ADHD FAMILY COUNSELING CENTER OF CENTRAL NEW JERSEY

Irv Finkelstein, LCSW

Licensed Clinical Social Worker

Tel.# **(908) 389-0683**

Fax: (908) 389-0218

220 St. Paul Street
Westfield, NJ 07090

Patient Name_____ Date_____

Address:_____

_____

City:_____State:_____Zip_____

Billing Address if different from above:

Address:_____

_____

City:_____State:_____Zip_____

Home Phone: (____)_____Marital Status:_____

Birthdate:_____SS#_____

Referring Physician/Person:_____

Address:_____

City:_____State:_____Zip_____

With whom do you live (relationship, if any)? _____

_____

Person to notify in emergency:

Name_____Phone:(_____)_____

Address:_____

City:_____State:_____Zip_____

Employment Information

Employer Name:_____

Address:_____

City:_____State:_____Zip_____

Occupation:_____

PRESENTING PROBLEM

Please check the major problem(s) for which you are seeking help at this time

1. □ Problems at work
2. □ Difficulty forming an intimate relationship
3. □ A sexual problem
4. □ Problems getting along with others
5. □ An unsatisfactory social life
6. □ Reacting too emotionally to events or people
7. □ Feeling uncomfortable with people in general
8. □ Problems with memory
9. □ Alcohol or drug use problems
10. □ An eating problem
11. □ Chronic pain or irritable bowel symptoms
12. □ Unexplained physical symptoms
13. □ Other problems
    (Specify)_____
    _____
    _____
14. □ Low Self Esteem
15. □ Problems with depression or sadness
16. □ Not enjoying things as much as I used to
17. □ Feeling excessive anger or irritability
18. □Difficulties with sleep
19. □ Thought about ending my life
20. □ Very strong mood swings (highs and lows)
21. □ Thoughts that seem to race through my mind
22. □ Needing very little sleep
23. □ Problems with anxiety or excessive nervousness
24. □ Having repetitive or bothersome thought or actions that I cannot stop
25. □ Having to avoid certain places or situations because of being too afraid
26. □ Problems with excessive fears or suspicions
27. □ Difficulty paying attention and/or hyperactivity
28. □ Hearing voices or seeing things
29. □ Procrastination
30. □ Problems with my spouse or romantic partner
31. □ Problems in my family
32. □ Other relationship problems

What problems designated here do you consider the most disturbing at this time. (Please identify numbers)

_____

_____

_____

Overall, To what degree are you affected by these problems currently

Not at all Very Much

1 2 3 4 5

How have these problems affected your:

	Does not apply	slightly very
Marriage partner relationship	□	1 2 3 4 5
Family	□	1 2 3 4 5
Job/School performance	□	1 2 3 4 5
Friendship	□	1 2 3 4 5
Financial situation	□	1 2 3 4 5
Health	□	1 2 3 4 5
Anxiety level/nerves	□	1 2 3 4 5

	Does not apply	slightly very
Financial situation	□	1 2 3 4 5
Health	□	1 2 3 4 5
Anxiety levels/nerves	□	1 2 3 4 5
Mood	□	1 2 3 4 5
Eating habits	□	1 2 3 4 5
Sleeping habits	□	1 2 3 4 5
Ability to concentrate	□	1 2 3 4 5
Child rearing	□	1 2 3 4 5
Ability to control your temper	□	1 2 3 4 5

How long have you been experiencing the problem, which you've identified as most disturbing to you?

- ❑ Less than 4 weeks
- ❑ 1 to several months
- ❑ More than a couple of months
- ❑ All my life

Your current condition is best characterized by:

- ❑ First occurrence with no previous difficulty
- ❑ Repeat of a previous problem
- ❑ Worsening of a long standing condition(s)

At the present time I feel: (Circle best choice)

Extremely Poor Fair Very well

0 1 2 3 4 5 6 7 8 9 10

Are you currently in psychotherapy? ☐ Yes No☐

If so, with whom? _____

How long have you been in treatment? _____

Briefly describe the type of therapy?_____

What effect if any have you noticed._____

Are you currently taking medication for this problem? ☐ Yes No☐

If so , prescribed by whom_____

Please list names and dosages of psychiatric medications currently being used.

