Dr. Linda Caterino, Ph.D., A.B.P.P.
Licensed Psychologist

Intake, Insurance, and History Form

Patient Contact Information

Full Name: _____ Date: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Secure Email: _____

Birthdate: _____ Social Security No.: _____ Referred by: _____

Emergency Contact Name: _____ Emergency Contact Phone Number: _____

Insurance Information and Policies

Does the patient have Insurance? _____ Name of Policy Holder: _____

Policy Holder's Birthdate: _____ Policy Holder's Employer:

Policy Holder's Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Name of Insurance Carrier: _____ Insurance Phone Number: _____

Insurance ID #: _____ Insurance Group Number: _____

In signing the below, I confirm the information herein is true and correct to the best of my knowledge. Dr. Linda Caterino and/or her billing company has permission to contact my insurance carrier named above and discuss my coverage and services provided. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dr. Linda Caterino or my insurance company to release any information required to process my claims. Finally, if signed electronically, my electronic signature has the same force and effect as a handwritten signature.

_____ _____
Patient Signature or Parent/Guardian Signature for Minor Patients Date

Cancellation Policy

Dr. Caterino is committed to providing exceptional care. Unfortunately, when a client cancels or does not show without giving enough notice, that client prevents another client from having an appointment. Please call (480) 668-9392 or e-mail by 4:00 p.m. on the day prior to your scheduled appointment to notify Dr. Caterino of any changes or cancellations. If timely notification is not given, you will be charged $50.00 for the missed appointment. In signing the below (electronically or by hand), the patient or responsible guardian/parent understands and agrees to abide by the terms of this policy.

_____ _____
Patient Signature or Parent/Guardian Signature for Minor Patients Date

Patient's Developmental History

The following questions relate to the patient:

Mother's Age at Birth: _____ **Patient's Birth Weight:** _____ **Did Mother receive pre-natal care?** Yes

Medications or Drugs Taken during Pregnancy:

Please describe any complications during or after childbirth:

At what age did the patient began doing the following?

Rolling Over by Self?

Sitting Without Support:

Crawling on Hands/Knees?

Toilet Trained Completed:

Walking Independently?

Saying first words?

Talking 2 -3 word sentences?

Patient's Medical History

Please check below if any of the following have occurred in the patient's lifetime?

- ☐ Seizures
- ☐ Concussion
- ☐ Head Injury
- ☐ Hearing Problems or Repeated Ear Infections
- ☐ Vision Problems
- ☐ Repeated Ear Infections
- ☐ Difficulty Eating or Drinking

Please describe any serious accidents or significant illnesses/injuries requiring hospitalization:

Please describe any current medical conditions or diagnoses (with dates and diagnosing professional):

Please provide a list of all medication patient is taking including the name and dosage of each:

Name of Current Pediatrician/Primary Care Physician: _____ **Phone:** _____

Name of Current Psychologist: _____ **Phone:** _____

Name of Current Psychiatrist: _____ **Phone:** _____

Please check if the patient's parents or siblings have been diagnosed with and/or suffer from any of the following conditions or disorders:

☐	Substance Abuse	☐	Physical Disability
☐	Intellectual Disability	☐	Violence/Abuse
☐	Speech Language Disorder	☐	Mental Illness or Disorder
☐	Learning Disability	☐	Medical Illness

Please provide details for each checked item above: _____

Patient's Educational History

Is the patient a full-time or part-time student? Full-Time **Name of Current School:** _____

Patient's current grade (if in school): _____

Have the patient's teachers/educators expressed a concern about the patient in school at any time? Yes _____

Please provide details regarding any concern expressed by teachers/educators regarding the patient: _____

Does the patient have an IEP/504 Plan/MET/ISP? _____

If so, please provide the last meeting date and information regarding the patient's accommodations/services: _____

Patient's Highest Level of Education Completed: _____

Last School/Educational Institution Attended: _____

From: **To:** **Degree obtained:**

Has the patient ever been retained in school? Unknown **Year and Reason:** _____

Patient's Mother's Highest Level of Education Completed: _____

Patient's Father's Highest Level of Education Completed: _____

Patient's Siblings

Names/Ages/Gender of Siblings: _____

Number of Siblings Living in Home: 0 **Number of Siblings Not Living in Home:** 0

Please describe the patient's relationship with their siblings:

Patient's Parents

Names/Ages/Gender of Parents:

Is there a court-order regarding custody/guardianship of the patient: Unknown **If so, please compete the Consent for Treatment of Minor Form.**

Please describe the patient's relationship with their parents:

Patient Social History

Does the patient have friends? No **Does the patient respond and interact appropriately with peers?**

Please describe the patient's current social group (# of friends, frequency of contact, & quality). Unknown

Patient's Interests/Hobbies/Strengths

Please list at least 3 of the patient's best qualities or strengths:

Please list at least 3 of the patient's favorite activities, interests, or hobbies:

Treatment

As it relates to the last year, please check any of the following concerns/issues that apply to the patient:

☐	Substance Abuse	☐	Agitation
☐	Chronic Sadness	☐	Excessive Worry
☐	Difficulty Concentrating	☐	Fear of Dying or Others Dying
☐	Nausea/Vomiting	☐	Flashbacks
☐	Hopelessness	☐	Overeating or Loss of Appetite
☐	Low Energy/Fatigue	☐	Restlessness
☐	Confusion	☐	Suicidal Statements or Actions
☐	Low Self-Esteem	☐	Panic Attacks

☐	Withdrawal From Others	☐	Mood Swings
☐	Easily Frustrated	☐	Temper Tantrums
☐	Inattention	☐	Lying
☐	Fear of Leaving Home	☐	Cheating
☐	Sleep Problems	☐	Trembling/Shaking
☐	Difficulty Completing Tasks	☐	Difficulty with School
☐	Difficulty w/ Friends or Partners	☐	Indecision
☐	Paranoia	☐	Self-Injury
☐	Seeing Things	☐	Hearing Voices
☐	Fear of Failure	☐	Nightmares

Please provide details regarding those items checked above:

Please describe why the patient is seeking treatment or testing with Dr. Caterino:

By signing this Patient History Form, I verify that I have answered all questions to the best of my ability and as truthfully as possible in regard to the patient's history. I verify that I am an individual in the position of accurately providing responses to these questions. I understand that this form and my answers are strictly confidential. I understand that the purpose of this form is to begin the intake process with Dr. Linda Caterino, to aide with treatment and evaluation planning as necessary. I also understand that the answers on this form will not be the only information used in planning treatment and/or evaluation and/or in assigning a diagnosis to the patient, should a diagnosis be necessary or deemed appropriate. I further understand that Dr. Linda Caterino will follow the completion of this form with an interview session with the patient and/or the parent/guardian as well as interactions and observations of the patient as deemed necessary and that she will obtain additional information not contained herein. My electronic signature is the same as my handwritten signature.

Signature: _____ Date: _____

Printed Name: _____

Relationship to Patient: _____