_\_\_\_\_

SSN: \_\_\_\_\_

Gender: M F Marital Status: \_\_\_\_\_

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

\_\_\_\_\_  
School/Grade: \_\_\_\_\_

Email address: \_\_\_\_\_

Primary Physician: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

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

Guardian Name: \_\_\_\_\_

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

\_\_\_\_\_

**Authorization to Release Information:** I authorize the release of any medical or other information necessary to process insurance claims.

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

**Authorization to Pay Benefits to Provider:** I authorize payment of benefits directly to the therapist for the services provided. Where applicable I also request payment of government benefits to the party who accepts assignment.

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

### RESPONSIBLE PARTY

\_\_\_\_\_  
First Name MI Last Name

\_\_\_\_\_  
Address (if different)

\_\_\_\_\_  
City State Zip

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

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

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

May we leave messages on Home? \_\_\_ Cell? \_\_\_ Work? \_\_\_

Birth date: \_\_\_\_\_ D/L No.: \_\_\_\_\_

SSN: \_\_\_\_\_

Gender: M F Marital Status: \_\_\_\_\_

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

\_\_\_\_\_  
Email address: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_

Primary Insurance Company: \_\_\_\_\_

\_\_\_\_\_  
Policy #: \_\_\_\_\_

Group #: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_

\_\_\_\_\_  
Policy #: \_\_\_\_\_

Group #: \_\_\_\_\_

Secondary Insured's Name: \_\_\_\_\_

**PERSONAL INFORMATION**

Name: \_\_\_\_\_

Referred by: \_\_\_\_\_

Previous Counseling/Treatment:

(Who) \_\_\_\_\_ (Where) \_\_\_\_\_ (When) \_\_\_\_\_

(Results) \_\_\_\_\_

(Who) \_\_\_\_\_ (Where) \_\_\_\_\_ (When) \_\_\_\_\_

(Results) \_\_\_\_\_

Nature of Current Problems: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Others Living in the Home:

Name \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_ School/Employer: \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_ School/Employer: \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_ School/Employer: \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_ School/Employer: \_\_\_\_\_

**MEDICAL INFORMATION**

Primary Care Physician: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

Address: \_\_\_\_\_ Medical Issues: \_\_\_\_\_

Physician's Phone: \_\_\_\_\_

Allergies: \_\_\_\_\_ Current Medications: *(Included dosage and length of usage)* \_\_\_\_\_

Adverse Reaction to Medications \_\_\_\_\_

**OFFICE USE ONLY**

**Diagnosis**

Date First Seen: \_\_\_\_\_

DSM - IV

ICD 9 CM Date

of First Symptom: \_\_\_\_\_

Axis 1 \_\_\_\_\_

1. \_\_\_\_\_

Fee: \_\_\_\_\_

Axis II \_\_\_\_\_

2. \_\_\_\_\_

\_\_\_\_\_ Axis III \_\_\_\_\_ 3. \_\_\_\_\_

Axis IV \_\_\_\_\_

4. \_\_\_\_\_

Axis V \_\_\_\_\_

5. \_\_\_\_\_

## CLIENT REPORT OF PROBLEM

Name \_\_\_\_\_ Today's Date \_\_\_\_\_ Case # \_\_\_\_\_

Briefly describe your reason(s) for seeking help

How long have you had the problem(s)?

Why did you decide to seek help now?

What other ways have you tried to deal with this problem?

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### History of treatment for emotional problems and family history

