

Please complete the information below. However, refrain from signing until you have read the Lewis Consulting Services, PA (LCS) Service and Fee Agreement and understand the information. You will have an opportunity to read this agreement in our office when you arrive a few minutes prior to your first appointment. Your signature below indicates that you have read the Services and Fee Agreement and also serves as acknowledgement that you have received the HIPAA Notice.

I have read and understand the LCS Service and Fee Agreement. I agree to the statements and the terms of payment.

Signature of Client Date

Print Signatory Name Legibly

CLIENT INFORMATION:

ADDRESS _____
STREET CITY STATE ZIP CODE

HOME PHONE _____ WORK PHONE _____

CELL PHONE _____ IS IT OK TO LEAVE A MESSAGE? Yes No

PERSONAL EMAIL FOR APPOINTMENTS AND BILLING _____

BIRTH DATE / AGE _____ / _____ ETHNICITY/RACE _____

EMPLOYER _____ JOBTITLE _____

EMERGENCY CONTACT PERSON _____
NAME HOME or CELL PHONE

ADDRESS EMPLOYER WORK PHONE

RELATIONSHIP STATUS AND NAME, AGE, AND RELATIONSHIP OF PERSONS LIVING IN YOUR HOUSEHOLD _____

PHYSICIAN _____
NAME ADDRESS PHONE

CURRENT MEDICATIONS _____

PRIOR THERAPY? ___ Yes ___ No Dates of treatment: _____

Therapist name and address: _____

1. What are the main reasons for seeking psychological services at this time? _____

2. What efforts have you made to deal with these concerns? _____

3. Do you currently have suicidal thoughts? ___ yes ___ no. Have you ever attempted suicide? ___ yes ___ no
4. Do you currently have violent or homicidal thoughts or plans? ___ yes ___ no
5. How often do you drink alcohol? ___ 1 p/month ___ 1-2 p/week ___ daily ___ none
On the days you drink, how many drinks do you usually have? _____
Do you consider it a problem? _____
6. Do you use non-prescription substances? If so, please list what substances and how often. _____
7. Please describe your diet: _____

8. Do you engage in regular exercise? ___ yes ___ no
9. Please check all symptoms that are currently problems for you.

___ anger	___ fears and phobias	___ obsessive thinking
___ anxiety	___ flashbacks	___ procrastination
___ aggressive behavior	___ headache	___ perfectionism
___ attention problems	___ impulsive behavior	___ panic
___ compulsive behavior	___ irritability	___ stress
___ depression	___ learning problems	___ seasonal mood
___ disorganization	___ moodiness	___ worry
___ eating problems	___ negativity	___ passing out
___ sleep problems	___ social anxiety	___ dizziness
___ stomach pains	___ problems w/ friends	___ love relationship concerns
___ sexuality concerns	___ marital problems	___ abuse in past or present
___ tiredness	___ family problems	___ time loss
___ parenting issues	___ guilt	___ academic problems
___ health problems	___ substance abuse	___ bingeing or purging

Referral Source: Please indicate how you heard about our practice.

- ___ Professional Referral (Dr./attorney/etc.) ___ Friend/Colleague ___ Family Member
- ___ Newspaper (Which one?): ___ Carolina Parent ___ Carolina Woman Other _____
- ___ Website (Please tell us how you found our site):
___ psychologytoday.com ___ somethingfishy.org ___ other _____
- ___ Flyer or Brochure (Where did you find this?) _____
- ___ Yellow Pages ___ Other: _____

Information about person who referred you: Name _____

Address _____ Phone _____

May we thank this person? ___ yes ___ no