Name Dosage

1._____

2._____

3._____

4._____

Have you experienced any of the following emotional/psychological problems in the past?

- ❑ Problems with depression or sadness
- ❑ Thoughts about ending my life
- ❑ Very strong mood swings (highs and lows)
- ❑ Problems with anxiety or excessive nervousness
- ❑ Having repetitive or bothersome thoughts or actions that I cannot stop
- ❑ Having to avoid certain places or situations because of being afraid
- ❑ Problems with excessive fears or suspicions
- ❑ Difficulty paying attention and/or hyperactivity
- ❑ Hearing voices or seeing things
- ❑ Difficulty forming an intimate relationship
- ❑ Alcohol or drug use problems
- ❑ An eating problem
- ❑ Chronic pain or irritable bowel symptoms
- ❑ Unexplained physical symptoms
- ❑ Other problems

Have you ever had outpatient psychological, psychiatric, or substance abuse treatment before? ☐ Yes No☐
If yes, please complete.

From Whom	Dates of treatment	Was it helpful (yes or no)

Have you ever been treated with psychiatric medications in the past? ☐ Yes No☐
If so, complete

Name of Medication	Approx. maximum daily dosage	Approx. how long did you remain on medication	Was it useful? Yes or No	Reason for discontinuation (i.e. side effects, inadequate response etc.)

Have you ever been hospitalized for emotional, psychological or substance abuse problems?
☐ Yes No☐ If yes, please complete.

Name of Hospital or Program	Approx year of admission	Reason for hospitalization	Was it helpful? Yes or No

(To be completed by adults 18 years or older)

How many alcoholic (beer and wine included) do you consume in the average day? _____

Do you have a history or excessive alcohol/drug use? ☐ Yes No☐

Have you ever been told by someone that they thought you needed to cut back on alcohol or drug use? ☐ Yes No☐

Have you ever had social, legal or work problems due to your alcohol or drug use? ☐ Yes No☐

Are you a recovering alcohol or drug user? ☐ Yes No☐

Have you ever used utilized pain medications on a prolonged or excessive basis? ☐ Yes No☐

Are you currently using any drugs on a recreational basis? ☐ Yes No☐

If yes, which drugs are you using_____

Are you using ☐ Daily ☐ 1-2 times per week ☐ 1 to 2 time a month ☐ almost never

(To be completed by adolescents 18 years or younger)

Have you ever thought about suicide? ? ☐ Yes No☐

1. If "yes", When was the last time _____

2. What were the circumstances? _____

Have you ever attempted to kill yourself? ☐ Yes No☐

If "yes", When _____

1. Have you ever intentionally cut or injured yourself? ☐ Yes No☐
2. Are you currently having suicidal thoughts? ☐ Yes No☐
3. Do you have a plan to harm yourself? ☐ Yes No☐
4. Is there a gun in your home? ☐ Yes No☐
5. Has anyone in your family attempted a suicide? ☐ Yes No☐

Do you have a family doctor/internist? ☐ Yes No☐
If so, Name: _____

Address: _____

Phone#: ( ) _____ -_____

Please note any significant medical history including past operations and major illnesses.

_____

_____

Please list all medications you are currently taking. _____

Medication Daily amount

What is your weight in pounds? _____
Has your weight increased or decreased by more than ten pounds in the last 3 years? ☐ Yes No☐
If yes, Explain:
_____

Do you drink tea, coffee or colas with caffeine? ☐ Yes No☐

If yes, How many drinks per day _____

Do you have difficulty falling asleep? ☐ Yes No☐
Do you have problems with waking up and unable to fall back asleep? ☐ Yes No☐
Do you have bad dreams, wet bed, sleep walk or other sleep disturbances? ☐ Yes No☐

Smoking

Do you currently smoke or chew tobacco? ☐ Yes No☐
If so, estimate average daily use _____

Have you previously used tobacco? ☐ Yes No☐
If yes, what was your maximum daily use? _____

How many years did you use? _____

When did you stop? _____

Sexual

Do you have any sexual problems? ☐ Yes No☐
If yes, please describe:

Social/Family History

1. Place of birth: _____
2. Are your parents divorced or separated? ☐ Yes No☐
   If yes, your age at the time _____
3. Do you have step parents? ☐ Yes No☐
   If yes, please specify: _____
4. Who were you raised by?_____
5. Where were you raised? _____

Family History - Please complete as well as possible.

