MARCIE O'NEIL, LISW, MSW

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Patient Information

Name:_____
First Initial Last
Street:_____
City_____State_____Zip_____
Home# _____Work#_____Cell#_____
Social Security Number _____Birth Date_____
Sex: __male ___ female
Relationship to Insured _____ Self _____Spouse _____Child
Marital Status:
___ Single ____Married ___Widow ___ Separated ____ Divorced
Work: ____ Full Time ___Part Time ____Unemployed _____ Student ____

Insured Information

Name:_____
Street:_____
City:_____ State_____ Zip_____
Home # _____Work #_____ Cell:_____
Social Security Number _____
Date of Birth _____
Sex ___male ___ female
Relationship to Patient:
____Self ____Spouse ____Natural Child ___Step-Child

Employer_____
Employer's Address _____

Insurance Information

Insurance Company_____
Policy # _____ Group #_____
Phone # _____

MENTAL HEALTH AND PHYSICAL HEALTH HISTORY

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No
□ Yes, previous therapists/practitioners/hospitalizations
_____
_____

Are you currently taking any prescription medication?
□ Yes
□ No
Please list:
_____
_____
_____

Have you ever been prescribed psychiatric medication?
□ Yes
□ No
Please list and provide dates and response to medication.
_____
_____
_____

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Please Circle List Family Member
Alcohol/Substance Abuse yes/no_____
Anxiety yes/no_____
Depression yes/no_____
Domestic Violence yes/no_____
Eating Disorders yes/no_____
Obesity yes/no_____
Obsessive Compulsive Behavior yes/no_____
Schizophrenia yes/no_____
Bipolar Disorder yes/no_____
Suicide Attempts yes/no_____
Suicide Completion yes/no_____

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:
_____
_____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:
_____
_____

3. How many times per week do you generally exercise? _____
What types of exercise to you participate in:
_____

4. Please list any difficulties you experience with your appetite or eating patterns.
_____

5. Are you currently experiencing overwhelming sadness, grief or depression?
□ No
□ Yes
If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias?
□ No
□ Yes

If yes, when did you begin experiencing this?
_____

7. Are you currently experiencing any chronic pain?
□ No
□ Yes
If yes, please describe?
_____
_____

8. Do you drink alcohol more than once a week? □ No □ Yes. If yes, how often and what type of alcohol do you drink?
_____
_____

9. How often do you engage recreational drug use?
□ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. Are you currently in a romantic relationship? □ No □ Yes
If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently_____
_____
_____

ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes
If yes, what is your current employment situation: _____
_____

Do you enjoy your work? Is there anything stressful about your current work?
_____
_____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes
If yes, describe your faith or belief:

_____
_____

3. What do you consider to be some of your strengths?

_____
_____
_____
_____

4. What do you consider to be some of your weakness?

_____
_____
_____

5. What would you like to accomplish out of your time in therapy?

_____
_____
_____
_____