



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

Agor Behavioral Health Services, Inc.
 24402 W Lockport Street, Suite 204 ♦ Plainfield, Illinois 60544
 6600 W. College Drive, Suite 101 ♦ Palos Heights, Illinois 60463
 630-621-5824
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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)

Substances used: (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

- nicotine/cigarettes
PCP
prescription
other

Treatment History:

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

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

Delayed developmental milestones

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

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

Emotional/behavior problems (Check all that apply)

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

Social interaction (Check all that apply)

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

Intellectual/academic functioning (Check all that apply)

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



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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) _____