CORNERSTONE COUNSELING CENTER, PC
6011 Jonestown Road, Harrisburg, PA 17112
(717) 671-9520, FAX (717) 671-9524

PATIENT DATA FORM

PATIENT'S NAME:_____REFERRED BY:_____
PHONE: (H)_____(W)_____(CELL)_____
ADDRESS:_____CITY:_____ZIP:_____
SS#:_____ AGE:_____ BIRTH DATE:_____ RELIGION:_____
EMPLOYER/SCHOOL:_____ OCCUPATION:_____
YEARS OF EDUCATION:_____ **PRIMARY INSURANCE COMPANY**:_____
SUBSCRIBER NAME: _____**INSURANCE ID#**:_____GROUP #:_____
SUBSCRIBER SS#: _____ DOB:_____ SUBSCRIBER EMPLOYER_____
SECONDARY INS CO:_____ SECONDARY INS ID#_____
Subscriber Name:_____ DOB:_____ Subscriber Employer_____

NAME AND PHONE NUMBER OF EMERGENCY CONTACT PERSON (NOT LIVING IN YOUR HOUSE).
_____

OTHER PERSONS LIVING IN YOUR HOUSEHOLD (NAMES, DATES OF BIRTH, AND RELATIONSHIP TO YOU):
_____
_____
_____
_____
_____

WHAT BROUGHT YOU TO SEEK HELP AT THIS TIME?
_____
_____
_____
_____

IF PATIENT IS UNDER 18 YEARS OF AGE, COMPLETE THE FOLLOWING

MOTHER:_____PHONE:(H)_____(W)_____
ADDRESS:_____CELL:_____
BIRTH DATE:_____SS#:_____
EMPLOYER/OCCUPATION:_____INSURANCE ID#:_____
INSURANCE CARRIER:_____GROUP #:_____

FATHER:_____PHONE:(H)_____(W)_____
ADDRESS:_____CELL:_____
SS#:_____BIRTH DATE_____EMPLOYER/OCCUPATION:_____
INSURANCE CARRIER:_____ID#:_____GROUP #:_____

NAME OF SCHOOL:_____CURRENT GRADE PLACEMENT:_____
CURRENT GRADE AVERAGE/GPA:_____GUIDANCE COUNSELOR:_____
HISTORY OF ACADEMIC PERFORMANCE:_____
_____
HISTORY OF DIFFICULTIES WITH CONDUCT, HOMEWORK, PEERS, OR AUTHORITIES: _____
_____

 PATIENT'S NAME/ID: _____

MEDICAL INFORMATION

PHYSICIAN'S PRACTICE AND/OR INDIVIDUAL NAME: _____

ADDRESS: _____ PHONE #: _____

DATE OF MOST RECENT COMPLETE MEDICAL EXAM: _____ LAST APPT. DATE: _____

ALLERGIES (Medications, Food, Substance): _____

MAJOR PAST OR PRESENT MEDICAL ILLNESSES:

____ Stroke	____ Seizures	____ Migraines	____ Liver Damage	____ Thyroid Problems
____ Anemia	____ Diabetes	____ Chronic Pain	____ Chronic Fatigue	____ Cardiac Problems
____ Asthma	____ Hepatitis	____ Tuberculosis	____ Eating Disorder	____ Hypertension
____ Cancer	____ Urinary Tract Infection	____ Persistent Flu-Like Symptoms		____ Infectious Disease

LIST ALL KNOWN MEDICAL/PHYSICAL PROBLEMS:

_____

_____

_____

MEDICATION HISTORY:

Current Medications: ___ None ___ Psychiatric ___ Medical ___ No Information

Name of Medication	Dosage/Frequency	Start Date	Length/Duration	Effectiveness

Past Medications: ___ None ___ Psychiatric ___ Medical ___ No Information

Name of Medication	Dosage/Frequency	Start Date	Length/Duration	Effectiveness

SUBSTANCE USE/ABUSE HISTORY: note Use = "U", Abuse = "A", Dependence = "D"

List all substances that you currently use and/or have used in the recent past:

___ Tobacco/Nicotine ___ Caffeine ___ Alcohol ___ Prescription Meds ___ Other

Have you used any of the following?

