PSYCHOLOGICAL RESOURCE ASSOCIATES

1627 Oak Avenue, Suite A
Davis, CA 95616

Please provide us with the following information, which will assist us to best serve you. All information will be held in the strictest confidence. Thank you.

Client's Name_____ **Spouse** _____ **Date** _____

Address _____ **City** _____ **Zip** _____

Sex: M F Other Birth date _____ **Age** _____ **Marital Status** _____

Home Phone_____ **Cell Phone** _____ **Email** _____

Referred by: ❒ **Self** ❒ **Physician** _____ ❒ **Insurance** _____ ❒ **Other** _____

_____	_____	_____
Occupation	**Place of Employment**	**Phone**
_____	_____	_____
Occupation of Spouse	**Place of Employment**	**Phone**

Emergency Contact: _____ _____ _____
Name **Relationship** **Phone**

EAP clients please indicate which office is your employer:

❒ Davis Waste Removal ❒ DJUSD ❒ Yolo County Office of Education

❒Other* _____ (*Please complete insurance section below)

Will you be paying the full fee for service (not using insurance)?: ❒ Yes ❒ No

If not, please complete the sections below

PLEASE COMPLETE THIS SECTION IF YOU WILL BE USING HEALTH INSURANCE

Name of Insurance _____ Phone _____

Subscriber's Name _____ Birthday _____

Insurance I.D. # _____ (for UC Davis employees, please use your Employee ID#)

Subscriber's Social Security # _____

Client's relationship to Subscriber: ❒ Self ❒ Spouse ❒ Child ❒ Other _____

Co-Pay Responsibility $_____ Is there a deductible? ❒ Yes ❒ No $_____

Is authorization required? ❒ Yes ❒ No Authorization #_____

DO YOU HAVE A SECONDARY INSURANCE? ❒ YES ❒ NO

Name of Insurance _____ **Phone** _____

Insurance Billing Address: _____

***Subscriber's* Name** _____ **Birthday**_____

Insurance I.D. # _____ **Subscriber's Social Security #** _____

Client's relationship to Subscriber: ❒ Self ❒ Spouse ❒ Child ❒ Other _____

Co-Pay Responsibility $**_____ **Is there a deductible?** ❒ Yes ❒ No **$_____

Is authorization required? ❒ Yes ❒ No **Authorization #**_____

Who is your primary physician? _____

When did a physician last examine you? _____

List any major health problems for which you currently receive treatment: _____

_____

List any medications you are now taking: _____

Please check any of the following areas in which you are having problems:

❒ Nervousness	❒ Depression	❒ Fears	❒ Suicidal thoughts
❒ Sexual problems	❒ Shyness	❒ Family	❒ Inability to cope
❒ Job dissatisfaction	❒ Sleep	❒ Relaxation	❒ Children
❒ Separation	❒ Divorce	❒ Finances	❒ My thoughts
❒ Low morale on job	❒ Alcohol use	❒ Friends	❒ Being a parent
❒ Unhappiness	❒ Self-control	❒ Anger	❒ Temper
❒ Not motivated at work	❒ Stress	❒ Drug use	❒ Appetite
❒ Conflict at work	❒ Headaches	❒ Tiredness	❒ Nightmares
❒ Legal matters	❒ Memory	❒ Ambition	❒ Marriage
❒ Making decisions	❒ Insomnia	❒ Energy	❒ Stomach troubles
❒ Inferiority feelings	❒ Concentration	❒ Loneliness	❒ Bowel trouble
❒ Health problems	❒ Career choices	❒ Education	❒ Death family/friend

Briefly describe your reason for seeking help: _____

_____

_____

_____

Have you ever received psychological help or counseling of any kind before? _____

If you have, please describe:

_____

List the members of your family and all others in your home:

Name(s)	*Age/Birthday*	*Relationship*	*Occupation*
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

Please add any additional information that you feel may be useful to us: _____

_____

I assign all insurance benefits for which I am entitled to PRA, and authorize PRA to release any information necessary to bill my HMO, Medicare, or private insurance. I acknowledge that I have received a copy of HIPAA privacy regulations from this office.

Guarantor's Signature _____ Date _____

For office use only. Therapist: please complete this portion

Diagnosis_____ Therapist _____

First Seen_____ Other Info:_____

Billing information: