

PSYCHOLOGICAL RESOURCE ASSOCIATES

1627 Oak Avenue, Suite A
Davis, CA 95616

285 W. Court St., Ste. 202
Woodland, CA 95695

Please provide us with the following information, which will assist us to best serve you. All information will be held in the strictest confidence. Thank you.

Client's Name _____ Spouse _____ Date _____

Address _____ City _____ Zip _____

Phone (____) _____ Age _____ Birth date _____ Marital Status _____

Cell Phone (____) _____ Email Address _____

Referred by: Self Physician _____ Insurance _____ Other _____

Occupation _____ Place of Employment _____ Phone (____) _____

Occupation of Spouse _____ Place of Employment _____ Phone (____) _____

Emergency Contact: _____
Name _____ Relationship _____ Phone (____) _____

EAP clients, please indicate which office is your employer:

AQMD DJUSD Office of Education Yolo County

Other* _____ (*Please complete insurance section below)

In order to better serve your needs, may we send you a confidential survey at the end of your sessions?

No Yes, to my home Yes, to this address _____

PLEASE COMPLETE THIS SECTION IF YOU WILL BE USING HEALTH INSURANCE

Name of Insurance _____ Phone (____) _____

Insurance Billing Address: _____

Subscriber's Name _____ Birthday _____

Insurance I.D. # _____ Subscriber's Social Security # _____

Client's relationship to Subscriber: Self Spouse Child Other _____

Co-Pay Responsibility \$ _____ Is there a deductible? Yes No \$ _____

Is authorization required? Yes No Authorization # _____

DO YOU HAVE A SECONDARY INSURANCE? YES NO

Name of Insurance _____ Phone (____) _____

Insurance Billing Address: _____

Subscriber's Name _____ Birthday _____

Insurance I.D. # _____ Subscriber's Social Security # _____

Client's relationship to Subscriber: Self Spouse Child Other _____

Co-Pay Responsibility \$ _____ Is there a deductible? Yes No \$ _____

Is authorization required? Yes No Authorization # _____

Who is your primary physician? _____

When did a physician last examine you? _____

List any major health problems for which you currently receive treatment: _____

List any medications you are now taking: _____

Please check any of the following areas in which you are having problems:

- | | | | |
|--|---|-------------------------------------|--|
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Depression | <input type="checkbox"/> Fears | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Sexual problems | <input type="checkbox"/> Shyness | <input type="checkbox"/> Family | <input type="checkbox"/> Inability to cope |
| <input type="checkbox"/> Job dissatisfaction | <input type="checkbox"/> Sleep | <input type="checkbox"/> Relaxation | <input type="checkbox"/> Children |
| <input type="checkbox"/> Separation | <input type="checkbox"/> Divorce | <input type="checkbox"/> Finances | <input type="checkbox"/> My thoughts |
| <input type="checkbox"/> Low morale on job | <input type="checkbox"/> Alcohol use | <input type="checkbox"/> Friends | <input type="checkbox"/> Being a parent |
| <input type="checkbox"/> Unhappiness | <input type="checkbox"/> Self-control | <input type="checkbox"/> Anger | <input type="checkbox"/> Temper |
| <input type="checkbox"/> Not motivated at work | <input type="checkbox"/> Stress | <input type="checkbox"/> Drug use | <input type="checkbox"/> Appetite |
| <input type="checkbox"/> Conflict at work | <input type="checkbox"/> Headaches | <input type="checkbox"/> Tiredness | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Legal matters | <input type="checkbox"/> Memory | <input type="checkbox"/> Ambition | <input type="checkbox"/> Marriage |
| <input type="checkbox"/> Making decisions | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Energy | <input type="checkbox"/> Stomach troubles |
| <input type="checkbox"/> Inferiority feelings | <input type="checkbox"/> Concentration | <input type="checkbox"/> Loneliness | <input type="checkbox"/> Bowel trouble |
| <input type="checkbox"/> Health problems | <input type="checkbox"/> Career choices | <input type="checkbox"/> Education | <input type="checkbox"/> Death family/friend |

Briefly describe your reason for seeking help: _____

Have you ever received psychological help or counseling of any kind before? _____

If you have, please describe:

List the members of your family and all others in your home:

<i>Name(s)</i>	<i>Age/Birthday</i>	<i>Relationship</i>	<i>Occupation</i>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

Please add any additional information that you feel may be useful to us: _____

I assign all insurance benefits for which I am entitled to PRA, and authorize PRA to release any information necessary to bill my HMO, Medicare, or private insurance. I acknowledge that I have received a copy of HIPAA privacy regulations from this office.

Guarantor's Signature _____ Date _____

Thank you for completing this questionnaire.

For office use only. Therapist: please complete this portion

Diagnosis _____ Therapist _____

First Seen _____ Other Info: _____

Billing information: