Dr. Mark Zuccolo, PhD, LMFT | Dr. Sonia Maxwell, PsyD, LMFT
5755 North Point Pkwy • Suite 33 • Alpharetta GA 30022 • (678) 554-5632
Bellagio Psychotherapeutics • www.bellagiopsych.com • www.drmarkzuccolo.com

Personal Information

Name _____ **Date** _____

Age _____ **Date of Birth** _____ **Sex** ☐ M ☐ F ☐ _____

Address _____

_____

Phone Number ☐ Home ☐ Cell _____
(Must be available for confidential messages from your clinician)

Email _____

Appointment Reminder (choose one) ☐ Email Me ☐ Text Me At _____

Emergency Contact (name, relationship, phone number) _____

_____

Employer (name of your business if self-employed)

_____

Relationship Status ☐ single ☐ married ☐ life partner ☐ divorced ☐ separated ☐ widowed

Who lives with you? _____

_____

Education (highest grade completed) _____ Student**?** ☐ Yes ☐ No

Reason you are seeking counseling/therapy at this time

_____

_____

_____

Overall, how distressed are you by this (0-10, with 10 = "extremely")? _____

How well are you currently functioning in your daily life? (0-10, with 10 = "extremely well") _____

Childhood Environment & Sibling Position
(e.g., 2 biological parents, blended stepfamily, adopted; oldest child, middle child)

_____

_____

Spiritual Beliefs (if any) _____

If you attend services, how often? _____

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EEF _____ CPT _____ DNUF _____ YAPOC _____ 2015/8

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Problem Areas (check all that apply)

__work __finances __legal __abuse of illicit or prescription drugs __abuse of alcohol __relationship/marriage/partner conflict __family conflict (e.g., children, parents, in-laws, extended family members) __social issues (problems making/keeping friends) __anxiety across most areas of life __anxiety in one specific area __specific fear or phobia (e.g., spiders, flying, germs, etc.) __panic attacks __social anxiety __obsessive thoughts and/or compulsive behaviors __body-focused repetitive behaviors (e.g., hair pulling, nail biting, skin picking)	__excessive anger (your opinion or you've been told) __sadness or depression __loss of energy __frequently or almost always fatigued __loss of pleasure in life __frequent crying __excessive mood swings (from feeling very low to feeling very energized and optimistic) __self-injurious behavior (e.g., cutting) __thoughts of suicide (you will be assessed for risk of suicide & <u>required</u> to provide an emergency contact should the clinician suspect that you are at risk) __problems with appetite (loss of or overeating) __problems with sleeping (cannot fall asleep, middle of night waking, wake up too early) __nightmares __racing thoughts __attention and concentration __temper __history of abuse, by parent or partner

Other (e.g., fibromyalgia, IBS) _____

Current Medication _____

_____

Prescribing Physician (MD's name, name of practice, phone number)

_____

Reason/Diagnosis Indicated by Prescribing Physician

_____

Previous Psychological Counseling ☐ Yes ☐ No When _____

Length _____

Where _____

Reason _____

_____

If you have ever been hospitalized for psychological problems, please indicate when & reason

_____

How did you hear about us? _____

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