Megan Ogle, PsyD
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Client Information

Date:_____Name:_____ Preferred First Name:_____

Date of Birth:____/____/_____ SSN:_____-____-_____

Address:_____ City: _____ State: _____ Zip:_____

PHONE NUMBERS OK to leave Messages?

HOME:_____ ◯Yes ◯No ◯Primary Contact?

WORK:_____ ◯Yes ◯No ◯Primary Contact?

MOBILE:_____ ◯Yes ◯No ◯Primary Contact?

EMAIL:_____

EMERGENCY CONTACT: Name:_____ Phone:_____Relation:_____

Insurance Information

Primary Insurance Carrier:_____ Phone:_____

Claim Address:_____City:_____ Zip:_____

Name of Insured:_____Relation to Client:_____

Insured ID:_____Group #:_____

Insured DOB:_____/_____/_____ Phone:_____Employer:_____

Insured's address:_____City:_____ Zip:_____

Secondary Insurance Carrier:_____Phone:_____

Claim Address:_____City:_____ Zip:_____

Name of Insured:_____Relation to Client:_____

Insured ID:_____Group #:_____

Insured DOB:_____/_____/_____ Phone:_____Employer:_____

Insured's address:_____ City:_____ Zip:_____

I hereby authorize the release of all medical records necessary to process an insurance claim. I hereby authorize my insurance carrier to make payments directly to Megan Ogle, PsyD, Clinical Psychologist. I understand that I am financially responsible for all charges, regardless of insurance, unless otherwise written by Megan Ogle, PsyD, Clinical Psychologist.

Name:_____ Signature:_____ Date:_____

Background Information Today's Date:____/___/____

Name:_____ Referred By:_____

Gender: ◯Male ◯Female ◯Queer ◯Trans Male ◯Trans Female

Sexual Orientation: ◯Straight ◯Bisexual ◯Gay/Lesbian ◯Asexual ◯Prefer Not To Answer

With which racial/ethnic groups do you identify?

◯African American
◯Asian
◯Bi-Racial
◯Caucasian/White
◯Latino/a/Hispanic
◯Multi-ethnic
◯Native American
◯Other:_____

Please describe the problems that brought you here today:

_____

_____

_____

_____

Have you sought treatment for this problem before? ◯Yes ◯ No

How is your sleep? (how many hours/night, waking, difficulty)

_____

_____

Have you gained or lost weight without trying in the last six months? ◯Yes ◯No

Are you struggling with any the following?

◯Aggression
◯Alcohol or drug use
◯Anxiety/worry
◯Body image concern
◯Change in appetite
◯Compulsive behavior
◯Crying spells
◯Distractibility
◯Eating problems
◯Fatigue
◯Gambling problems
◯Guilt/shame
◯Hallucinations
◯Hearing voices
◯Hopelessness
◯Hyperactivity
◯Impulsivity
◯Irritability
◯Loneliness
◯Loss of pleasure
◯Low self-worth
◯Memory difficulties
◯Nightmares
◯Obsessive thoughts
◯Overuse of internet
◯Panic attacks
◯Parenting problems
◯Racing thoughts
◯Relationship problems
◯Sadness
◯Self-harm
◯Sexual problems
◯Sleep problems
◯Stress
◯Suspicion/paranoia
◯Thoughts of death visual
◯Thoughts of harming others
◯Wide mood swings
◯Work/school problems

Are your problems affecting any of the following?

◯Exercise
◯Finances
◯General health
◯Handling everyday tasks
◯Housing relationships
◯Hygiene
◯Legal matters
◯Sexual functioning
◯Recreational activities
◯Self-esteem
◯Sexual activity
◯Spirituality/faith

Have you ever had thoughts, made statements, or attempted to hurt yourself ? ◯Yes ◯No

Have you ever had thoughts, made statements, or attempted to hurt someone else? ◯ Yes ◯ No

Personal History

Family of Origin: Please list the members of your family of origin (parents, brothers, sisters, etc.)

Name Relationship Age Occupation/School Quality of Relationship

Chosen Family: Please list the members of your chosen family or community who are important in your daily life

Name Relationship Age Occupation/School Quality of Relationship

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With whom did you live when you were a child? _____

During your childhood were you ever injured from the discipline used by your parents? ◯Yes ◯No

During your childhood did you ever see your care takers have physical fights with each other? ◯Yes ◯No

Were you ever arrested by the police before you turned age 16? ◯Yes ◯No

You are currently: ◯Single ◯Dating ◯Engaged ◯Partnered ◯Divorced
◯Domestic Partnership ◯Married ◯Widowed

How long?_____

Do you feel safe in your current relationship? ◯Yes ◯No

How satisfied are you with your relationship with your spouse/partner? (circle #)

Extremely Dissatisfied 1 2 3 4 5 6 7 Extremely Satisfied

How satisfied are you with your partner as a significant other? (circle #)

Extremely Dissatisfied 1 2 3 4 5 6 7 Extremely Satisfied

How satisfied are you with your sex life in your current relationship? (circle #)

Extremely Dissatisfied 1 2 3 4 5 6 7 Extremely Satisfied

Previous relationships/marriages: _____

Is there a partner from a previous relationship that is making you feel unsafe now? ◯Yes ◯No

Do you have any children under the age of 18 living with you in your home? ◯Yes ◯No

Child #1 - Age: ____ Sex: Male Female

Child #2 - Age:____ Sex: Male Female

Child #3 - Age:____ Sex: Male Female

Highest level of education:_____

Employed? ◯Yes ◯No Position & how long?_____

Religious or spiritual practice or affiliation?_____

Please describe your support system:_____

Medical Information

Primary Care Provider:_____Clinic:_____

PCP-Address:_____PCP-Phone:_____

Last Physical:_____

Current health concerns or illnesses:_____

Past illnesses or surgeries:_____

Have you ever had a head injury or concussion from a fall, crash, or other kind of accident?

_____

Mental Health History

Have you ever participated in therapy before? ◯Yes ◯No

Dates Provider What was Helpful/Unhelpful?

_____

Are you currently taking any kind of medication? If so, please list

_____

_____

Have you previously been prescribed medication for any conditions? If so, please list

_____

_____

Have you ever been hospitalized or received inpatient treatment for a mental health condition? If so, please list when, where, and why:

_____

_____

Are there members of your family who have been on medication, hospitalized, or in some other way treated for a mental health issue? If yes, please explain:

_____

Substance Abuse

Please describe your alcohol use: _____

Alcohol use in the past: _____

Please describe any current or past drug use:

_____

_____

Expectations

What do you hope to get out of counseling? What would you like to see change?

_____

_____

_____

_____

_____

After counseling, I expect my problem(s) to be:

◯No better ◯Slightly better ◯Moderately better ◯Mostly better ◯Completely better

The pain and distressed caused by my problem(s) is:

◯ Very mild ◯Mild ◯Moderate ◯Severe ◯Very Severe

The pain and distress caused <u>for others</u> by my problem(s) is:

◯ Very mild ◯Mild ◯Moderate ◯Severe ◯Very Severe

_____

Thank you for providing me with this important information

_____