

# Summit Counseling Associates, Inc.

*Helping you succeed in your most important relationships*

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Licensed Marriage & Family Therapist  
Licensed Addiction Counselor

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## Patient Information

PLEASE HELP US PROVIDE YOU WITH QUALITY CARE BY COMPLETING THIS FORM. IF YOU HAVE ANY QUESTIONS, PLEASE ASK.			1.A. INSURED'S ID NUMBER		
2. PATIENT'S NAME (LAST, FIRST, MI)		3. PATIENT'S DATE OF BIRTH (MM/DD/CCYY)	SEX	4. INSURED'S NAME (LAST, FIRST, MI)	
2.A. PATIENT'S SOCIAL SECURITY NUMBER				4.A. INSURED'S SOCIAL SECURITY NUMBER	
5. PATIENT'S ADDRESS (NO. STREET)		6. PATIENT'S RELATIONSHIP TO INSURED SELF SPOUSE CHILD OTHER _____		7. INSURED'S ADDRESS (NO. STREET)	
CITY	ZIP	8. PATIENT STATUS (MARK ALL THAT APPLY)  SINGLE MARRIED OTHER EMPL UNEMP STUDENT (F-T / P-T)		CITY	ZIP
TELEPHONE #				TELEPHONE #	
PATIENT'S EMPLOYER'S NAME		10. IS PATIENT'S CONDITION RELATED TO:		INSURED'S EMPLOYER'S NAME	
9. OTHER INSURED'S NAME (LAST, FIRST, MI)		10.A. EMPLOYMENT (Y / N) 10.B. AUTO ACCIDENT (Y / N) IF YES, WHICH STATE? 10.C. OTHER ACCIDENT (Y / N)		11. INSURED'S POLICY GROUP OR FECA NUMBER	
9.A. OTHER INSURED'S POLICY OR GROUP NUMBER				11.A. INSURED'S DATE OF BIRTH (MM/DD/CCYY)	SEX
9.B. OTHER INSURED'S DATE OF BIRTH (MM/DD/CCYY)				11.B. EMPLOYER'S NAME OR SCHOOL NAME	
9.C. EMPLOYER'S NAME OR SCHOOL NAME				11.C. INSURANCE PLAN NAME OR PROGRAM NAME	
9.D. INSURANCE PLAN NAME OR PROGRAM NAME				11.D. IS THERE ANOTHER HEALTH BENEFIT PLAN? (Y / N) (IF YES, PLEASE COMPLETE 9.A - 9.D)	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
SIGNED		DATE		SIGNED	

Patient's e-mail address for scheduling purposes only. You are not obligated to provide us with an email address.

**Marital Status**

Husband / Male	Wife / Female
<input type="checkbox"/> Single, never married <input type="checkbox"/> Engaged <input type="checkbox"/> Married, first marriage <input type="checkbox"/> Married, second marriage <input type="checkbox"/> Married, third or more marriage <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	<input type="checkbox"/> Single, never married <input type="checkbox"/> Engaged <input type="checkbox"/> Married, first marriage <input type="checkbox"/> Married, second marriage <input type="checkbox"/> Married, third or more marriage <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed

**Emergency Contact Information**

I give my permission to Dr. Craig Loving to contact the above person(s) in case of emergency. I authorize this person to answer questions about my physical and mental health. I understand that I may revoke this authorization at any time by **giving Dr. Loving written notice.**

Signature	Date
Name (Last, First)	Relationship to you
Street Address	
City	Zip
Telephone	Cell

**If client is minor, name of adult seeking treatment**

Name (Last, First)	
Street Address	
City	Zip
Telephone	Cell
Relationship to minor: <input type="checkbox"/> Parent <input type="checkbox"/> Step-Parent <input type="checkbox"/> Legal Guardian	
I have legal right to seek treatment for this minor: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Signature	Date

**Primary Care Physician**

Name	
Address	
City	Zip
Telephone	Date of last visit (approx)
(OPTIONAL) I authorize Dr. Craig Loving to contact my PCP to discuss relevant information concerning medical condition (e.g., diagnosis, prescribed medications, treatment history, etc.). I understand that I may revoke this authorization at any time by <b>giving Dr. Loving written notice.</b>	

How would you describe your **physical health** at present?

- Poor       Unsatisfactory       Satisfactory       Good       Very good

Please list any **current diagnoses** or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

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**Please list any prescription medications you are currently taking**

Name of Prescription	Diagnosis or Condition	Dosage x per day	How long have you taken this medication?

**Please list any over-the-counter medicines that you are currently taking**

Name	Diagnosis or Condition	Dosage x per day	How long have you taken this medication?

**Please list any vitamins or supplements that you are currently taking**

Name	Diagnosis or Condition	Dosage x per day	How long have you taken this medication?

Do you regularly use alcohol?

Yes  No

In a typical month, how often do you have 4 or more drinks in a 24 hour period? \_\_\_\_\_

Do you consider your alcohol use a problem?

Yes  No  Unsure

Has someone told you they are concerned about your alcohol use?

Yes  No

Circle any of the following drugs or medications you have used in the last year.

