Celeste Emelia Mattingly, LCSW
Psychotherapist/Healing Facilitator/ Author
Celestial Psychology®
Reconnecting Where Mind & Body Meet Spirit
860-586-8700 (p)
860-236-1909 (f)
10 Grassmere Avenue, Suite #300
West Hartford, CT 06110

Dx:	Referral Source:	Date:

PATIENT INFORMATION

First Name	Middle	Last	Birth Date / /	Age	Gender ☐ M ☐ F
Street Address		City		State	Zip Code
Home Phone	Work Phone	Cell Phone		Social Security #	
Current Employer		Current Employer's Address			

INDIVIDUAL RESPONSIBLE FOR PAYMENT

First Name	Middle	Last	Birth Date / /	Age	Gender ☐ M ☐ F
Street Address		City		State	Zip Code
Home Phone		Work Phone		Social Security #	
Employer		Employer's Address			

PRIMARY INSURANCE COMPANY

Name	Policy ID No.	Group #		
Street Address		City	State	Zip Code
Name of Policy Holder		Birth Date / /	Relationship to Insured	
Employer		Employer's Address		

SECONDARY INSURANCE COMPANY

Name	Policy ID No.	Group #	
Street Address	City	State	Zip Code
Employer	Employer's Address		

Assignment of Benefits

I understand that I am responsible for payment in full of all charges not covered by insurance. I authorize payment of benefits from my insurance be paid directly to Celeste Mattingly, LCSW. I also authorize her to release to my insurance company any and all information necessary for the processing of insurance claims in accordance with HIPAA statutes and NASW-CT guidelines.

Signature: X _____ **Date:** _____

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Current Employer:			**Position**	**Number of Years**
Past Employer:			**Position**	**Number of Years**
Education:	**Current Grade:** **Highest Grade:**	**High School Graduate?** **GED Recipient?**		**College Education:**
Marital Status:	☐ **Single** ☐ **Separated**	☐ **Married** **_____Years Married**		**____Times Married** **____Times Divorced**
Children:	**Names:** _____ _____ _____ _____ _____ _____ ____	**Age(s): Health Issues:** _____ _____ _____ _____ _____ _____		**Dependent Family Member(s):** **List Aging Parents (if appropriate)** _____ _____ _____ _____ _____
Emergency Contact:	**Name:**		**Telephone Number:**	**Relationship:**

Military Experience: _____
_____

MEDICAL INFORMATION: **Primary Care Physician: Name:** _____
Address:_____
Phone:_____

Date of last physical: ____/___/___ Date of last EKG: __/__/__ Medication allergies: ☐ Yes (Explain below)
☐ No _____
Do you see any specialists for medical problems? ☐ Yes ☐ No If yes, list types of specialists:
_____

Do you use over-the-counter medications? If so, list: _____
_____

Do you take vitamins/herbs/supplements? If so, list: _____
_____

List current (non-psychiatric) medications: _____
_____
Medical History (Illness, Injury, Hospitalization, Operations, etc.):
_____
_____
_____

Check if you experience or have experienced any of the following:

☐ **Hypertension**	☐ **Pancreatic problems**	☐ **Head Trauma**	☐ **Epilepsy**
☐ **Liver Problems**	☐ **Blackouts**	☐ **Thyroid Disease**	☐ **Respiratory**
☐ **Irregular Heartbeat**	☐ **Night Sweats**	☐ **Immune Disorder(s)**	**problems/Asthma**
☐ **HIV/AIDS**	☐ **Diabetes**	☐ **D.T.s**	☐ **ETOH Seizures**
☐ **GI Disease**	☐ **Tremors**	☐ **Cardiovascular problems**	☐ **Other:**

_____

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PSYCHIATRIC INFORMATION:

Psychiatrist: Name: _____
Address:_____ Phone:_____
Date of last visit: ____/___/___

List current psychiatric medications: _____
_____
List of psychiatric medications prescribed in the past: _____
_____
Check if you have ever seen any of the following (Please indicate who and when for any checked area):

☐ **Therapist/Counselor - Name: _____ Approx. Dates/# of years _____**
☐ **Psychiatrist - Name: _____ Approx. Dates/# of years _____**
☐ **EAP/Other: _____**

