**ROBERT E. MATEFY, PH.D.**

Date:

Name of Client: (If the client is a child, please answer all questions on their behalf)

Address & Town (include zip code): Phone: (H) (W) (Cell) E-mail address:

Session reminders? Circle your choice(s): text message/ automated call to cell phone/ automated call to home phone

Social Security Number: DOB: Age: Circle Marital Status: Single Married Divorced Separated Widowed

Living together

Occupation: Where: Education or grade: Where: Spouse: Occupation of spouse Referred by: Primary Care Physician: PCP Address and Phone: Emergency Contact: Phone (H): (W): Relationship to Client:

Family Members

Name DOB School & Grade, or Marital Status &/or Occupation

What is the ethnic, cultural, and religious heritage of the client? It often helps with the treatment planning.

PRESENTING PROBLEM(S)

Reason(s) for seeking counseling:

Date and circumstances of the first occurrence of the problem:

**IMPORTANT FOR TREATMENT SUCCESS:** Which words listed below best describe how you (or your child) feel and behave at present? Which words describe problems that we should discuss? **Circle all that apply.**

Anxious Low Self-esteem

Fearful Over-sleeping

Worried Trouble Falling or Staying Asleep

Depressed Eating Problems (No Appetite or Overeating)

Sad Purging or Binging

Manic or Extremely Elevated Mood (i,e. Euphoria) Weight Loss

“Flat” Affect Weight Gain

Panic Attacks Body Aches and Pains

Irritable Thoughts of Hurting Self

Grieving Carried Out Plan to Hurt Self

Hopeless Thoughts of Physically Hurting Other(s)

Helpless Actually Physically Hurt Another Person

Worthless Victim of Abuse (Sexual, Physical or Emotional)

Lonely

Excessive or Inappropriate Anger or Rage Problems of Childhood **(16 years or younger)**

Mood Swings Isolates from Family

Guilty Withdraws from Social Interaction

Apathetic Excessive Clinging to Mother or Father

Restless/Fidgety/Hyperactive Fear of Being Alone

Decreased Energy Avoids Group or Team Activities

Compulsive Spender or Shopper Excessive Passive or Obedient

Other Uncontrollable Habits or Compulsions Cruel to Pets

Disorganized Impulsive Behavior

Aggressive/ Assaultive Dangerous Risk Taker

Irrational or Disruptive Thoughts Poor Attention Span

Tics/ Tremors Easily Distracted

Impulsive Unusually Sad, or Depressed

Oppositional/ Defiant Excessive Sibling Rivalry

Marriage or Love Relationship Problem Mean to Playmates/ Classmates

Sexual Difficulties Victims of Bullying

Alcohol Abuse Oppositional Defiant

Drug Abuse Poor Conduct in School or Home

Uncontrollable Gambling Soiling Underwear

Reclusive/ Socially Withdrawn Holding Bowel Movements

Poor Judgment Rituals/ Compulsive Actions

Poor Insight Inappropriate Sexual Behavior

Delusional Excessive Anxiety or Fears

Excessively Suspicious/ Paranoid Refuses to Attend School,

Hallucinations Academic Underachievement

Racing Thoughts

Disoriented What other problems would you like to

Obsessive Thoughts, Can’t Get Them Out of Your Mind discuss about **yourself** or your **family**? Memory Problems

Dissociation/ Blank periods Concentration/ Attention Problems Distractable

Confused

Which of the following areas in life are causing **undue stress** now? **Circle all that apply.**

|  |  |  |
| --- | --- | --- |
| Family | Legal | Health Concerns |
| Marriage | Living Quarters | Sports |
| Children | Finances | Friends |
| Parents | School | Life Change |
| Job | Love Relationship | Death or Other Loss |
| Traumatic event | Other? |  |

**HISTORY**

**Psychological/Psychiatric History**: Include all prior treatment for **mental health, alcohol, or other drug problems, including medication.**

Are there any psychological/psychiatric disorders among family members? Include extended family up to grandparents.

**Medical History** (Please include medical problems relevant to the current psychological issues.)

When was the **last medical exam**? Findings?

**Developmental History**: For children and adolescents up to18 years of age, please describe important **prenatal and perinatal events**, along with a **developmental history** that includes essential **physical, psychological, social, intellectual**, and **academic** milestones. Is there anything else I should know about your child’s developmental history?

**School Functioning**: Please describe how they currently function in school (academically and socially).

Are you experiencing any of the following **medical symptoms**?

