

**ADHD FAMILY COUNSELING CENTER OF  
CENTRAL NEW JERSEY**

**Irv Finkelstein, LCSW**

**Licensed Clinical Social Worker**

**Tel.# (908) 389-0683**

**Fax: (908) 389-0218**

**220 St. Paul Street  
Westfield, NJ 07090**

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

Billing Address if different from above:

Address: \_\_\_\_\_  
\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Marital Status: \_\_\_\_\_

Birthdate: \_\_\_\_\_ SS# \_\_\_\_\_

Referring Physician/Person: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

With whom do you live (relationship, if any)? \_\_\_\_\_  
\_\_\_\_\_

Person to notify in emergency:

Name \_\_\_\_\_ Phone:(\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

Employment Information

Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

Occupation: \_\_\_\_\_

# PRESENTING PROBLEM

Please check the major problem(s) for which you are seeking help at this time

1.  Problems at work
2.  Difficulty forming an intimate relationship
3.  A sexual problem
4.  Problems getting along with others
5.  An unsatisfactory social life
6.  Reacting too emotionally to events or people
7.  Feeling uncomfortable with people in general
8.  Problems with memory
9.  Alcohol or drug use problems
10.  An eating problem
11.  Chronic pain or irritable bowel symptoms
12.  Unexplained physical symptoms
13.  Other problems  
(Specify) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
14.  Low Self Esteem
15.  Problems with depression or sadness
16.  Not enjoying things as much as I used to
17.  Feeling excessive anger or irritability
18.  Difficulties with sleep
19.  Thought about ending my life

20.  Very strong mood swings (highs and lows)
21.  Thoughts that seem to race through my mind
22.  Needing very little sleep
23.  Problems with anxiety or excessive nervousness
24.  Having repetitive or bothersome thought or actions that I cannot stop
25.  Having to avoid certain places or situations because of being too afraid
26.  Problems with excessive fears or suspicions
27.  Difficulty paying attention and/or hyperactivity
28.  Hearing voices or seeing things
29.  Procrastination
30.  Problems with my spouse or romantic partner
31.  Problems in my family
32.  Other relationship problems

What problems designated here do you consider the most disturbing at this time. (Please identify numbers)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Overall, To what degree are you affected by these problems currently

Not at all Very Much

**1            2            3            4            5**

### *How have these problems affected your:*

	Does not apply	slightly	very
Marriage partner relationship	<input type="checkbox"/>	1 2 3 4 5	
Family	<input type="checkbox"/>	1 2 3 4 5	
Job/School performance	<input type="checkbox"/>	1 2 3 4 5	
Friendship	<input type="checkbox"/>	1 2 3 4 5	
Financial situation	<input type="checkbox"/>	1 2 3 4 5	
Health	<input type="checkbox"/>	1 2 3 4 5	
Anxiety level/nerves	<input type="checkbox"/>	1 2 3 4 5	

	Does not apply	slightly	very
Financial situation	<input type="checkbox"/>	1 2 3 4 5	
Health	<input type="checkbox"/>	1 2 3 4 5	
Anxiety levels/nerves	<input type="checkbox"/>	1 2 3 4 5	
Mood	<input type="checkbox"/>	1 2 3 4 5	
Eating habits	<input type="checkbox"/>	1 2 3 4 5	
Sleeping habits	<input type="checkbox"/>	1 2 3 4 5	
Ability to concentrate	<input type="checkbox"/>	1 2 3 4 5	
Child rearing	<input type="checkbox"/>	1 2 3 4 5	
Ability to control your temper	<input type="checkbox"/>	1 2 3 4 5	

How long have you been experiencing the problem, which you've identified as most disturbing to you?

- Less than 4 weeks
- 1 to several months
- More than a couple of months
- All my life

Your current condition is best characterized by:

- First occurrence with no previous difficulty
- Repeat of a previous problem
- Worsening of a long standing condition(s)

At the present time I feel: (Circle best choice)

Extremely Poor	Fair	Very well
0 1 2 3 4	5 6 7	8 9 10

Are you currently in psychotherapy?  Yes  No

If so, with whom? \_\_\_\_\_

How long have you been in treatment? \_\_\_\_\_

Briefly describe the type of therapy? \_\_\_\_\_

What effect if any have you noticed. \_\_\_\_\_

Are you currently taking medication for this problem?  Yes  No

If so, prescribed by whom \_\_\_\_\_

Please list names and dosages of psychiatric medications currently being used.

