

## Client Information

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

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Referred by: \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Current Medication: \_\_\_\_\_

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

Name	Relationship	Age	Any Mental Health, Drug/Alcohol Problems
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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:

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# PATIENT LETTER OF AGREEMENT

## INSURANCE BILLING AND PAYMENT POLICY

*PLEASE INITIAL EACH ITEM BELOW*

\_\_\_\_\_ I request Dr. Mary Ann Thirakul, Psy.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

WITNESSED BY:

\_\_\_\_\_

\_\_\_\_\_

DATE \_\_\_\_\_

DATE \_\_\_\_\_

**INFORMED CONSENT FOR TREATMENT**

I \_\_\_\_\_ DOB \_\_\_\_\_ SSN: \_\_\_\_\_

1. I have been informed of my rights and responsibilities as a patient of Dr. Mary Ann Thirakul, Psy.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 Mary Ann Thirakul 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. Mary Ann Thirakul'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. Thirakul 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. Thirakul 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. Mary Ann Thirakul. 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. Mary Ann Thirakul if there are unexpected changes in my condition.

\_\_\_\_\_  
Signature of patient or legal consenter

Date \_\_\_\_\_

\_\_\_\_\_  
Signature of staff providing the information

**Mary Ann B. Thirakul, Psy.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): \_\_\_\_\_

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## 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? \_\_\_\_\_

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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 \_\_\_\_\_

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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 pregnancies? \_\_\_\_\_

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):

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

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### 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 \_\_\_\_\_

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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: \_\_\_\_\_

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

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

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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.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Mary Ann Thirakul, Psy.D**  
4115 E. Valley Auto Drive, Ste. 203, Mesa, AZ 85206  
TEL: (480) 507-7880 FAX: (480)507-8013

## List of Medicines

List/Name of Meds	Dosage	Reason for Taking
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		