Turning Point Psychotherapy Associates, LLC

558 West Uwchlan Avenue, Suite 100, Exton, PA 19341
Office: 484-879-4292 Fax: 484-879-4290

Name _____ Date _____/_____/_____

Date of Birth _____/_____/_____ Age _____ ☐ Female ☐ Male

Address _____ Apt _____

City_____ State _____ Zip _____

Home Phone _____ May we leave a message? ☐ Yes ☐ No

Cell Phone _____ May we leave a message? ☐ Yes ☐ No

E-mail* _____ May we email you? ☐ Yes ☐ No

**Please note that E-mail is not considered to be a confidential form of communication*

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Other

Employment Status ☐ Full-time ☐ Part-time ☐ Student ☐ Retired ☐ Disability ☐ Other

Employer _____ Occupation _____

Emergency Contact _____ Phone _____

Relationship to Patient _____ Referral Source _____

INSURANCE INFORMATION

Primary Insurance Co: _____ ID #_____

Policy Holder name (if other than self):_____

Relationship to patient: _____ Policy Holder DOB _____/_____/_____

Secondary Insurance Co: _____ ID #_____

Mail bills to:_____

MEDICAL & MENTAL HEALTH INFORMATION

Primary Care Physician_____ Phone _____

How would you rate your current physical health? ☐ Good ☐ Fair ☐ Poor

Please list the name(s) of your medical specialist(s): _____

_____

Please list any specific health conditions/symptoms you are currently experiencing:

_____

_____

Please list medication(s) you are currently prescribed:

NAME OF MEDICINE	DOSE	CONDITION BEING TREATED

How often do you engage in exercise/physical activity in a week? _____

Have you previously received any type of mental health services? ☐ No ☐ Yes

If yes, please list previous provider(s) and duration of treatment: _____

_____

_____

Please list significant life changes or stressful events that you have recently experienced:

_____

_____

Please indicate current or past history of use:

SUBSTANCE	FREQUENCY of USE	AMOUNT	AGE of FIRST USE	LAST USE
Alcohol				
Tobacco				
Marijuana				
Hallucinogens				
Opioids				
Other				

Please indicate symptoms that you are currently experiencing:

- ☐ Anxiety/Worry
- ☐ Panic Attacks
- ☐ Poor Memory
- ☐ Physical Complaints
- ☐ Poor Concentration
- ☐ Obsessions/Compulsions
- ☐ Appetite Changes
- ☐ Sleep Disturbance
- ☐ Suicidal Thoughts
- ☐ Impulsivity
- ☐ Mania
- ☐ Decreased Energy
- ☐ Guilt
- ☐ Hopelessness
- ☐ Tearfulness
- ☐ Withdrawal/Isolation
- ☐ Phobias
- ☐ Grief/Loss
- ☐ Irritability
- ☐ Depressed Mood
- ☐ Chronic Pain
- ☐ Aggression Behaviors
- ☐ Paranoia
- ☐ Self-Injurious Behavior
- ☐ Sexual Dysfunction
- ☐ Binging/Purging
- ☐ Other _____

FAMILY MENTAL HEALTH HISTORY

In the section below, please indicate if you or any family member(s) have a current or past history of the following:

CONDITION	SELF	MOTHER	FATHER	CHILD	SIBLING	G/PARENT	SPOUSE
Alcohol/Substance Abuse							
Attention-Deficit Disorder							
Anxiety/Panic Disorder							
Bipolar Disorder							
Depression							
Domestic Abuse							
Eating Disorder							
Obsessive Compulsive Disorder							
Psychiatric Hospitalization							
Psychotic Disorder							
Sexual Abuse							
Suicide Attempt(s)							

ADDITIONAL INFORMATION

Do you consider yourself to be spiritual or religious? ☐ Yes ☐ No

If yes, please describe your faith or belief: _____

What do you consider to be some of your strengths?_____

_____

What do you consider to be some of your weaknesses?_____

_____

What would you like to accomplish with your time in therapy?_____

_____