Name	Dosage
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

**Have you experienced any of the following emotional/psychological problems in the past?**

- Problems with depression or sadness
- Thoughts about ending my life
- Very strong mood swings (highs and lows)
- Problems with anxiety or excessive nervousness
- Having repetitive or bothersome thoughts or actions that I cannot stop
- Having to avoid certain places or situations because of being afraid
- Problems with excessive fears or suspicions
- Difficulty paying attention and/or hyperactivity
- Hearing voices or seeing things
- Difficulty forming an intimate relationship
- Alcohol or drug use problems
- An eating problem
- Chronic pain or irritable bowel symptoms
- Unexplained physical symptoms
- Other problems

Have you ever had outpatient psychological, psychiatric, or substance abuse treatment before?  Yes  No  
 If yes, please complete.

From Whom	Dates of treatment	Was it helpful (yes or no)

Have you ever been treated with psychiatric medications in the past?  Yes  No  
 If so, complete

Name of Medication	Approx. maximum daily dosage	Approx. how long did you remain on medication	Was it useful? Yes or No	Reason for discontinuation (i.e. side effects, inadequate response etc.)

Have you ever been hospitalized for emotional, psychological or substance abuse problems?

Yes      No       If yes, please complete.

Name of Hospital or Program	Approx year of admission	Reason for hospitalization	Was it helpful? Yes or No

**(To be completed by adults 18 years or older)**

How many alcoholic (beer and wine included) do you consume in the average day? \_\_\_\_\_

Do you have a history or excessive alcohol/drug use?  Yes      No

Have you ever been told by someone that they thought you needed to cut back on alcohol or drug use?  Yes      No

Have you ever had social, legal or work problems due to your alcohol or drug use?  Yes      No

Are you a recovering alcohol or drug user?  Yes      No

Have you ever used utilized pain medications on a prolonged or excessive basis?  Yes      No

Are you currently using any drugs on a recreational basis?  Yes      No

If yes, which drugs are you using \_\_\_\_\_

Are you using     Daily       1-2 times per week     1 to 2 time a month       almost never

**(To be completed by adolescents 18 years or younger)**

**Have you ever thought about suicide? ?**    Yes      No

1. If "yes", When was the last time \_\_\_\_\_

2. What were the circumstances? \_\_\_\_\_

**Have you ever attempted to kill yourself?**  Yes      No

If "yes", When \_\_\_\_\_

- 1. Have you ever intentionally cut or injured yourself?    Yes      No
- 2. Are you currently having suicidal thoughts?             Yes      No
- 3. Do you have a plan to harm yourself?                     Yes      No
- 4. Is there a gun in your home?                                 Yes      No
- 5. Has anyone in your family attempted a suicide?        Yes      No

Do you have a family doctor/internist?  Yes      No

If so, Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone#: (    ) \_\_\_\_\_ - \_\_\_\_\_

Please note any significant medical history including past operations and major illnesses.

\_\_\_\_\_  
\_\_\_\_\_

Please list all medications you are currently taking. \_\_\_\_\_

Medication	Daily amount
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What is your weight in pounds? \_\_\_\_\_

Has your weight increased or decreased by more than ten pounds in the last 3 years?  Yes  No

If yes, Explain:

\_\_\_\_\_

Do you drink tea, coffee or colas with caffeine?  Yes  No

If yes, How many drinks per day \_\_\_\_\_

Do you have difficulty falling asleep?  Yes  No

Do you have problems with waking up and unable to fall back asleep?  Yes  No

Do you have bad dreams, wet bed, sleep walk or other sleep disturbances?  Yes  No

### **Smoking**

Do you currently smoke or chew tobacco?  Yes  No

If so, estimate average daily use \_\_\_\_\_

Have you previously used tobacco?  Yes  No

If yes, what was your maximum daily use? \_\_\_\_\_

How many years did you use? \_\_\_\_\_

When did you stop? \_\_\_\_\_

### **Sexual**

Do you have any sexual problems?  Yes  No

If yes, please describe:

### **Social/Family History**

1. Place of birth: \_\_\_\_\_

2. Are your parents divorced or separated?  Yes  No

If yes, your age at the time \_\_\_\_\_

3. Do you have step parents?  Yes  No

If yes, please specify: \_\_\_\_\_

4. Who were you raised by? \_\_\_\_\_

5. Where were you raised? \_\_\_\_\_

**Family History - Please complete as well as possible.**

	Current Age (if alive)	If dead, their age at death and your age at the time	Cause of death	Their occupation (when you were growing up)	Your relationship with person when growing up. (Excellent, good, friendly, cordial, cool, cold supportive, stiff, hostile, abusive, distant)	Specify if any history of mental illness, suicidal problems or substance abuse
<b>Mother</b>						
<b>Father</b>						
<b>Step Parents If applicable</b>						
	Current Age (Specify if deceased)	Nature of relationship (currently and when growing up) cold supportive, stiff, hostile, abusive, distant			(Excellent, good, friendly, cordial, cool, cold supportive, stiff, hostile, abusive, distant)	Specify if any history of mental illness, suicidal problems or substance abuse
<b>Brothers/Sisters</b>						
<b>Your Children</b>						

