Behavioral Health Solutions

William J. Kuzbyt, Psy.D., JD, CAP
Licensed Psychologist, PY6646
4061 Bonita Beach Rd, Suite 105
Bonita Springs, FL 34134
(239)221-3399

Confidential Patient Information Form

GENERAL INFORMATION

Date: _____ Referred By: _____

Full Name: _____

Age: _____ Date of Birth: _____ Sex: Male Female

CONTACT INFORMATION

Street Address: _____

City: _____ State: _____ Zip Code: _____

May we send mail here: YES NO

Mailing Address or PO Box: _____

City: _____ State: _____ Zip Code: _____

May we send mail here: YES NO

Home Phone: ( )_____
May we leave a message here: YES NO

Mobile Phone: ( )_____
May we leave a message here: YES NO

Work Phone: ( )_____
May we leave a message here: YES NO

Email Address: _____
May we leave a message here: YES NO

EMERGENCY CONTACT

Name: _____

Relationship: _____

Home Telephone: ( ) _____ Mobile Telephone: ( ) _____

EMPLOYMENT INFORMATION

Employer: _____

Length of Employment: _____

Occupation: _____

Average Hours Worked per Week: _____

Retired: YES What year: _____ NO

EDUCATION INFORMATION

Highest education completed: _____

Are you currently attending school: YES NO

If Yes, What Level: _____ Degree Pursuing: _____

RELATIONAL INFORMATION

Current Marital Status: Single Engaged Married Separated Divorced Widowed

Are you content with your current status: YES NO

If no, Briefly Explain: _____

If Married, How Long: _____ # of Previous Marriages for you: _____
for Spouse: _____

If Separated or Divorced, How Long: _____

If Widowed, How Long: _____

With Whom Do You Currently Live (circle all that apply):

Alone Spouse Children Parents Siblings Boyfriend Girlfriend Other: _____

SPOUSE / PARTNER INFORMATION

Full Name: _____

How Long Have You Known Your Partner: _____ Age: _____

Preferred Name:_____

Sex: Male Female

Occupation: _____Avg. Hours Worked per Week: _____

Highest Education Completed: _____

CHILDREN

List Your Children (Living or Deceased) as well as Children You Have Placed for Adoption

Name	Sex M/F	Current Age or Date of Death	Relationship to You (e.g. Natural, Step, Adopted)	Living with You	Describe Him/Her

M**EDICAL INFORMATION**

Primary Physician: _____

Phone: ( ) _____

Address: _____

City: _____ Zip:_____

Specialty (e.g. Family Practice, OB/GYN, Internal Medicine): _____

Are You Currently Receiving Medical Treatment: YES NO

If Yes, Please Specify:_____

List any Conditions, Illnesses, Surgeries, Hospitalizations, Traumas, or Related Treatments you've had (Use back if necessary):

_____

_____

MEDICAL INFORMATION:

List all current medications you are taking, including those you seldom use or take only as needed (use back if necessary):

Medication	Dosage	Improves, Prevents, Controls	Treating

Are you taking these medications according to your Doctor's Recommendations: **YES** **NO**

If no, please explain: _____

PHYSIOLOGICAL SYMPTOMS

Please circle any of the following Physiological Symptoms/Sensations that apply to you presently or in the recent past:

Headaches	Past	Present	Dizziness	Past	Present	Stomach Trouble	Past	Present
Visual Trouble	Past	Present	Sleep Trouble	Past	Present	Trouble Relaxing	Past	Present
Weakness	Past	Present	Tension	Past	Present	Rapid Heart Rate	Past	Present
Difficulty Breathing	Past	Present	Intestinal Trouble	Past	Present	Hearing Noises	Past	Present
Change in Appetite	Past	Present	Tiredness	Past	Present	Pain	Past	Present
Hearing Voices	Past	Present	Seeing Things	Past	Present	Other	Past	Present

Your Height: _____ Your Weight:_____ How has your weight changed in the last 2-3 Months:_____

CURRENT STATUS

Please circle any of the following problems that apply to You and/or Family:

Stress	You	Family	Nervousness	You	Family	Anxiety	You	Family
Panic	You	Family	Unhappiness	You	Family	Depression	You	Family
Guilt	You	Family	Apathy	You	Family	Terminal Illness	You	Family
Recent Death	You	Family	Grief	You	Family	Hopelessness	You	Family
Inferiority Feelings	You	Family	Defective Feelings	You	Family	Loneliness	You	Family
Shyness	You	Family	Fears	You	Family	Friends	You	Family
Marriage	You	Family	Communication	You	Family	Physical Abuse	You	Family
Emotional Abuse	You	Family	Verbal Abuse	You	Family	Sexual Abuse	You	Family
Temper	You	Family	Anger	You	Family	Aggressiveness	You	Family
Bad Dreams	You	Family	Concentration	You	Family	Racing Thoughts	You	Family
Unwanted Thoughts	You	Family	Memory	You	Family	Loss of Control	You	Family
Impulsive Behavior	You	Family	Self-Control	You	Family	Compulsivity	You	Family
Sexual Problems	You	Family	Pregnancy	You	Family	Abortion	You	Family

LEVEL OF DISTRESS

Indicate how distressed you are by placing an "X" on the scale below
(1=Very Little Distress; 10 = Extreme Distress)

1 2 3 4 5 6 7 8 9 10

Are you currently experiencing any suicidal thoughts: YES NO

Have you Experienced Them in the Past: YES NO

Have you ever attempted Suicide: YES NO

If Yes, When & How: _____

PRESENTING ISSUES AND GOALS

Please describe why you are coming to counseling (i.e. What are your issues, problems?):

_____

_____

_____

Why have you decided to come for counseling at this time:

_____

_____

_____

What do you hope to gain or change by coming to counseling:

_____

_____

_____

How long do you believe counseling should last:

_____

PREVIOUS COUNSELING

Please list any previous counseling psychiatric treatment, or residential/in-patient care you have received:

Therapist	Location	Dates	Reason

RELIGIOUS/SPIRITUAL BACKGROUND

Do you regularly attend a place of worship: YES NO

If Yes, Where:_____

Do you have a Personal Support System: YES NO

If Yes, Who: _____

PATIENT INSURANCE INFORMATION

Insurance Policyholder Information

Full Name: _____

Relationship to Patient: _____

Employment Status: (circle) FULL-TIME PART-TIME RETIRED DISABLED UNEMPLOYED

Employers Name: _____

Employers Address: _____

Primary Insurance Company:

Primary Policy #: _____

Insurance Plan Name: _____ Group #: _____

Primary Insurance Address: _____

Primary Insurance Telephone: _____

Relationship to Patient: _____

Secondary Insurance Company:

Secondary Policy #: _____

Insurance Plan Name: _____ Group #: _____

Secondary Insurance Address: _____

Primary Insurance Telephone: _____

Relationship to Patient: _____

Thank you