

PATIENT INFORMATION



TED PETROCCHI, LPC, MAC

ted@tedpetrocci.com ~ 804-822-0271

Please complete the following form (all five pages) and bring it to your first session.

Today's Date: _____ Referred by: _____

PATIENT DATA

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell phone: _____

Email Address: _____

Social Sec. #: _____

Birth date (MO/DA/YEAR): _____ Age: _____

Emergency Contact

Name/Relationship: _____ Phone: _____

PREPARING FOR YOUR FIRST SESSION

We can be more productive if you have spent some time determining how counseling might help you. Please come prepared with a list of objectives for your sessions, and/or for long-term. Bring any questions you may have for me as well. Please feel free to visit my site for information on my approach to treatment, my experience, and my areas of expertise.

PAYMENT FOR SERVICES

1. Payment in full is due to me at the time of each appointment. I accept cash, checks and credit cards.

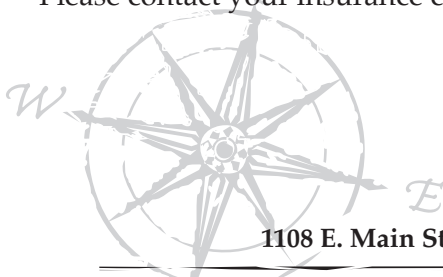
First session: \$150

Each following session: \$125

2. I will provide an itemized receipt for you to file with your insurance.

3. Your insurance company will send you a reimbursement check.

- Sessions with me are often still covered by insurance even though I am out-of-network.
- To help you manage your reimbursements, links to claim forms and instructions for common insurance companies in our area are on my website at: tedpetrocci.com/rates.
- Please contact your insurance company or employer to verify reimbursement requirements.



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PATIENT HISTORY

Current Living Situation:

- Single Married / Permanent Partner (How long: _____)
 Separated Divorced Widowed

<u>Names of Persons Living in Household</u>	<u>Age</u>	<u>Gender</u>	<u>Relationship to patient</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medical/History:

Name of primary care physician: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Most recent medical exam: _____ (month/year)

Current health: Poor Fair Good Excellent

Medication(s) currently used:

<u>Medication/dose</u>	<u>Date prescribed</u>	<u>why prescribed</u>	<u>prescribing physician</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you allergic to any medications? No Yes _____

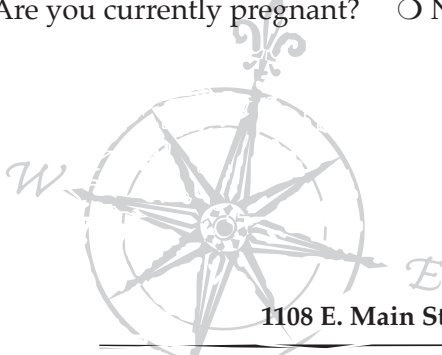
Are you taking any herbs and/or nutritional supplements? No Yes _____

Reproductive History:

Number of pregnancies: _____

Number of live births: 2 _____

Are you currently pregnant? No Yes



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Past Hospitalizations:

Hospital	Date	Reason for hospitalization
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Lifestyle History:

How often do you use alcohol? Never Monthly Weekly Daily
On the days you drink, how much do you have? Less than 2 2-5 5 or more
Do you consider it a problem? No Yes Do others consider it a problem? No Yes

Do you smoke now? No Yes
How much? _____ When did you start? _____
Have you smoked or used tobacco in the past? No Yes
How much? _____ When did you stop? _____

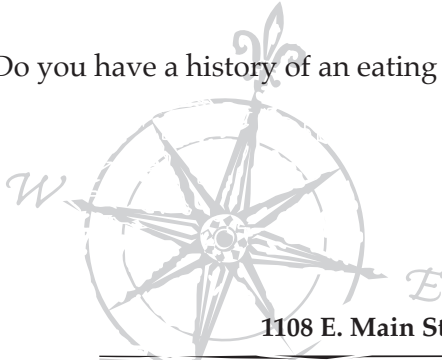
How many cups of caffeinated coffee/tea do you drink a day? _____
How many caffeinated soft drinks? _____
How much chocolate/cocoa? _____

Do you use other non-prescription or illegal substances (including opiates)?

