Client Information

Date: _____

Client Name: _____ Date of Birth: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Referred by: _____

Primary Physician: _____ Current Medication: _____

Allergies to Medication: _____

Emergency Contact: _____

Relationship to Client: _____ Phone No.: _____

Responsible Party: ( ) Self ( ) Spouse ( ) Parent

Name: _____ Address: _____

Social Security Number of Responsible Party: _____

His/Her Employer: _____ Address: _____

His/Her Job Title: _____ Work Phone: _____

Health Insurance: _____ Group No: _____

Please list each professional, program, or hospital that has provided behavioral health services to you or your family. If you don't have their current addresses, please bring this information to the next appointment.

Professional/Program or Hospital Address/Location Dates

Close Family Members (Parents, Siblings, Spouse, Children, etc.)

Name Relationship Age Any Mental Health, Drug/Alcohol Problems

_____
_____
_____
_____

Client Name: _____ Date: _____

Client Information

Reason for seeking help. Current problems experienced by the Client. Please circle any relevant problems.

Sadness Anxiety Drug Abuse Parenting Spouse Stress Limited Communications
Behavior problems Sexual behavior Anger control Work conflicts Lonely Nightmares
Lack of energy Confused thinking Sexual dysfunction Marriage problems Family conflicts
Stealing Sibling conflicts Physical abuse Criminal/delinquent behavior Assertiveness
Co-dependency Panic attacks Fears Compulsive behavior Underachievement Hyperactivity
Short Attention Eating disorder Stuttering Apathy Job Stress Learning disability
Financial problems Physical disability Death/loss Spirituality Weight/appearance Legal problems

My Goals for Treatment:

_____
_____
_____
_____
_____
_____
_____
_____

PATIENT LETTER OF AGREEMENT

INSURANCE BILLING AND PAYMENT POLICY

PLEASE INITIAL EACH ITEM BELOW

_____ I request Dr. Daniel J. Christiano, Ph.D to submit billing on my behalf directly to my Insurance Carrier.

_____ I acknowledge that payment for services will be forwarded directly to your provider.

_____ I authorize the release of any information necessary to process the claim for payment.

_____ Payment liability for Non-insured patients and for charges of DENIED services rests with the patient, or responsible party, who is the beneficiary of those services.

_____ I agree to be personally responsible for payment of those services, as well as, any legal fees, court costs, collection fees, and late fees connected with collection of payment.

_____ I agree to pay a **$25.00** fee for any personal checks returned for insufficient funds.

_____ I agree that the person who brought the child in to see the doctor, is responsible for all the fees associated with the visit.

APPOINTMENT POLICY

_____ The cooperation of each patient is necessary to assure that everyone's needs are met. Frequently, patients are placed on a "waiting list" for appointment cancellations. It is therefore necessary that every consideration be given to avoid missed appointments that could be used by someone else.

_____ Each patient is responsible for keeping appointments with his or her provider. If it becomes necessary to break an appointment, it is EXPECTED that a patient contact this office 24 hours in ADVANCE of scheduled appointment.

_____ If a patient misses his or her scheduled appointment or fails to provide **24 hours advance notice**, there will be a charge of **$50.00**. This charge will not and cannot be billed to your insurance company. You are personally responsible for this charge. **In the event my account is turned over for collection. I understand that I will be responsible for all collection costs.**

SIGNATURE OF AGREEMENT _____

DATE _____

WITNESSED BY: _____

DATE _____

INFORMED CONSENT FOR TREATMENT

I_____DOB_____SSN:_____

1. **I have been informed of my rights and responsibilities as a patient of Dr. Daniel J Christiano, Ph.D.**

2. **I have been informed about the limits of confidentiality of my records.**

3. **I have been informed of the cost of services from Dr. Daniel Christiano I understand that I am responsible to pay a co-pay and that it is payable each time I come for treatment.**

4. **I have been informed about Dr. Daniel J Christiano's qualifications.**

5. **I understand that I may address any concerns or grievances with my therapist/doctor at any time. I understand that I may also contact the licensing board which regulates therapist's/doctor's professional practice.**

6. **I am freely choosing to enter into treatment, and I understand that I may Discontinue treatment at any time however, I agree to let Dr. Christiano Know before stopping treatment.**

6. **I agree that if at any time I feel that I may be a threat to myself or others I will call Dr. Christiano or Banner Helpline (602) 254-4357 before calling 911**

