David Margolis, Ph.D., PA
477 Congress St., Ste 1300
Portland, ME 04101

Please provide the following information and answer the questions below. The information you provide here is protected by HIPAA as confidential information

Name____
(Last) (First) (Middle Initial)

Address:____
(Street & Number)

____
(City) (State) (Zip)

Birth Date ____/____/______ Home Phone____________________ Cell Phone________________

Can I leave a message at: home phone _____ Y/N Cell Phone____ Y/N

Email Address:____
** Email correspondence is NOT considered to be a confidential means of communication

Referred by____

Insurance Information

Please note that you are responsible for payment of your co-pay amount at the time of service. We will file all the necessary paperwork with your insurance carrier.

Primary Insurer_______________________________________ID#________________________________
Address____
City__________________________________Zip_________Deductible_________ Met?___________

Secondary Insurer_______________________________________ID#________________________________
Address____
City__________________________________Zip_________Deductible________ Met?_____________

Copay Amount: $_________

Have you previously received any type of mental health services?
___No
___Yes Please list previous therapist, psychiatrist

Please list any prescription psychiatric medications you are currently taking
____

____

General Health and Mental Health Information

Please rate your current physical health (circle one)

Poor Unsatisfactory Satisfactory Good Very Good

List any Sleep Problems____

____

Exercise: What Kind, how many times per week____________________________________

Tobacco use: (circle) Cigarette Cigar Pipe Dip

How Often?____

Are you Currently Experiencing overwhelming sadness, grief, or depression? Y_____ N_____

If Yes, how long have you felt this way?____

Are you experiencing anxiety, panic attacks, or phobias? Y_____ N_____

If yes, when did these symptoms begin?____

Amount /type of alcohol consumed per week:____

Do you use any recreational drugs? Please list_______________________________________

Are you currently in a romantic relationship? Y_____ N_____ If yes, for how long?_________________

Have you ever been admitted to a psychiatric facility Y_____ N_____

Number of times admitted to Detox program?_______________________

Problems with any of the following (Please check)

_____Organization of paperwork at home or work

_____ Difficulty estimating how long a project will take

_____ Difficulty being on time

_____ Difficulty interrupting or talking over others

_____ Fiscal management e.g. paying bills on time, or knowing how much money you have in your checking account.

Family Mental Health History

Please identify if there is a family history of any of the following. If Yes, please indicate the family relationship to you (e.g. maternal uncle)

	Family Member
Alcohol/Substance Abuse	
Anxiety	
Depression	
Domestic Violence	
Learning Disabilities	
Eating Disorders	
ADD/ADHD	
Obsessive Compulsive Disorder	
Schizophrenia	
Suicide Attempts	

Are you currently Employed? If yes, what is your current situation____

____

What are some of your strengths?

____

____

____

What are some of your weaknesses ?

____

____

____