	Current Age (if alive)	If dead, their age at death and your age at the time	Cause of death	Their occupation (when you were growing up)	Your relationship with person when growing up. (Excellent, good, friendly, cordial, cool, cold supportive, stiff, hostile, abusive, distant)	Specify if any history of mental illness, suicidal problems or substance abuse
Mother						
Father						
Step Parents If applicable						
	Current Age (Specify if deceased)	Nature of relationship (currently and when growing up) (Excellent, good, friendly, cordial, cool, cold supportive, stiff, hostile, abusive, distant)				Specify if any history of mental illness, suicidal problems or substance abuse
Brothers/Sisters						
Your Children						

If more space is needed	Current Age (Specify if deceased)	Nature of relationship (currently and when growing up) (Excellent, good, friendly, cordial, cool, cold supportive, stiff, hostile, abusive, distant)	Specify if any history of mental illness, suicidal problems or substance abuse
Brothers/Sisters			
Your Children			

Check any of the following that applied during your childhood and adolescence

❑ Happy childhood	❑ Had difficulty with reading, writing, or math	❑ Cruelty to animals
❑ Unhappy childhood	❑ Were truant	❑ Failed or repeated a grade
❑ Emotional/behavior problems	❑ Not enough friends	❑ Sexually abused
❑ Strong religious convictions	❑ School problems	❑ Exposed to incest
❑ Death in family	❑ Financial problems	❑ Severely bullied or teased
❑ Severely punished	❑ Legal trouble	❑ Eating disorder
❑ Moved frequently	❑ Used alcohol	❑ Drug use
❑ Was afraid to go to school	❑ Promiscuous	❑ Ignored
		❑ Living away from home

Education; (Check the highest level completed)

6th☐ 7th☐ 8th☐ 9th☐ 10th☐ 11th☐ 12th☐

College: 1st☐ 2nd☐ 3rd☐ 4th☐

Graduate school degree ☐

School Attended

	Name	years attended	Degree
High School			
Post High			

What was school like for you? _____

What kind of student were you? _____

Scholastic strengths _____

Scholastic weaknesses _____

Did you make friends easily? ☐ Yes No☐ Did you keep them? ☐ Yes No☐

Did you date much during High School? ☐ Yes No☐ College? ☐ Yes No☐

Rate the degree to which you generally feel relaxed and comfortable in social situations

Very relaxed 1 2 3 4 5 6 7 8 9 10 Very anxious

What situations if any, cause you extreme anxiety? _____

What hobbies or activities do you engage in? _____

Describe your occupation: _____

How long have you been in this field? _____

Describe your current position/job _____

How long have you been at your current position? _____

How do you feel about your occupational life/career? ☐ Gratified ☐ Neutral ☐ Ungratified

Have you ever been in trouble with the law? ☐ Yes No☐
If so describe: _____

With whom do you live? (Check all that apply)

☐ Self ☐ Parents ☐ Spouse ☐ Roommate ☐ Child(ren) ☐ Friend(s)

☐ Other (specify) _____

Place where you live:
☐ House, Rental
☐ House, Own
☐ Apartment
☐ Room
☐ Dormitory
☐ Other

Marital Status:

☐ Never married ☐ Living cooperatively
☐ Married ☐ Separated
☐ Divorced ☐ Marriage annulled
☐ Widow/Widower ☐ Remarried

If you have been married, how many times?
1☐ 2☐ 3☐ ☐More

If you have been divorced, how many times?
1☐ 2☐ 3☐ ☐More

If currently married

What is your spouses age?_____

His/Her occupation: _____

Describe your spouse's personality: _____

How do you feel about your marriage? ☐ Gratified ☐ Neutral ☐ Ungratified

Where do your parents (if alive) and siblings currently reside?

