



Patient Name _____ Patient ID# _____ Patient SS# _____
Provider Name _____ Date _____

Agor Behavioral Health Services, Inc.
24402 W Lockport Street, Suite 204 ♦ Plainfield, Illinois 60544
630-621-5824

CLIENT REGISTRATION INFORMATION

First Name _____ Last Name _____
Street Address _____ City _____ State _____ Zip _____
Billing Address Same as above See below
Billing Street Address _____ City _____ State _____ Zip _____
E-mail Address _____
Preferred Address for correspondence or statements Billing Address E-mail Address
Birth Date _____ Age _____ Social Security # _____
If minor (under age 18) please write name of legal guardian _____
Employer/School _____
Employer/School Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____
Cell Phone _____ How late can calls be returned? _____
Preferred Phone Number Home Phone Work Phone Cell Phone Referred by _____
Relationship to insured: Self Spouse Child Other
Marital Status: Single Married Widowed Divorced Other
Employment Status: Employed Full-time Student Part-time Student

POLICY HOLDER/GUARDIAN'S INFORMATION (if different from above)

First Name _____ Last Name _____
Street Address _____ City _____ State _____ Zip _____
Birth Date _____ Age _____ Social Security # _____
Employer/School _____
Home Phone _____ Work Phone _____
Caseworker's Name _____ Phone _____

PRIMARY AGENCY/INSURANCE INFORMATION (if applicable)

Agency/Insurance Carrier Name _____
Insured's ID # _____ Group/Policy # _____ Agency/Insurance Phone _____
Insurance Claims Mailing Address _____
City _____ State _____ Zip _____
Subscriber Name _____ Subscriber Date of Birth _____
Co-pay amount _____ Authorization # _____ Number of Sessions Authorized _____
Secondary Insurance No Yes – Complete Secondary Insurance Information Form
Are services pertaining to psychotherapy or testing? _____

A copy of your insurance or Medicaid card is needed at the time of service. Please read the following carefully and sign below.

Assignment of Benefits and Release of Information

I give permission to Agor Behavioral Health Services, Inc. and billing staff to send required information to my insurance company or my Employee Assistance Program (EAP). I am aware that I am placing my signature on file and that this authorization shall remain valid until written notice is given by me revoking said authorization. I also understand that I will be responsible for any unpaid balances including copayments, deductibles and non-covered services. I understand that appointments missed or cancelled less than 24 hours before the appointment will be billed at 100%. I understand that my insurance or EAP does not cover the cost of missed sessions.

Signature of Responsible Party

Date



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SYMPTOM CHECKLIST

Place a check mark in the appropriate column.

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
aggressive behaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	laxative/diuretic abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
agitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	loose associations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
angry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	loss of energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
anorexia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	mood swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
appetite disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	need to repeat actions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
believe someone is watching you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	obsessions/compulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
bingeing/purging	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	oppositional behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
circumstantial symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	panic attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
concomitant medical condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	paranoid ideation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
conduct problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	phobias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
crying/tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	physical trauma perpetrator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
delusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	physical trauma victim	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
depressed mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	poor concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
difficulty getting out of bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	poor grooming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
difficulty making decisions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	psychomotor retardation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
dissociative states	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	racing thoughts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
elevated mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	self-mutilation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
elimination disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sexual dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
emotional trauma perpetrator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sexual trauma perpetrator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
emotional trauma victim	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sexual trauma victim	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
emotionality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	significant weight gain/loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
fatigue/low energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sleep problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
feeling empty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	social isolation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
feeling sad	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	somatic complaints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
generalized anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
grief	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	thoughts of death	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
guilt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	trouble concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	use of alcohol/recreational drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
hearing voices that others do not	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	wishing you were dead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
heart palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	worried	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
hopelessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	worthlessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	other_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
irritable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	other_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CURRENT MEDICATIONS

Please list all medications.

Medication

Dosage

PRESENTING PROBLEMS

Please list presenting problems

Duration (months)

Additional Information



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EMOTIONAL/PSYCHIATRIC HISTORY

No Yes Prior outpatient psychotherapy?

If yes, how many occasions? ___ Longest Treatment by _____ (Provider Name) for ___ sessions from ___/___ to ___/_____.
(Month/Year) (Month/Year)

Prior Provider Name	City	State	Phone	Diagnosis	Intervention/Modality	Beneficial?
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

No Yes Has any family member had outpatient psychotherapy? If yes, who/why (list all)?

