



Celeste Emelia Mattingly, LCSW  
 Psychotherapist

Celestial Psychology®

"Where Mind & Body Meet Spirit"

100 South Main Street  
 West Hartford, CT 06107  
 860-586-8700 (p)  
 860-236-1909 (f)

Dx:		Referral Source:			Date:	
PATIENT INFORMATION						
First Name	Middle	Last	Birth Date / /	Age	Gender <input type="checkbox"/> M <input type="checkbox"/> F	
Street Address			City	State	Zip Code	
Home Phone	Work Phone		Cell Phone	Social Security #		
Current Employer			Current Employer's Address			
INDIVIDUAL RESPONSIBLE FOR PAYMENT						
First Name	Middle	Last	Birth Date / /	Age	Gender <input type="checkbox"/> M <input type="checkbox"/> F	
Street Address			City	State	Zip Code	
Home Phone	Work Phone		Social Security #			
Employer			Employer's Address			
PRIMARY INSURANCE COMPANY						
Name	Policy ID No.		Group #			
Street Address			City	State	Zip Code	
Name of Policy Holder			Birth Date / /	Relationship to Insured		
Employer			Employer's Address			
SECONDARY INSURANCE COMPANY						
Name	Policy ID No.		Group #			
Street Address			City	State	Zip Code	
Employer			Employer's Address			

**Assignment of Benefits**

I understand that I am responsible for payment in full of all charges not covered by insurance. I authorize payment of benefits from my insurance be paid directly to Celeste Mattingly, LCSW. I also authorize her to release to my insurance company any and all information necessary for the processing of insurance claims in accordance with HIPAA statutes and NASW-CT guidelines.

Signature: X \_\_\_\_\_ Date: \_\_\_\_\_

Current Employer:		Position	Number of Years
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<b>Past Employer:</b>		<b>Position</b>	<b>Number of Years</b>
<b>Education:</b>	<b>Current Grade:</b> <b>Highest Grade:</b>	<b>High School Graduate?</b> <b>GED Recipient?</b>	<b>College Education:</b>
<b>Marital Status:</b>	<input type="checkbox"/> Single <input type="checkbox"/> Separated	<input type="checkbox"/> Married ____ Years Married	____ Times Married ____ Times Divorced
<b>Children:</b>	<b>Names:</b> _____ _____ _____ _____ _____	<b>Age(s): Health Issues:</b> _____ _____ _____ _____ _____	<b>Dependent Family Member(s):</b> <b>List Aging Parents (if appropriate)</b> _____ _____ _____ _____
<b>Emergency Contact:</b>	<b>Name:</b>	<b>Telephone Number:</b>	<b>Relationship:</b>

**Military Experience:** \_\_\_\_\_  
 \_\_\_\_\_

**MEDICAL INFORMATION: Primary Care Physician: Name:** \_\_\_\_\_

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

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

**Date of last physical:** \_\_\_/\_\_\_/\_\_\_ **Date of last EKG:** \_\_\_/\_\_\_/\_\_\_ **Medication allergies:**  Yes (Explain below)

No \_\_\_\_\_

**Do you see any specialists for medical problems?**  Yes  No **If yes, list types of specialists:**

\_\_\_\_\_

**Do you use over-the-counter medications? If so, list:** \_\_\_\_\_

\_\_\_\_\_

**Do you take vitamins/herbs/supplements? If so, list:** \_\_\_\_\_

\_\_\_\_\_

**List current (non-psychiatric) medications:** \_\_\_\_\_

**Medical History (Illness, Injury, Hospitalization, Operations, etc.):**

\_\_\_\_\_

\_\_\_\_\_

**Check if you experience or have experienced any of the following:**

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Hypertension        | <input type="checkbox"/> Pancreatic problems | <input type="checkbox"/> Head Trauma             | <input type="checkbox"/> Epilepsy        |
| <input type="checkbox"/> Liver Problems      | <input type="checkbox"/> Blackouts           | <input type="checkbox"/> Thyroid Disease         | <input type="checkbox"/> Respiratory     |
| <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Night Sweats        | <input type="checkbox"/> Immune Disorder(s)      | <input type="checkbox"/> problems/Asthma |
| <input type="checkbox"/> HIV/AIDS            | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> D.T.s                   | <input type="checkbox"/> ETOH Seizures   |
| <input type="checkbox"/> GI Disease          | <input type="checkbox"/> Tremors             | <input type="checkbox"/> Cardiovascular problems | <input type="checkbox"/> Other:          |

\_\_\_\_\_

**PSYCHIATRIC INFORMATION:**



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Psychiatrist: Name: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Date of last visit: \_\_\_/\_\_\_/\_\_\_

