Bernard J. Sullivan, Ph.D. LLC Information Form (Please Print)

Client's Name_____ Date_____

Address:_____
Street City State Zip

Phone: (H)_____ (W)_____ (Cell)_____

Direct Postal Mail to the Above Address _____ No, Please mail me at: _____

You may call me at (circle all that apply) (H) (W) (Cell) You may leave messages at (H) (W) (Cell)

Restrictions on messages and/or Special Instructions regarding contacting you: _____

Social Security Number_____Date of Birth_____Age_____Sex: M F

Place of Employment:_____ Occupation:_____

Person responsible for charges:_____

Spouse (or parent if minor): _____Occupation:_____

Place of Employment:_____Phone_____

Address:_____
Street City State Zip

Children (names and ages):_____

Relative to contact in emergencies:_____Phone_____

Medications:_____

_____

Personal Physician_____ Referred by:_____

Previous Psychological Consultation: _____Was it helpful?_____

Health Problems _____

Education _____

Please check all of the following problems that currently apply to you:

_____ I have no problems or concerns
_____ Abuse
_____ Anxiety or Fears
_____ Appetite/Eating disturbances
_____ Anger
_____ Alcohol/Drugs (myself)
_____ Alcohol/Drugs (my family)_____
_____ Attention, Concentration, Distractibility
_____ Bizarre thoughts or behaviors
_____ Compulsive behaviors
_____ Depression
_____ Destructive behaviors
_____ Family Problems (Current or Historical)
_____ Fatigue
_____ Financial Concerns, Impulsive Spending
_____ Grief/Mourning/Death/Loss/Divorce
_____ Health concerns
_____ Impulsive/ reckless behaviors
_____ Legal involvement or concerns
_____ Obsessions/Compulsions/Repetitive
_____ Parenting/Children
_____ Perfectionism
_____ Relationship concerns
_____ Self-Esteem/Poor Self-Care
_____ Shyness/Sensitivity
_____ Sexual concerns
_____ Sleep disturbance
_____ Suicidal thoughts
_____ Suicidal Attempts
_____ Violent thoughts or actions
_____ Withdrawal/ social isolation
_____ Work/Employment related problems
_____ Other concern:_____
_____ Other concern:_____

Briefly describe what brings you to seek psychotherapy now?

_____

_____

Initial Treatment Goals

What do you want to be different (please be specific) as a result of seeking psychotherapy?

_____

_____

INSURANCE INFORMATION

If you are the insured and have Insurance Cards that we can copy, you may skip this section.
If you have Insurance Cards and are **not** the insured, please fill in insured's information.

Phone# for Benefits info:_____

Insurance Company:_____Phone:_____

Where should claims be mailed:_____

Street City State Zip

Insured's Name:_____ID#_____

Date of birth:_____ Certificate or Group #_____

Secondary Insurance Co.:_____Phone:_____

Where should claims be mailed:_____

Street City State Zip

Insured's Name :_____ID# _____

Insured's Date of birth: _____Certificate or Group #_____

Assignment of Benefits: I hereby assign all psychological benefits to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan to Dr. Bernard J. Sullivan. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signed: _____Date:_____

Payment is requested at the time services are rendered unless otherwise arranged with Dr. Sullivan.

This information will be maintained as part of your confidential file with Dr. Sullivan.