THERAPY YOUR WAY

COUNSELING AND CONSULTING SERVICES

Phone: 803-708-6014 Fax: 803-708-5315

New Patient Form

Last Name:	**First Name:**		**MI:**
Social Security Number:	**Date of Birth:**		**Race:**
Address:	**City:**	**State:**	**Zip Code:**
Contact Phone Number(s): Cell -		**Home:**	
Contact email address:			

Primary Insurance : _____

Insured's Name: _____ **Insured's Date of Birth**_____

Employer: _____ **Relationship to patient**_____

Policy #: _____ **Group#**_____

Personal Responsible for services rendered if Insurance/Medicaid/ Medicare does not pay:

Name: _____ **SSN#:** _____

Address: _____ **City, State, Zip Code:** _____

Relationship to patient: _____ **Cell/Home #:** _____

Check all that apply below:

Race: __ American Indica/ Alaska Native ___ Asian __ Black/ African American __ White/ Caucasian

__ Native Hawaiian or Another Pacific Islander

Ethnicity: ___ Hispanic or Latino ___ Not Hispanic or Latino

Gender: ___ Male ___ Female __ - ( )

Marital Status: ___ Single ___ Married ___ Divorced ___ Widowed ___ Separated

Employment Status: ____ Employed ___ Unemployed ___ Student (School): _____

Emergency / Alternative Contact Information:

Name: _____ **Relationship:** _____

Address: _____

Phone: _____ **Email:**_____

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Current Medications: Name/ Dose	Medical Issues or concerns: Known Allergies:	Primary Care Physician:

List any previous mental health services and providers (to include home/ community-based services, outpatient, inpatient admission etc.) include provider's name and dates:

What brings you into services today? Current Symptoms Checklist: (Rate following symptoms below that apply. Rate each section that applies as 1- Mild or 2- Moderate or 3- Severe.

	Depressed mood		Perfectionism		Argumentative / Defiant		Grief / Loss
	Mood Swings		Increase risky behavior		Discipline Problem		Impulsive
	Restlessness		Concentration/forgetfulness		Headaches / stomachaches		Fire Setting
	Excessive energy		Fatigue/ low energy		Appetite / weight changes		Bedwetting /soiling
	Racing thoughts		Crying spells		Easily distracted		Hurting others
	Excessive worry fear		Avoidance / Withdrawn		Stealing / Dishonest /Lying		Fighting / Bullying
	Unable to enjoy activities		Increased libido		Difficulty following rules		Bullied /
	Loss/lack of interest		Decreased libido		Resistance to change		Running Away
	Anger Issues/ Easily Angered		Increased irritability / Irritable		Expulsion/ Suspension		Destructive
	Anxiety or panic attacks		Excessive guilt		Short Attention Span		Frequent Tantrums
	Sleep pattern disturbance		Blames other for mistakes		Truancy/School Refusal /Skipping		Nightmares /terrors
	Decrease need for sleep		Hallucinations		Problem Completing Schoolwork		Bedwetting /soiling
	Relationship Issues/Concerns		Alcohol/ Drug Use		Suicidal thoughts or threats		Morbid thoughts
	Separation problems		Legal Issues		Easily annoyed/ Annoys others		Self-Harm/Injurious Behaviors

Additional Information:		**Referral Source: How did you hear about us?** ___Family/ Friend ___ Physician's Office ___ Social Medial ___Online/ Internet ___Psychology Today ___ Other: (_____)