	Within Past 6 Months	Past 12 Months	Past 2 Years	Past 5 Years	Never
Marijuana	_____	_____	_____	_____	_____
Cocaine/crack	_____	_____	_____	_____	_____
Tranquilizers	_____	_____	_____	_____	_____
Sleeping Pills	_____	_____	_____	_____	_____
Pain Pills	_____	_____	_____	_____	_____
Inhalants	_____	_____	_____	_____	_____
Hallucinogens	_____	_____	_____	_____	_____

Do others in the home also use any of the above substances? If yes, who and how much: _____

_____

Substance use/abuse/dependency related problems:

___ None ___Legal ___ Occupational ___Educational ___ Financial ___ Family ___ Health

 PATIENT'S NAME/ID: _____

HISTORY OF TREATMENT

PRIOR EXPERIENCE WITH PSYCHOTHERAPY, COUNSELING, OR DRUG REHAB:

____ **NONE**

____ **PSYCHOLOGICAL/PSYCHIATRIC/MENTAL HEALTH** (mark all that apply)

____ self-help/educational/community resources ____ EAP ____ out-patient
____ day treatment ____ partial hx ____ in-patient ____ residential ____ med management
____ long term hospitalization ____ other (explain): _____

____ **SUBSTANCE ABUSE/CHEMICAL DEPENDENCY**

____ self-help/educational/community resources (AA, NA, ACOA) ____ EAP
____ out-patient CD ____ structured out-patient ____ residential or day treatment
____ hospitalization/medical detox ____ residential/halfway house/recovery home
____ other (explain)

Name of Prior Provider(s)	**Approximate Dates of Service**	**Outcome**
_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY HISTORY (Immediate and Extended) OF EMOTIONAL/PSYCHOLOGICAL/PSYCHIATRIC AND/OR DRUG AND ALCOHOL DIFFICULTIES AND TREATMENT: ____ None known ____ Yes, as explained: _____
_____
_____

LIST AND ASSESSMENT OF CURRENT CONCERNS
(please circle an answer for each of the items below)

____ Panic Attacks	No difficulties	1	2	3	4	5	Severe
____ Relationship Problems	**No difficulties**	**1**	**2**	**3**	**4**	**5**	**Severe**
____ Anxiety/Worry	No difficulties	1	2	3	4	5	Severe
____ Sadness/Depression	**No difficulties**	**1**	**2**	**3**	**4**	**5**	**Severe**
____ Suicidal Thoughts or Feelings	No difficulties	1	2	3	4	5	Severe
____ Anger/Explosiveness	**No difficulties**	**1**	**2**	**3**	**4**	**5**	**Severe**
____ Impulsive Behavior	No difficulties	1	2	3	4	5	Severe
____ Obsessions/Compulsions	**No difficulties**	**1**	**2**	**3**	**4**	**5**	**Severe**
____ Memory/Concentration	No difficulties	1	2	3	4	5	Severe
____ Confusion/Disorganization	**No difficulties**	**1**	**2**	**3**	**4**	**5**	**Severe**
____ Financial / Legal	No difficulties	1	2	3	4	5	Severe
____ Troublesome Memories	**No difficulties**	**1**	**2**	**3**	**4**	**5**	**Severe**
____ Sleep / Appetite	No difficulties	1	2	3	4	5	Severe
____ Family Problems	**No difficulties**	**1**	**2**	**3**	**4**	**5**	**Severe**
____ Health/Medical	No difficulties	1	2	3	4	5	Severe
____ Sexual Problems	**No difficulties**	**1**	**2**	**3**	**4**	**5**	**Severe**
____ Work / School	No difficulties	1	2	3	4	5	Severe
____ Alcohol / Other Drug Abuse	**No difficulties**	**1**	**2**	**3**	**4**	**5**	**Severe**
____ Overall Satisfaction in Life	No difficulties	1	2	3	4	5	Severe
____Other	**No difficulties**	**1**	**2**	**3**	**4**	**5**	**Severe**
____	No difficulties	1	2	3	4	5	Severe
____	**No difficulties**	**1**	**2**	**3**	**4**	**5**	**Severe**
____	No difficulties	**1**	2	3	4	5	Severe