Do you exercise routinely? No Yes How often? _____
Do you follow any special diets? No Yes Vegan Vegetarian Other

Do you have any food allergies? No Yes _____

Do you have a history of an eating disorder? No Yes Obesity Bulimia Anorexia



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Mental Health History:

Is there a family history of (check all that apply)

- Alcoholism Substance Abuse Mental Illness Suicide Eating disorder
Relationship Problem

As a child did you have any problems with the following:

- Learning disability? No Yes Age: _____
Hyperactivity? No Yes Age: _____
Bed wetting? No Yes Age: _____
School fears? No Yes Age: _____
Depression? No Yes Age: _____
Sexual/physical abuse? No Yes Age: _____

List all other childhood (0-17) learning or emotional problems:

Have you ever taken work leave for mental health/chemical dependency problems?

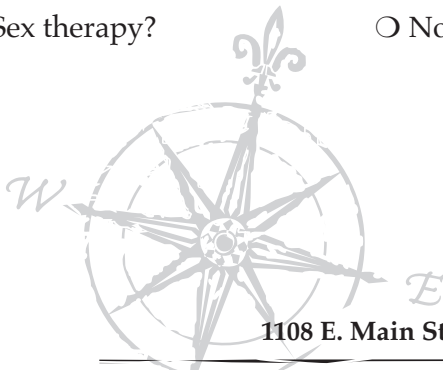
- No Yes For how long and when? _____

Have you ever attempted suicide? No Yes

Do you currently have suicidal thoughts? No Yes

Have you ever seen anyone or are you currently seeing anyone for:

- Individual therapy? No Yes
Group psychotherapy? No Yes
Marital/couples therapy? No Yes
Sex therapy? No Yes





Reason for visit: _____

Please put a 1, 2 or 3 next to all the following items that you believe apply to your current condition.

1 = mildly affecting you 2 = moderate difficulty 3 = severe difficulty

- | | |
|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Déjà vu |
| <input type="checkbox"/> Seasonal variations | <input type="checkbox"/> Loss of time |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Unpleasant dreams |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Sensitivity to bright lights |
| <input type="checkbox"/> Rapid heartbeat | <input type="checkbox"/> Sensitivity to noise |
| <input type="checkbox"/> Frequent indigestion | <input type="checkbox"/> Premenstrual problems |
| <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Irregular menstrual cycles |
| <input type="checkbox"/> Rapid weight loss | <input type="checkbox"/> Frequently sad |
| <input type="checkbox"/> Rapid weight gain | <input type="checkbox"/> Overweight |
| <input type="checkbox"/> Increased appetite | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Frequently crying/near crying | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Frequently irritable | <input type="checkbox"/> Toothaches |
| <input type="checkbox"/> Loss of interest socially | <input type="checkbox"/> Teeth grinding |
| <input type="checkbox"/> Worrying much of the time | <input type="checkbox"/> Jaw pain |
| <input type="checkbox"/> Unable to enjoy life | <input type="checkbox"/> Jaw clenching |
| <input type="checkbox"/> Dislike for weekends/holidays | <input type="checkbox"/> Problems with alcohol |
| <input type="checkbox"/> Uncomfortably shy around others | <input type="checkbox"/> Problems with drugs |
| <input type="checkbox"/> Uncomfortable in crowds | <input type="checkbox"/> Tired most of the time |
| <input type="checkbox"/> Difficulty making friends | <input type="checkbox"/> Sleeping more than usual |
| <input type="checkbox"/> Unable to relax | <input type="checkbox"/> Unable to get to sleep |
| <input type="checkbox"/> Loss of interest in sex | <input type="checkbox"/> Restless sleep or waking up early |
| <input type="checkbox"/> Other sexual concerns | <input type="checkbox"/> Waking up frequently |
| <input type="checkbox"/> Problems with decision making | <input type="checkbox"/> Waking up without feeling rested |
| <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Sometimes panicky | <input type="checkbox"/> Recurring thoughts |
| <input type="checkbox"/> Increasingly anxious | <input type="checkbox"/> Homicidal thoughts |
| <input type="checkbox"/> Specific fears (list on back of sheet) | <input type="checkbox"/> Hair loss, hair changes |
| <input type="checkbox"/> Seeing things that aren't there | <input type="checkbox"/> Dry skin, oily skin |
| <input type="checkbox"/> Smell odors which are not present | <input type="checkbox"/> Other (specify on the back of this sheet) |
| <input type="checkbox"/> Cold sensitivity | |