<b><i>If more space is needed</i></b>	Current Age (Specify if deceased)	Nature of relationship (currently and when growing up) (Excellent, good, friendly, cordial, cool, cold supportive, stiff, hostile, abusive, distant)	Specify if any history of mental illness, suicidal problems or substance abuse
<b>Brothers/Sisters</b>			
<b>Your Children</b>			

<b>Check any of the following that applied during your childhood and adolescence</b>			
<input type="checkbox"/> Happy childhood <input type="checkbox"/> Unhappy childhood <input type="checkbox"/> Emotional/behavior problems <input type="checkbox"/> Strong religious convictions <input type="checkbox"/> Death in family <input type="checkbox"/> Severely punished <input type="checkbox"/> Moved frequently <input type="checkbox"/> Was afraid to go to school	<input type="checkbox"/> Had difficulty with reading, writing, or math <input type="checkbox"/> Were truant <input type="checkbox"/> Not enough friends <input type="checkbox"/> School problems <input type="checkbox"/> Financial problems <input type="checkbox"/> Legal trouble <input type="checkbox"/> Used alcohol <input type="checkbox"/> Promiscuous		<input type="checkbox"/> Cruelty to animals <input type="checkbox"/> Failed or repeated a grade <input type="checkbox"/> Sexually abused <input type="checkbox"/> Exposed to incest <input type="checkbox"/> Severely bullied or teased <input type="checkbox"/> Eating disorder <input type="checkbox"/> Drug use <input type="checkbox"/> Ignored <input type="checkbox"/> Living away from home

**Education;** (Check the highest level completed)

6th  7th  8th  9th  10th  11th  12th

College: 1st  2nd  3rd  4th

Graduate school degree

School Attended

	Name	years attended	Degree
High School	_____	_____	_____

Post High	_____	_____	_____
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What was school like for you? \_\_\_\_\_

What kind of student were you? \_\_\_\_\_

Scholastic strengths \_\_\_\_\_

Scholastic weaknesses \_\_\_\_\_

Did you make friends easily?  Yes  No  Did you keep them?  Yes  No

Did you date much during High School?  Yes  No  College?  Yes  No

Rate the degree to which you generally feel relaxed and comfortable in social situations

Very relaxed 1 2 3 4 5 6 7 8 9 10 Very anxious

What situations if any, cause you extreme anxiety? \_\_\_\_\_

What hobbies or activities do you engage in? \_\_\_\_\_

Describe your occupation: \_\_\_\_\_

How long have you been in this field? \_\_\_\_\_

Describe your current position/job \_\_\_\_\_

How long have you been at your current position? \_\_\_\_\_

How do you feel about your occupational life/career?  Gratiied  Neutral  Ungratiied

Have you ever been in trouble with the law?  Yes      No

If so describe: \_\_\_\_\_

With whom do you live? (Check all that apply)

Self       Parents       Spouse       Roommate       Child(ren)       Friend(s)

Other (specify) \_\_\_\_\_

Place where you live:

- House, Rental
- House, Own
- Apartment
- Room
- Dormitory
- Other

Marital Status:

- Never married
- Married
- Divorced
- Widow/Widower
- Living cooperatively
- Separated
- Marriage annulled
- Remarried

If you have been married, how many times?

1  2  3   More

If you have been divorced, how many times?

1  2  3   More

**If currently married**

What is your spouses age? \_\_\_\_\_

His/Her occupation: \_\_\_\_\_

Describe your spouse's personality: \_\_\_\_\_

How do you feel about your marriage?  Gratifed     Neutral     Ungratifed

Where do your parents (if alive) and siblings currently reside?

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**Patient-Clinician Authorizations and Agreements**

**Authorizations and agreements with Irv Finkelstein, LCSW.**

Please read carefully and sign. The paragraphs below contain several agreements.

