Karen M. Aronoff, PsyD
1201 13th St, Suite 103
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Office (360) 715-1165
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Information Questionnaire

Please complete both sides.

Name: _____ Age: _____ Today's date ____-____-____
First Middle Last

Nickname: _____

[ ] Male [ ] Female Birthdate ____-____-____ SS# ____-____-____

Mailing Address: _____
Street City Zip Code

Home Phone: _____
Okay to call [ ] yes [ ] no Leave message [ ] yes [ ] no

Work Phone: _____
Okay to call [ ] yes [ ] no Leave message [ ] yes [ ] no

Cell Phone: _____
Okay to call [ ] yes [ ] no Leave message [ ] yes [ ] no

Preferred method of communication:
Home phone [ ] Work phone [ ] Cell phone [ ]

Occupation/Job title: _____ Employer _____

Currently a student [ ] no [ ] Full-time [ ] Part-time Where? _____

Married? [ ] yes [ ] no Children? [ ] yes [ ] no Children's ages _____

Spouse's name (or parent's name if unmarried minor): _____

Emergency Contact: _____ Phone number: _____

Information about Payment Options

Insurance billing requires diagnosing a disorder for payment of your claim. Some people are reporting that once a mental health or chemical dependency diagnosis is on their health insurance records, it becomes more difficult to purchase health, disability, or life insurance at a fair price at any point in the future. Also, insurance companies usually exclude *court ordered evaluations, life situation problems, and/or marital therapy* from coverage. *If you elect to use insurance*, please provide the receptionist with your insurance card and information.

Private Payment by cash, check or credit card means that no diagnosis will go anywhere without your authorization. You would have maximum confidentiality. *If you elect to pay privately* in advance or at the time of service we will reduce your bill by $30 per 50 minute session and by $50 for the initial session.

Continue on other side ----------→

Office use only below:

Health insurance company: _____ Authorization # _____

Consumer/ID # _____ Group # _____

Insured's Name *(if different)*: _____ Policy # _____

Insured's Employer: _____

DOB ____-____-____ SS# ____-____-____ Relationship: _____

DSM: _____ CPT: _____

PCP notification completed ____-____-____ NA [ ]

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Your Primary Care Physician: _____

Who referred you? _____

List any significant prior and current medical problems and surgeries — Date

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

List all medications you are taking:

_____
_____

Do you smoke cigarettes? [ ] yes [ ] no

List any allergies you may have: _____ I have none I know of [ ]

_____
_____

Previous experience in counseling? [ ] yes [ ] no

With whom? _____ When? _____

_____ _____
_____ _____

Please state briefly the reason(s) you are seeking assistance – what brings you in?

_____
_____
_____
_____
_____
_____

What goals would you like to achieve with counseling help?

_____
_____
_____
_____
_____
_____