Vanessa Pikler, PhD, LLC

www.vanessapiklerphd.com

600 Wyndhurst Avenue, Suite 125B p. 410.246.4150
Baltimore, MD 21210 vanessa@vanessapiklerphd.com

NEW PATIENT INFORMATION PERSONAL INFORMATION

Patient's Last Name _____ First Name _____

Home Address _____

City & State _____ Zip Code _____

Home Telephone _____ Cell Telephone _____

Email address _____

Birth Date _____ Age _____

How do you identify in regard to gender: _____

What pronouns do you prefer when you are addressed (e.g., he/she, they/them) _____

How did you hear about this office? _____

Relationship Status: Single Married Partnered Separated Divorced Widowed

Employer Name: _____

Employer Address: _____

PREVIOUS THERAPY

Have you been in therapy before? Yes No When? _____

Name(s) of previous therapist(s)? _____

Do I have permission to contact your last therapist? _____

If so, please provide contact information _____

How long were you in therapy? _____

Have you ever been evaluated by a psychiatrist for medication? Yes No

Psychiatrist's Name and Contact Information: _____

When?_____ What was the reason? _____

_____

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Medications Prescribed: _____

_____

Have you ever been hospitalized for mental health issues? Yes No

When? _____ For how long? _____

Where: _____

MEDICAL

Primary Care Doctor: _____ Doctor's Phone: _____

Address: _____

Please check **all** that apply:

- □ Depression
- □ Anxiety
- □ Post-Traumatic Stress
- □ Grief/Loss
- □ Suicidal/Homicidal Thoughts
- □ Substance Abuse
- □ Sexual Dysfunction
- □ Relationship Problems
- □ Adjustment to New Situation
- □ Eating Problems
- □ Panic Attacks
- □ Medical Crisis
- □ HIV/AIDS
- □ Other

PRIMARY COMPLAINTS AT THIS TIME (please tell me what brings you to therapy)

_____

_____

_____

_____

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INSURANCE INFORMATION

Please complete **all** information that relates to your insurance company, even though I don't file insurance this may be necessary at times.

Insurance Co.: _____

Card Holder's Name: _____ Patient Name: _____

Patient's SS #: _____ Patient's DOB #: _____

Member #: _____

Insurance ID #: _____

Group #: _____

Other information on your insurance card: _____

EMERGENCY CONTACT INFORMATION

In case of emergency who should I contact?

_____

Contact Person's Phone Numbers:

Home _____ Work _____

Cell _____

Contact person's relationship to Patient _____

The effective date of this Notice is January 1, 2018