Cognitive Behavioral Therapy Services, Inc.

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Chris Tammariello, LCSW (#LCS19544)

Please update your information that may have changed since you were last seen.

Patient Name:	Home Tel: ( ) -	Cell/Work: ( ) -	
Date of Birth:	Marital Status:	Remarried? Yes #___ / No	
Social Security # - -	Education (Yrs.):	Highest Degree:	
Home Address:	City:	State:	Zip:
Names of Parents/Guardians (*if minor*):			
Social Security # - -	Name:		
Home Tel: ( ) -	Cell/Work: ( ) -		
Patient's Occupation:	Position:		How long?
Employer:			
Work Address:	City:	State:	Zip:
Name of Primary Physician:			
Physician's Address :	City:	State:	Zip:
Physician's Tel: ( ) -	Fax: ( ) -		
Are you currently seeing a Psychiatrist?			
Psychiatrist 's Address :	City:	State:	Zip:
Tel: ( ) -	Fax: ( ) -		

Please list any people currently living in your home:

Name:	Age:	Relationship:
Name:	Age:	Relationship:
Name:	Age:	Relationship:
Name:	Age:	Relationship:

Person to notify in case of an emergency (required information):

Name:		Relationship:	
Address:	City:	State:	Zip:
Home Tel:	Cell/work:		

Please complete this section if you believe insurance may cover all or a portion of your visits:

Insurance Co:	Name of policy holder:
Group#:	Policy#:

I_____ hereby authorize Cognitive Behavioral Therapy Services and Chris Tammariello to release any information to the above named insurance company which might be needed to process this claim. This information may include the diagnosis, dates of service and any other needed information to assist in the processing your claim. Your information may also be shared with Theramanager to aid in your billing and your insurance claims.

_____ _____

Signature Date:

Cognitive Behavioral Therapy Services, Inc.

I. Current Problems

*What are the chief problems that caused you to seek treatment at this time:*_____

_____

_____

_____

_____

_____

_____

Circle a number indicating the severity of your problems **described above**: (circle number)

None	Slight	Mild	Moderate	Very	Extreme	Totally Incapacitating
0	1	2	3	4	5	6

Have you been experiencing any these problems listed? If yes, please indicate how long you have had the symptom. Example: Nervousness (3 weeks)

Nervousness ( )	Depression ( )	Fears ( )	Mood Changes ( )
Shyness ( )	Sexual Problems ( )	Suicidal ( ) Thoughts	Family Conflict ( )
Divorce ( )	Boredom ( )	Finances ( )	Racing Thoughts ( )
Drug Use ( )	Alcohol Use( )	Friends ( )	Confusion( )
Anger ( )	Self-control( )	Unhappiness ( )	Attention( )
Sleep ( )	Stress( )	Work ( )	Organization ( )
Relaxation( )	Headaches( )	Dating ( )	Social Anxiety ( )
Legal Matters ( )	Chronic Pain( )	Decision ( ) Making	Thinking Problems ( )
Loneliness ( )	Self-esteem( )	Concentration ( )	Obsessions ( )
Education ( )	Career Choices ( )	Performance Anxiety ( )	Compulsiveness( )
Health Problems( )	Nightmares ( )	Marital/ ( ) Relationship	Family Conflict ( )
Parenting ( )	Eating Disorder ( )	Irritability ( )	Weight loss ( )

Circle a number indicating the severity of your problems **described above**: (circle number)

None	Slight	Mild	Moderate	Very	Extreme	Totally Incapacitating
0	1	2	3	4	5	6

*What is the main reason for returning?*_____

_____

*What has been going on in your life since you were last seen?*_____

_____

_____

_____

_____

*What seems to have worsen your problems?*_____

_____

_____

*What seems to help your problems?*_____

_____

_____

Please briefly describe what you do on a typical weekday, starting with the time you wake up in the morning, and ending with the time you go to sleep at night. _____

_____

_____

_____

_____

_____

Did this pattern change when your present difficulties begin? Yes_____ No_____

*If yes, in what way?*_____

_____

Please briefly describe what you do on your weekends or days off. _____

_____

_____

_____

_____

_____

Did this pattern change when your present difficulties begin? Yes_____ No_____

*If yes, in what way?*_____

_____

II. Current Social Life

Describe how you are getting along with people other than your family or those with whom you live (e.g., friends, acquaintances, neighbors, co-workers), and how people generally seem to feel about you. If you are having any problems relating to people, please describe those problems.

