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Date _____

Name _____ Birth Date ____ / ____ / ____

Address _____

City, State, and Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Other Phone _____

Referred by _____

Relationship Status _____

In Case of Emergency Contact _____

Their Home Phone _____ Work/Cell Phone _____

Name of Your Physician _____ Phone _____

Insurance Company _____

What do you hope to accomplish in therapy? _____

Current Symptoms Checklist (check once for any symptoms present, twice for major symptoms)

- | | | |
|--|--|--|
| <input type="checkbox"/> Depressed mood | <input type="checkbox"/> Racing thoughts | <input type="checkbox"/> Excessive worry |
| <input type="checkbox"/> Unable to enjoy activities | <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Sleep pattern disturbance | <input type="checkbox"/> Increase risky behavior | <input type="checkbox"/> Avoidance |
| <input type="checkbox"/> Loss of interest | <input type="checkbox"/> Increased libido | <input type="checkbox"/> Hallucinations |
| <input type="checkbox"/> Concentration/forgetfulness | <input type="checkbox"/> Decrease need for sleep | <input type="checkbox"/> Suspiciousness |
| <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Excessive energy | <input type="checkbox"/> Decreased libido |
| <input type="checkbox"/> Excessive guilt | <input type="checkbox"/> Increased irritability | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Crying spells | <input type="checkbox"/> _____ |

Medical History

Allergies _____

Please place a check mark next to medical issues you have experienced.

- | | | |
|--|---|---|
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Anemia | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Asthma/respiratory problems | <input type="checkbox"/> Stomach/Intestinal | <input type="checkbox"/> Cancer (type) |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Epilepsy or seizures |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Head Trauma | <input type="checkbox"/> Liver problems | |
| <input type="checkbox"/> Other _____ | | |

Current medical problems:

Other past medical problems, nonpsychiatric hospitalization, or surgeries:

Do you have any concerns about your physical health that you would like to discuss?

- Yes No

Psychiatric History

Outpatient Treatment Yes No If yes, please provide any information that would be helpful for your current therapy.

Psychiatric Hospitalization Yes No If yes, please provide any information with which you are comfortable sharing.

Family Psychiatric History

Has anyone in your family been diagnosed with or treated for:

- | | | | | | |
|-----------------------|--|---------------|--|---------------|--|
| Bipolar disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | Schizophrenia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Depression | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Post-traumatic stress | <input type="checkbox"/> Yes <input type="checkbox"/> No | Anxiety | <input type="checkbox"/> Yes <input type="checkbox"/> No | Alcohol abuse | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anger | <input type="checkbox"/> Yes <input type="checkbox"/> No | Suicide | <input type="checkbox"/> Yes <input type="checkbox"/> No | Violence | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Substance abuse | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |

Substance Use

Please list substances used on a regular basis _____

Family/Childhood History

Were you adopted? () Yes () No

Where did you grow up? _____

Please list your siblings and their ages:

Who were/are your primary caregivers? _____

If your parents divorced, with whom did/do you live? _____

Please briefly describe your relationship each of your immediate family members _____

Education

Highest Grade Completed? _____ Where? _____

Did you attend college? _____ Where? _____ Major? _____

My favorite subjects in school were _____

What did/do you think of school? (circle one)

Love(d) It Like(d) It Meh Did/Do Not Like It Hate(d) It Not My Thing

Occupational History

Are you currently: () Working () Student () Unemployed () Disabled () Retired

How long in present position? _____

What is/was your occupation? _____

Where do/did you work? _____

Have you ever served in the military? _____ If so, what branch and when? _____

Consent to email or Text Usage for Appointment Reminders and Other Healthcare Communications:

I give my psychologist permission to enter my name and phone number in her password protected phone, and to use her phone calendar to schedule my appointments. I understand that confidentiality cannot be guaranteed through the internet or text messaging and any engagement in such forms of communication, I take at my own risk.

Client may be contacted via email and/or text messaging to remind you of an appointment, reschedule an appointment, and to provide general health reminders or information. I understand that once I have consented to receive communication via text or email, I still have the right to revoke that consent at any time.

If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications at that email or text address from Dr. Korinek. These reminders may come either directly from a phone, or via online appointment scheduling and reminder software. While there is no charge for this service, standard text messaging and data rates may apply as provided in your wireless plan.

_____ (Initials) I consent to receive text and voice messages from Dr. Lauri Korinek on my cell phone and any number forwarded or transferred to that number, and to receive emails messages providing communication as stated above. I understand that this request to receive emails, and text and voice messages will apply to all future appointment reminders/health information unless I request a change in writing.

The cell phone number that I authorize to receive text or voice messages for appointment reminders and general health information is_____.

The email that I authorize to receive email messages for appointment reminders and general health information is_____.

Signature of Client/Guardian

Date

Printed Name of Client/Guardian