



PEACE OF MIND THERAPY • 6502 GRAND TETON PLAZA STE 204 • MADISON, WI 53719

PEACEOFMIND-MADISON.COM • 608.338.1786 • fax 608.831.4383

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CONTACT INFORMATION

NAME WITH MIDDLE INITIAL: _____

AGE: _____ DATE OF BIRTH: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

EMAIL ADDRESS: _____

PLEASE CHECK ONE: SINGLE MARRIED MINOR DOMESTIC PARTNER DIVORCED WIDOWED

IN THE EVENT WE NEED TO LEAVE A CONFIDENTIAL VOICE MESSAGE DO YOU GRANT US PERMISSION? ____ YES (NUMBER _____) ____ NO

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INSURANCE

HEALTH INSURANCE PLAN: _____ CO-PAY AMOUNT FOR OFFICE VISITS: \$ _____

WHAT IS YOUR ANNUAL DEDUCTIBLE? _____ HAS IS IT BEEN MET? _____

HAVE YOU CONFIRMED THAT YOU CAN USE YOUR INSURANCE FOR MENTAL HEALTH? YES NO

POLICY HOLDER NAME: _____ MIDDLE NAME: _____ BIRTHDATE: _____
PHONE: _____

PRIMARY CARD HOLDER'S INSURANCE ID # (Please include dash & two digits) _____

IF PRIMARY CARD HOLDER HAS A DIFFERENT ADDRESS PROVIDE THEIR ZIP CODE: _____

YOUR INSURANCE ID # (Please include dash & two digits) _____

GROUP ID# _____

**Please note we cannot bill insurance for couples therapy. We ask that you refer to our sliding fee scale on our website to determine your out-of-pocket rate. **

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MORE ABOUT YOU

WITH WHOM DO YOU LIVE? _____ CURRENT EMPLOYER: _____

JOB POSITION: _____ JOB ROLES: _____

WHAT BRINGS YOU TO THERAPY? _____

EVER ATTEMPTED SUICIDE? _____ WHEN? _____ SUICIDAL NOW/HAVE A PLAN? _____

HAS SUBSTANCE USE OR ABUSE EVER CAUSED A PROBLEM? _____

PRIMARY CARE PHYSICIAN: _____ PSYCHIATRIST: _____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

MEDICATION	DOSAGE	PURPOSE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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HOW CAN WE HELP?

PRIMARY REASON FOR SEEKING THERAPY? _____

HAVE YOU ENGAGED IN THERAPY BEFORE? WAS IT A GOOD EXPERIENCE? _____

WHO DID YOU SEE? _____

WHAT GOALS WOULD YOU LIKE TO FOCUS ON IN THERAPY? _____

HOW DID YOU HEAR ABOUT US?

GOOGLE PSYCHOLOGY TODAY INSURANCE DOCTOR/PROVIDER OTHER

WHAT SEARCH WORDS DID YOU USE IF YOU FOUND US ONLINE? _____

REFERRED BY? _____

WHAT ARE YOUR THREE GREATEST STRENGTHS?

- 1.
- 2.
- 3.

WHAT COMPLIMENTS HAVE YOU RECEIVED FROM FAMILY AND FRIENDS? _____

WHAT HAS THE COUPLE/FAMILY DONE IN THAT MAKES YOU PROUD? _____

WHAT HAVE YOU DONE IN YOUR LIFE OF WHICH YOU ARE PROUD? _____

WHAT ARE THE STRENGTHS OF THE COUPLE/FAMILY? _____

WHO IS YOUR BIGGEST SUPPORTER? _____ WHY? _____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. MOST PEOPLE WHO KNOW ME WOULD DESCRIBE ME AS (PLEASE CIRCLE ONE)
 - a. FEELING CENTERED
 - b. THOUGHT CENTERED
 - c. ACTION CENTERED

2. I WOULD DESCRIBE MYSELF AS (PLEASE CIRCLE ONE)
 - d. FEELING CENTERED
 - e. THOUGHT CENTERED
 - f. ACTION CENTERED

3. WHEN I AM UNDER A GREAT DEAL OF STRESS OR TENSION (PLEASE CIRCLE ONE)
 - g. I SIMPLY CANNOT SIT STILL; I NEED TO BE BUSY
 - h. I WILL SOMETIMES DO SOMETHING TO TAKE MY MIND OFF THE STRESS
 - i. I AM IMMOBILIZED

