Mark MacDonald & Associates, PC

600 West Roosevelt Rd., Suite A2, Wheaton, IL 60187 | phone: 630.462.8810 | fax: 630.462.8820 | email: info@mmacounseling.com

CLIENT CONTACT INFORMATION

Today's Date: _____

Client Name: _____

Street Address: _____

City, State, Zip: _____

Primary Phone: _____ ☐ Cell ☐ Home ☐ Work May we leave a message? ☐ Y ☐ N

Secondary Phone: _____ ☐ Cell ☐ Home ☐ Work May we leave a message? ☐ Y ☐ N

Email Address: _____ May we contact via email? ☐ Y ☐ N

Date of Birth: _____ Age: _____ Gender: ☐ Male ☐ Female

I authorize Mark MacDonald & Associates, PC to leave a message containing medical, appointment or billing information as indicated above. *I understand that if no selection is made, no messages will be left.*

Signature: _____ Date: _____

CLIENT & FAMILY INFORMATION

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Remarried

Your Spouse's Name (if applicable): _____ Age: _____

Names and Ages of Children (if applicable):

Name:_____ Age: _____ Name: _____ Age:_____

Name:_____ Age: _____ Name: _____ Age:_____

Is religion an important part of your life? ☐ Yes ☐ No ☐ Uncertain Affiliation: _____

Would you like your faith to be an explicit part of treatment? ☐ Yes ☐ No ☐ Indifferent

Work Status: ☐ Employed, full-time ☐ Employed, part-time ☐ Unemployed ☐ Student

Place of Employment/School: _____

Highest Education Level: ☐ Jr. High ☐ High School ☐ Trades ☐ College ☐ Advanced **Ave. Grades**:_____

Have you sought counseling in the past? ☐ Yes ☐ No Reason: _____

Please list counselor names and dates of treatment: _____

Please briefly describe your reasons for seeking counseling today: _____

_____

_____

REFERRAL INFORMATION

How did you hear about us? *Please circle from the options below:*

Friend Doctor Professional Internet Insurance Co. Phone Book Other

Referrer & Address: _____

May we send a note of thanks to this person for their referral? If so, we can identify you by name or omit your name; which would you prefer? Please indicate your preference by initialing next the appropriate response.

_____*Yes, you may use my name* _____*Yes, but please omit my name* _____*Please do not send a thank you note*

For office use only **DSM:** **CPMT:**

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RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge receipt of the Notice of Privacy Practices from Mark MacDonald & Associates, PC. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information. I understand that my therapist has reserved the right to change the privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available.

Signature: _____ Date: _____

CANCELLATION POLICY

Mark MacDonald & Associates, P.C. would like to make you aware of our 24-hour cancellation policy. A reserved time has been set aside especially for you, and when missed, that time cannot be used to see another client. Therefore, 24 hours notice is required to cancel at no charge, otherwise full fees will apply. Thank you for your attention to this policy.

Signature: _____ Date: _____

COMMERCIAL INSURANCE

I hereby authorize release of information necessary to file a claim with my insurance company. I hereby assign benefits otherwise payable to me to Mark MacDonald & Associates, PC. The assignment and authorization will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges incurred for services rendered to me, and I hereby agree to pay all charges that exceed or that are not covered by insurance.

Name of Insured: _____ Relationship: ☐Self ☐Spouse ☐Dependent

Subscriber ID: _____ Group Number: _____ Birthdate: _____

Signature: _____ Date: _____

ACCOUNT PAYMENT AGREEMENT

Full payment of your account is expected at time of service. If you are using insurance and your benefits have been confirmed, you will be expected to pay the patient responsibility amount only (e.g., copay/coinsurance). If this is your first visit or your benefits remain unconfirmed, you will be required to pay the full amount for your visit. Once your benefits are confirmed, any overpayment will be applied to your account or reimbursed to you. Alternatively, your credit/debit card may be placed on file as assurance of payment. In this case, your card will be charged for any account balances owed by the client. This amount includes the patient responsibility amounts as determined by your insurance company or missed appointment fees as described above.

