Cognitive and Behavioral Consultants
Of Westchester, LLP

1 North Broadway, Suite 704
White Plains, New York 10601
914-385-1150

PATIENT INFORMATION (ADULT):

Name: ____________________________________

Date of Birth: ______________ Age: _____________ Sex: ____M ____F

Address: __________________________________

____

____

Phone: Home:________________ Work: ________________ Cell: _____________

Primary Care Physician: __________________________ Phone: _________________

Emergency Contact: ____

Name of person/s who referred you: ____

Phone Number: ______________ Address: _______________________________________

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BACKGROUND / FAMILY INFORMATION
Education level (circle highest level achieved):

some high school high school graduate some college

college graduate graduate degree

Your occupation: ___________________________________

Marital Status (circle):
single dating long-term relationship (not living together)
married / domestic partner separated divorced other

For Office Use Only:

Diagnosis: Axis I:
Axis II:
Fee: $

Please list all individuals who are currently living with you:

Name Relationship to You Age

____

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If you have children who are not living with you, write down the following information:

Child's name Child's age Where Child Resides

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Have there been any deaths/separations in your family? If so, please explain (include dates, relationship to you):

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…………………………………………………………………………………………………

MEDICAL HISTORY

Please list your medical problems:

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____

____

Hospitalizations / Surgeries:

Dates Reason for Hospitalization / Surgery

____

____

____

Current Medications & Diagnosis if Known:

____________________ ____________________

____________________ ____________________

____________________ ____________________

PREVIOUS PSYCHO-SOCIAL TREATMENT

Are you currently receiving mental health services of any kind? Y / N

Please list all present and previous mental health services received below in chronological order:

Mode of Treatment	Dates	Reason for Treatment
Outpatient psychotherapy:		
individual		
family/couple		
group		
other		

Psychiatric Hospitalizations ____

____

____

Psychotropic Medications ____

____

Other Forms of Treatment

____

If you are currently on psychotropic medication, please write the name and phone number of the psychiatrist or doctor who prescribes it:

____

……………………………………………………………………………………………

REASON FOR REFERRAL

Describe why you are seeking treatment/what issues you would like help with:

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Please check off which problems / symptoms apply to you currently:

_____ sad/depressed mood

_____ anxious/tense

_____ panic attacks

_____ angry outbursts

_____ withdrawn

_____ fatigue

_____ decreased appetite

_____ increased appetite

_____ excessive weight loss

_____ excessive weight gain

_____ purging

_____ increased sleep

_____ difficulty falling asleep

_____ early morning waking

_____ nightmares

_____ poor attention/concentration

_____ hyperactivity

_____ stealing

_____ alcohol use

_____ drug use

_____ physical aggression/fighting

_____ problems with the law

_____ suicidal thoughts

_____ suicide attempt

_____ self-injurious behavior (e.g. cutting)

_____ auditory hallucinations

_____ visual hallucinations

_____ sexual problems

_____ inappropriate sexual behavior

_____ problematic peer relationships

_____ problematic family relationships

_____ problematic romantic relationships

_____ poor work performance

Please use this space to describe any other problems, questions, or concerns you would like us to know about.

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AUTHORIZATION TO **RECEIVE** AND **RELEASE** INFORMATION

DATE:

I, ____________________________, authorize _____________________ at Cognitive and Behavioral Consultants of Westchester, LLP to discuss my information and treatment (includes any pertinent psychological and medical background information and current issues) with the following parties:

1. Name: ____________________________ Affiliation: ______________________

Address: ____

Phone Number: ____

2. Name: _____________________________ Affiliation: _______________________

Address: ____

Phone Number: ____

3. Name: _____________________________ Affiliation: _______________________

Address: ____

Phone Number: ____

I understand this authorization will expire at termination of treatment or at any time prior upon written request.

I hereby consent that this communication can take place through:

____ *telephone* _______*fax* ______ *email* ______ *mail*

I understand that email is not a confidential method of communication and that there is a risk that email communications may be intercepted by a 3rd party or may be transmitted to unintended parties. I am aware that the staff of CBCW will take all necessary measures to avoid using identifying information in email communications.

Date: ____________________

Name of Authorized Patient Representative (Print): ______________________________

Signature of Authorized Patient Representative: _________________________________

Authorized Representative's Relation to Patient: ________________________________

Name of Party Accepting Authorization (Print): _________________________________

Signature of Party Accepting Authorization: ____________________________________