Nike F. Carli, LCSW-R
Phone: 716-633-6900 ◆ Fax: 716-633-6902
5500 Main Street, Suite 207, Williamsville, New York 14221
Individual, Couple, and Family Therapy

Patient Information & History

Please provide the following information as best you can. I appreciate your willingness to cooperate in helping me obtain your history. *Thank you for printing.*

Full Name: ______________________ **Date:** ______________ **Sex: (M) (F)**

Address: ____
Street **City** **State** **Zip**

Telephone: ______________________

Date of Birth: ______________ **Age:** ________ **Marital Status: Check One (S) (M) (D) (W)**

Number of years married or cohabitating: ______ **Spouse/Companion's Name** ______________________

Employer's Name: ______________________________ **Telephone:** ______________

Employers Address: ____
Street **City** **State** **Zip**

Emergency Contact Name: ______________________ **Relationship:** ______________________

Address: ______________________________________ **Telephone:** __________
Street **City** **State** **Zip**

How did you hear about me? (Who referred you?) ______________________________

INSURANCE INFORMATION: Please List All Insurances

Primary Insurance: ______________________________ **Is pre-authorization required? (Yes) (No)**

__________/______________/______________________/__________
Certificate ID # **Group #** **Subscriber Name** **Effective Date**

Secondary Insurance: ______________________________ **Is pre-authorization required? (Yes) (No)**

__________/______________/______________________/__________
Certificate ID # **Group #** **Subscriber Name** **Effective Date**

Have you used your benefits this year with any other counseling service? (Yes) (No) Number of visits: __________

Insured's or Authorized person's Signature:

I authorize the release of any medical or other information necessary to process any insurance claim(s). I also authorize payment of medical benefits for services described on above mentioned claim(s). I understand that I am ultimately responsible for payment of all services rendered and that I will be charged for appointments if canceled with less than 24 hours notice. In order to utilize insurance, I understand that all copays must be paid at time of service.

Signed: ______________________ **Date:** ______________________

Patient History ~ Page 2 Name:

1) Prior Mental Health History:

Have you ever seen a psychiatrist, therapist, or counselor? (Yes) (No)
If so, give names and dates:

____
____
____

Was it helpful, not helpful, or harmful?

____
____
____

Have you been or are you on medication? (tranquilizers, antidepressants, others) (Yes) (No)
If so, give names of medications and dates that you have been on them and how you responded to them.

____
____
____

2) Family History: (circle one)

Do any members of your family (grandparents, uncles, etc.) see a mental health professional? (Yes) (No)
Is there alcoholism in your family? …………………………………………………………… (Yes) (No)
Have any members of your family ever committed suicide?.. (Yes) (No)
(Yes) (No)

If yes to any of the above please describe the relationship. ______________________________
____

Do you have any children?.. (Yes) (No)

Name of child: ____________________________ Age ________________
Name of child: ____________________________ Age ________________
Name of child: ____________________________ Age ________________
Name of child: ____________________________ Age ________________

Do you have any brothers or sisters?

Name of sibling: ____________________________ Age ________________
Name of sibling: ____________________________ Age ________________
Name of sibling: ____________________________ Age ________________
Name of sibling: ____________________________ Age ________________

3) Social History

Education:
(Circle highest grade completed) K 1 2 3 4 5 6 7 8 9 10 11 12 College 1 2 3 4+

Are you currently employed (Yes) (No)
Are you having problems related to your present job, with others workers or supervisors? (Yes) (No)
If yes, please describe the problem.

____
____

4) Military History:

Have you been in the Military? (Yes) (No)
If yes, give branch of service, dates, rank on discharge, disciplinary action, and any disability.

____
____

Patient History ~ Page 3 Name:

5) Legal History:

Have you ever been arrested? (Yes) (No)
Do you have any legal problems? (Yes) (No) If yes please describe:

____
____
____

6) Medical History:

Are you on medication for a medical condition (ex: insulin, heart pills, seizure medication)? (Yes) (No)
Names and dosages of all current medications:

____
____
____

Have you had any surgery? (Yes) (No)
If yes, give approximate year and name of procedure (ex: appendix, tonsils, open heart, etc.):

____
____
____

List all medical conditions (ex: allergies, diabetes, heart disease, high blood pressure, etc.)

____
____
____

Primary Care Doctor's Name: ____

Address: ____ **Phone Number:** ____________________

Have you ever had any of the following symptoms or difficulties (circle one)

1. Repeated headaches……………………………………………………..…………… (Yes) (No)
2. Dizziness or loss of balance ……………………………………………………….. (Yes) (No)
3. Blurring of vision ………………………………………………………………….. (Yes) (No)
4. Epilepsy or seizures ……………………………………………………………….. (Yes) (No)
5. Head Injury ………………………………………………………………………... (Yes) (No)
6. Back Injury ………………………………………………………………………… (Yes) (No)
7. Loss of strength or loss of sensation in part of your body ………………………. (Yes) (No)
8. Excessive use of alcohol ………………………………………………………… (Yes) (No)
9. Drug use (heroin, cocaine, marijuana, barbiturates, diet pills, etc) ……………. (Yes) (No)
10. Excessive use of prescription medication (Valium, sleeping pills, etc.) ………… (Yes) (No)
11. Glaucoma ………………………………………………………………………... (Yes) (No)
12. Menstrual or prostate difficulties ………………………………………………… (Yes) (No)
13. Sexual difficulties ………………………………………………………………….. (Yes) (No)
14. Physical abuse ………………………………………………………….………... (Yes) (No)
15. Sexual abuse/rape ………………………………………………………………….. (Yes) (No)
16. Other (please list) ………………………………………………………………….. (Yes) (No)

Patient History ~ Page 4 Name:

7) Summary:

What do you expect from your treatment? What are your goals?

Is there any other information which might help to better understand your problems?

What brings you joy or helps you deal with current stressors?