Quo Vadis Therapy Center, LLC

Located at Arden Woods Psychological Services
CLIENT INFORMATION/REGISTRATION FORM

Joseph W. Pribyl, MA, LMFT
900 Long Lake Road, #320
New Brighton, MN 55112
Phone: 651-398-5847
www.qvtherapy.com

Date: ______________

Client Name: ______________________________________ **Gender: M F Date of Birth:** ________________

Client Address: ____
(Please provide contact information at which you are comfortable receiving correspondence from Quo Vadis)

Responsible Party Name:____
(Person consenting to therapy and person who is to receive billing statements)

Billing Address:____
(Responsible party's address to where billing statements should be sent)

May we correspond by email? Y / N Email address:____

Client Home Phone:__________________**Daytime Phone:**_________________**Cell Phone:**_________________
(Please indicate which number is preferred and if it is NOT ok to contact you or leave messages at any of these numbers)

Marital Status: Single Dating Engaged Married Divorced Domestic Partner Widowed

Person filling out form, if not client: ____________________________ **Relationship to client:** ______________

Primary Care Physician: _____________________________________ **Phone:** ___________________________

Emergency Contact: _______________________ **Relationship to Client:** ____________ **Phone:** ___________

INSURANCE INFORMATION – Complete if you intend to use insurance benefits for services provided
(Please include any secondary insurance coverage on the back of this page)

Primary Insurance: __________________________________ **Insurance Company Phone:** _________________

Name of Primary Policy Holder Exactly as It
Appears on the Card: ____ **Date of Birth:** __________________

Policy Holder I.D. #: ___________________**Group #:** ________________ **Group Name:** ___________________

Policy Holder Mailing Address (if different from client's): ____

Policy Holder Phone: ________________________________ **Relationship to Client:** ______________________

My signature below authorizes Quo Vadis Therapy Center/Arden Woods Psychological Services to bill and release all necessary information to all of my insurers/3rd party payers for the purpose of Quo Vadis Therapy Center to receive reimbursement for services provided to me. I understand that my signature will apply to any/all insurance and/or 3rd party submissions. I agree to the payment agreement/policies provided to me under separate cover.

_______________________________________ ___________________________ ______________________
Responsible Party Signature Relationship to Client Date

Are you involved in any legal proceedings which could involve your therapist? Y / N
How were you referred to Quo Vadis Therapy Center, LLC?____

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For Office Use Only:

Dx: ______________**DX Description** _______________________ **Fee**_________ **Adj** ___________ **CP** _____
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ADDITIONAL INSURANCE INFORMATION

Secondary Insurance: _____ Insurance Company Phone: _____

Name of Primary Policy Holder Exactly as It Appears on the Card: _____ Date of Birth: _____

Policy Holder I.D. #: _____Group #: _____ Group Name: _____

Policy Holder Mailing Address (if different from client's): _____

Policy Holder Phone: _____ Relationship to Client: _____

CLIENT HISTORY, CONCERNS, AND GOALS

Please fill in the following information as completely as possible. All information is covered by our confidentiality policy (see attached office policies). Use the back of form as necessary.

1) Describe what has happened recently that led you to seek counseling now. _____
_____
_____

2) Current Concerns and Symptoms (check those that occur to you more often than you would like)

__ Aggression
__ Alcohol dependence
__ Anger
__ Antisocial behavior
__ Anxiety
__ Avoiding people
__ Chronic pain
__ Chest pain
__ Cyber addiction
__ Disorientation
__ Distractibility
__ Dizziness
__ Drug dependence
__ Eating (over/under)
__ Elevated mood
__ Elevated energy level
__ Fatigue
__ Gambling
__ Hallucinations
__ Headaches
__ Heart palpitations
__ Helplessness
__ High blood pressure
__ Hopelessness
__ Impulsivity
__ Judgment errors
__ Loneliness
__ Memory problems
__ Mood shifts
__ Panic attacks
__ Phobias/fears
__ Racing thoughts
__ Recurring, unwanted thoughts
__ Relationship problems
__ Sadness/depression
__ Sexual addiction
__ Sexual difficulties
__ Shortness of breath
__ Sick often
__ Sleeping problems
__ Speech problems
__ Stomach/digestive problems
__ Suicidal thoughts
__ Thoughts disorganized
__ Thoughts of harming others
__ Tightness in chest
__ Trembling
__ Withdrawing behavior
__ Loss of interest in hobbies
__ Loss of appetite
__ Feeling stuck in routine
Other (specify):_____
_____
_____
_____
_____

Briefly discuss how the above symptoms impair your ability to function more effectively. _____
_____
_____
_____

Provide any other information that might help your therapist understand your concerns. _____
_____
_____

3) Circle the one response which best applies for each of (A) and (B):

