Nancy Marwick DeMuth, Ph.D., M.B.A.
Licensed Psychologist
205 Grandview Avenue, Suite 204 • Camp Hill, Pennsylvania 17011
(717)763-8144

GENERAL INFORMATION

Date: _____ Referred By: _____

Name: _____ Date of Birth: _____Age_____

Your Nickname - If preferred, check here ☐ and list : _____

Home Address: _____

Home Phone ☐: _____ Work Phone ☐: _____Cell Phone ☐: _____

(Check the phones above where it is OK to leave voice messages. Circle the number you prefer us to call first.)

Would you like a reminder call about your appointment? YES NO

Occupation: _____Employer: _____

Marital Status: ☐ M ☐ S ☐D ☐W

No. Of Mos./Yrs. Married: _____
No. Of Mos./Yrs. Separated: _____
No. Of Mos./Yrs. Divorced: _____

Partner's First Name: _____

Partner's Nickname - If preferred, check here ☐ and list : _____

Children's Names, Ages, and where the children live (city and state if over 18): _____
_____

Family Doctor's Name and Contact Numbers: _____
_____
(ADDRESS) (CITY, STATE, ZIP) (PHONE) (FAX)

Education: School/University Last Attended: _____
_____ Degree: _____

Payment Options: You may pay by cash or check. Credit cards are not accepted at this office.

REGARDING INSURANCE: If you are insured by Highmark Blue Shield or Capital Blue Cross, this office will submit directly for you. You are responsible for any Blue Cross or Blue Shield copayment at each visit. If you are not the primary insured on your Blue policy, please indicate the policyholder who is, and include their date of birth:
Policy Holder: _____ **Date of Birth**: _____

NOTE: Dr. DeMuth does not participate with Magellan, United Behavioral Health (UBH), or HMOs and does not accept Medicare. If you are insured under these or other plans, you will be responsible for full payment at the time of service. Insurance forms from your insurance company must be obtained and submitted by you to your insurer.

Late Cancellation Policy: If you miss or cancel an appointment late (less than 24 hours) without sufficient reason or forget an appointment, you will be charged the full amount of your visit which cannot be submitted to or reimbursed by insurance.

RECENT LIFE EVENTS IN THE PAST 12 MONTHS: Please circle any of the following life events that you have experienced in the past 12 months.

☐1. Marriage
☐2. Marital reconciliation
☐3. Marital separation
☐4. Divorce
☐5. Death of spouse
☐6. Death of close family member
☐7. Personal injury or illness
☐8. Fired from work
☐9. Retirement
☐10. Change in health of family member
☐11. Pregnancy
☐12. Sexual difficulties
☐13. Gain of new family member
☐14. Business readjustment
☐15. Change in financial state
☐16. Death of close friend
☐17. Change to different line of work
☐18. New mortgage/large loan over $25K
☐19. Foreclosure of mortgage or loan
☐20. Change in responsibilities at work
☐21. Change in # or arguments w/ spouse
☐22. Son or daughter leaving home
☐23. Trouble with In-laws
☐24. Outstanding personal achievement
☐25. Spouse begins/stops work/changes job
☐26. Begin or end school
☐27. Change in living conditions
☐28. Revision of personal habits
☐29. Trouble with boss
☐30. Change in work hours or conditions
☐31. Change in residence
☐32. Change in school
☐33. Change in recreation
☐34. Change in church activities
☐35. Change in social behaviors
☐36. Change in # of family get-togethers
☐37. Change in eating or sleeping habits
☐38. Vacation
☐39. Christmas/holiday season "blues"
☐40. In contact with attorney or lawsuit
☐41. Violations of the law
☐42. Quitting or trying to quit smoking
☐43. Chemical dependency and recovery
☐44. Attending any 12-step groups or pgms
☐45. Receiving therapy/counseling, of any type,** (Please describe/ list providers)
_____

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Name: _____ Date: _____

PRIMARY SYMPTOMS CHECKLIST

Check symptoms below that you have experienced *for most of each day and for more days than not.* Also indicate for how long—number of days, weeks, months, or years (e.g., 10 days, 2 years, a lifetime) for each symptom below:

How Long	Symptom
☐ _____	Poor appetite or overeating or weight loss or gain *(circle ones that apply)*
☐ _____	Insomnia or sleeping too much *(circle ones that apply)*
☐ _____	Low energy or fatigue, or feeling tired all of the time
☐ _____	Low self-esteem
☐ _____	Poor concentration or difficulty making decisions
☐ _____	Feelings of hopelessness
☐ _____	Slowed down, restless, and/or unable to sit still *(circle ones that apply)*
☐ _____	Being anxious or worried
☐ _____	Feeling sad, blue, or down in the dumps
☐ _____	Loss of interest in things you used to enjoy: hobbies, intimate relations, etc.
☐ _____	On the verge of tears too much
☐ _____	Feeling worthless or guilty
☐ _____	Headaches
☐ _____	Other aches and pains
☐ _____	Digestive problems
☐ _____	Sexual problems
☐ _____	Thoughts of death or suicide or suicide attempts

Other Symptoms:

☐ _____ Feeling unusually "high," euphoric, or irritable *(circle ones that apply)*
☐ _____ Needing less sleep night after night
☐ _____ Talking a lot or feeling that you can't stop talking
☐ _____ Being easily distracted
☐ _____ Having lots of ideas go through your head very quickly at one time
☐ _____ Doing things that feel good but have bad effects (spending too much money, excessive sexual activity, foolish business investments)
☐ _____ Having feelings of greatness
☐ _____ Making lots of plans for activities (work/school/social/sexual) or feeling that you have to keep moving

Medications: List medications and dosages that you are currently taking and for how long:

_____

_____

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Client's Consent for Evaluation and/or Treatment

I give my consent for psychological services to be provided to me by Dr. DeMuth, a licensed psychologist.

I understand that:

- Keeping scheduled appointments and completing "therapy assignments" between sessions will likely produce maximum benefits.
- I am expected to provide at least 24 hours' advance notice if I need to cancel and/or reschedule an appointment. In the absence of such advance notice, a full charge will be made to me for the missed session. It cannot be billed to my insurance company (if applicable). *Exceptions: For sudden illness and bad weather, the 24-hour rule is waived.*
- Life changes (which I choose to implement as a result of and during therapy) may bring temporary increased stress or intensification of symptoms.
- If my psychological condition declines or I do not make satisfactory progress during treatment, I agree to make this known to Dr. DeMuth so that treatment options can be discussed.
- Payment (or copayment) is required for all services rendered at the time of service.

I understand that the law protects the confidentiality of psychological information. Confidentiality of psychological information is waived only in cases of:

- Life-threatening emergency.
- Being a danger to myself or others.
- Child abuse or neglect.*
- A court order requires release of psychological information.

I understand that, if my needs are pressing or in case of emergency, I am to contact directly my family physician or Crisis Intervention (West Shore 763-2222 or in Carlisle 243-6005).

I desire no further explanations for the purpose of this consent.

I acknowledge receiving, reading, and fully understanding this information:

_____	_____	_____
Client Name (PLEASE PRINT)	Client Signature	Date

*__Pennsylvania's expanded rules for child abuse reporting (as of 12/2014)__: If Dr. DeMuth has reason to suspect, on the basis of her professional judgment, that a child is or has been abused, she is required to report her suspicions to the authority/agency vested to conduct child-abuse investigations. She is also required to make such reports even if she does not see the child in her practice. She is mandated to report suspected child abuse if anyone: (a) aged 14 or older tells her that he or she committed child abuse, even if the victim is no longer in danger, or (b) tells her that they know of any child who is currently being abused.