**Lois J. Veronen, Ph.D.**
**Licensed Clinical Psychologist #259**
**Wellstone Center, 229 Johnston Street, Rock Hill, SC 29730**
**(803) 448-6333**
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Date: _____ Counselor: _____

Legal name of patient: _____
Last First Middle initial

Address: _____
Number Street City, State Zip

Phone (Work) _____ Birth date: ____/_____/_____

(Home) _____ Gender _____ Age _____

(Cell) _____ Marital Status: S M D Sp W

SS # _____-_____-_____ Employment: _____

Email: _____

Date last worked/attended: _____

How did you hear about us? _____

Spouse/Parent/Guardian/Friends name: _____
Last First Middle initial

Address (if different): _____
Number Street City, State Zip

Phone (Work) _____ Birth date: ____/_____/_____

(Home) _____ Gender _____ Age _____

(Cell) _____ Marital Status: S M D Sp W

SS # _____-_____-_____ Employment: _____

Children: _____yes _____ no Names and Ages: _____

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Previous marriages: _____

***Authorization of Treatment***

I hereby authorize Dr. Veronen or associates to conduct assessments and administer treatments of counseling/ psychological nature for me or my child (if minor).

Date: _____ Patient: _____

Date: _____ Patient: _____

***Insurance Information***

Have you filed for Victim's compensation? _____ Yes _____ No

Do you have insurance you would like us to file? _____ Yes _____ No

*Please give us the following information for your insurance company or companies:*

Name of Company (primary carrier): _____

Address: _____

Phone: _____

Name of Policyholder: _____ Relationship to patient: _____

Policy Number: _____ Group Number: _____

Name of Company (secondary carrier): _____

Address: _____

Phone: _____

Name of Policyholder: _____ Relationship to patient: _____

Policy Number: _____ Group Number: _____

***Authorization to release information to my insurance company or companies:***

I hereby authorize the Dr. Veronen or associates to release information, as requested, by my insurance company for payment.

Date: _____ Signed: _____
(Patient, or Parent/Guardian, if minor)

**Biographical Information**

Primary reason for seeking services:

_____
_____
_____

How have you tried to cope with the problem to date?

_____
_____

What have you found to be helpful in the past?

_____

**PLEASE MARK ALL THAT APPLY:**

____crying spells
____unable to have fun
____feelings easily hurt
____lacking in confidence
____constipation
____feeling grouchy
____always tired
____poor appetite
____depressed
____trouble sleeping
____feeling lonely
____loss of weight
____not enjoying things
____suicidal thoughts
____feeling inferior
____loss of sexual interest
____no one understands me
____worried about health
____can't concentrate
____can't "get along"
____feeling angry
____don't like being alone
____lack energy

____fast heartbeat
____always worried
____frequent sweating
____dizziness
____shaky hands
____stomach trouble
____nightmares
____feeling tense
____cold feet and hands
____feeling panicky
____diarrhea
____shy with people
____muscle twitching
____nausea or vomiting
____can't make decisions
____can't make friends
____headaches
____fainting spells
____unable to relax
____feeling fearful
____overly sensitive
____anxious inside
____weight gain

____money problems
____relationship concerns
____work difficulties
____sexual problems
____can't hold a job
____excessive drinking
____excessive medication use
____excessive drug use
____problems with children
____problems with parents
____poor physical health
____fighting and quarreling
____dislike my body
____full of energy
____overly ambitious
____easily excited
____quick tempered
____impatient with people
____binge eating
____very restless
____feel like hurting
____someone
____feel like smashing things

Are there any active legal issues in your life? _____ Yes _____ No

If yes, please elaborate: _____
_____

Education completed: _____

Are you experiencing any financial issues at the present time? _____ Yes _____ No

**Treatment History**

Are you receiving mental health services at present? yes no

If yes, briefly describe: _____
_____
_____

Have you received mental health services (counselor, psychologist, hospitalization) in the past? ____Yes _____No

If yes, briefly describe: _____
_____
_____

Have you attempted suicide? _____ Yes _____ No

If yes, please elaborate: _____
_____

At the present time, do you have any suicidal thoughts? _____ Yes _____ No

If yes, please elaborate: _____
_____
_____

**Medical History**

Name of primary physician: _____ Name of practice: _____

Are you allergic to any medications? _____ Yes _____ No

If yes, please describe: _____
_____
_____

Last doctors' visit, date and purpose: _____
_____
_____

Date of last dental visit: _____

Please describe any medical problems/surgeries, past and current: _____
_____

Please list currently used medications, purpose, and dosage: _____
_____
_____

List any vitamins/herbs/over-the-counter drugs you are currently taking: _____
_____

I would describe my nutritional level as: _____Poor _____Fair _____ Good _____ Excellent

How would you rate your overall health? _____Poor _____Fair _____ Good _____ Excellent

On average, how many hours of sleep do you get daily? _____

Do you have trouble falling asleep or staying asleep at night? _____ Yes _____ No

If yes, please elaborate: _____
_____
_____

Please describe any chemical/alcohol abuse history: _____
_____
_____

**Family History**

Considering your grandparents, parents, aunts, and siblings, is there a history of mental health problems, including alcohol and other chemical abuses? _____ Yes _____ No

If yes, please elaborate: _____
_____
_____

Which of the following (on a scale of 1 to 9) best describes the family you grew up in? (Circle one number)

| Warm and accepting | | | Average | | Hostile and fighting | |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

Which of the following (scale of 1 to 9) best describes the way your family raised you?

| Allowed much independence | | | Average | | Attempted to control | |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

If your parents separated or divorced, how old were you at that time? _____

Number of brothers _____ Number of sisters _____

I was child number _____in a family of _____ children.

Were you adopted or raised by parents other than your biological parents? _____ Yes _____ No

Briefly describe your relationship with your siblings growing up: _____
_____

Briefly describe your relationship with your mother growing up: _____
_____

How much time did she spend with you? _____
_____

Describe your relationship currently: _____
_____

Briefly describe your relationship with your father growing up: _____
_____

How much time did he spend with you? _____
_____

Describe your relationship currently: _____
_____

Growing up, how were you disciplined? Who disciplined? _____
_____

Were you previously married? ____ Yes ____ No Date of divorce: _____

Children from former marriage: ____ Yes ____ No Names and ages: _____
_____

Current spouse previously married: ____ Yes ____ No Date of divorce: _____

_____

Stepchildren from spouse's previous marriage: ____ Yes _____ No Names and ages: _____
_____

Any lingering problems with previous marriages: _____
_____

**Religious/Spiritual Issues**

How important are spiritual matters? _____

Are you affiliated with a religious or spiritual group? _____Yes _____ No

If yes, please describe: _____

Would you like your spiritual or religious beliefs incorporated into the counseling? _____ Yes ____ No

Comments: _____

**Cultural/Ethnic Issues**

To which cultural or ethnic group do you belong? _____

Are you experiencing any problems due to cultural or ethnic issues? _____ Yes _____ No

If yes, please elaborate: _____
_____

**Social Relationships**

Check how you generally get along with people (check all that apply)

___Affectionate ____ Aggressive ____ Avoidant ____ Fight/Argue ____ Follower

____ Friendly ____ Leader ____Outgoing ___ Shy/withdrawn ____Submissive

____ Assertive ____Independent

How many people do you have in your life that you can and do look to for emotional support? _____

How many family members? _____ How many friends? _____

**Additional Information/Comments**

_____
_____
_____
_____