Paul Olander
change is now

Paul Olander, MSW, JD, LCSW, NBCCH, CCTP
Change Is Now, LLC
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DEMOGRAPHIC INFORMATION

Date_____ Referral Source_____

Patient Name _____ Date of Birth _____

Address _____

City_____ State_____ Zip Code_____

Cell Phone _____ Home Phone_____

Email Address_____

Social Security Number_____

Place of Employment _____ Work Phone_____

FINANCIALLY RESPONSIBLE PARTY

Name_____ Relation_____ Date of Birth_____

Address_____

City_____ State_____ Zip Code_____

Home/Cell phone_____ Email Address _____

I hereby authorize treatment by Paul Olander, MSW, JD, LCSW, NBCCH, CCTP, RRT-P, TIH. I understand that I am financially responsible for all services regardless of any insurance benefits. I authorize Paul Olander, MSW, JD, LCSW, NBCCH, CCTP, RRT-P, TIH to release information to process and secure payment for services if necessary. A cancellation fee will be charged for appointments not cancelled at least 24 hours in advance (48 hours for weekend appointments).

Patient or Guardian Signature_____

Financially Responsible Party _____

MARITAL STATUS

☐ Never Married ☐ Domestic Partnership ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Please list any children/age:

_____

_____

_____

GENERAL MEDICAL AND MENTAL HEALTH INFORMATION

Allergies_____

Current Medical Conditions_____

Current Medications _____

Current Physicians _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

☐ No

☐ Yes, previous therapist/practitioner: _____

Have you ever been prescribed psychiatric medication?

☐ No

☐ Yes, please list and provide dates:_____

_____

How would you rate your current physical health? (please circle)

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good ☐ Excellent

Please list any specific current health problems:_____

_____

How would you rate your current sleeping habits? (please circle)

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good ☐ Excellent

Please list any specific current sleep problems: _____

How many times per week do you generally exercise? _____

What types of exercise? _____

_____

Please list any difficulties you experience with food, appetite or eating patterns:

_____

Are you currently experiencing significant sadness, grief or depression?
☐ No
☐ Yes
If yes, for approximately how long and about what? _____

_____

Are you currently experiencing anxiety, panic attacks or any phobias?
☐ No
☐ Yes
If yes, when did you begin experiencing this? _____

Are you currently experiencing any chronic pain?
☐ No
☐ Yes
If yes, please describe:

_____

Do you drink alcohol more than once a week?
☐ No
☐ Yes
If yes, how often and how much?

_____

What happens when you drink? _____

How often do you engage recreational drug use?
☐ Daily
☐ Weekly
☐ Monthly
☐ Infrequently
☐ Never
If so, which drugs? _____

Are you currently involved in a romantic relationship?
☐ No

☐ Yes
If yes, for how long?_____
On a scale of 1-10, how would you rate your relationship?_____

What significant life changes or stressful events have you experienced recently:_____

FAMILY HISTORY

If any of the following apply, please indicate the family member's relationship to you in the space provided (e.g. father, grandmother, uncle, brother, cousin, etc.)

	Please Circle	List Family Member(s)
Alcohol/Substance Abuse	☐ yes/no ☐	
Anxiety	☐ yes/no ☐	
Depression	☐ yes/no ☐	
Domestic Violence	☐ yes/no ☐	
Eating Disorders	☐ yes/no ☐	
Obesity	☐ yes/no ☐	
Obsessive Compulsive Behavior	☐ yes/no ☐	
Schizophrenia	☐ yes/no ☐	
Bipolar Disorder/Mania	☐ yes/no ☐	
Suicide Attempts	☐ yes/no ☐	

ADDITIONAL INFORMATION

Are you currently employed?
☐ No
☐ Yes
If yes, who is your current employer and what kind of work? _____

_____

Do you enjoy your work?
☐ No
☐ Yes

Is there anything stressful about your current work?
☐ No
☐ Yes
If yes, what?_____

Do you consider yourself to be spiritual or religious?
☐ No
☐ Yes
If yes, please briefly describe your faith or beliefs: _____

Have you experienced anything traumatic during your life?

☐ No
☐ Yes

If yes, what and when? _____

_____

What if any current legal issues do you have?_____

_____

What qualities do you value in yourself and others? _____

_____

What do you consider to be your strengths?_____

_____

What do you consider to be weaknesses or areas you want to change? _____

_____

What do you like to do for fun or enjoyment? _____

_____

What would you like to first or most accomplish or change during your time in therapy?

_____

_____

_____