The Meridian Group of Chesterfield

MeridianHelp.com

10109 Krause Rd., Suite 100
Chesterfield, VA 23832-6501

Office: (804) 751-8644
Fax: (804) 751-0648

Adult Questionnaire

_____ Clinician:
Time and Date of First Appointment

___ Marci Andrews, LCSW
___ John Dwyer, PhD
___ Melissa Findlay, LCSW
___ Elizabeth Novak, LCSW
___ David Epstein, PsyD
___ Mary Sciotto, PsyD
___ Tawana Olds, LCSW
___ George White, LPC

Name: _____
first middle initial last

Age:_____ Date of Birth:_____ Gender: M F Education Level: _____

Street Address _____City:_____ State:_____ Zip:_____

Primary Phone: _____ cell home work
Please list only phone numbers your clinician may call

Second Phone Contact: _____ cell home work

Place of Employment: _____Occupation:_____

Who Referred You to our Office?:_____Your Email:_____
Please list only if your clinician may use

Primary Care Physician (PCP):_____ Practice Name:_____

Who Will Be Responsible for Payment of This Account?

Name:_____ Phone:_____ SSN#:_____

Street Address (if different from above):_____
street city state zip

Signature:_____ Date:_____
Cannot sign for someone else.

Agreement to Allow Direct Insurance Payment

I authorize medical payments from:_____
Insurance Company(s)

_____
Name of Individual Holding Insurance Their Date of Birth Insurance ID Their SSN

to The Meridian Group and/or specific clinician seen for services rendered.

Employer of Insured:_____ Your Co-pay for each session (if known): _____

Do you have a deductible?: ___No ___ Unsure ___Yes If yes, amount and start date: _____

Does your insurance require pre-authorization?: ___Yes ___ No ___ Unsure

If yes, have you called your insurance company to have services approved?: ___No ___ Yes ___ Auth #

Signature: _____ Date: _____

Marital Status: S M Partnered W Div Sep Presently Living With:_____

Spouse's Name:_____ Date of Marriage:_____

Spouse's Occupation::_____ Dates of Previous Marriages (You):_____ (Spouse):_____

Is Your Father ___ Living ___Deceased Age (or year he died):_____

Is Your Mother ___ Living ___Deceased Age (or year she died):_____

Number of Brothers & Sisters: _____ Ages & Gender of Your Children:_____

Names of Emergency Contact:_____ Phone: _____

Please Briefly Describe Why You Are Seeking Services At This Time:

_____

_____

Current Medications:_____

Describe Current Health Status: _____Approximate Date of Last Physical Exam:_____

Major Illnesses, Accidents, or Surgeries (include year): _____

Current & Previous Mental Health and or Substance Abuse Treatment, Including Medication: _____

_____

Family History of Problems with Mental Health, Substance Abuse, Trauma, Etc. (including parents, spouse, children)

_____

Personal Symptoms History

Check any that apply to you now. Place a "P" by those that have been problems in the past but are not problems now.

____Depression
____Insomnia/Sleep Problems
____No Appetite
____Fatigue
____Irritable
____Can't Make Decisions
____Low Self Esteem
____Mood Swings
____Inferiority Feelings
____Anger Problems
____Attention & Focus
____Concentration
____Violent Behavior
____Compulsive Behavior
____Overeating
____Weight Problems
____Sexual Problems
____Sexual Preoccupation
____Suicidal Thoughts
____Past Suicidal Attempts

____Anxiety
____Feel Tense
____Constant Worrying
____Panic Attacks
____Excessive Fears
____Withdrawn
____Excessive Guilt
____Over Ambitious
____Overly Suspicious
____Headaches
____Stomach Problems
___ Dizziness
____Fainting Spells
____Seizures
____Disorientation
____Memory Problems
____Chronic Pain
____Nightmares
____Medical Problems
____Significant Childhood Illness

____School Problems
____Work Problems
____Financial Problems
____Legal Problems
____Marital Problems
____Relationship Problems
____Physical Abuse
____Emotional Abuse
____Dislike Weekend/Holidays
____Family Conflict
____Loneliness
____Recent Loss
____Childhood Trauma
____History of Sexual Abuse
____History of Sexual Assault
____Flashbacks
____Excessive Alcohol Use
____Drug Abuse
____Hallucinations

Other: