Michelle Heller, Ph.D.
100 North Village Avenue, #26
Rockville Centre, NY 11570
516-902-2407

Today's date: _______________

Individual's Information

Name: _____________________________________ DOB: ________________________

Home Phone: ________________________ Work Phone: ______________________

Cell Phone: _________________________ Email address: _____________________

Address: ____

Occupation/Place of business: ____

Insurance Information

Insurance Company: ____________________________________

Policy Holder ______________________ DOB: _______________

ID#: _______________________________

SS#:_________________________________

Relationship to Patient Self ( ) Spouse ( ) Child ( )

Address: ____

Occupation/Place of business: ____

Referral Source

Who referred you to this office? ________________

Current Family Living Situation

Name Relationship to you Age Where resides

____________________ ________________ __________
____
____________________ ________________ __________
____
____________________ ________________ __________
____
____________________ ________________ __________
____
____________________ ________________ __________
____

School History

Grade Completed ________________

History of Special Education (yes/no) ________________

If yes, what type ________________

Medical History (Indicate yes or no. If yes, please specify.)

Current medical conditions: _______________________________

Hospitalizations: _______________________________

Surgeries: _______________________________

Prior Medications Dosage What Taken for Length of Time Taken

____
____

____
____

Current Medications Dosage What Taken for Length of Time Taken

____
____

____
____

Mental Health Treatment History

Have you ever received counseling/psychotherapy before? Yes ____ No____
If yes, complete below:

Name of Therapist/Clinic	Dates of Treatment	Type of Treatment (individual, group, marital, outpatient, inpatient, drug/alcohol counseling)

Family History

Is there history of mental health problems in family? If yes, list family member(s) and type(s) of problems

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Is there history of alcohol or drug abuse in family? If yes, list family member(s) and type(s) of substances.

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Any other relevant information:

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