FROM THE FOLLOWING LIST PLEASE CHOOSE THE AREAS THAT ARE OF CONCERN:

- DEPRESSION PHYSICAL PAIN HOPELESSNESS LONELINESS
- SADNESS ANXIETY GUILT GRIEF/LOSS
- ANGER OBSESSIONS ADDICTIONS DELUSIONS
- FEAR SELF-HARM SUICIDE CHRONIC ILLNESS
- LIMITED PHYSICAL ABILITIES LACK OF MOTIVATION

PLEASE ANSWER THE FOLLOWING QUESTIONS:

- 1. I AM COMFORTABLE WITH MY EMOTIONAL SELF**
 YES NO
- 2. PEOPLE PERCEIVE ME AS HAVING A POSITIVE ATTITUDE**
 YES NO
- 3. I GET DEPRESSED OFTEN**
 YES NO
- 4. I GET ANGRY OFTEN**
 YES NO
- 5. I HOLD IN MY FEELINGS**
 YES NO
- 6. I USE ALCOHOL OR OTHERS DRUGS TO NUMB MY FEELINGS**
 YES NO
- 7. I TYPICALLY FEEL COMFORTABLE IN SOCIAL SITUATIONS**
 YES NO
- 8. I LAUGH OFTEN**
 YES NO
- 9. I CRY OFTEN**
 YES NO
- 10. I FEEL I HAVE A SENSE OF PURPOSE**
 YES NO
- 11. I FEEL MY FAMILY AND FRIENDS NEED ME**
 YES NO
- 12. I THINK ABOUT COMMITTING SUICIDE**
 YES NO
- 13. I LOOK FORWARD TO MY FUTURE**
 YES NO

HOW ARE YOU NOW?

PLEASE MARK AND X IN ONE OF THE THREE BOXES TO REPRESENT WHERE YOU ARE CURRENTLY.

YES NEUTRAL YES

HOPELESS				HOPEFUL
FATIGUED				ENERGIZED
SAD				HAPPY
DIMINISHED CONCENTRATION				NORMAL CONCENTRATION
TENSE				RELAXED
OBSESSIVE THOUGHTS/ BEHAVIORS				NO OBSESSIVE THOUGHTS/ BEHAVIORS
NOT SLEEPING				SLEEPING
ANGRY				PEACEFUL
SOCIALLY DISENGAGED				SOCIALLY ENGAGED
NO IDENTITY				STRONG SENSE OF SELF
FEELINGS OF GUILT OR WORTHLESSNESS				NO GUILT AND WORTHY
SUICIDAL				ENGAGED IN LIVING

PLEASE CHECK "STRENGTH" OR "GROWTH" FOR THE FOLLOWING QUESTIONS. **PLEASE FILL OUT INDIVIDUALLY.**

STRENGTH GROWTH

1. COMMUNICATION WE SHARE FEELINGS AND UNDERSTAND EACH OTHER.		
2. CONFLICT RESOLUTION WE ARE ABLE TO DISCUSS AND RESOLVE DIFFERENCES		
3. PARTNER/OR FAMILY SYTLE AND HABITS WE APPRECIATE EACH OTHER'S PERSONALITY AND HABITS		
4. FINANCIAL MANAGEMENT (COUPLES ONLY) WE AGREE ON BUDGET AND FINANCIAL MATTERS		
5. LEISURE ACTIVITIES WE HAVE A GOOD BALANCE OF ACTIVITIES TOGETHER AND APART		
6. SEXUALITY AND AFFECTION (COUPLES ONLY) WE ARE COMFORTABLE DISCUSSING SEXUAL ISSUES AND SHOWING AFFECTION		
7. FAMILY AND FRIENDS WE FEEL GOOD ABOUT OUR RELATIONSHIPS WITH RELATIVES AND FRIENDS		
8. RELATIONSHIP ROLES WE AGREE ON HOW TO SHARE DECISION-MAKING AND RESPONSIBILITIES		
9. CHILDREN AND PARENTING WE AGREE ON ISSUES RELATED TO HAVING/ RAISING CHILDREN		
10. SPIRITUAL BELIEFS WE HOLD SIMILAR RELIGIOUS VALUES AND BELIEFS		