

Henry W. Beck, Ph, D.
Psychotherapy: Individual, Couple, and Group
License # CW 000107-L

North Wales Crossing, Suite 201
115 W. Montgomery Ave.
North Wales, PA 19454

All mail to:
P.O. Box 143
Gwynedd, PA 19436

Patient Information Questionnaire

Patient Name: _____ Today's date _____

Address: _____

Phone:(home) _____ (work) _____

(cell) _____

Email: _____ Soc Sec # _____

Age: _____ Sex: _____ Birth date: _____ Marital Status: _____

Occupation: _____ Education: _____

Who else lives in the home? Please list names and ages.: _____

Emergency Contact: Name: _____ Relationship: _____

Address: _____

Who referred you to us? _____ Address: _____

Who is your Physician? _____ May we contact him or

her? _____ Address: _____ Phone: _____

When was your last physical examination? _____

Briefly describe your reasons for seeking help. _____

List any major health problem(s). _____

Medications that you are currently taking (Dosage, times, and reason) _____

Have you ever received psychiatric, psychological help, psychotherapy or
counseling of any kind before? _____ If yes please indicate Therapist

Name, approximate date(s), and type of problems _____

Please Complete Side Two

Please Circle any of the following problems or problem areas that pertain to you (Adult)

nervousness	depression	fears	shyness
divorce	sexual problems	separation	finances
suicidal thoughts	drug use	alcohol use	friends
anger	self control	hearing voices	sleep
stress	work	relaxation	headaches
violent thoughts	memory	ambition	legal matters
energy	insomnia	making decisions	loneliness
concentration	inferiority feelings	education	marriage
health problems	temper	nightmares	career choices
children	appetite	stomach trouble	bowel trouble
parenting	my thoughts	unhappiness	tiredness

If you are seeking help for your child please circle any of the following problems or problem areas that concern you.

stealing/lying	tiredness	school problems	problems
eating problems	over-activity	shyness	easily upset
under activity	running away	self-critical	temper tantrums
toilet problems over-	extreme fears	aggression	jealousy/resentment
dependency	depression	cruelty	overly guilty
destructiveness	sleep problems over-	unusual habits	physical complaints
nervousness	sensitive clumsiness	suicidal thoughts sex	

Who will pay for this account? _____ Address: _____

For Patients intending to utilize insurance

Policy Holder's Name _____ Birthdate _____ SS# _____
 Employer _____ Insurance Plan _____ ID# _____
 Group # _____ Insurance Company _____

If other Insurance:

Policy Holder's Name _____ Birthdate _____ SS# _____
 Employer _____ Insurance Plan _____ ID# _____
 Group # _____ Insurance Company _____

Assignment Release: I hereby authorize my insurance benefits be paid directly to Henry W. Beck, Ph.D.. I understand that I am financially responsible for any non covered services and unpaid balances. I authorize Henry W. Beck, Ph.D. to release any information necessary to process claims.

Signed _____ Date _____

Signature on File

I authorize use of this form on all my insurance submissions. I further authorize release of information to all my insurance carriers and/or managed care companies. I authorize Henry W. Beck, Ph.D., to act as my agent in helping me obtain payment from my insurance carriers. I understand that I am financially responsible for any non-covered services or unpaid balances. I authorize payment directly to Henry W. Beck, Ph.D.. I permit a copy of this authorization to be used in place of the original.

Signature _____ Date _____