Check if you have ever been in any of the following (Please indicate where and when for any checked area):
☐ Psychiatric Hospital _____
_____
☐ Substance Abuse Treatment Center or Detox_____
_____
☐ Outpatient Treatment /Partial Hospital Program _____
_____
Check any of the following symptoms that you are currently experiencing:

☐ **Depression** ☐ **Sadness** ☐ **ADD/ADHD** ☐ **Sleep problems**
☐ **Harmful or Dangerous Thoughts** ☐ **Anxiety/Panic Attacks** ☐ **Throw or break things**
☐ **Hit or punch others** ☐ **Phobias** ☐ **Racing thoughts** ☐ **Obsessive Acts (like hand-washing or** ☐ **Hoarding Behaviors** ☐ **Binging/Purging** ☐ **Other _____** **counting or Ruminating)**

Personal habits section:

1. Do you exercise? ☐ Yes ☐ No If no, rate how much it bothers you on a scale from 1 to 10, 10 being the most troublesome: _____
_____
2. Do you gamble? ☐ Yes ☐ No If yes, list your favorite games in order of preference: _____
_____

2. Do you surf the web? ☐ Yes ☐ No If yes, list your favorite web sites and estimate how much time you spend surfing the web and/or on any computer sites including pornography and virtual life sites: _____
_____
4. Do you play games (including video)? ☐ Yes ☐ No If yes, list your favorite ones in order of importance and estimate average time spent on each in any given period of time: _____
_____
5. Do you manage your money well? ☐ Yes ☐ No If no, rate how much it bothers you on a scale from 1 to 10, 10 being the most troublesome: _____

6. What is your spiritual preference?
☐ Religious - If yes, list your denomination:_____ _____

□ Spiritual - List your practices: _____

6**.a.** Do you pray □ Yes □ No If yes, please elaborate:_____

6.b. Do you meditate? □ Yes □ No If yes, elaborate:_____ ___

7. What is your sexual preference? □ Heterosexual □ Bi-sexual □ Homosexual □ Asexual

7.a. How would you describe your sexual activity?

□ Monogamous - Please check: □ Past □ Present _____

□ Abstinent - Please check: □ Past □ Present _____

□ Multiple partners - Please check: □ Past □ Present _____

□ Asexual - Please check: □ Past □ Present _____

8. How would you describe your eating habits?

□ Average □ Obsessive □ Vegan □ Vegetarian □ Omnivore □ Anorexic □ Binge/Purge □ Body Dysmorphia

Check if you are using any of the following (Please indicate how much/how often for any checked area): Include whether you have stopped due to addiction issues and how long you have been abstinent

□ Alcohol _____

□ Cocaine _____

□ Marijuana _____

□ Heroin _____

□ LSD _____

□ Ecstacy_____

□ Cigarettes _____

□ Cigars_____

□ Caffeine _____

□ Energy Drinks (such as Monster, Red Bull, etc.)_____ ___

□ Amphetamines _____

□ Benzodiazepines _____

□ Pain Medication _____

□ Other _____

Check and circle if you are or have been in any of the following:

□ AA currently in the past □ CA currently in the past □ OA currently in the past

□ NA currently in the past □ ACOA currently in the past □ Alanon currently in the past

Please discuss: _____

_____

Check if you have ever been arrested or convicted of the following (Please explain any checked area):

□ DWI _____ □ Domestic Violence _____

□ Drug related _____ □ Other_____

Please discuss: _____

_____

Family-of-origin History (Briefly):

Relative	Name	Current Age (Or age at death)	Location & Emotional Closeness	Medical Illness (or cause of death, if deceased)	Mental Illness or Substance Abuse
Father					
Mother					
Stepparents					
Grandparents					

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Uncles					
Aunts					
Brothers					
Sisters					

Have you ever been abused?

☐ Physically_____
_____

☐Verbally_____
_____

☐ Emotionally_____
_____

☐ Sexually (including rape) _____
_____

What are your current living arrangements?

_____
_____
_____

What is the primary reason you are seeking Group Psychotherapy at this time?

_____
_____

_____
_____

_____
_____

DO NOT EMAIL THIS COMPLETED FORM
Please fax this document to the secure and dedicated fax line: 860-236-1909

You will be further screened for appropriateness by phone and required to come in ½ hour early for your first group session.

During your first group session you will receive a packet with specific information about the nature of group therapy, the guidelines for the group, and a confidentiality statement to sign.

Thank you.