Lauri L. Korinek, Ph.D., LLC, PC
Licensed Psychologist, Neuropsychologist

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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?____
____
____
____

<u>Current Symptoms Checklist</u> (check once for any symptoms present, twice for major symptoms)

( ) Depressed mood	( ) Racing thoughts	( ) Excessive worry
( ) Unable to enjoy activities	( ) Impulsivity	( ) Anxiety
( ) Sleep pattern disturbance	( ) Increase risky behavior	( ) Avoidance
( ) Loss of interest	( ) Increased libido	( ) Hallucinations
( ) Concentration/forgetfulness	( ) Decrease need for sleep	( ) Suspiciousness
( ) Change in appetite	( ) Excessive energy	( ) Decreased libido
( ) Excessive guilt	( ) Increased irritability	( ) Suicidal thoughts
( ) Fatigue	( ) Crying spells	( ) ________________

Medical History

Allergies____
____

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

( ) Thyroid Disease	( ) Anemia	( ) Liver Disease
( ) Chronic Fatigue	( ) Kidney Disease	( ) Diabetes
( ) Asthma/respiratory problems	( ) Stomach/Intestinal	( ) Cancer (type)
( ) Fibromyalgia	( ) Heart Disease	( ) Epilepsy or seizures
( ) Chronic Pain	( ) High Cholesterol	( ) High blood pressure
( ) Head Trauma	( ) Liver problems	

( ) 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	( ) Yes ( ) No	Schizophrenia	( ) Yes ( ) No	Depression	( ) Yes ( ) No
Post-traumatic stress	( ) Yes ( ) No	Anxiety	( ) Yes ( ) No	Alcohol abuse	( ) Yes ( ) No
Anger	( ) Yes ( ) No	Suicide	( ) Yes ( ) No	Violence	( ) Yes ( ) No
Substance abuse	( ) Yes ( ) 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? ________________

Relationship History and Current Family

Are you currently: ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( ) Widowed   How long?_____

If not married, are you currently in a relationship? ( ) Yes ( ) No If yes, how long? ____________

Who do you currently live with?____
____

Do you have children? ( ) Yes ( ) No If yes, list ages and gender: ____________________________
____
____
____

Describe your relationship with your children:____
____
____
____

Your Exercise Level

Do you exercise regularly? ( ) Yes ( ) No

How many days a week do you get exercise?____

How much time each day do you exercise?____

What kind of exercise do you do?____

Is there anything else that would be helpful for me to know?
____
____
____
____
____
____
____
____
____
____
____

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