Jonathan Farrell-Higgins, Ph.D.

PATIENT INFORMATION (ADULT)

Last name: _____

First name: _____

Middle name: _____

Preferred name: _____

Street Address: _____

_____

City: _____

State: _____ Zip Code: _____

Cell phone: _____

Work phone: _____

Home phone: _____

Social Security no.: _____

Birth Date: _____

Sex assigned at birth: _____

Gender identity: _____

Preferred pronouns: _____

Race: _____

Ethnicity: _____

Language (primary): _____

Home email: _____

May we contact you through email? _____

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 Date

Jonathan M. Farrell-Higgins, Ph.D.
3649 SW Burlingame Road, Ste 100 Topeka, KS
785-266-6751

Personal and Family History

If you are comfortable doing so, please respond to these questions so that I can better serve you:

Relationship Status: _____ Single _____ Married _____ Coupled _____ Divorced
_____ Widowed/Widower

Authorized Emergency Contact:

Name: _____ Relationship: _____

Phone Number: _____

Current living arrangement (e.g., alone, family, extended family): _____

_____

Religion/Spiritual Tradition: _____

Employment Status: _____ Type of Employment: _____

Highest Level of Education: _____

Active Service Member or Veteran: _____ Yes (Branch: _____; Years Served: _____) _____ No

Primary Care Physician:_____ Date of last visit: _____

Current psychiatric medications (or bring current medication list to your first appointment):
_____

List approximate dates of any previous psychological treatment:_____

_____

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

_____

Are you having suicidal thoughts or made a recent suicide attempt: _____ Yes _____ No
If yes, please describe: _____

Are you engaged in self-harming behaviors: _____ Yes _____ No
If yes, please describe: _____

Are you in or considering a legal matter (e.g., custody issues, disability case, divorce):
_____ Yes (Describe:_____) _____ No

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Underline 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 your primary reason(s) for seeing Dr. Farrell-Higgins:

_____

_____

_____

What are your goals for therapy (if different from reasons above):

_____

_____

_____

Were you referred to see me? _____ Yes. If yes, by whom: _____

If not referred, how did you locate me? _____

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