Day Hill Psychotherapy
110 Day Hill Road, Windsor, CT 06095

Therapist (circle): J. Gialopsos, LCSW T. Bodine, LCSW J.Rush, LPC, T. Reif, PhD

PATIENT INFORMATION

Name _____Today's date _____

Home address _____

City _____ State _____Zip_____ Home phone (_____) _____

Work Phone _____ Cell Phone _____ SSN _____

Date of Birth _____ Age _____ Marital Status _____ Occupation _____

Education _____ Employer _____

Emergency contact _____ Phone (_____) _____

Referred to us by _____

Name of primary care provider (PCP) _____ Phone _____

PCP Address _____

Any current or chronic illness?_____

Please list all medications (include dosage) you take: _____

_____

Current physical health: __Good __ Fair __Poor

Check if condition is related to: __ auto accident __employment __other accident

HEALTH INSURANCE CARRIER

Name of primary insurance plan _____Policy# _____

Group # _____ Name of policy holder_____

Address or policyholder _____

Home Phone _____ Work Phone _____ Birthdate _____ SSN _____

Policyholder's relationship to patient (circle) self spouse child other _____

Secondary insurance _____ Policy #_____

PERSON RESPONSIBLE FOR PAYMENT OF SERVICES:

Name _____Relationship to patient _____

Signature_____Date _____

Please circle any of the following that apply to you.

nervousness	depression	sexual	fears	shyness
suicidal thoughts	separation	divorce	finances	drug use
alcohol use	friends	anger	self-control	sleep
unhappiness	tiredness	headaches	loneliness	legal matters
inferior feelings	career choices	temper	children	relaxation
work	insomnia	appetite	memory	agitated
ambition	energy	decisions	education	expectations
concentration	nightmares	health	marriage	bowels
stomach	stress	worries	irritability	anxiety
mood swings	cravings	crying	confusion	grief
sadness	physical pain	isolation	weight	guilt
restlessness	panic	hopelessness		

Please add any other information you think may be helpful:

24 HOUR CANCELLATION POLICY

Please understand that your insurance does not cover sessions that you do not attend. Therefore it is important that you notify me within 24 hours if you will be unable to attend your session.

Sessions cancelled with less than 24 hours advance notice are subject to charge. Charges range, depending on circumstances, from 50-100% of the amount allowed by your insurance company.

Should you have any questions, please ask when we meet.

My signature acknowledges that I accept and agree with the cancellation policy.

Signature _____ **Date** _____