Palpitations or pounding heart Dizziness or fainting

High blood pressure Shortness of breath

Chronic fatigue Kidney disease

Stomach pains Stroke

Chronic pain Jaundice/liver disease

Headaches (severe or often) Arthritis/gout/rheumatism

Overeating/too little AIDS/HIV positive

Tremor or shakiness Hypoglycemia

Indigestion, nausea, gas Tumor/cancer

Recent weight gain/loss Venereal disease

Nosebleeds Diabetes

Eye problems Epilepsy/seizures

Hearing problems/earaches Neurological disease

Head injury Lupus

Thyroid trouble Ulcer

Asthma OB-GYN problems (females)

Chronic cough Multiple sclerosis

Tuberculosis Urination problems

Heart trouble/heart attack Pregnant or planning (females)

Stomach/bowel problems Other? Prostate trouble (males)

**Allergies**: Please list all allergies (food, plants, animals, medicine, etc.) and side effects or adverse reactions.

Except as prescribed by an MD, please **circle** the drugs used and indicate the date of last use and the typical amount.

Heroin Sedatives

Cocaine LSD, other hallucinogens,

Marijuana (Medical or Recreational) Amphetamines

Tranquilizers Over-the-counter drugs

Barbiturates Other drugs?

Were you tested for any **drug/alcohol abuse**? If yes, **when, where,** and **by whom**?

How much and how often do you use the following items? If not applicable, please indicate.

**Caffeine** products (coffee, tea, soda, etc) **Cigarettes Alcohol**

Have you ever attempted **suicide**? If yes, please provide the dates and details.

Has anyone in your family or close relatives ever attempted **suicide**? If yes, please provide details.

# INSURANCE INFORMATION

**Primary** Insurance Company: Policy Holder’s Name: Policy Holder’s ID#: Policy #: Group #: Employer:

**Secondary** Insurance Company: Policy Holder’s Name: Policy Holder’s ID#: Policy #: Group #: Employer:

# CONSENT FOR TREATMENT

**I authorize and request that Robert E. Matefy, Ph.D., carry out mental health counseling, diagnostic procedures, and mental status examinations that, now or during my care as a patient, are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the counseling course is designed to be helpful, it may sometimes be difficult and challenging.**

X

**Signature** of Client (Parent/Guardian if the client is a minor) Date

# RELEASE OF INFORMATION FOR BILLING AND DIRECT PAYMENT TO DR. MATEFY

I authorize the release of information for claims, certification/case management/quality improvement, and other purposes related to the benefits of my Health Plan. I further authorize payment of medical benefits from my Health Plan directly to Dr. Matefy. Please note that Melissa Velez of MV Medical Billing, LLC manages billing.

**X Signature** of Client (or Parent/Guardian if the client is a minor) Date

# EXCHANGE OF INFORMATION WITH MY PRIMARY CARE PHYSICIAN

**Note: Exchanging medical and psychological/psychiatric information is essential for the continuity of care with your health provider(s). If you have any questions, do not hesitate to discuss them with me.**

I (name of Client or Parent/Guardian) authorize Dr.

Robert E. Matefy and

(Name of Primary Doctor) to exchange information regarding my (or my child’s) mental health/substance abuse treatment and medical healthcare for continuity of care purposes as may be necessary for the administration and provision of my healthcare coverage and treatment. The information exchanged may include information on mental health care or substance abuse treatment. I understand that this authorization shall remain in effect for one year past the course of this treatment. I understand I may revoke this authorization by written notice to Dr. Matefy. I understand that information used or disclosed according to the authorization may be subject to re-disclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule.

**X Signature** of Client (or Parent/Guardian if the client is a minor) Date

**NOTICE OF PRIVACY PRACTICES**: In accordance with the Health Insurance Portability & Accountability Act (“HIPAA”), the ‘” Notice” of Psychologist’s Policies and Practices to Protect the Privacy of Your Health Information, which describes how I may use and disclose your protected health information (“PHI”), your privacy rights regarding your PHI and my obligations concerning the use and disclosure of your PHI is available for review upon your request..

**X Signature** of Client (or Parent/Guardian if the client is a minor) Date

**CANCELLATION POLICY:** I understand that when an appointment cannot be kept, I must cancel 24 hours before the appointment. I will be charged a $50 fee that cannot be processed through my medical insurance if I don’t cancel my appointment in a timely manner. Of course, legitimate emergencies will be exempted from this cancellation policy.

**X Signature** of Client (or Parent/Guardian if client is a minor) Date

Revised 12/23