

**Richard I Jontry, Ph.D., MAC, CAC Diplomate  
Licensed Psychologist  
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**CONFIDENTIAL CLIENT QUESTIONNAIRE**

Your cooperation in completing this form will help us plan the most appropriate services for you. Please answer each Item carefully and ask for clarification if you do not understand a question.

Name- \_\_\_\_\_ Date: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code \_\_\_\_\_

May I mail to you at this address? \_\_\_\_\_ Y\_\_N

Email \_\_\_\_\_ May I email you? \_\_\_\_\_ Y\_\_N

Phones (H) \_\_\_\_\_ (W) \_\_\_\_\_

Cell Phone: \_\_\_\_\_

May I contact you and leave messages at these numbers? \_\_\_\_\_ Y\_\_N

Marital Status: \_\_\_\_\_ Religion: \_\_\_\_\_ Education: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Phones(H) \_\_\_\_\_ (W) \_\_\_\_\_

Spouse's Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Education: \_\_\_\_\_

Your Insurance Co.: \_\_\_\_\_ Plan Name: \_\_\_\_\_ Name of Insured: \_\_\_\_\_

Relationship to Insured: \_\_\_\_\_ Insured's SSN: \_\_\_\_\_ Your SSN: \_\_\_\_\_

Your Date of Birth: \_\_\_\_\_ Insured Date of Birth: \_\_\_\_\_

Your Insurance ID#: \_\_\_\_\_ Group# \_\_\_\_\_ pre-certification required? \_\_\_\_\_

Phone # of Insurance CO: \_\_\_\_\_

Address to submit claims: \_\_\_\_\_

Family Physician: \_\_\_\_\_ May we consult with your physician? \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about this practice?

Describe briefly your reason for seeking help at this time:

Are you presently under a physician's care and/or on any medications? Please list medications (if any)

List any family events over the last five years that have had a major impact on your life (births, deaths, separations, divorces, moves, job change, etc.). Include dates.

Please indicate how often and how much of each of the following you use:

Caffeine (coffee, tea, soft drinks, chocolate)

Alcohol (Wine, beer, other)

Tobacco

Prescription, over-the-counter, and/or street drugs: (please identify).

We are all influenced by those closest to us. Please describe family members as well as others who've been significant in your life, Include names, ages, deaths, mental or physical health problems; drug or alcohol problems; emotional, physical or sexual abuse; and your relationship with and feelings about the person.

Current mate.

Former mate (s)..

Children.

Mother.

Father.

Brothers/sisters

Grandparents.

Step or Foster parents.

Pets.

Please circle any of the following problems that pertain to you:

Nervousness	Depression	Fears	Shyness
Sleep Problems	Suicidal Thoughts	Separation	Divorce
Finances	Drug use	Alcohol Use	Friends
Anger	Chronic Pain	Unhappiness	Steep
Stress	Work	Relaxation	Tiredness
Legal Matters	Memory	Ambition	Energy
Decision Making	Loneliness	Inferiority Feelings	Education
Concentration	Career	Health Problems	Temper
Nightmares	Marriage	Children	Parenting
Eating Disorder	Weight Control	Smoking	<i>Gambling</i>

Are there other problems not listed above? Please describe.

Please add any additional information that you feel might be helpful. Use reverse side if necessary.

In order to control your cost, I request payment or co-pay at the conclusion of each visit. Payment may be in the form of cash or check. Indemnity insurance reimburses patients for fees already paid. Some companies pay fixed allowances and others pay a percentage of the charge. If I am a provider for your insurance company I will submit the necessary forms. If I am not on the provider list for your company then it is your responsibility to seek reimbursement from your carrier. I will be happy to help you with the forms.

If unable to keep an appointment, Please give 24 hours notice. Otherwise, you will be charged for the time reserved for you.

To the extent necessary to determine liability for payment or to obtain reimbursement from my insurance company, I authorize disclosure of portions of my records. I understand that disclosure of such information will be the minimal required for such payment. In the event Dr. Jontry applies for my insurance reimbursement because I am unable to pay for my services at the time they are rendered, I assign directly to him all medical benefits and authorize the use of this signature for all insurance submissions.

SIGNED \_\_\_\_\_ DATE: \_\_\_\_\_

RESPONSIBLE PARTY \_\_\_\_\_ DATE: \_\_\_\_\_