_____

_____

_____

_____

_____

_____

*Have your relationships changed as a result of your current difficulties? Yes____ No_____ If yes, briefly explain the ways in which they have changed.*_____

_____

_____

_____

*How difficult is it for you to **make** friends these days?(circle number)*

Very Difficult		*Somewhat Difficult*		*About Average*			*Somewhat Easy*		*Very Easy*
1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*

*How difficult is it for you to **keep** friends these days?(circle number)*

Very Difficult		*Somewhat Difficult*		*About Average*			*Somewhat Easy*		*Very Easy*
1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*

About how many close friends do you have (people you can confide in)? _____

*How often do you talk to them?*_____

*How often do you see them?*_____

Rate the degree to which you generally feel relaxed and comfortable in social situations (circle a number)

Very Tense & Uncomfortable		*Somewhat Tense & Uncomfortable*		*Neutral*		*Somewhat Relaxed & Comfortable*			*Very Relaxed & Comfortable*
1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*

III. Current Work Life

Briefly describe your attitude and behavior at work, school or home. Describe any problems you are having carrying out your responsibilities or dealing with problems.

_____

_____

_____

_____

_____

*Did your attitude or behavior change when your present difficulties began? Yes____ No____ If yes, in what way?*_____

_____

_____

*What do you like about your current line of work?*_____

_____

_____

IV. Intimate Relationships

How comfortable are you with the idea of being trusting, open, and close (vulnerable) in a love relationship. (circle a number)

Very Tense & uncomfortable comfortable with closeness; very self-Protective		*Somewhat Tense & uncomfortable with comfortable self-protective*		*Neutral; Fairly self-protective but willing to be vulnerable at Times*		*Moderately Relaxed & with closeness; Pretty willing to be vulnerable*		*Extremely comfortable with closeness very willing to to be vulnerable*	
1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*

IF NOT MARRIED OR COHABITATING*: Are you currently dating any one? Yes_____ No_____ If yes,*

Are you experiencing significant difficulties in this/these dating relationship(s)? Yes_____ No_____

*If yes, please describe.*_____

_____

_____

If you are not currently dating anyone, how satisfied are you with this situation (circle a number).

Completely Dissatisfied		*Mostly Dissatisfied*	*Somewhat Dissatisfied*	*Neutral*	*Evenly Mixed Feelings*		*Somewhat Satisfied*		*Completely Satisfied*
1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*

V. Children and Family Relationships

List below each child with whom you have a parental relationship whether as a biological parent, step-parent, or other relationship.

Name:	Age:	Relationship:
Custody/Living arrangement:		
Name:	Age:	Relationship:
Custody/Living arrangement:		
Name:	Age:	Relationship:
Custody/Living arrangement:		
Name:	Age:	Relationship:
Custody/Living arrangement:		
Name:	Age:	Relationship:
Custody/Living arrangement:		

*Do any of your children present special problems to you or your spouse/partner? Yes_____ No_____ if yes, please describe.*_____

_____

_____

_____

_____

_____

How would you describe your present relationship with your family of origin? _____

_____

_____

_____

_____

*Indicate which , if any of these relationships is currently a significant source of support or distress for you. If a relationship is problematic, describe briefly what the problem(s) seems to be.*_____

_____

_____

_____

_____

VI. Medical History

When was the last time you had a physical examination/check-up? _____

Have you been treated by a physician or hospitalized in the last year? Yes____ No____

If yes, please specify: _____

Have there been any changes in your general health in the past year? Yes____ No____

If yes, please specify: _____

Are you taking any non-psychiatric medication or over –the-counter drugs at the present time? Yes____ No____If yes, please list:

Medication	*Dosage*	*Frequency*	*Name of Provider*
1.			
2.			
3			
4.			

Have been told you have a thyroid problem? Yes____ No____

Have been told you have diabetes? Yes____No____

Do you get short of breath on mild exertion or when you lie down? Yes____ No____

Have you had: (check all that apply)

Stroke___ Anemia___ Rheumatic Fever___ Asthma___ High/Low Blood Pressure___

Heart Murmur___ Tuberculosis____ Heart Surgery____ Angina____ Ulcers___ Heart Attack___

Are you pregnant or think you may be pregnant? Yes ____ No____ N/A____

Have you had seizures, convulsions, or epilepsy? Yes____ No____

Do you have a prosethic heart valve? Yes____ No____

Do you have any other medical condition? Yes____ No____

If yes, specify_____

Do you have any medication or food allergies? Yes____ No____

If yes, specify_____

Have you had a major illness or injury? Yes___ No___ If yes, specify_____

_____

_____