Hornstein, Platt & Associates™
COUNSELING & WELLNESS CENTERS OF PHILADELPHIA

255 South 17th Street, Suite 1010, Philadelphia, PA 19103 O# 215-732-6308 F# 215-732-8240
WWW.HPTHERAPY.COM

Complete ALL sections (I-II-III) of this form and bring with you to your appointment. This will ensure that we have more time to discuss your current concerns.

Thank you!

I. Universal Consent

By signing below, you agree to the content, as listed below and provided to you, in a separate document, in their entirety. This Universal Consent will be held and maintained until and through the length of your treatment with Hornstein, Platt and Associates.

1. *Notice of Privacy Practices*
2. *Policies and Procedures*
3. *Consent to Treatment*
4. *Member's Rights and Responsibilities*

_____

Print Client Name (*or person acting for client*)

_____ _____

Client Signature (*or person acting for client)* Date

If client is under 14 years of age:

_____

Print Parent/Legal Guardian #1 Name

_____ _____

Parent/Legal Guardian #1 Signature Date

_____

Print Parent/Legal Guardian #2 Name

_____ _____

Parent/Legal Guardian #2 Signature Date

_____ _____

Signature of Provider

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Thank you!

II. New Patient Registration Form (please attach separate page if more space is needed)

Client Name:

_____

Last First Middle Initial

Birth Date: _____ /_____ /_____ Age: _____ Gender descriptor: _____

Emergency Contact:

Name: _____

Last First Middle Initial

Relationship to Patient _____

Telephone: ( ) _____ May we leave a message? □ Yes □ No

Parent / Guardian Contact (if patient is under 18 years)

Name: _____/_____

Last First Phone

Address: _____

Street and Unit / Ste: Number City State Zip

Primary Care Physician

□ **I do** / □ **I do not** wish for my PCP to be occasionally informed about my treatment.

Name: _____/_____

Last First Phone

Address: _____

Street and Unit / Ste: Number City State Zip

Employee Assistance Program (EAP) (skip if you do not have EAP)

Company: _____Authorization Number: _____

Referred by: Please provide contact information so we can contact to thank them:

Name: _____/_____

Last First Phone

Address: _____

Street and Unit / Ste: Number City State Zip

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GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. Have you previously received any type of mental health services?
(e.g. psychotherapy, psychiatric, services, etc.) □ No □ Yes

Name of Therapist(s): _____

2. Have you ever been prescribed psychiatric medication? □ No □ Yes

Please list and provide dates: _____

_____

3. How would you rate your current physical health?
□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good
Please list any specific health problems you are currently experiencing: _____

_____

4. How would you rate your current sleeping habits? (Please check one)

□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good
Please list any specific sleep problems you are currently experiencing: _____

_____

5. How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

6. Please list any difficulties you experience with your appetite or eating patterns: _____

_____

7. Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes

Approximately how long? _____

8. Are you currently experiencing anxiety, panic attacks or have any phobias? □ No □ Yes
When did you begin experiencing this? _____

9. Are you currently experiencing any chronic pain? □ No □ Yes
If yes, please describe _____

10. Do you drink alcohol more than once a week? □ No □ Yes

11. How often do you engage in recreational drug use?
□ Daily □ Weekly □ Monthly □ Infrequently □ Never

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12. Are you currently taking any prescription medication? □ No □ Yes

Please list: _____

_____

13. Do you have any allergies? □ No □ Yes If Yes please list type(s) _____

14. Are you currently in a romantic relationship? □ No □ Yes
If yes, for how long? _____ On a scale of 1-10, how would you rate your relationship? _____

15. Do you enjoy your work/school? Is there anything stressful about your current work/school? _____

_____

16. What significant life changes or stressful events have you experienced recently? _____

_____

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FAMILY MENTAL HEALTH HISTORY

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

		Family Member
Alcohol/Substance Abuse	□ No	□ Yes _____
Anxiety	□ No	□ Yes _____
Depression	□ No	□ Yes _____
Domestic Violence	□ No	□ Yes _____
Eating Disorders	□ No	□ Yes _____
Obsessive Compulsive Behavior	□ No	□ Yes _____
Schizophrenia	□ No	□ Yes _____
Suicide Attempts	□ No	□ Yes _____

ADDITIONAL INFORMATION:

1. Do you consider yourself to be spiritual or religious? □ No □ Yes
If yes, describe your faith or belief: _____

_____

2. What do you consider to be some of your strengths? _____

_____

3. What do you consider to be some of your weakness? _____

_____

4. What would you like to accomplish out of your time in therapy? _____

_____