8. **I give my authorization and consent to receive outpatient diagnostic and treatment services from Dr. Daniel J Christiano. I understand that my therapist/doctor believes that this treatment will help me and there is no guarantee as to the result. I also understand that on occasion there are negative consequences to treatment and I agree to inform Dr. Daniel Christiano if there are unexpected changes in my condition.**

_____

Signature of patient or legal consenter **Date_____**

_____

Signature of staff providing the information

Dr. Daniel Christiano, Ph.D

ADULT HISTORY FORM

(Confidential)

The purpose of this questionnaire is to obtain a comprehensive picture of your background. By completing these as fully questions and accurately as you can, you will facilitate your therapeutic program. You benefit by completing these routine questions in your own time instead of using your actual consulting time. Case records are strictly confidential. No outsider is permitted to see your case record without your written permission. If you do not desire to answer any question, merely write: "Do not care to answer."

Insurance: _____

Date: _____

GENERAL

Name

Address _____

Home Phone _____ Work Phone _____

Age _____ Date of Birth and Place _____

Occupation_____ Employer_____

Do you live in a house, hotel room, apartment, etc.? _____

MARITAL HISTORY

Marital Status (Circle): Single Married Separated Widowed Divorced

How many times have you been married, including marriage above? _____Length of present marriage_____

How long did you know your marriage partner before engagement? _____

For how long were you engaged? _____ Husband's/Wife's age? _____

Husband's/Wife's occupation? _____ Employed now? _____

How many hours per week? _____

Describe his or her personality in your own words: _____

_____

In what areas is there compatibility? _____

In what areas is there incompatibility? _____

How do you get along with your in-laws? (This includes brothers and sisters-in-law) _____

_____

_____

How many children do you have? (List names, ages, sex, and personality). Note any from previous marriage. List marriages if any. _____

_____

Give any details of any previous marriage(s): _____

_____

INDIVIDUAL PAST HISTORY

Are you adopted? ____ If yes: When _____ Where_____

What age _____ By Whom _____

What age did you find out _____ What was your reaction _____

When you were born, were there any medical or emotional complications for you or your mother? _____

If yes, explain: _____

List all serious diseases or illnesses you had as a child or teenager. (Include age) _____

_____

List all serious operations or accidents that you had as a child and what age you were _____

_____

Please describe any fearful or distressing experiences you've had which have not been previously mentioned.

_____

_____

Underline any of the following that applied during your childhood. Problems with:

Sleep-walking, thumb-sucking, nail-biting, stammering, fears, night terrors, shyness, tantrums, tics, day-dreaming, overweight, imaginary playmates, repeated fighting, dreams, slow development, special classes, excessive masturbation, bowel problems, nightmares, bed-wetting.

Do you remember your childhood as being happy or unhappy? _____

Games and interest during childhood (including make-believe) _____

Interests and hobbies during adolescence (teens) _____

Athletic or other accomplishments _____

Have you ever bullied or given a nickname which hurt your feelings? _____

Present interests, hobbies, activities _____

Relationship with brothers and sisters: _____

Past: _____

Present:_____

Give a description of your father's personality and his attitudes towards you. (Past and present) _____

_____

Give a description of your mother's personality and her attitudes towards you. (Past and present) _____

_____

In what ways did your parents punish you as a child? _____

Describe the home atmosphere in which you grew up, any family problems, and the status of compatibility between parents and between parents and children: _____

_____

At what age were parents divorced? _____

How did you react to divorce? _____

If you were not reared by your parents, who reared you and between what years? _____

_____

Who are the most important people in your life? _____

Are there any other members of the family about whom information regarding illness, etc. is relevant?

_____

SCHOOL HISTORY

Age Started _____ _____Last grade and age completed _____

Number of grammar schools attended _____Were you often truant _____

Were you ever in special classes? Yes/No Which classes? _____

Problems in going to school because of fears or of repeated illnesses _____

Did you have difficulties or problems in school not listed? If yes, explain:_____

_____

Have you had any trade/technical training in addition to formal schooling? If yes, describe: _____

_____

OCCUPATIONAL HISTORY

Current Job? _____ Previous jobs? _____

Ever fired? _____ If yes, why? _____

Are you satisfied with your current job? _____

What ambitions do you have for your future? _____

Do you have any financial problems? _____

Any problems relating to your supervisors or co-workers? _____

RELIGION

Your religion _____

Have you or your spouse changed religion? Yes/No If yes, why? _____

Do you attend services? _____

Your church? _____

HOBBIES

List your interests and hobbies _____

_____

Have there been any changes in your interest or involvement in these activities? _____

