North Shore Psychology and Behavioral Medicine Associates

North Shore Medical Center
6 Essex Drive
Peabody, MA 01960
978-532.7588

Winthrop Doctors Building
52 Crest Avenue
Winthrop, MA 02152
781- 846-7088

FOR OFFICE USE ONLY

Service: _____ Date: _____ Amt.: _____ Notes: _____

Dx _____ _____

Note: Only fill in subscriber column for items that are DIFFERENT from Client information

Client

Name: _____

Rel. to Subscriber:: _____

Address: _____

City, State, Zip: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Employer: _____

DOB: _____

SS#: _____

Insurance _____

INS. ID#: _____

2ND INS: _____

2ND INS. ID: _____

SUBSCRIBER

NAME: _____

EMPLOYER: _____

DOB: _____

SS#: _____

Name of Previous Therapist/Or Clinics: _____

Address: _____

City, State, Zip _____

Medical/Psychiatric Hospitalizations:

_____

_____

_____

_____

PERSON TO CONTACT IN EMERGENCY: _____

ADDRESS, CITY, STATE, ZIP: _____

PHONE: _____

THERAPIST SEEING HERE: _____ IND. _____ COUPLE/FAMILY _____ MED.MANAGEMENT _____

CONTACT WITH INS. CO.: _____ PHONE: _____

Date: _____ # of Sessions: _____ Auth. # _____

Rep.: _____ Start/end dates: _____ Per year limits: _____

Co-pay: _____ Misc. _____

What do you feel is the reason for seeking help at this time? _____

What does your referring person feel is the problem? _____

Describe if and when you have had the same or similar problems before, what you did to resolve them and what the results were?

FAMILY HISTORY

	Name:	Age:	City of Residence	Occupation	Date/Cause of Death
Spouse					
Children					
1st					
2nd					
3rd					
Father:					
Mother					
Siblings					
1st					
2nd					
3rd					

Other Places You Have Lived: _____

Food and Alcohol Pattern/Describe a typical day: _____

Describe your exercise habits: _____

List allergies and/or sensitivities to food, medication, etc.: _____