Virginia Celmer, IHM, PhD, LCDC
Licensed Psychologist
Licensed Chemical Dependency Counselor

DATE_____

NAME_____BIRTHDATE_____AGE_____ GENDER_____

STREET_____CITY_____STATE_____ZIP _____HOME#_____

WORK_____CELL PHONE_____eMAIL_____

SOCIAL SECURITY#_____OCCUPATION_____

NAME/ADDRESS OF EMPLOYER_____

YOUR MARITAL STATUS____SPOUSE'S NAME_____OCCUPATION_____

NAME/ADDRESS/PHONE OF SPOUSE'S EMPLOYER_____

_____

NAME/PHONE OF SOMEONE TO CALL IN CASE OF AN EMERGENCY_____

_____RELATIONSHIP_____

NAME/ADDRESS OF YOUR PRIMARY CARE PHYSICIAN_____

DATE OF LAST COMPLETE PHYSICAL EXAMINATION_____RESULTS_____

_____

LIST ANY CHRONIC MEDICAL CONDITIONS SUCH AS ASTHMA, ARTHRITIS, ETC_____

_____

PLEASE LIST ANY ALLERGIES THAT YOU HAVE_____

_____

_____

APPROXIMATE CURRENT WEIGHT_____APPROXIMATE WEIGHT ONE YEAR AGO_____HEIGHT_____

CURRENT MEDICATIONS (Name, Strength, How often you take them) _____

_____

_____

_____

HAVE YOU SEEN A MENTAL HEALTH PROFESSIONAL BEFORE? YES NO IF YES, WHOM DID YOU SEE, WHEN, FOR HOW LONG AND FOR WHAT REASON? _____

HAVE YOU EVER BEEN HOSPITALIZED FOR MENTAL HEALTH REASONS? YES NO IF YES, WHEN, WHERE AND FOR WHAT REASON? _____

HAVE YOU HAD ANY SURGICAL PROCEDURES OR HOSPITALIZATIONS? YES NO

DATE REASON

WHO REFERRED YOU TO THIS OFFICE? _____

MAY WE HAVE YOUR PERMISSION TO THANK THIS PERSON FOR THEIR REFERRAL OF YOU TO THIS OFFICE?

PLEASE CIRLE AND INITIAL YOUR PREFERENCE: _____YES _____NO _____DOES NOT APPLY

WHAT CONCERNS BRING YOU TO THIS OFFICE TODAY? _____

_____ _____

Signature of person completing this form Date

OFFICE USE ONLY:

DIAGNOSIS _____

INSURANCE COMPANY _____ CO-PAY AMOUNT _____

INSURANCE COMPANY _____ CO-PAY AMOUNT _____