Nona L. Patterson, Ph.D. • Licensed Psychologist
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704-366-3400

Adult Information Form

Name:_____ Birth Date:_____ Age:_____

Marital Status: _____

Home Address: _____ _____ _____
Address City Zip code

Please list all phone numbers where we may contact you:

Home:_____ Cell:_____ Work: _____

Employer: _____ Occupation: _____

Spouse's Name: _____ Birth Date: _____ Age: _____

Spouse's Employer: _____ Occupation:_____

Emergency Contact: In case of an emergency whom should we contact?

_____ _____ _____
Name Contact Number Relationship

Who referred you? _____ May we thank the person for the referral? ❑Yes ❑No

If not referred, how did you get our name? _____

PRIMARY INSURANCE

Authorization to Pay Benefits & Release Information: I authorize payment of benefits to Nona Patterson,Ph.D, for services provided and I authorize Nona Patterson, Ph.D. to release to my insurance company any medical information necessary to process this claim and/or to obtain authorization for treatment.

Signed:_____ Date: _____

Name of Insurance Plan: _____ Policy #:_____ Group#:_____

Patients Relationship to Insured: ❒ self ❒ spouse ❒ child ❒ other

Insured's Name _____ **Insured's Phone Number:** _____

Insured's Address: _____City:_____State:_____Zip:_____

Insured's Date of Birth: _____**Insured's Gender:** _____**Employer:** _____

Release of Information to Primary Care Physician: Many insurance companies encourage coordination of treatment between the Psychologist and the Primary Care Physician. Please indicate below if you are willing to allow such communication.

❑ I **do not authorize** Nona Patterson, Ph.D., to release information to my **Primary Care Physician**

❑ I hereby **authorize** Nona Patterson, Ph.D., to release confidential clinical information, including intake summary, treatment goals, treatment recommendations, and pertinent progress notes to my Primary Care Physician in order to aid in treatment planning and coordination. This release is valid for one year unless otherwise stated. I hereby acknowledge that this consent is truly voluntary and is valid until such request is fulfilled. Further understand that I may revoke this consent at any time except to the extent that action based on this consent has been taken.

Signed: _____ PCP Name:_____ Date:_____

Please see other side

Past/Current Psychiatric/Psychological Treatment: Name of treating Psychiatrist, if any:

Describe any type of counseling or psychiatric treatment you have received in the past:

Medical:

Name of Physician/PCP: PCP Group or Practice Name:

Physicians Address: Phone:

Name of any other current physicians treating you:

Describe any current health problems that you are being treated for:

Current Medications:

Name	Dosage	Start Date	Side Effects

Briefly describe your reason for seeking help at this time:

Please circle any of the following problems that you feel may be troubling you

panic attacks/intense anxiety	guilt feelings	relationship issues
nervousness	parenting issues	separation/divorce
shyness/ lack of assertiveness	irritability	marital problems
feeling sad/depressed	quick temper/anger	sexual dysfunction
loss of appetite	health problems	unsatisfactory job/ loss of job
increased appetite	racing, recurring thoughts	financial problems
sleep problems	difficulty concentrating	flashbacks
suicidal thoughts	difficulty making decisions	nightmares
feeling tired/fatigued	poor memory	drug/alcohol use

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ Age: ____ Sex: ❑ Male ❑ Female Date:_____

If this questionnaire is completed by an informant, **what is your relationship with the individual? _____**
In a typical week, approximately how much time do you spend with the individual? _____ hours/week

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	