Dr. Kathleen Donaghy
10245 E Via Linda Ave, Ste 220
Scottsdale, AZ 85255   480-668-3474

Date of initial visit __________

Referral source ______________________   E-mail _________________________

Patient's Name _____________ ____ ___________ Phone___________________

SS# _ _ _ - _ _ - _ _ _ _   Date of Birth ___________ Age ______

Marital Status __________________

Mailing Address ___________________________

City ___________________   State ____ Zip _____________

Employer ______________   Occupation _________________________

Insurance company ________________ Your co-payment and/or deductible_______

Insured's name ___________________Insured's ID# ________________________

Insured's Group # ___________________   Pre-Auth #____________________

Insured's DOB ___________________ Insured's Employer ___________________

Children:
Name/age ____

____

____

Your therapy goals:

Have you sought help before with this problem? With whom?

Are you currently working with another therapist?

Primary Care Physician or Psychiatrist ______________________________________

Their contact info (if desired) ___________________________________

Current medical conditions:

Prescribed Medications/dosages:

Do you use:

Alcohol	Y	N	Amount
Recreational drugs	Y	N	Amount
Tobacco	Y	N	Amount
Caffeine	Y	N	Amount

Do you exercise? Y N Amount

Do you describe yourself as spiritual or religious?

Do you have a history of physical or sexual abuse as a child or adult? Y N

(FOR DIVORCED PARENTS ONLY):
Would custodial parent need to be notified if non-custodial parent requests copy of child's records?

YES _____ NO _____ NA _____

Please provide instructions ____