(A) My current concerns and symptoms are:

the continuation of a long-standing condition

a recent worsening of an on-going condition

the reoccurrence of a previous condition

significantly different from any previous condition

my first occurrence of any condition

(B) My current symptoms developed:

suddenly (less than four weeks)

gradually (one to several months)

very gradually (one to several years)

4) Medical History. Please list major injuries, illnesses, or surgeries.
Condition(s) _____
Dates _____
Treatment_____

5) Are you currently on any medication or over-the-counter drugs for a medical condition? Y/ N
Condition(s)_____
Medication(s)_____
Dosage _____
Prescribing Physician _____
Date Started _____

Allergies/Sensitivities to medications _____

6) Any psychiatric medications you have taken in the past (and are not currently taking):
Medication(s) _____
Dosage _____
Prescribing Physician _____
Date Started _____

7) Please list other substances that you use. Include amount, frequency, and when you tend to use them.
Alcohol _____
Heroin _____
Marijuana _____
Psychedelics_____
Caffeine _____
Methamphetamine _____
Tobacco (cigarettes, etc.) _____
Other _____

8) What does your typical daily diet consist of? (Include general food selections at mealtime and number of meals daily, as well as snacks and beverages throughout the day.) _____
_____
_____

9) Describe any exercise you do. (For example, describe the kinds of exercise or general physical activities you do and how often you participate in these activities each day/week.) _____
_____
_____

10) Have you utilized psychotherapy in the past? (If yes, please list names of past therapists, dates, and reason for treatment.). _____
_____

11) Have you ever been hospitalized for a psychiatric/mental health condition? (Please list names of past therapists, hospitalizations, dates, and reason for treatment.)._____
_____
_____

Family Information

Relationship	Name	Age	Living? (circle)	Living with you? (circle)	Frequent contact with this person?
Mother			Yes No	Yes No	Yes No
Father			Yes No	Yes No	Yes No
Siblings			Yes No	Yes No	Yes No
			Yes No	Yes No	Yes No
			Yes No	Yes No	Yes No
			Yes No	Yes No	Yes No
			Yes No	Yes No	Yes No
Spouse			Yes No	Yes No	Yes No
Significant Other (if not married)			Yes No	Yes No	Yes No
Children			Yes No	Yes No	Yes No
			Yes No	Yes No	Yes No
			Yes No	Yes No	Yes No
			Yes No	Yes No	Yes No
			Yes No	Yes No	Yes No
Maternal Grandfather			Yes No	Yes No	Yes No
Maternal Grandmother			Yes No	Yes No	Yes No
Paternal Grandfather			Yes No	Yes No	Yes No
Paternal Grandmother			Yes No	Yes No	Yes No
Other (indicate relationship)					
			Yes No	Yes No	Yes No
			Yes No	Yes No	Yes No

12) Describe your relationship history within your family of origin (i.e. parents, siblings, other relatives). Include parental substance abuse issues as well as other relevant life events (i.e. significant difficulties and/or advantages your family experienced). _____

_____

_____

_____

_____

12 b) Briefly describe your relationships within your family of origin at present. _____

_____

_____

_____

13) Has anyone in your immediate or extended family had a physical or psychiatric illness? Please list relationship and nature of illness. _____

_____

_____

14) Please indicate any significant prenatal and/or other developmental events that affect you now or have affected you in the past (e.g. mother using alcohol/drugs while pregnant with you, verbal, physical, or sexual abuse, neglect, inadequate nutrition, disability, divorce, etc.)._____

_____

_____

_____

15) Briefly describe your marital history and current family situation (e.g. the nature and quality of your relationship with your spouse, history with any previous spouse(s), children, in-laws, etc.).

_____
_____
_____

16) Briefly describe the nature of your friendships and professional relationships. _____

_____
_____
_____

17) Describe your educational background. _____

_____

18) Current employment and work history (brief summary). _____

_____
_____

19) What hobbies do you have or recreational activities do you enjoy? _____

_____

20) Briefly describe your current support system (family, friends, organizations, self). _____

_____
_____
_____

21) What, if any, religious affiliation or spiritual practices do you maintain? _____

_____

20 b) At this time, do you want any particular consideration given to religious/spiritual issues in your therapy? If yes, please briefly describe the nature of these concerns and/or how you'd like them incorporated into your therapy._____

_____
_____

22) Briefly describe your strengths and weaknesses.

_____
_____

23) From which cultural or ethnic group do you belong?_____

23 b) Are you experiencing any problems due to cultural or ethnic issues? If so, please describe.

_____
_____

24) Please describe your goals for therapy.

A. _____
B. _____
C. _____

25) Do you have thoughts about hurting yourself or someone else? Yes No (Please circle one)
Please describe. _____

_____