THERAPIST: Jonathan Farrell-Higgins, Ph.D.

PATIENT INFORMATION

Last name: _____

First name: _____

Middle name: _____

Preferred name: _____

Street address: _____

_____

City: _____

State: _____ Zip Code: _____

Home phone: _____

Work phone: _____

Mobile phone: _____

Social Security no.: _____

Sex assigned at birth: _____

Gender identity: _____

Preferred pronouns: _____

Race: _____

Ethnicity: _____

Language (primary): _____

Marital status: _____

Home email: _____

May we contact you through email? _____

Birth date: _____

Today's date: _____

Primary insurance: _____

Policy number: _____

Group number: _____

Policy holder: _____

Policy holder's DOB: _____

Policy holder's phone: _____

Co-pay: _____

Secondary insurance: _____

Policy number: _____

Group number: _____

Policy holder: _____

Policy holder's DOB: _____

Policy holder's phone: _____

Co-pay: _____

ICD code (to be filled by therapist):

_____

_____

All appointments will be billed unless cancelled no less than 24 hours prior or excused by the therapist.

I grant permission to release information requested by my insurance carrier for the purpose of reimbursement. I also authorize insurance payment to be paid directly to my therapist.

_____

Signature of patient or legal guardian

(Next page)

PATIENT INFORMATION, **Continued**

Primary Care Physician:_____ Date of last visit: _____

Current medications: _____

List approximate dates of any previous psychological treatment:_____

_____

Please briefly state the focus of any previous psychological treatment: _____

_____

_____

List your children's names and ages (in birth order)_____

_____

List your parents' and siblings' names and ages (in birth order)_____

_____

Underline or highlight any of the following symptoms that apply to you now:

headache; dizziness; palpitations; stomach trouble; poor appetite; bowel disturbance; chronic fatigue; insomnia; nightmares; alcoholism; chronic tension; panic; specific fears; tremors; depression; "burned-out"; suicidal ideas; drug abuse; unable to relax; sexual problems; unable to have a good time; difficulty relating to others; can't keep a job; inferiority feelings; financial problems; workaholic; job dissatisfaction; high anxiety; child-rearing concerns; unusual visual or auditory experiences; confusion; absence of feelings; loss of control; afraid of "going crazy"; anger control problems; recent losses.

Please briefly state other reasons for seeing Dr. Farrell-Higgins: _____

_____

_____

_____