M. Gene Ondrusek, Ph.D.
Clinical and Consulting Psychology

Patient Name _____ **Today's Date**_____

Address _____ **Date of Birth** _____ **Age** _____

City _____ **State** _____ **Zip** _____ **Social Security #** _____

Phone Numbers: Home _____**Work** _____

Cell _____ **Email** _____

Marital Status: **Single** **Married** **Separated** **Divorced** **Widowed** **Living Together**

Employer/School _____ **Occupation** _____

Primary Care Physician _____ **Phone Number** _____

Referred By _____

Insurance Information:

Insurance Company _____ **Policy # / Grp #** _____

Mental Health 800 # _____

Emergency Contact _____

Presenting Problem(s): Please describe your reason for seeing counseling.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

When did this problem begin? Was there an issue that made these issues surface? If so, please describe

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

CLIENT QUESTIONNAIRE

Your cooperation in completing the following questions will be helpful in planning our services for you. Please answer each item carefully and completely. All information is confidential and will not be released without your written approval.

(Please circle any of the following areas in which you are having difficulty)

Nervousness	**Depression**	**Family**	**Abuse**	**Concentration**
Shyness	**Sexual Problems**	**Fears**	**Relationships**	**Bowl Troubles**
Divorce	**Boredom**	**My Thoughts**	**Self-Esteem**	**Chronic Pain**
Drug Use	**Alcohol Use**	**Perfectionism**	**Dating Skills**	**Assertiveness**
Anger	**Self-Control**	**Marriage**	**Education**	**Irritability**
Sleep	**Stress**	**Finances**	**Nightmares**	**Memory**
Relaxation	**Headaches**	**Friends**	**Work**	**Decision Making**
Legal Matters	**Eating Problems**	**Suicidal Thoughts**	**Children**	**Isolation**
Energy	**Sudden Mood Changes**	**Health Problems**	**Career Choices**	**Loneliness**
Being a Parent	**Unhappiness**	**Other:**	**Other:**	

History of Abuse? **Physical** **Emotional** **Sexual** **Verbal**

Religious Affiliation *(If any, how important is it in your life?)*_____
_____

Sexual Orientation: **Heterosexual** **Bisexual** **Homosexual** **Other**

How Often Do You Drink Alcohol? _____ Family History of Alcoholism *(Yes/No)***? _____**

Are You Currently Taking Any Medication *(Yes/No)***? _____ If yes, please describe below:**

Medication	**Dosage/Frequency**	**Prescribed By**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Where were you born? _____ Where were you raised? _____ By Whom _____

List the ages of bothers and sisters in relation to yourself and give their sex *(M/F)***: _____**

Have you ever seen a therapist before *(Yes/No)***? _____**

What was the reason?
_____
_____
_____

What was the outcome?
_____
_____
_____

Confidential

All information between counselor and patient is help strictly, confidentially unless:

1. the patient authorizes release of information with his/her signature.
2. the patient presents a physical danger to self.
3. the patient presents a danger to others.
4. child/elder abuse/neglect are suspected.

In the latter two cases, we are required by law to inform potential victims and legal authorities so that protective measures can be taken.

Financial Terms

Upon verification of health plan/insurance coverage and policy limits, your insurance carrier will be billed for you and your provider will be paid directly by the carrier. The patient will be responsible for any applicable deductibles and co-payments. Office visit co-payment is billed separately, with a personal statement being sent monthly. The amount of the co-pay may vary, according to your insurance carrier or your agreement with your therapist.

I hereby assign all medical and/or mental health benefits to include Major Medicine Insurance Plans entitled, including Medicare, TRICARE, private insurance, or any other health plan to:

M. Gene Ondrusek, Ph.D, Clinical Psychologist, California License# PSY8461.

A copy of this assignment is to be considered valid and as an original. ***I understand that I am financially responsible for all charges whether or not paid by said insured.*** I hereby authorize said assignee to release all information necessary to secure payment.

Canceled/Missed Appointments

A scheduled appointment means that time is reserved only for you. If an appointment is missed or canceled within less than 24 hours notice, the patient will be billed according to the scheduled fee or according to the rules of the patient's health plan.

Release of Information

I authorize the release of information for claims, certification/case management/quality improvement, and other purposes related to the benefits of my Health Plan. [Releases of information to provider, family, etc., requires separate form].

I understand and agree to all of the above information,

_____

Patient (or Parent/Guardian) name, ***printed***

_____ _____

Patient (or Parent/Guardian) name, ***signature*** Date