Michael L. Stern, PhD

PSYCHOLOGIST

GREEN KNOLL PROFESSIONAL CENTER
60 OLD NEW MILFORD ROAD
BROOKFIELD, CT 06804
TELEPHONE (203) 740-2900

Thank you for choosing this office!
Please complete the information below.

Note: The information you provide here is protected as confidential information.

Date:_____

Name (First/Middle/Last): _____

Name of parent/guardian (if under 18 years):

(First/Middle/Last)_____

Address (Street): _____

(City, State, ZIP): _____

Home Phone: ( ) May we leave a message? □ Yes □ No

Cell/Other Phone: ( ) May we leave a message? □ Yes □ No

Work Phone: ( ) May we leave a message? □ Yes □ No

E-mail: _____ May we email you? □ Yes □ No

**Please note: Email correspondence is not considered to be a confidential medium of communication.*

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Marital Status:

□ Never Married □ Domestic Partnership □ Married

□ Separated □ Divorced □ Widowed

Please list any children/age: _____

How were you referred to this office? _____

If an agency or individual referred you, may I contact them to acknowledge this referral? □ Yes □ No

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ No

□ Yes, previous therapist/practitioner and dates:_____

Are you currently taking any prescription medication?

□ No

□ Yes Please list: _____

_____

Have you ever been prescribed psychiatric medication?

□ No

□ Yes Please list and provide dates:

_____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)
Poor Unsatisfactory Satisfactory Good Very good
Please list any specific health problems you are currently experiencing:

_____

2. How would you rate your current sleeping habits? (please circle)
Poor Unsatisfactory Satisfactory Good Very good
Please list any specific sleep problems you are currently experiencing:

_____

3. How many times per week do you generally exercise? _____
What types of exercise to you participate in? _____
4. Please list any difficulties you experience with your appetite or eating patterns:

_____

5. Are you currently experiencing overwhelming sadness, grief, or depression?
□ No
□ Yes
If yes, for approximately how long? _____
6. Are you currently experiencing anxiety, panic attacks, or have any phobias?
□ No
□ Yes
If yes, when did you begin experiencing this? _____
7. Are you currently experiencing any chronic pain?
□ No
□ Yes
If yes, please describe: _____
8. Do you drink alcohol more than once a week? □ No □ Yes
9. How often do you engage recreational drug use?
□ Daily □ Weekly □ Monthly □ Infrequently □ Never
10. Are you currently in a romantic relationship? □ No □ Yes
If yes, for how long? _____
On a scale of 1-10, how would you rate your relationship? _____
11. What significant life changes or stressful events have you experienced recently:

_____
_____
_____

Name of your physician: _____

Address**:** _____

Last physical exam: _____Can I contact your doctor regarding your treatment? □ Yes □ No

FAMILY MENTAL HEALTH HISTORY:

In the section below, identify if there is a family history of any of the following. *If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).*

Please Circle	**List Family Member**
Alcohol/Substance Abuse yes/no	
Anxiety yes/no	
Depression yes/no	
Domestic Violence yes/no	
Eating Disorders yes/no	
Obesity yes/no	
Obsessive Compulsive Behavior yes/no	
Schizophrenia yes/no	
Suicide Attempts yes/no	

ADDITIONAL INFORMATION:

1. **Are you currently employed?** □ No □ Yes

If yes, what is your current employment situation?

_____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

2. **Do you consider yourself to be spiritual or religious?** □ No □ Yes

If yes, describe your faith or belief:

_____

3. **What do you consider to be some of your strengths?**

_____

_____

_____

_____

4. **What do you consider to be some of your weaknesses?**

_____

_____

_____

_____

5. **What would you like to accomplish out of your time in therapy?**

_____

_____

_____

Emergency Contact (Name, Relationship, Address, Phone)

_____

_____

_____

Insurance Information:

Primary Policy

Insurance Company: _____

Insurance Company Phone Number: _____

Name of policyholder (First, MI, Last): _____

Street Address (if different from patient): _____

City, State, ZIP: _____

Sex: _____ Date of Birth: _____ Relationship to Patient: _____

Phone: _____

Patient ID #: _____ Copay Amount _____

Group #: _____

Group Name: _____ Date Policy in Effect: _____

Employer: _____

I authorize the release of any medical or other information necessary to process this claim.

Signed: _____ Date: _____

I authorize my insurance benefits to send payment directly to Michael L. Stern.

Signed: _____ Date: _____

I accept responsibility for charges which are not paid by the insurer. Unpaid charges are subject to a monthly service charge of 1% on overdue balance.

Signed: _____ Date: _____

If there is additional insurance, please complete below:

Insurance Company: _____

Name of policyholder (First, MI, Last): _____

Street Address (if different from patient): _____

City, State, ZIP: _____

Sex: _____ Date of Birth: _____ Relationship to Patient: _____

Phone: _____

Patient ID: _____

Group #: _____

Group Name: _____Employer: _____