



**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: \_\_\_\_\_

Partner's First Name: \_\_\_\_\_ No. Of Mos./Yrs. Divorced: \_\_\_\_\_

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:

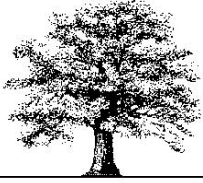
**Policy Holder:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

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



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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:

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

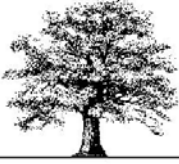
### Other Symptoms:

- \_\_\_\_\_ 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.