If yes, explain: _____

LEGAL ISSUES/LAW VIOLATIONS

Have you ever been arrested, imprisoned, or appeared before a Youth Service Board?_____ If yes, explain: _____

MILITARY/SERVICE HISTORY

Were you in the services? _____Years _____ Branch _____

Date and type of discharge _____

Rank at discharge _____

SEXUAL HISTORY (General)

What is your sexual orientation? _____

If married or in a relationship, is sex life with spouse/partner satisfactory? Yes/No

Have you ever had any unusual, unpleasant, or frightening sexual experiences? Yes/No

If yes, explain: _____

SEXUAL HISTORY (Women)

Age of onset of periods? _____ Do you experience any menstrual pain or irregularity? Yes/No

Do periods affect your mood? Yes/No If yes, explain: _____

Have you been pregnant? Yes/No Any complications during pregancies? _____

Have you ever had a miscarriage? Yes/No If yes, when and what was your emotional reaction? _____

_____

Have you undergone or are you going through menopause? Yes/No If yes, how has it affected you? _____

_____

MEDICAL

List all serious illnesses, operations, injuries, and hospitalizations not previously mentioned (Give dates, doctor, hospital, and treatment) _____

_____

_____

List all current medications and doses and reasons for taking _____

_____

_____

Are there any hereditary diseases in your family? Yes/No If yes, explain: _____

_____

Any recent weight changes? Yes/No If yes, explain: _____

Last physical checkup _____Why? _____

Results_____

Current medical problems for which you are receiving treatment for _____

_____

Any problems with pain? _____ Any other physical symptoms? _____

ALCOHOL AND DRUG HISTORY

Present use: _____

_____

Past use:_____

_____

How have alcohol and drugs affected your life? (e.g, legal issues, relationship problems, employment, health):

_____

_____

Have you experienced any physical or emotional reactions to your discontinuing use of drug or alcohol? _____

_____

CURRENT PROBLEMS

Underline any of the following that apply to you:

Delay in falling asleep, intermittent awakening, early morning awakening, oversleeping, mood swings, low energy level, changes in appetite, recent weight loss or gain, agitation, wishing to be dead, strange or fearful thoughts, excessive guilt, crying, decreased effectiveness at work or inability to concentrate headaches, dizziness, fainting spells, palpitations, stomach trouble, bowel disturbances, nightmares, take sedatives, alcoholism, feel tense, feel panicky, tremors, depressed, suicidal ideas, drugs, unable to relax, sexual problems, unable to have a good time, don't like weekends and vacations, over-ambitious, shy with people, can't make friends, feel lonely, can't make decisions, can't keep a job, inferiority feelings, home conditions bad, financial problems, hearing problems, vision problems, guilty, hearing voices

Explain the most important items underlined _____

_____

My main reason for seeking help is:_____

Since they started, my problems have: Stayed the same _____ Improved _____Worsened _____

I feel the cause of my problems are: _____

_____

My problems would be improved if: _____

How strongly do you want treatment for your problem? **Circle your answer**

Very much Much Moderately Could do without if necessary

Have you had suicidal ideas? Yes/No Ever attempted suicide? Yes/No Do you think you would? Yes/No

List suicide attempts you have made:

Date or Age Method of Attempt Hospitalized? How Long?

_____

_____

Previous Mental Health Counseling or Psychiatric Treatment (List type of counseling/therapy, when it occurred, frequency, duration, name and location of therapist, results.)

_____

_____

_____

Prior Psychiatric Hospitalizations (List Date, Hospital name and address, length of stay, voluntary or involuntary)

_____

_____

Please list family members names and ages: _____

_____

FAMILY MEDICAL HISTORY

Please list family members who have had mental health issues and/or substance abuse issues:

_____

_____

_____

With whom do you live at present? (List name, age, sex, relationship to you) _____

_____

SOCIAL CONTACTS

Other important persons: Please list those persons with whom you have a strong current and continuing relationship.

_____

_____

Have you or do you take medications for medical problems and/or psychiatric problems? Yes/No If yes, please list below

Name Daily Dose Reason/Results

_____

_____

_____

Please summarize below the most important aspect of your life and would help our therapist understand you better.

_____

_____

_____

_____

_____