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Patient-Clinician Authorizations and Agreements

Authorizations and agreements with Irv Finkelstein, LCSW.

Please read carefully and sign. The paragraphs below contain several agreements.

For _____

1. Medical Insurance. I authorize the medical insurance company to pay directly for the above clinical services. I, however, understand that the person who signs below are responsible for all my fees, including any fees not paid by the insurance company. I understand that if I have not provided Irv Finkelstein, LCSW with adequate information in order to allow for the verification of my insurance coverage, that I will be fully responsible for all fees incurred. Also, that as a result, I may not be eligible for reimbursement from my insurance company.

2. It is also understood that it is my responsibility to update Irv Finkelstein, LCSW with any changes in insurance coverage that may occur during treatment with this office.

Release of Information: I authorize Irv Finkelstein, LCSW to release information about me to the medical insurance company and the referring physician. This authorization will end if I give written instructions to Irv Finkelstein, LCSW to that effect, which I may do at any time.

Financial Responsibility*: We, the undersigned; understand and agree that each of us is responsible for the patient's fees to Irv Finkelstein, LCSW including fees not paid by medical insurance; that if the account is not paid when due, reasonable collection costs will be paid by the undersigned; that interest at the rate of 1% per month will be charged on any balance outstanding after 90 days; that we are responsible for full therapy fees resulting from appointments not kept or canceled without a 24-hour notice; that fees for out patient services must be paid at the time services are rendered; and that the patient is responsible for filing for insurance reimbursement.*

I understand that if I have not provided Irv Finkelstein, LCSW with adequate information in order to allow for the verification of my insurance coverage, that I will be fully responsible for all fees incurred. Also, that as a result, I may not be eligible for reimbursement from my insurance company.

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DISCLAIMER

In an attempt to provide quality customer service to our patients any verification of your insurance is only an estimate and is not a guarantee of payment by your insurance company. Any insurance approval implied or otherwise is subject provisions in force at the time services are rendered. As a result, **you the patient will be held responsible for all fees incurred.**

Patient or Parent's signature: _____ Date: _____

Relationship to patient (If patient is a minor) _____

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Consent to Release Confidential Information

I hereby authorize and request,

Irv Finkelstein, LCSW

ADHD Family Counseling Center of Central New Jersey

to release confidential information, including personal, psychological, psychiatric, drug/alcohol, medical records and opinions, resulting from my contacts with the above to:

Name

Title/Functions:

Address:

Disclosure shall be limited to the following specific types of information:

Use of this information shall be limited to the following purpose(s):

I understand that any cancellation or modifications of this authorization must be in writing, and that I have a right to receive a copy of this authorization. A photocopy of this authorization shall be as effective and valid as the original.

This authorization shall remain valid until:

I furthermore release all parties stated here within from any legal liability resulting from the release of this information, with the understanding that all parties involved will exercise appropriate safeguards while using this information

Signature _____ **Date** _____

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CREDIT CARD AUTHORIZATION FORM

CREDIT CARD TYPE ☐ **VISA** ☐ **MASTERCARD** ☐ **DISCOVER**

CREDIT CARD NUMBER _____

EXPIRATION DATE _____ **Card Code (on back)** _____

CARD HOLDER NAME _____

BILLING ADDRESS _____

CITY/STATE/ZIP _____

PHONE _____

AMOUNT **Only to pay for professional services**

I, _____, authorize the use of the above listed credit card to pay the fees for **Irv Finkelstein, LCSW**. I understand that the credit card will be used at my request to pay for session fees**. I also give authorization to use the card to pay for any outstanding fees that are over 90 days overdue. I also authorize the card to be used to cover the cost for any fees occurred for missed sessions or sessions canceled with less than the 24 hours notice required. I understand that these transactions will occur without additional notice.** I understand that fee payment deadlines, and/or late fees are my responsibility. I further understand that I may be charged a penalty fee if the credit card company denies my credit card. I understand that a facsimile or photocopy of this form with my signature on it is the same as an original. A copy of the transaction will be mailed for your personal record. Please ensure that you complete this form in its entirety.

Signature Date

Phone: 908 389-0682 *Fax: 908 389-0218*

Email: irv@adhd911.com