**Welcome to Auxilium Mental Health**

**PATIENT**: This section for the patient only: Date\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex \_\_\_\_\_Age\_\_\_\_\_ Spouse\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_Zip \_\_\_\_\_\_\_\_ Drivers License # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status M S D SEP W

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_ Zip\_\_\_\_\_\_\_ Work Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Please sign here if you authorize Justin LaPilusa, Psy.D. and/or his associates to contact this person in the case of an emergency.

How did you hear about our practice? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RESPONSIBLE PARTY FOR BILL** if other than patient:

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_ Zip\_\_\_\_\_ Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_Zip\_\_\_\_\_

Home phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please Check One:

Private Insurance ( ) Cash ( )

**PRIMARY** Insurance Carrier **SECONDARY** Insurance Carrier

Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_Zip\_\_\_\_\_\_\_

Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INSURED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ INSURED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(name on insurance card) (name on insurance card)

Insured’s Relationship to Patient: Insured’s Relationship to Patient

Self ( ) Spouse ( ) Child ( ) Other ( ) Self ( ) Spouse ( ) Child ( ) Other( )

INSURED ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ INSURED ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group or Plan # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group or Plan # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Effective Date of Insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Effective Date of Insurance \_\_\_\_\_\_\_\_\_\_\_\_\_

Authorization to pay benefits to provider: I hereby authorize payment direct to Auxilium Mental Health of the Insurance benefits otherwise payable to me, and authorize release of information necessary to process a claim with my insurance company. I hereby accept responsibility for any charges not covered by my insurance, and for missed appointments or cancellations with less than 24-hour notice. A copy of this signature is valid as the original. Please also see informed consent document.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(if a minor, parent or guardian must sign)

**PROBLEM CHECK LIST**

Below is a list of troublesome problems which many people often face. Read each one and place a ( √ ) before those items of concern to you. Place two ( √ √ ) before those items which are of the **most** concern to you.

\_\_\_ Slow in getting acquainted with people \_\_\_\_ The idea that something is wrong with \_\_\_ Feelings of worthlessness my mind

\_\_\_ Physical health complaints \_\_\_\_ Trouble controlling my temper

\_\_\_ Feeling tired much of the time \_\_\_\_ Lacking self-control

\_\_\_ Concerned about physical or sexual abuse \_\_\_\_ Marital Problems

in my family \_\_\_\_ Not reaching the goal I set for myself

\_\_\_ Sometimes bothered by thoughts of insanity \_\_\_\_ Sexual problems

\_\_\_ Trouble falling asleep \_\_\_\_ Boredom

\_\_\_ Feeling inferior \_\_\_\_ Too little social life

\_\_\_ Being watched or talked about by others \_\_\_\_ Feelings of guilt

\_\_\_ Thoughts of suicide \_\_\_\_ Being made fun of

\_\_\_ Not knowing what I really want \_\_\_\_ Wondering if I’ll find a suitable mate

\_\_\_ Poor appetite \_\_\_\_ Being ill-at-ease with other people

\_\_\_ Trouble in keeping a conversation going \_\_\_\_ Legal problems

\_\_\_ Awakening in the early morning \_\_\_\_ Trouble concentrating

\_\_\_ Depressed “down in the dumps” \_\_\_\_ Can’t forget some mistake I’ve made

\_\_\_ Concerned about my alcohol use \_\_\_\_ Dissatisfied with current job

\_\_\_ Wanting love and affection \_\_\_\_ Afraid I might hurt someone

\_\_\_ Having feelings of extreme loneliness \_\_\_\_ Difficulties in raising my children

\_\_\_ Nervousness, or finding it difficult to relax \_\_\_\_ Being timid or shy

\_\_\_ Not knowing where I belong in the world \_\_\_\_ Financial problems

\_\_\_ Finding things to do in my spare time \_\_\_\_ Difficulty remembering things as I \_\_\_ Spells of terror or panic once could

\_\_\_ Concerned about my drug use \_\_\_\_ Hearing voices that other people do not hear

Please tell us about any other special problems or issues that you would like to discuss**:**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_