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 concerns.

Thank you!

I. Universal Consent

By signing below, you agree to the content 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. *Release of Information*
4. *Consent to Treatment*
5. *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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II. Psychiatry New Patient Registration Form

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

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

_____

3. 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: _____

_____

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

What types of exercise do you participate in? _____

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

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

For approximately how long? _____

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

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

_____

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

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

11. Do you have any allergies? □ No □ Yes If Yes, type of allergies _____

13. 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 _____

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Past Medical History: (please include all pre-existing & current medical conditions i.e. asthma, heart conditions etc.)

_____

_____

_____

Past Surgical History: (please include any previous surgeries & Month/year)

_____

_____

_____

Past Psychiatric History: (please include any psychiatric or substance abuse hospitalizations & diagnosis made by a psychiatric provider):

_____

_____

_____

Alergies & Sensitivities to Medications:

_____

_____

_____

Family Psychiatric History: (Examples would be depressions, anxiety, OCD, ADHD,bi-polar DO, addiction, etc. within blood related family)

_____

_____

_____

Current Medication List: Please include OTC medications, Vitamins, Supplements and Birth Control (please attach separate page if more space is needed)

Medication	Dose	Frequency	Purpose

Comments: _____

_____

_____

Previously Psychiatric Medications: (please attach separate page if more space is needed)

Medication	Dose	Frequency	Purpose

Comments: _____

_____

_____

Please list anything else you would like the medical provider to know:

_____

_____

_____

_____

_____

_____

_____

Revision Date: February 26, 2018 – Combined Psychiatry Form
Client name:
Provider Name:

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III. Release of Information

I, _____ _____
Patient Name **Date of Birth** (MM/DD/YYYY)

hereby authorize: **(practitioner's name)**

_____ of **Hornstein, Platt & Associates**

to release information pertaining to my evaluation and or counseling sessions to: (**please check ONE title**)
____ physician _____ parent _____ therapist _____ other _____

_____
Last Name First Name

_____
Street and Unit / Apt. Number

_____
City State Zip

Phone: (_____) _____ _____ FAX: (_____) _____ _____

for the purpose of: (indicate the specific reason)

_____

_____

This request and authorization applies to: (check one)

☐ Treatment Summary

☐ Healthcare Information relating to the following treatment, condition, or date: (enter below)

_____

_____

☐ Other: (enter below)_____

This Authorization Expires at the conclusion of treatment.

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