RHONDA PERDUE, PH.D.

Obtaining a thorough patient history is an important part of a good evaluation. Completing the following information will help me understand you better and assist in planning your most effective treatment. All information is confidential. Thank you for your cooperation.

Referred by (if any): ____

PATIENT INFORMATION

NAME: (Last)__________________(First)_____________________(MI)___

ADDRESS:____

(City) _______________________________(State)___________(Zip)________

May I send mail to this address? Yes __ No __

List only the telephone numbers you authorize me to call you at. Please indicate if you have a preference as to which number I call.

TELEPHONE: (Home) _______________________________

May I leave a message? Yes__ No__

(Work)_______________________________

May I leave a message? Yes __ No __

(Cell)________________________________

May I leave a message? Yes __ No__

E-MAIL: ___________________________________

May I email you? Yes___ No___

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

BIRTHDATE: _______________ AGE: _________SS#:______________________

RELATIONSHIP STATUS: Never Married ___ Married ___
Domestic Partnership___ Separated ___ Divorced ___ Widowed ___

If married, for how long? __________ Number of prior marriages: ____

Please list any children/age: _______________________________________

OCCUPATION: __________________________________
EMPLOYER: ____________________________________

EMERGENCY CONTACT: ______________________ (Phone) __________________
RELATIONSHIP TO YOU: ____________________________

MEDICAL HISTORY:
Name of Primary Care Physician:________________________________

Phone and Address of Physician: ____
____

Would you like information regarding your treatment with this psychologist be released to your physician? Yes____ No ____ (If so, please complete the attached **Release of Information Form**)

Date of Last Physical Exam/Visit: _________ Reason for last visit: _________________

Current Medical Conditions: ____

Past Medical Conditions: ____

Allergies:____

Current Medications, Dosages, Date started, and Prescribing Physician:
____
____

Have you ever been prescribed psychiatric medications? Yes ____ No ____ (If so please list their names and date prescribed)

____
____-

Do you use tobacco? Yes ____ No ___ If so, how much?_________________________

Do you use alcohol? Yes ___ No ___ If so, how much? __________________________

Do you use recreational drugs? Yes ___ No ___ If so, what kind and what is your pattern of use?
____

Do you have any health problems related to substance abuse? _____________________
____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? Yes___ No___
If so, when? ____
Where? ____
What type of treatment? ____
For what concern? ____
What was your response to treatment? ________________________________

Have you ever been hospitalized for a psychiatric problem? Yes___ No___
If so, when? ____
Where? ____
For what reason? ____

If you have received treatment may I obtain information regarding your previous mental health treatment?
Yes ___ No ___ (If yes, please complete the attached **Release of Information Form**)

Has anyone in your family been treated for a mental health problem? Yes__ No __
If so, who? ____
What was their diagnosis? ____

ADDITIONAL INFORMATION:

What significant life changes or stressful events have you experienced recently?
____
____
____
____

How would you describe your childhood**?**
____

Is there other information about you or your life hat you would like me to know at this time?
____
____
____
____
____

LEGAL HISTORY

Are you presently engaged in litigation? Yes ___ No___

Have you ever been arrested for anything other than a minor traffic offense?
Yes ___ No___ If yes, please explain. ____

INSURANCE INFORMATION

NAME OF INSURED: ______________________________DOB: __________________

SS#: ____

ADDRESS: ____
____

TELEPHONE: ____

EMPLOYER NAME: ____

NAME OF PRIMARY INSURANCE COMPANY:____

TELEPHONE: ____

POLICY OR GROUP NO.: ____

NAME OF SECONDARY INSURANCE CO.: _______________________________

TELEPHONE: ____

POLICY OR GROUP NO: ____

AUTHORIZATION NO: ____

I authorize Rhonda Perdue, Ph.D. to release all information necessary to secure the payment of benefits or obtain authorization to be seen. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that if a problem occurs with the insurance company regarding payments I am responsible for following up with the company. If fees are not paid they may be sent to a collection agency and the insured will be responsible for any collection fees.

I understand that in order to receive the highest quality service, my appointment time has been reserved exclusively for me (appointments are not "double booked"). I understand that any changes with the appointment date or time must be made 48 hours in advance. **If I do not provide the 48-hour notice prior to canceling, I will be financially responsible for the appointment** (unless we both agree that you were unable to attend due to circumstances beyond your control)**. This fee is not covered by your insurance and will apply regardless of the type of insurance you carry.**

I acknowledge that I have received a copy of the **Notice of Policies and Practices to Protect the Privacy of Your Health Information** and had the opportunity to review it. I understand that if I think my privacy rights have been violated I may contact Rhonda Perdue, Ph.D. or send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

I acknowledge that I have received a copy of the **Therapy Information** form and agree to abide to its terms during our professional relationship.

I consent to psychological services for myself or my minor child (if I am consenting for treatment for my child I acknowledge that I am legally authorized to provide this consent). I have made this choice voluntarily and understand I can stop treatment at any time. I understand that psychological treatment requires my cooperation with the psychologist in order to be effective, and that issues discussed may be upsetting. I understand that all information and records collected about me will be strictly confidential, except for the following circumstances.

- If I sign a written request for the release of the records (If we do family or couple therapy and you want to have my records of this therapy sent to anyone, all of the adults present will have to sign a release)
- If a court orders the release of these records
- If there is evidence or strong suspicion of the abuse of a child or elderly person

- If there is evidence or a strong suspicion to believe that I may harm myself or others
- If I choose to raise my mental status or competency in a legal proceeding
- If I agree to submit claims for these services to an insurance company for reimbursement, and that company requests information about the services or diagnosis

Signature: ________________________________Date: ____________________