McDaniel's Consulting & Counseling, Inc.

130 Tibet Ave. Ste. 107 • Savannah, GA 31406 •Tel. 912-349-0030• Fax 912-349-7708
e-mail:info@mcdanielscounseling.org • Website: mcdanielscounseling.org

Today's Date:____/_____/____

Patient's Full Name:
Mr./Miss/Ms./Mrs./Dr._____ SSN:_____

Patient's Address_____ City_____ State_____ Zip_____

Home#:_____ Can we leave a message?_____ How should we identify ourselves?_____

Patient's Place of employment:_____ Wk#:_____

Cell#:_____ Can we leave a message?_____ How should we identify ourselves?_____

Age:_____ DOB:____/____/_____ Single /Married /Divorced /Separated /Widowed Ethnicity:_____

Highest education completed: elementary to high school_____ College:_____ Highest degree earned:_____

Name of school attended/attending_____

If patient is a minor and if parents are separated or divorced, with whom does the patient reside?_____

Which parent has the legal right to authorize treatment?_____

Mother's Name:_____ DOB:____/____/_____ Phone#:_____ wk#:_____ cell#_____

Father's Name:_____ DOB:____/____/_____ Phone#:_____ wk#:_____ cell#_____

Have you had any prior treatment with a therapist?_____ If yes, When?_____ How long?_____

How did you hear of our practice?_____

Presenting Complaint *Please check any that* ***presently*** *applies to you, the patient.*

___Tension	___Obsessions	___Divorce	___Anger
___Fatigue	___Panic Attacks	___Custody Issues	___Violence
___Fear	___Eating Disorder	___Marital Problems	___Self-Esteem
___Anxiety/ Nervous	___Nightmares	___Parent/Child Conflicts	___ADD/ADHD
___Stress	___Bed Wetting	___Problems w/ Conduct	___Childhood Problems
___Depression	___Insomnia	___Alcohol Abuse/Addiction	___Work Problems
___Suicidal Thoughts	___Hallucinations	___Drug of choice	___Other_____

Do you have any legal problems?_____ If yes, explain_____
_____

I have received a copy of the Notice of Counselors' Policies and Practices to Protect the Privacy of Health Information

_____ ___/___/____ _____
Signature of Client (over 18) Date Signature of Legal Guardian (over 18)

_____
Relationship to Patient

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Do you want us to receive or give information to your Primary Care Physician (PCP)/Pediatrician? ____yes ____no

PCP/Pediatrician's name:_____ Phone:_____

Address:_____

If yes, please complete and sign a Release of Information form

Are you currently on any medication(s)? ____yes ____no (Please list all medications for last six months)

Medications	Dosage/Quantity	Diagnosis
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you been in a car or any accident recently that resulted in injury? ____yes ____no If yes, explain_____

_____

Date of accident:____/____/_____ Are you still in treatment for the injury?____ yes ____no

Doctor/Facility_____ Phone#:_____

Responsible Party for Payment

Full Name:_____ DOB:____/____/_____ SSN:_____

Address:_____ City:_____ State:_____ Zip:_____

We accept insurances. Our policy is that all services are to be paid in full at the time of visit; this includes the copayments and sessions cancelled without a 24 hour notice.
I have read and understand this statement:_____
Date:____/____/_____

Printed name

_____
Signature

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In Case of Emergency: Please list two people we may contact in case of emergency

Name:_____ Relationship:_____

Tel.#_____

Name:_____ Relationship:_____

Tel.#_____

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Family/Significant Relationships

List immediate family members according to order of birth (including deceased):

Relationship/Name	Age	Education	Occupation	Present Health	

Did anyone else live with you while you were growing up? If so, please fill in the following:

Name/Relationship	Age	Education	Occupation	Present Health	

Describe your mother:_____

Describe your father:_____

Who did you get along with best in your family?_____

Who are you closest to now?_____

Who did you have a difficult relationship with and why?_____

_____

_____

Please describe your current relationship status: (□single □monogamous □married □engaged □dating □ other_____)

If in a relationship, how long? _____

Any relationship problems? □Yes □No

Describe your current relationship/significant other:

_____

_____

_____

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Medical History

Is there a family history of or have you ever had any of the following problems?

Yes	No		Which relative	Approx. age at onset
___	___	Headache		
___	___	Aneurysm or malformation		
___	___	Movement Disorder		
___	___	Shakes or tremors		
___	___	Convulsions, seizures or epilepsy		
___	___	Sleep Disorder		
___	___	Intellectual deterioration before age 60		
____	___	Other neurological disorder		

Is there a family history of or have you ever had any of the following psychiatric problems?

Yes	No		Which relative	Approx. Age at onset
___	____	Depression		
___	____	Mania		
___	____	Suicide or attempts		
___	____	Anxiety or panic disorder		
___	____	Eating disorder		
___	____	Paranoia		
___	____	Schizophrenia		
____	____	Substance abuse		
____	____	Hospitalization for mental illness		
____	____	Outpatient treatment for mental illness		
____	____	Untreated mental illness		

Is there any other known inherited illness in your family? Yes_____ No_____

If yes, which:_____

How often do you usually see a doctor? _____

Do you have a vision problem? Yes _ No____ If yes, please describe_____

Do you wear glasses? Yes _ No ___ If so, how long have glasses been worn?_____

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Do you have a hearing problem? Yes__ __ No____ If yes, describe briefly_____
_____

Do you have a hearing aid? Yes___ _____No____ If so, do you wear it? Yes____ No_____

Was a hearing aid ever suggested by a doctor? Yes___ ____No_____

Substance Use

Please indicate non-prescribed substances you have used, even if only a few times.

Ever used (Check all that apply)		**How often**	**Age of first use**	**Last time used**	**How much**
	Alcohol				
	Cigarettes				
	Tranquilizers				
	Glue/Paint Sniffing				
	Marijuana				
	LSD ("Acid")				
	PCP ("Angel Dust")				
	Amphetamines				
	Cocaine				
	Other				

List any substance abuse treatment programs in which you have participated:

When (Dates)	Facility (Name and address)	How long	Substance(s) treated for

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