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

PEACEOFMIND-MADISON.COM • 608.338.1786 • fax 608.831.4383

1 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

2 INSURANCE

HEALTH INSURANCE PLAN: ____________________ CO-PAY AMOUNT FOR OFFICE VISITS: $ ______

WHAT IS YOUR ANNUAL DEDUCTABLE?______________ HAVE YOU MET IT? __________

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

POLICY HOLDER NAME: ________________________ MIDDLE NAME: __________________

BIRTHDATE: ____________________ PHONE: ____________________________________

PRIMARY HOLDER'S INSURANCE ID# (include dash & two digits) ______________________________

IF PRIMARY CARD HOLDER HAS A DIFFERENT ADDRESS PLEASE PROVIDE WITH ZIP CODE:

____

YOUR INSURANCE ID# (include dash & two digits)____________________________________

GROUP POLICY ID# ________________________

Please note we ask you to come to your first session with a knowledge of the above information. It will not be Peace of Mind's responsibility to determine your insurance coverage. We will bill you out of pocket ($160) should insurance deny your claim. In the case of minors, it is the guardian's responsibility to ensure that the co-pay amount is provided at the time of **each session.**

3 MORE ABOUT YOU

WITH WHOM DO YOU LIVE? ______________________CURRENT EMPLOYER: __________________

JOB POSITION: _______________________JOB ROLES: _____________________________________

WHAT BRINGS YOU TO THERAPY? ____
____

EVER ATTEMPTED SUIDCIDE? _____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

4 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? ____

5

STRENGTHS

WHAT ARE YOUR THREE GREATEST STRENGTHS?

1.

2.

3.

WHAT COMPLIMENTS HAVE YOU RECEIVED FROM FAMILY AND FRIENDS? ___________________

____

____

WHEN FAMILY AND FRIENDS HAVE TURNED TO YOU FOR HELP, WHAT KIND OF HELP HAVE THEY USUALLY BEEN SEEKING FROM YOU? ____

____

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

____

TELL ME ABOUT SOME OF THE THINGS IN YOUR PAST IN WHICH YOU HAVE FELT YOU HAVE BEEN AT YOUR BEST. ____

____

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

6

CONCERNS

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

□ DEPRESSION □ PHYSICAL PAIN □ HOPELESSNESS □ LONELINESS

□ SADNESS □ ANXIETY □ GUILT □ GRIEF/LOSS

□ ANGER □ OBESSIONS □ 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
FRAGMENTED				WHOLE
SAD				HAPPY
CONSTRAINED				FREE
TENSE				RELAXED
SPENT				ENERGIZED
RESENTFUL				GRATEFUL
ANGRY				PEACEFUL
SOCIALLY DISENGAGED				SOCIALLY ENGAGED
NO IDENTITY				STRONG SENSE OF SELF
LASH OUT EASILY				COMPOSED
SUICIDAL				ENGAGED IN LIVING