For \_\_\_\_\_

1. Medical Insurance. I authorize the medical insurance company to pay directly for the above clinical services. I, however, understand that the person who signs below are responsible for all my fees, including any fees not paid by the insurance company. I understand that if I have not provided Irv Finkelstein, LCSW with adequate information in order to allow for the verification of my insurance coverage, that I will be fully responsible for all fees incurred. Also, that as a result, I may not be eligible for reimbursement from my insurance company.
2. It is also understood that it is my responsibility to update Irv Finkelstein, LCSW with any changes in insurance coverage that may occur during treatment with this office.

**Release of Information: I authorize Irv Finkelstein, LCSW to release information about me to the medical insurance company and the referring physician. This authorization will end if I give written instructions to Irv Finkelstein, LCSW to that effect, which I may do at any time.**

***Financial Responsibility:*** *We, the undersigned; understand and agree that each of us is responsible for the patient's fees to Irv Finkelstein, LCSW including fees not paid by medical insurance; that if the account is not paid when due, reasonable collection costs will be paid by the undersigned; that interest at the rate of 1% per month will be charged on any balance outstanding after 90 days; that we are responsible for full therapy fees resulting from appointments not kept or canceled without a 24-hour notice; that fees for out patient services must be paid at the time services are rendered; and that the patient is responsible for filing for insurance reimbursement.*

*I understand that if I have not provided Irv Finkelstein, LCSW with adequate information in order to allow for the verification of my insurance coverage, that I will be fully responsible for all fees incurred. Also, that as a result, I may not be eligible for reimbursement from my insurance company.*

*It is also understood that it is my responsibility to update Irv Finkelstein, LCSW with any changes in insurance coverage that may occur during treatment with this office.*

**DISCLAIMER**

In an attempt to provide quality customer service to our patients any verification of your insurance is only an estimate and is not a guarantee of payment by your insurance company. Any insurance approval implied or otherwise is subject provisions in force at the time services are rendered. As a result, **you the patient will be held responsible for all fees incurred.**

Patient or Parent's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to patient (If patient is a minor) \_\_\_\_\_

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**Consent to Release Confidential Information**

I hereby authorize and request,

**Irv Finkelstein, LCSW**

**ADHD Family Counseling Center of Central New Jersey**

to release confidential information, including personal, psychological, psychiatric, drug/alcohol, medical records and opinions, resulting from my contacts with the above to:

Name

Title/Functions:

Address:

Disclosure shall be limited to the following specific types of information:

Use of this information shall be limited to the following purpose(s):

I understand that any cancellation or modifications of this authorization must be in writing, and that I have a right to receive a copy of this authorization. A photocopy of this authorization shall be as effective and valid as the original.

**This authorization shall remain valid until:**

I furthermore release all parties stated here within from any legal liability resulting from the release of this information, with the understanding that all parties involved will exercise appropriate safeguards while using this information

**Signature \_\_\_\_\_ Date \_\_\_\_\_**

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CENTRAL NEW JERSEY**

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**Signature \_\_\_\_\_ Date \_\_\_\_\_**

# ADHD FAMILY COUNSELING CENTER OF CENTRAL NEW JERSEY

*Irv Finkelstein, LCSW*  
Licensed Clinical Social Worker

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220 St. Paul Street  
Westfield, NJ 07090

## CREDIT CARD AUTHORIZATION FORM

CREDIT CARD TYPE     VISA                       MASTERCARD                       DISCOVER

CREDIT CARD NUMBER \_\_\_\_\_

EXPIRATION DATE \_\_\_\_\_ Card Code (on back) \_\_\_\_\_

CARD HOLDER NAME \_\_\_\_\_

BILLING ADDRESS \_\_\_\_\_

CITY/STATE/ZIP \_\_\_\_\_

PHONE \_\_\_\_\_

AMOUNT                      Only to pay for professional services

I, \_\_\_\_\_, authorize the use of the above listed credit card to pay the fees for **Irv Finkelstein, LCSW**. I understand that the credit card will be used at my request to pay for session fees. **I also give authorization to use the card to pay for any outstanding fees that are over 90 days overdue. I also authorize the card to be used to cover the cost for any fees occurred for missed sessions or sessions canceled with less than the 24 hours notice required. I understand that these transactions will occur without additional notice.** I understand that fee payment deadlines, and/or late fees are my responsibility. I further understand that I may be charged a penalty fee if the credit card company denies my credit card. I understand that a facsimile or photocopy of this form with my signature on it is the same as an original. A copy of the transaction will be mailed for your personal record. Please ensure that you complete this form in its entirety.

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Signature

Date

---

Phone: 908 389-0682

Fax: 908 389-0218

Email: [irv@adhd911.com](mailto:irv@adhd911.com)