No Yes Prior inpatient treatment for psychiatric, emotional or substance use disorder?

If yes, on ___ occasions. Longest treatment at _____ from ___/___ to ___/_____.
(month/year) (month/year)

Inpatient Facility Name	City	State	Phone	Diagnosis	Intervention/Modality	Beneficial?
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

No Yes Has any family member had inpatient treatment for a psychiatric, emotional or substance use disorder? If yes, who/why (list all)? _____

No Yes Prior or current psychotropic medication usage? If yes:

Medication	Dosage	Frequency	Start Date	End Date	Physician	Side Effects	Beneficial?
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

No Yes Has any family member used psychotropic medications? If yes, who/what/why (list all)?:

FAMILY HISTORY

Family of Origin

Present During Childhood:

	Present entire childhood	Present part of childhood	Not present at all
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Parents' Current Marital status:

- married to each other
- separated for ___ years
- divorced for ___ years
- mother remarried ___ times
- father remarried ___ times

Describe parents:

Father	Mother
full name _____	_____
occupation _____	_____
Education _____	_____
General health _____	_____



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- Stepmother mother involved with someone
 Stepfather father involved with someone
 Brother(s) mother deceased for __ years
 Sister(s) age of patient at mother's death __
 Other (specify) father deceased for __ years
 _____ age of patient at father's death __

Describe childhood family experience:

- outstanding home environment
 normal home environment
 chaotic home environment
 witnessed physical/verbal/sexual abuse towards others
 experienced physical/verbal/sexual abuse from others

Age of emancipation from home: _____ Circumstances: _____

Special circumstances in childhood: _____

Medical History

Check all that apply

Describe current physical health Good Fair Poor

List name of primary care physician

Name _____ Phone _____

List name of psychiatrist (if any)

Name _____ Phone _____

List any medications currently being taken (give dosage & reason)

List any known allergies: _____

List any abnormal lab test results:

Date _____ Result _____
 Date _____ Result _____

Is there a history of any of the following in the family:

- tuberculosis heart disease
 birth defects high blood pressure
 emotional problems alcoholism
 behavior problems drug abuse
 thyroid problems diabetes
 cancer Alzheimer's disease/dementia
 mental retardation stroke
 other chronic or serious health problems

Describe any serious hospitalization or accidents:

Date _____ Age _____ Reason _____
 Date _____ Age _____ Reason _____
 Date _____ Age _____ Reason _____

Substance Use History

Check all that apply

Family alcohol/drug abuse history:

- father stepparent/live-in
 mother uncle(s)/aunt(s)
 grandparent(s) spouse/significant other
 sibling(s) children
 other _____

Substance use status:

- no history of abuse
 active abuse
 early full remission

Substances used:

(complete all that apply)

(complete all that apply)	First use age	Last use age	Current use (yes/no)	Frequency	Amount
<input type="checkbox"/> alcohol	_____	_____	_____	_____	_____
<input type="checkbox"/> amphetamines/speed	_____	_____	_____	_____	_____
<input type="checkbox"/> barbiturates/owners	_____	_____	_____	_____	_____
<input type="checkbox"/> caffeine	_____	_____	_____	_____	_____
<input type="checkbox"/> cocaine	_____	_____	_____	_____	_____
<input type="checkbox"/> crack cocaine	_____	_____	_____	_____	_____
<input type="checkbox"/> hallucinogens (e.g., LSD)	_____	_____	_____	_____	_____
<input type="checkbox"/> inhalants (e.g., glue, gas)	_____	_____	_____	_____	_____
<input type="checkbox"/> marijuana or hashish	_____	_____	_____	_____	_____



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- early partial remission
- sustained full remission
- sustained partial remission

Treatment History:

- outpatient (ages[s] _____)
- inpatient (age[s] _____)
- 12-step program (age[s] _____)
- stopped on own (age[s] _____)
- other (age[s] _____)
describe: _____

- nicotine/cigarettes _____
- PCP _____
- prescription _____
- other _____

Consequences of substance abuse (check all that apply):

- hangovers withdrawal symptoms sleep disturbance binges
- seizures medical conditions assaults job loss
- blackouts tolerance changes suicidal impulse arrests
- overdose loss of control amount used relationship conflicts
- other _____

Developmental History

Check all that apply

Problems during mother's pregnancy:

