ERIKA BOKOR Ph.D.
Clinical Psychologist

INSTRUCTIONS: Please complete this form in order to provide information about your history.

PATIENT DATA

Name____ Date______________________

Street Address____

City____________________________________ Zip Code_________________________

Telephone (home)___________________________ (work)__________________________

(cell)___________________________E-mail address______________________________

Any restrictions on sending correspondence to the above street or e-mail address or to calling you at the above phone numbers? ____

Marital Status_________________ Date of Birth___________________ Age_____________

Current living situation (who is in the household)_______________________________

Employer_____________________________________ Occupation____________________

In case of emergency contact____

Telephone__________________________ How is he/she related?_________________________

Nearest hospital to your home____

Who referred you____

MEDICAL HISTORY

Current Primary Care Physician____

Address_______________________________________Telephone____________________

Current Medications____

Have you ever taken any psychiatric medications? Please list__________________________

Psychiatrist name if currently under one's care_____________________________________

Address_______________________________________Telephone____________________

Allergies?___________________________________ Ave. number of hours of sleep/night_____________________

Alcohol use?________________ Frequency & amount____

Street drugs use?_____________ Type, frequency & amount____

Smoking?___________________ Frequency & amount____

Caffeine use?________________ Frequency & amount____

Please circle the health conditions for which you have been/are treated, and put a check-mark next to the ones that blood relatives have been treated for.

AIDS	Fainting spells/dizziness	Lung disease
Alcohol abuse	Gastrointestinal problems	Psychological problems
Anemia	Headaches	Seizures
Asthma	Heart Disease	Stroke
Cancer	Hepatitis/liver disease	Thyroid problems
Diabetes	High blood-pressure	Ulcer
Drug abuse	Injury/accident	Other_________________

Have you ever received therapy?_____________ Reason____

When___________________________ Name of therapist____

Current reasons for seeking treatment/please describe your concerns____________________________________

____

When did these problems start? ____

Does anyone else in the family have similar difficulties? ____

PROBLEM LIST

Place a check-mark next to any of the following that you currently experience as a problem. Place a double check-mark next to the main problems as you see it.

Anxiety	Loss of appetite	Relationship difficulties
Depressed mood	Overeating	Work problems
Panic attacks	Recent weight changes	Legal problems
Mood swings	Trouble falling asleep	Memory problems
Irritability	Early morning awakening	Poor concentration
Frequent crying	Low energy	Excessive use of alcohol
Anger	Restlessness	Drug abuse
Stress	Lack of interest in usual activities	Excessive self-criticism
Repetitive thoughts, worries, fears	Trouble completing tasks	Fear of social situations
Periods of high energy with little sleep	Other____	

CURRENT STRESSORS

Circle the ones that apply and/or fill in with your information.

Occupational School Financial Health Legal Social Marital/family Other______________________

To what extent have your current problems interfered with your ABILITY TO FUNCTION on a day-to-day basis? Represent your response with a number from 0-100, where 0 means NOT AT ALL and 100 means EXTREMELY. Putting 0 down would mean that your current problems have not affected your ability to function at all, while putting 100 down would mean that your current problems are affecting your ability to function to an extreme degree.

INSURANCE INFORMATION

Method of payment (Self or Insurance) ____

If using insurance, name of primary insurance ____

Insurance phone ______________________________ Policy-holder name ______________________________

Date of birth ______________________________ Place of employment ______________________________

Member ID number ______________________________ Group number ______________________________

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with ______________________________ and assign directly to Dr. Erika Bokor all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Dr. Bokor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

____ ______________________________

Signature of the Insured Date

ver. March 25, 2020