Hashish Marijuana	Barbiturates Benzodiazepine Flunitrazepam GHB Methaqualone	Ketamine PCP	LSD Mescaline Psilocybin Mushrooms	Codeine Fentanyl Heroin Morphine Opium Oxycodone HCL Hydrocodone Bitartrate Acetaminophen	Amphetamine Methamphetamine Cocaine
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How often do you currently use any of these drugs?

Daily  Weekly  Monthly

If you are currently using any of these drugs, are you concerned about using them?

Yes  No  Unsure

Briefly describe the issue you are seeking help for

PROBLEM INTENSITY: How would you **rate the intensity** of the problem or concern that brought you in? (Check the appropriate number):

1  2  3  4  5  6  
Not Intense Moderately Intense Extremely Intense

How long has this issue been a problem for you?

Briefly describe what you have done to try to resolve this issue

Briefly describe your goal for this issue.

Name(s) of other counselor(s) you have seen about this issue.

(OPTIONAL) I authorize Dr. Craig Loving to contact my previous counselors to discuss relevant information concerning my treatment with them. I understand that I may revoke this authorization at any time by **giving Dr. Loving written notice.**

Signature

Date

**How do you feel generally about changing this issue?**

- Optimistic     Undecided     Pessimistic

**How does this issue affect your *family relationships*?**

- Negative     Neutral     Not a problem yet

**How does this issue affect your *work relationships*?**

- Negative     Neutral     Not a problem yet

**How does this issue affect your *social relationships (friends, associates, church, etc)*?**

- Negative     Neutral     Not a problem yet

**How does this issue affect your relationship with God?**

- Negative     Neutral     Not a problem yet

**How does this issue affect your attitude toward yourself?**

- Negative     Neutral     Not a problem yet

- Have you ever seriously contemplated suicide?  Yes  No
- Have you ever attempted suicide?  Yes  No
- Are you currently considering suicide?  Yes  No
- Have you had a family member or close friend who committed suicide?  Yes  No

**FAMILY BACKGROUND**

Please list the members of your current family, including ages and occupations (e.g. father, 42, lawyer; stepmother, 40, teacher; brother 16, student; etc.)

Please check any past, present, or impending special problems in your family:

- |  |   |
|--|---|
| <input type="checkbox"/> deaths                        | <input type="checkbox"/> divorce                            |
| <input type="checkbox"/> frequent relocations          | <input type="checkbox"/> debilitating injuries/disabilities |
| <input type="checkbox"/> serious illness               | <input type="checkbox"/> psychiatric disorder               |
| <input type="checkbox"/> alcohol/drug abuse            | <input type="checkbox"/> physical / sexual abuse            |
| <input type="checkbox"/> financial crisis/unemployment | <input type="checkbox"/> legal problems                     |
| <input type="checkbox"/> attempted/completed suicide   | <input type="checkbox"/> eating disorders                   |
| <input type="checkbox"/> other                         |   |

Please specify family member(s), which special problem, and approximate year of occurrence (e.g. mother-serious illness, 1998 etc.)

**Have you personally experienced abuse?**

- None  Unsure  Emotional  Physical  Sexual

**Have you personally experienced legal problems?**

- No  Yes

**Did you experience learning difficulties in elementary or high school?**

- None  Little  Some  Substantial

**In general, how happy were you growing up?**

- Poor  Average  Completely

**How much is your immediate family a source of emotional support for you?**

- None  Little  Somewhat  Substantial

**How much is your extended family a source of emotional support for you?**

- None  Little  Somewhat  Substantial

**Who in your family do you currently feel closest to?** \_\_\_\_\_

**Most distant from?** \_\_\_\_\_ **In most conflict with?** \_\_\_\_\_

**How would you rate the quality of your peer relationships?**

- Unsatisfactory  Average  Good  Excellent

Besides family members, approximately who can you count on right now for friendship or emotional support?

\_\_\_\_\_

### HEALTH AND SOCIAL ISSUES

**Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):** \_\_\_\_\_

**Are you having any problems with your sleep habits?**

- No  Yes

(If yes, check where applicable):

- Sleeping too little  Sleeping too much  Poor quality sleep  
 Disturbing dreams  Other

**How many times per week do you exercise?** \_\_\_\_\_ **How long?** \_\_\_\_\_

**Are you concerned about your appetite or eating habits?**

- No  Yes

(If yes, check where applicable):

- Eating less  Eating more  Binging  Restricting

**Have you experienced any significant weight change in the last 2 months?**

- No  Yes

**Do you have any problems or concerns about sexual functioning?**

- No  Yes

(If yes, check where applicable):

- Lack of desire  Performance Problem  Sexual Impulsiveness  
 Difficulties maintaining arousal  Worried about sexually transmitted disease  Other

**Have you ever experienced sexual assault, unwanted sex or uncomfortable touching?**

- Unsure  Never  Once  A few times  Frequently

How did you hear about us?

- Friend, neighbor, co-worker  
 Referral from other counselor  
 Referral from pastor  
 Web search  
 Insurance / EAP referral  
 Other