Please print clearly.

Standish McCleary III, J.D., Ph.D. **Licensed Psychologist**

Confidential Client Information

Client Name: _____ *DOB:*_____

Gender: M F Marital Status: _____

Address:_____ City:_____State:____ Zip_____

Home Phone: _____ Work Phone: _____

Cellular: _____ Email: _____

May messages be left for you at home? ___ Work?___ Cell? ___ Email?____

Insurance Information Please provide a copy of your insurance card(s), front and back, or bring your card(s) to your first appointment so that copies can be made.

Primary Insurance Carrier: _____ Phone: _____
Claims Address: _____City:_____State:____ Zip:_____
Name of Insured: _____ Relation to Client: _____

Insured ID Number: _____ Group Number: _____

Insured DOB: _____ Phone: _____
Employer:_____Insured'sAddress:_____
City:_____ State:_____ Zip: _____

Secondary Insurance Carrier: _____Phone: _____

Claims Address: _____City: _____ Zip: _____
Name of Insured: _____ Relation to Client: _____

Insured ID Number: _____ Group Number: _____

Insured DOB: _____ Phone: _____Employer: _____
Insured's Address: _____City: _____ Zip:_____

I hereby authorize the release of all medical information necessary to process an insurance claim. I understand that I am financially responsible for all charges, regardless of insurance, unless otherwise agreed by Standish McCleary Ph.D. I understand the financial policy established by Standish McCleary Ph.D., and that there is a charge for missed appointments and appointments cancelled with less than 24 hours notice.

Signed: _____ Date: _____

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Confidential Client Information

Client Name:_____

Your Occupation _____ Education_____
Employer_____
Who else lives in your household (name, DOB)
_____
_____
Partner's occupation _____Education _____
Employer _____
Your emergency contact (name, phone) _____
Who referred you to me? _____

What problems led you to see me today?

How much are you bothered by the following symptoms?
(0=not at all, to 10 =severely)

Depression_____ Feeling hopeless _____ Extreme sadness _____

Feeling anxious _____Feeling tearful_____ Trouble concentrating _____
Change in sleeping habits_____ Lack of enjoyment of usual activities _____
Physical Pain _____Memory problems _____Weight changes _____
Self-esteem problem _____ Easily irritated ____ Obsessions or compulsions ____
Problems getting along with friends or family ____ Muscle tension ____
Problems with anger ____ Lack of energy _____ Change in eating habits _____
Mind racing _____ Perfectionism ____ Feeling stressed ____
Trouble performing your job ____ Feeling guilty ____ Feeling fearful ____
Sudden panic _____ Using more alcohol or drugs ____ Acting violently ____
Thought of hurting yourself or others ____ Thoughts of killing yourself or others ____

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Client Name _____

Have you been in counseling before? _____

Who did you see? _____ Dates _____
Explain what happened:

Medical Information

Who is your primary care provider? _____
Phone _____ Date you last saw this person _____
For what problem _____

Please list medications you take, what dose, and for how long (prescription and over the counter):

Are you allergic to anything?

Do you use, or have you used any of the following (if yes, how much and for how long)?
Tobacco in any form _____
Alcohol _____
Current number of drinks per day or per week _____
Caffeine drinks (coffee, tea, cola) _____
Recreational drugs _____