- none
- high blood pressure
- kidney infection
- German measles
- emotional stress
- bleeding
- alcohol use
- drug use
- cigarette use
- other _____

Birth:

- normal delivery
- difficult delivery
- cesarean delivery
- complications _____
- birth weight ____lbs____oz

Infancy:

- feeding problems
- sleep problems
- toilet training problems

Childhood health:

- chickenpox (age _____)
- German measles (age _____)
- red measles (age _____)
- rheumatic fever (age _____)
- whooping cough (age _____)
- scarlet fever (age _____)
- autism
- ear infections
- allergies to _____
- significant injuries _____
- chronic, serious health problems _____
- lead poisoning (age _____)
- mumps (age _____)
- diphtheria (age _____)
- poliomyelitis (age _____)
- pneumonia (age _____)
- tuberculosis (age _____)
- mental retardation
- asthma

Delayed developmental milestones

(Check only those milestones that did not occur at expected age)

- sitting controlling bowels
- rolling over sleeping alone
- standing dressing self
- walking engaging peers
- feeding self tolerating separation
- speaking words playing cooperatively
- speaking sentences riding tricycle
- controlling bladder riding bicycle
- other _____

Emotional/behavior problems (Check all that apply)

- drug use repeats words of others distrustful
- alcohol abuse not trustworthy extreme worrier
- chronic lying hostile/angry mood self-injurious acts
- stealing indecisive impulsive
- violent temper immature easily distracted
- fire-setting bizarre behavior poor concentration
- hyperactive self-injurious threats often sad
- animal cruelty frequently tearful breaks things
- assaults others frequently daydreams other _____
- disobedient lack of attachment _____

Social interaction (Check all that apply)

- normal social interaction inappropriate sex play
- isolates self dominates others
- very shy associates with acting-out peers
- alienates self other _____

Intellectual/academic functioning (Check all that apply)

- normal intelligence authority conflicts mild retardation
 - high intelligence attention problems moderate retardation
 - learning problems underachieving severe retardation
- Current or highest education level _____



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Describe any other developmental problems or issues _____

Socio-Economic History

Check all that apply

Living situation:

- housing adequate
- homeless
- housing overcrowded
- dependent on others for housing
- housing dangerous/deteriorating
- living companions dysfunctional

Employment:

- employed and satisfied
- employed but dissatisfied
- unemployed
- coworker conflicts
- supervisor conflicts
- unstable work history
- disabled: _____

Financial situation:

- no current financial problems
- large indebtedness
- poverty or below-poverty income
- impulsive spending
- relationship conflicts over finances

Social support system:

- supportive network
- few friends
- substance-use-based friends
- no friends
- distant from family of origin

Military history:

- never in military
- served in military – no incident
- served in military – **with** incident

Legal history:

- no legal problems
- now on parole/probation
- arrest(s) not substance-related
- arrest(s) substance-related
- court ordered this treatment
- jail/prison _____time(s)
- total time served: _____
- describe last legal difficulty: _____

Sexual history:

- heterosexual orientation
- homosexual orientation
- bisexual orientation
- currently sexually active
- currently sexually satisfied
- currently sexually dissatisfied
- age first sex experience _____
- age first pregnancy/fatherhood _____
- history of promiscuity age ___to___
- history of unsafe sex age ___to___

Additional information _____

Cultural/spiritual/recreational history:

Cultural identity (e.g., ethnicity, religion): _____

Describe any cultural issues that contribute to current problem: _____

- Currently active in community/recreational activities? Yes No
- Formerly active in community/recreational activities? Yes No
- Currently engage in hobbies? Yes No
- Currently participate in spiritual activities? Yes No

If answered "yes" to any of the above, describe: _____

Sources of Data Provided Above

Patient self-report for all A variety of sources (if so, check appropriate sources below):

Presenting Problems/Symptoms

- patient self-report
- patient's parent/guardian
- other(specify) _____

Family History

- patient self-report
- patient's parent/guardian
- other(specify) _____

Developmental History

- patient self-report
- patient's parent/guardian
- other(specify) _____

Emotional/Psychiatric History

- patient self-report
- patient's parent/guardian
- other(specify) _____

Medical/Substance Use History

- patient self-report
- patient's parent/guardian
- other(specify) _____

Socioeconomic History

- patient self-report
- patient's parent/guardian
- other(specify) _____