Kathy Radina, M. Ed.

Licensed Professional Counselor

_480-488-6096_

Name ____ Age _________ Date of Birth ______________

Address ____ City ______________ Zip ______________

Occupation ____ Employer ______________________

Best numbers where you can be reached? Please indicate cell, work or home and at which numbers I may leave a message.

____

Partner Name ____ Age _________ Date of Birth ______________

Occupation ______________________ Employer ______________________ Phone ______________________

Children Names and Ages

____

Current Living Situation: Alone With Partner With Parents Roommate Other ________ Relationship Status (M, W, D) ______

Referred by ______________________________ Person to call in case of emergency ______________________

Relationship ______________________ Phone ____

Are you currently under the care of a Physician, Psychologist or Psychiatrist? ________ Name ______________________

Address ____ Phone ______________________

Reason for care? ____

Have you been hospitalized for any reason over the past five years? _________ Reason? ______________________

Please list any medications, drugs, or over the counter remedies you take, and for what. ______________________

____

Have you had counseling in the past? ________ With whom? ______________________________________

Diagnosis or reason for therapy? ____

What did you like most about it? ____

Least? ____

Are you currently in an emotional crisis? ______ If yes, please explain ______________________________

Please list any history of drug or alcohol abuse. ____

Please indicate any relevant history of loss i.e.; death, divorce, disability, other ______________________

Please indicate any history of trauma or abuse. ____

If you are experiencing the following symptoms, please indicate if they are MILD, MODERATE or SEVERE; Depression _________

Anxiety ________ Panic ________ Anger ________ Sleep Dysfunction ________ Eating Dysfunction ________ Relationship problems ________ Work problems ________ Other ______________________________

If I am required to bill your insurance company, please supply the following information.

United Behavioral Health certification _ _ _ _ _ _ - _ _ I.D. Number/ SS# ______________________

Insurance company name (if other than UBH) ______________________ Mental health phone number ______________

Address where I send the mental health claims ____

____

Deductible amount ______________ Prior authorization number ______________

Number of mental health sessions allowed __________ Mental health co-pay __________