Name: _____

CLIENT BACKGROUND INFORMATION

NAME: (First, Middle, Last) _____ DOB: _____ Age: _____

Sex: _____

ADDRESS: _____ City: _____

Zip: _____

Email Address: _____

May DR. Kern send mail/email to you at the above address? Y N

Permission to contact you and leave a message at these numbers?

HOME PHONE: _____ Y N

WORK PHONE: _____ Y N

CELL PHONE: _____ Y N

Employer: _____

Spouse/Partner's Name (If applicable): _____ DOB: _____

Marital Status: _____

Do you have children/dependents? If so, please list their names and ages:

_____

_____

Referred By: _____

Insurance Information:

Carrier Name/Insurance Company Name: _____

Address to which claims should be sent: _____

_____

Primary Person on Insurance: _____ DOB: _____

Phone#: _____

Identification or Policy Number: _____

Group Number: _____

Person Responsible for Payment: _____

Pre Certification Required? Y N

Deductible met? Y N

Current Medications (Name, dosage, prescribing physician's name):

_____
_____
_____

General Medical Health: Poor Fair Good Excellent

Operations and serious illnesses/medical conditions (include relevant dates:

_____
_____
_____

Have you received previous psychological services (outpatient counseling, inpatient hospitalization, substance abuse, etc.)? Y N If yes, please provide details (e.g., therapist or hospital name, dates of service, and contact information):

_____
_____
_____

Reasons for seeking therapy now:

_____
_____
_____

Concerns (Circle "P" for Past concerns and "C" for Current concerns; both if applicable:

1. Headaches	P	C	30. Self Injury/Cutting	P	C
2. Muscle Tension	P	C	31. Tremors	P	C
3. Worry/Anxiety	P	C	32. Post-partum Depression	P	C
4. Visual Hallucinations	P	C	33. Post-partum Anxiety	P	C
5. Hearing Voices	P	C	34. Increased Appetite	P	C
6. Digestive Concerns	P	C	35. Decreased Appetite	P	C
7. Chronic Pain	P	C	36. Racing Thoughts	P	C
8. Fatigue	P	C	37. Reduced Need for Sleep	P	C
9. Sexual Concerns	P	C	38. Impulsivity	P	C
10. Low Libido	P	C	39. Excessive Spending	P	C
11. High Libido	P	C	40. Excessive Risk-Taking	P	C
12. Insomnia	P	C	41. Road Rage	P	C
13. Sleeping too much	P	C	42. Violent Behavior	P	C
14. Excessive Exercise	P	C	43. Gambling Problems	P	C
15. Food Bingeing	P	C	44. Seizures	P	C
16. Food Purging	P	C	45. Head Injury	P	C
17. Abuse of Laxatives	P	C	46. Diabetes	P	C

18. Body Image Problems	P	C	47. Nightmares	P	C
19. Axorexia	P	C	48. Distractibility	P	C
20. Overeating	P	C	49. Irritability	P	C
21. Chest Pains	P	C	50. Panic Attacks	P	C
22. Breathing Problems	P	C	51. Obsessive Thoughts	P	C
23. Concentration Prob's	P	C	52. Compulsive Behaviors	P	C
24. 24. Heart Trouble	P	C	53. Phobia(s)	P	C
25. Thyroid Problems	P	C	54. Social Anxiety	P	C
26. Poor Memory	P	C	55. Stuttering	P	C
27. PMS	P	C	56. Tics/Tourette's	P	C
28. Vision Problems	P	C	57. Feeling Withdrawn	P	C
29. Hearing Problems	P	C	58. Trauma History	P	C

Alcohol Use (Averages)	**Present**	**Past**	**When?**
None	_____	_____	_____
Light (less than 1 drink/day)	_____	_____	_____
Moderate (1-2/day)	_____	_____	_____
Heavy (3 or more/day)	_____	_____	_____

Drug Use	**Present**	**Past**	**When?**
Marijuana	_____	_____	_____
Hallucinogens	_____	_____	_____
Amphetamines (uppers/downers)	_____	_____	_____
Abuse of Prescription Drugs	_____	_____	_____
Others _____			
_____	_____	_____	_____

Do you smoke? Y N Daily Amount: _____

Daily servings/amount of caffeine: _____

History of Suicidal Thoughts or Actions? Y N If yes, when?

_____

Current problems with suicidal thoughts or actions? Y N If yes, describe below:

_____

_____

_____

Current Strengths?

_____
_____
_____

What else would you like me to know about you?

_____
_____
_____

Emergency Contact Person:

Name: _____ Relationship: _____

Work Phone: _____

Home/Cell: _____

Sign below to permit Dr. Kern to contact the above individual in the event of an emergency:

Signature of patient and/or guardian: _____

Date: _____

Family/General Physician's Name and Contact Information:

_____
_____
_____

I authorize Dr. Leslie Kern to release/exchange treatment information with my family physician and health plan's utilization reviewers in order to facilitate my treatment by Dr. Kern. I understand that all parties will maintain professional confidentialities regarding the exchange of information. I understand that I am financially responsible for any balance or co-pay not covered by my insurance.

_____ _____

Signature of Patient or Parent/Guardian **Date**

Insured or authorized person's signature: I authorize payment of benefits to the undersigned physician or supplier of services provided:

Signed: _____