Welcome to the office of Dr. Daniel Maccia

Please complete this form in its entirety Date_____

PATIENT: This section for patient only:

Name_____ Sex _____Age_____ Spouse_____
Address_____ SS#_____ DOB ___/___/___
City_____ State ____Zip _____ Drivers License # _____
Employer_____ Marital Status M S D SEP W Partner
Occupation_____ Home Phone #_____
Address_____ Cell Phone #_____
City _____State_____ Zip_____ Work Phone #_____
Preferred method this office may contact you and leave a message (phone or email):_____
_____
Emergency Contact: _____Relationship:_____
Address_____ Phone # _____
How did you hear about this practice? _____

RESPONSIBLE PARTY FOR BILL *if other than patient*:

Name_____ Relationship to patient _____
Address_____ Employer_____
City _____State_____ Zip_____ Address_____
SS#_____ DOB ____/____/____ City_____ State ____Zip_____
Home phone # _____ Work phone #_____

Please Select Your Method of Payment:
Private Insurance ( ) Cash ( ) Personal Check ( )

PRIMARY Insurance Carrier

Company_____
Address_____
City _____State_____ Zip_____
Phone # _____
INSURED _____
(name on insurance card)

Insured's Relationship to Patient:
Self ( ) Spouse ( ) Child ( ) Other ( )
INSURED ID# _____
Group or Plan # _____
Effective Date of Insurance _____

SECONDARY Insurance Carrier

Company _____
Address_____
City_____ State ____Zip_____
Phone #_____
INSURED_____
(name on insurance card)

Insured's Relationship to Patient
Self ( ) Spouse ( ) Child ( ) Other( )
INSURED ID# _____
Group or Plan # _____
Effective Date of Insurance _____

Authorization to pay benefits to provider: I hereby authorize payment direct to Dr. Daniel Maccia of the Insurance benefits otherwise payable to me, and authorize release of information necessary to process a claim with my insurance company. I hereby accept responsibility for any charges not covered by my insurance, and for missed appointments or cancellations with less than 24 hour notice. A copy of this signature is valid as the original.

Signature _____ Date _____
(if a minor, parent or guardian must sign)

PROBLEM CHECK LIST

Below is a list of troublesome problems which may people often face. Read each one and place a (√) before those items of concern to you. Place two (√ √) before those items which are of the **most** concern to you.

___ Slow in getting acquainted with people
___ Feelings of worthlessness
___ Physical health complaints
___ Feeling tired much of the time
___ Concerned about physical or sexual abuse in my family
___ Sometimes bothered by thoughts of insanity
___ Trouble falling asleep
___ Feeling inferior
___ Being watched or talked about by others
___ Thoughts of suicide
___ Not knowing what I really want
___ Poor appetite
___ Trouble in keeping a conversation going
___ Awakening in the early morning
___ Depressed "down in the dumps"
___ Concerned about my alcohol use
___ Wanting love and affection
___ Having feelings of extreme loneliness
___ Nervousness, or finding it difficult to relax
___ Not knowing where I belong in the world
___ Finding things to do in my spare time
___ Spells of terror or panic
___ Concerned about my drug use

____ The idea that something is wrong with my mind
____ Trouble controlling my temper
____ Lacking self-control
____ Marital Problems
____ Not reaching the goal I set for myself
____ Sexual problems
____ Boredom
____ Too little social life
____ Feelings of guilt
____ Being made fun of
____ Wondering if I'll find a suitable mate
____ Being ill-at-ease with other people
____ Legal problems
____ Trouble concentrating
____ Can't forget some mistake I've made
____ Dissatisfied with current job
____ Afraid I might hurt someone
____ Difficulties in raising my children
____ Being timid or shy
____ Financial problems
____ Difficulty remembering things as I once could
____ Hearing voices that other people do not hear

Write about any special problems or issues you would like to discuss**:**

Estimate the severity of the above problems: **Mild — Moderate — Severe — Very Severe**

BIOGRAPHICAL AND SOCIAL HISTORY
(use back of page for any needed additional space)

Briefly Describe Your Past and Current Relationship History (first name, years together, nature of relationship, any abuse, any other significant information):

Any Children? (first name, age, custody, other significant information):

Current Support System (friends/family):

Family History-

Describe your relationship with your parents growing up and current:

Describe your childhood in general:

Siblings: (name, age, brief statement about relationship):

MEDICAL AND TREATMENT HISTORY

Past or Current Medical Conditions:

Current Medications:

Psychotherapy History (when and how long, name and degree of therapist, reason for treatment, what did you find helpful and what did you not like, how and why did treatment end):

Current or Past Substance Abuse: (include any treatment or support groups)

Describe Any Significant *Family* Medical History; Mental Health History; and Substance Abuse:

Thank you for taking the time to thoughtfully complete this paperwork. It will help me in planning your treatment and our work together. Please let me know in your session any other significant information you think is important for me to know about your history.