



**MEDICAL/PROFESSIONAL**

LIST CURRENT ILLNESSES AND RECENT SURGERIES \_\_\_\_\_

CURRENT MEDICATIONS AND DOSEAGES \_\_\_\_\_

HOW MUCH DO YOU USE: TOBACCO? \_\_\_\_\_ ALCOHOL? \_\_\_\_\_ CAFFEINE? \_\_\_\_\_

LIST ANY PRIOR PSYCHOTHERAPY (type of treatment, provider, length of treatment, outcome)

BRIEFLY DESCRIBE YOUR PRESENT DIFFICULTIES \_\_\_\_\_

HAVE YOU HAD ANY HISTORY OF SELF-INJURIOUS BEHAVIOR, SUICIDAL IDEATION, OR SUICIDE ATTEMPTS? IF SO, PLEASE DESCRIBE. \_\_\_\_\_

HAVE YOU HAD A HISTORY OF HARM/ABUSE AGAINST OTHERS? IF SO, PLEASE DESCRIBE. \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

PHONE \_\_\_\_\_

NEUROLOGIST \_\_\_\_\_

PHONE \_\_\_\_\_

PSYCHIATRIST \_\_\_\_\_

PHONE \_\_\_\_\_

ALLERGIES/ADVERSE REACTIONS TO MEDICATIONS OR OTHER SUBSTANCES: \_\_\_\_\_

REFERRAL SOURCE? \_\_\_\_\_

I hereby apply for evaluation, treatment and other services offered to me by Rich Morey, Ph.D. I am aware that the practice of psychotherapy is not an exact science, and I acknowledge that no guarantees have been made to me regarding the results of treatment. As I completed the insurance information on page 1 this indicates that I am asking Dr. Morey to bill my insurance on my behalf. I am authorizing Dr. Morey to release the required information to process this claim and to have payment sent to Dr. Morey. Yet, even though Dr. Morey provides this billing service--I understand that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read the information on these two pages and have completed the above items. This information is true and correct to the best of my knowledge. I will notify Dr. Morey of any changes in my health, emotional status, or above information.

\_\_\_\_\_  
Signature

Date \_\_\_\_\_

\_\_\_\_\_  
Parent (if patient is a minor)

Date \_\_\_\_\_