Personal Psychotherapy Data Form
Please Print

Date ______________________________

Mary McGinn Clark, Ph.D.

Name: ____________________________ Date of Birth: ______________ Age: _______

SSN: ____________________________ Cell: ______________________________

Home Phone: ____________________________ Work Phone: ______________________________

Address: ____________________________ City, State, Zip: ______________________________

Insurance: ____________________________ Authorization Number: ______________________

Employer: ____________________________ Occupation: ______________________

Drivers Lic #: ____________________________ Education: ______________________

Person to Notify in Emergency: ______________________ Phone: ________________

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Partner: ____________________________ Date of Birth: ______________ Age: _______

SSN: ____________________________ Cell: ______________________________

Home Phone: ____________________________ Work Phone: ______________________________

Address: ____________________________ City, State, Zip: ______________________________

Insurance: ____________________________ Authorization Number: ______________________

Employer: ____________________________ Occupation: ______________________

Drivers Lic #: ____________________________ Education: ______________________

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Child's Name: ______________________ Date of Birth: ______________ Age: _______

Child's Address: ______________________ City, State, Zip: ________________ SSN: __________

Referred by: ______________________________________ Phone: ________________

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Assignment of Insurance Benefits:

I, the undersigned, have insurance coverage with ______________________________ and assign directly to Mary M. Clark, Ph.D. all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Dr. Clark to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

______________________________________ ______________________________

Signature of Insured Date

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Mary McGinn Clark, Ph.D.

Date _____

Name: _____

Reason for the visit: _____

_____

_____

Medications that I take	**Dosage**	**Frequency**	**Prescribing Physician**	**Phone**

Do you smoke?

____ current every day smoker
____ current some day smoker
____ former smoker
____ never smoked
When did you start? _____

Please continue on back...

PLEASE CHECK THE ITEMS BELOW THAT DESCRIBE YOUR PROBLEMS.				
	ALMOST NEVER	SOME-TIMES	OFTEN	ALMOST ALWAYS
1. Feel exhausted.				
2. Trouble in my job.				
3. Trouble concentrating.				
4. I feel like crying.				
5. Thoughts about suicide.				
6. Hard to have a good time.				
7. I feel depressed.				
8. Trouble making decisions.				
9. Constipation and diarrhea.				
10. Planning to end my life.				
11. Trouble going to sleep.				
12. Hard to stay asleep.				
13. I drink too much.				
14. I use drugs too much.				
I think about harming others.				
16. Headaches or dizziness.				
17. Binge eating.				
18. I worry about my weight.				
19. Stomach trouble.				
20. Strange experiences.				
21. My heart beats faster.				
22. I imagine terrifying things.				
23. Panicky feelings.				
24. Uncontrollable worrying.				
25. I fear I may harm someone.				
26. Fear things I shouldn't.				
Feel apart from people.				
28. Hard for me to make friends.				
29. Trouble keeping friends.				
30. I see or hear things other people do not see or hear.				
31. My mind is not as clear as it was.				
32. People dislike me.				
33. I get so nervous I can't move.				
34. Afraid to go out alone.				
35. I'm afraid to be alone.				
36. I have had a recent, unplanned weight gain or loss. [ ] yes [ ] no If yes, how much?				
37. I have attempted suicide in the past. [ ] yes [ ] no If yes, when did this happen?				
38. Other:				

Signature _____ Date _____