I/We hereby authorize Mark MacDonald & Associates to charge this credit card for payment due by the patient. Any overpayment on my account will be credited back to my card. My credit card statements will serve as a receipt of payments processed. My signature below designates my signature for such charges. This authorization is to remain in effect until revoked in writing and delivered to Mark MacDonald & Associates. In the event that charges are processed incorrectly please provide your name, telephone number, and a brief written explanation of the problem and we will make any necessary adjustments to your account within 15 days. After 60 days all charges will be assumed to be correct.

Name on Card: _____ Signature: _____ Date: _____

Card Number: _____ Exp Date: _____ CVC# _____

Street Address and ZIP Code: _____

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SYMPTOMS CHECKLIST

Today's Date: _____

Client Name: _____

Person Completing Form (if different from Client): _____

Please indicate ( ) how often the following symptoms have occurred for the client <u>in the last six months</u>.

SYMPTOM	Never or Rarely	A few times per month	Nearly every day	SYMPTOM	Never or Rarely	A few times per month	Nearly every day
Guilty Feelings				Hopeless About Future			
Worrying				Thinking about Death			
Too Much Energy				Thinking about Suicide			
Aggressive				Problems with Family Members			
Uncontrolled Temper				Brooding about the Past			
Afraid of Work/School				Crying Excessively			
Afraid of Leaving the House				Feeling Sad or Down			
Excessive Sexual Appetite				Nightmares			
Problems Falling Asleep				Feeling Anxious			
Problems Staying Asleep				Feeling Panicky			
Memory Loss				Problems with Anger			
Trouble Making Decisions				Feeling Jealous			
Feeling Alone				Feeling Impatient			
Difficulty Concentrating				No Confidence in Self			
Sudden Mood Changes				Shortness of Breath/Chest Pains			
Restlessness				Fast Heart Beat			
Easily Distracted				Unwanted Thoughts/Fantasies			
Problems Getting Along with Others				Pornography Use			
Feeling Worthless				Feelings of Unreality			
Overly Tired				Lying			
Poor or No Appetite				Problems at Home			
Overeating				Alcohol Use			
Binging				Drug Use			
Preoccupation (Food, Sex, Thoughts)				Blackouts			
Vomiting				Stomach Problems			
Sleeping Too Much				Uncontrolled Thoughts			
Hearing Voices				Uncontrolled Behavior			
Problems at Work/School				Physical Abuse of Self or Others			
Stealing				Emotional Abuse of Self or Others			
Other:				Other:			

CURRENT MEDICAL CONDITIONS & PRESCRIBED MEDICATION

How frequently do you consume alcohol? _____ How frequently do you use drugs? _____

How frequently do you use tobacco? _____ How frequently do you exercise? _____

Please describe any present medical conditions: _____

_____

_____

Please list names and dosages of current prescribed medications:

Med: _____ Dosage: _____ Med: _____ Dosage: _____

Med: _____ Dosage: _____ Med: _____ Dosage: _____

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FAMILY OF ORIGIN COMPOSITION

Client Name: _____ Date: _____

Family of Origin

Father: _____ Age: _____ Mother: _____ Age: _____

Do you have stepparents? ☐ Yes ☐ No

Step Mother: _____ Age: _____ Step Father: _____ Age: _____

Siblings (please list sibling names and ages below):

Name: _____ Age: _____ Name:_____ Age: _____

Name: _____ Age: _____ Name:_____ Age: _____

Name: _____ Age: _____ Name:_____ Age: _____

FAMILY AND EXTENDED FAMILY MENTAL HEALTH HISTORY

Please indicate ( ) which of the following mental health conditions have affected <u>you</u>, <u>your spouse</u>, or <u>others in your extended family</u>. Where relevant, please describe further.

Mental Health Conditions	Client	Spouse	Extended Family	Please Describe
Depression				
Anxiety				
Bipolar (Manic-Depressive)				
Alcohol/Drug Abuse				
Promiscuity (affairs, pornography, poor boundaries)				
Eating Disorders (overweight, anorexic)				
Abuse (physical, sexual, verbal, emotional)				
Other _____				
Other _____				

ADDITIONAL INFORMATION

Please indicate any other medical, interpersonal, or family history information that you would like your counselor to know in order to better serve you. If applicable, please include any history of verbal, physical, or sexual abuse.

_____

_____

_____