PATIENT INFORMATION

TED PETROCCI, LPC, MAC
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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

Names of Persons Living in Household	Age	Gender	Relationship to patient

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:

Medication/dose	Date prescribed	why prescribed	prescribing physician

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: _____

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 ❍ Bulemia ❍ Anorexia

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Mental Health History:

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

❍ Alcoholism ❍ Substance Abuse Relationship ❍ Mental Illness Problem ❍ Suicide ❍ Eating disorder

_____

_____

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

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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

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