Karen Fox, Ph.D.
Client Information

***Note**:* If you have been a patient here before, please fill in only the information that has changed.

Date:
_____Name_____AGE:_____Sex_____

Street Address:_____City_____State_____

Zip:_____ Phone (Hm) _____(Wk)_____(Any restrictions on calling?)_____

Cell:_____DOB:_____SS#_____Dr. Lic. #_____

Place of Birth_____ e-mail: _____

Marital Status (circle): Marr. Div. Single If Single, indicate: Live-in-relationship Engaged

Separated Widowed Previous marriages (if any) How many?_____ 1. From:_____ to _____;

2. From:_____ to _____ **e-mail**:_____

Occupation_____Education_____

Name of Spouse or Parent (if minor)_____

Person to contact in case of emergency_____Phone_____

Relationship_____Address_____

Employer:_____ How long with current employer?_____

Referral Source:_____
May I have your permission to thank this person for the referral? Yes □ No □

Insurance Authorization #_____

Primary Medical Insurance_____Phone # for mental health_____

Subscriber Name_____D.O.B._____ID#_____

Group #_____ Claims Address_____

_____

Secondary Medical Insurance_____ Phone # for mental health_____

Subscriber Name_____D.O.B._____ID#_____

Group #_____ Claims Address_____

All patient accounts are due and payable within 30 days. Any account which is outstanding after 30 days may be charged a rebilling fee of $6.75 per month and/or assigned for collection. If an account which is unpaid after 30 days is assigned to collection, patient agrees to pay all necessary costs, expenses, and reasonable attorney fees which may be incurred by this action.

I consent to assessment and treatment under the care of Karen Fox, Ph.D. Regardless of insurance benefits, I realize that I am fully responsible for charges incurred for treatment rendered and I authorize benefits payable directly to Dr. Karen Fox. I authorize Dr. Fox to release to my insurance company any information necessary to process my insurance claim.

_____ _____

Signature **Date**

DSM –AX-I **Co-pay/Fee**

Your medical care: From whom or where do you get your medical care?

Clinic/doctor's name: _____ Phone: _____

Address: _____

Date of last appt?_____ Major health problems for which you are currently receiving treatment:_____

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she may be fully informed and we can coordinate your treatment? □ Yes □ No

Current medications (both prescription and over-the-counter); use back of sheet if you need more room:

_____

_____

Please circle any of the following items that represent problem areas for you:

Abandonment	Drug Use	Loss of Control	Sex/Sexual Functioning	Other:_____
Alcohol Use	Family	Low Energy	Shyness	_____
Ambition (too much/ too little)	Fears/Phobias	Memory	Smoking	_____
Anger	Finances	Nightmares	Social Skills	_____
Anxiety/Nervousness	Friends	Non-assertiveness/ passivity	Stomach Disorder	_____
Appetite (loss of/ Excessive)	Gambling	Obsessive thoughts	Stress	
Backaches	Grief	Panicky Feelings	Suicidal Thoughts	
Being a Parent	Guilt	Perfectionism	Temper	
Bowel Disturbance	Habits/ Compulsions	Procrastination	Tension	
Career Choice(s)	Headaches	Relationships	Tiredness/Fatigue	
Children	Health	Relaxation	Trust	
Communication Skills	Home Conditions	Self-Confidence	Unhappiness	
Concentration	Inferiority feelings	Self-Control	Weekends/Vacations	
Decisions	Insomnia	Self-Esteem	Work	
Depression	Legal matters	Separation	Play	
	Loneliness			

Please list all members of your immediate family (both current and family of origin –-- continue on the back of this sheet If you need more space).

Name(s)	Age	Relationship	Marital Status	Occupation	Live with you (Y/N)

Is there any history of mental illness in your family? Alcoholism? Depression? Please explain_____

_____

Please indicate any individual(s) whom you think it might be useful for me to confer with (given your signed release) during the course of your treatment (e.g., your physician, attorney, parent child(ren), etc.):

_____

_____

Please add any additional information you think may be helpful in understanding you, your situation and problem(s) better:

_____

_____

What is the problem you would like help with at this time?_____

_____

_____

When did it begin (or how long has it been going on)?_____

What is the worst part of the problem for you?_____

_____

Thank you for your patience in completing this questionnaire.