**Outpatient treatment**       yes       no  
Did it help                       yes       no

Therapist's name \_\_\_\_\_  
Dates in treatment \_\_\_\_\_

**Inpatient treatment**     yes       no

Where \_\_\_\_\_

When \_\_\_\_\_

How long \_\_\_\_\_

**Family history of emotional problems**       yes       no

Who \_\_\_\_\_

Relationship to you \_\_\_\_\_

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### Check any of the following items that apply to you:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Thoughts of suicide      | <input type="checkbox"/> Thoughts of harming others            | <input type="checkbox"/> Phobias                |
| <input type="checkbox"/> Trouble getting to sleep | <input type="checkbox"/> History of attempts to kill yourself  | <input type="checkbox"/> Panic attacks          |
| <input type="checkbox"/> Waking during the night  | <input type="checkbox"/> Cutting or otherwise hurting yourself | <input type="checkbox"/> Excessive guilt        |
| <input type="checkbox"/> Waking early every day   | <input type="checkbox"/> Feelings of hopelessness              | <input type="checkbox"/> Forgetfulness          |
| <input type="checkbox"/> Financial problems       | <input type="checkbox"/> Inability to make decisions           | <input type="checkbox"/> Mood swings            |
| <input type="checkbox"/> Loss of appetite         | <input type="checkbox"/> Trouble controlling your temper       | <input type="checkbox"/> Health problems        |
| <input type="checkbox"/> Hearing voices           | <input type="checkbox"/> Large weight gain or loss             | <input type="checkbox"/> Family problems        |
| <input type="checkbox"/> Problems at work         | <input type="checkbox"/> Seeing things others don't            | <input type="checkbox"/> Violence toward others |
| <input type="checkbox"/> Trouble concentrating    | <input type="checkbox"/> History of physical abuse             | <input type="checkbox"/> Tingling or numbness   |
| <input type="checkbox"/> Racing thoughts          | <input type="checkbox"/> History of sexual abuse               | <input type="checkbox"/> Depressed mood         |
| <input type="checkbox"/> Legal problems           |  |   |

(Please complete the other side of this form)

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**Health Status**

List any medical problems or physical problems and when they were diagnosed

- 1.
- 2.
- 3.

List any major (where you were put to sleep) surgeries you have had to date

- 1.
- 2.
- 3.

List any serious illness or injuries especially anything involving the head

- 1.
- 2.
- 3.

List **any** allergies to foods or drugs

- 1.
- 2.

- 3.
- 4.

Date of last physical examination \_\_\_\_\_ Doctor's name \_\_\_\_\_

May we contact your doctor?  yes  no

**Drug and Alcohol Information**

List all of the prescription and over-the-counter drugs you are taking

Check substances you use in any amount at all

**How much do you use per**

	Age first used	Weekday	Weekend	Month	Last used
<input type="checkbox"/> Beer	_____	_____	_____	_____	_____
<input type="checkbox"/> Liquor	_____	_____	_____	_____	_____
<input type="checkbox"/> Wine	_____	_____	_____	_____	_____
<input type="checkbox"/> Marijuana	_____	_____	_____	_____	_____
<input type="checkbox"/> Cocaine/Crack	_____	_____	_____	_____	_____
<input type="checkbox"/> Methamphetamine/Crystal	_____	_____	_____	_____	_____
<input type="checkbox"/> Heroin	_____	_____	_____	_____	_____
<input type="checkbox"/> Barbiturates (downers)	_____	_____	_____	_____	_____
<input type="checkbox"/> PCP, LSD (Hallucinogens)	_____	_____	_____	_____	_____
<input type="checkbox"/> Tobacco (in any form)	_____	_____	_____	_____	_____
<input type="checkbox"/> Other _____	_____	_____	_____	_____	_____

**To be completed by adults (18 yrs and older)**

- Have you ever felt like you should cut down on your drug or alcohol use?  yes  no
- Has a friend or relative expressed concerns about your use?  yes  no
- Have you ever felt guilty about your drinking or drug use?  yes  no
- Have you ever had to take a drink or use a drug the next day to steady your nerves?  yes  no
- Are you a recovering alcoholic or a recovering drug addict?  yes  no
- Is there a history of problems with drug or alcohol use in your family?  yes  no

**To be completed by adolescents (12 yrs to 17 yrs)**

- Have you ever used alcohol or drugs before or during school?  yes  no
- Have you ever missed school (or been truant) because of use or just to use?  yes  no
- Have you ever avoided non-users?  yes  no
- How often do you get drunk/high? \_\_\_\_\_
- About how often do you use more than one drug when you get high? \_\_\_\_\_
- Is there a history of problems with drug or alcohol use in your family?  yes  no

Therapist \_\_\_\_\_ Date \_\_\_\_\_

Client signature \_\_\_\_\_ Date \_\_\_\_\_