List current psychiatric medications: \_\_\_\_\_

List of psychiatric medications prescribed in the past: \_\_\_\_\_

Check if you have ever seen any of the following (Please indicate who and when for any checked area):

- Therapist/Counselor - Name: \_\_\_\_\_ Approx. Dates/# of years \_\_\_\_\_  
 Psychiatrist - Name: \_\_\_\_\_ Approx. Dates/# of years \_\_\_\_\_  
 EAP/Other: \_\_\_\_\_

Check if you have ever been in any of the following (Please indicate where and when for any checked area):

- Psychiatric Hospital \_\_\_\_\_  
 Substance Abuse Treatment Center or Detox \_\_\_\_\_  
 Outpatient Treatment /Partial Hospital Program \_\_\_\_\_

Check any of the following symptoms that you are currently experiencing:

- Depression       Sadness       ADD/ADHD       Sleep problems  
 Harmful or Dangerous Thoughts       Anxiety/Panic Attacks       Throw or break things  
 Hit or punch others       Phobias       Racing thoughts       Obsessive Acts (like hand-  
washing or  Hoarding Behaviors       Binging/Purging       Other \_\_\_\_\_  
 counting or Ruminating)

**Personal habits section:**

1. Do you exercise?  Yes  No If no, rate how much it bothers you on a scale from 1 to 10, 10 being the most troublesome: \_\_\_\_\_

2. Do you gamble?  Yes  No If yes, list your favorite games in order of preference: \_\_\_\_\_

2. Do you surf the web?  Yes  No If yes, list your favorite web sites and estimate how much time you spend surfing the web and/or on any computer sites including pornography and virtual life sites: \_\_\_\_\_

4. Do you play games (including video)?  Yes  No If yes, list your favorite ones in order of importance and estimate average time spent on each in any given period of time: \_\_\_\_\_

5. Do you manage your money well?  Yes  No If no, rate how much it bothers you on a scale from 1 to 10, 10 being the most troublesome: \_\_\_\_\_

6. What is your spiritual preference?

Religious - If yes, list your denomination: \_\_\_\_\_

Spiritual - List your practices: \_\_\_\_\_

6.a. Do you pray  Yes  No If yes, please elaborate: \_\_\_\_\_



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6.b. Do you meditate?  Yes  No If yes, elaborate: \_\_\_\_\_

7. What is your sexual preference?  Heterosexual  Bi-sexual  Homosexual  Asexual

7.a. How would you describe your sexual activity?

- Monogamous - Please check:  Past  Present \_\_\_\_\_  
 Abstinent - Please check:  Past  Present \_\_\_\_\_  
 Multiple partners - Please check:  Past  Present \_\_\_\_\_  
 Asexual - Please check:  Past  Present \_\_\_\_\_

8. How would you describe your eating habits?

- Average  Obsessive  Vegan  Vegetarian  Omnivore  Anorexic  Binge/Purge  Body Dysmorphia

Check if you are using any of the following (Please indicate how much/how often for any checked area):  
 Include whether you have stopped due to addiction issues and how long you have been abstinent

- Alcohol \_\_\_\_\_  
 Cocaine \_\_\_\_\_  
 Marijuana \_\_\_\_\_  
 Heroin \_\_\_\_\_  
 LSD \_\_\_\_\_  
 Ecstasy \_\_\_\_\_  
 Cigarettes \_\_\_\_\_  
 Cigars \_\_\_\_\_  
 Caffeine \_\_\_\_\_  
 Energy Drinks (such as Monster, Red Bull, etc.) \_\_\_\_\_  
 Amphetamines \_\_\_\_\_  
 Benzodiazepines \_\_\_\_\_  
 Pain Medication \_\_\_\_\_  
 Other \_\_\_\_\_

Check and circle if you are or have been in any of the following:

- AA currently in the past  CA currently in the past  OA currently in the past  
 NA currently in the past  ACOA currently in the past  Alanon currently in the past

Please discuss: \_\_\_\_\_

Check if you have ever been arrested or convicted of the following (Please explain any checked area):

- DWI \_\_\_\_\_  Domestic Violence \_\_\_\_\_  
 Drug related \_\_\_\_\_  Other \_\_\_\_\_

Please discuss: \_\_\_\_\_

Family-of-origin History (use back of page, as needed):

Relative	Name	Current Age (Or age at death)	Location & Emotional Closeness	Medical Illness (or cause of death, if deceased)	Mental Illness or Substance Abuse
Father					
Mother					
Stepparents					
Grandparents					
Uncles					



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Aunts					
Brothers					
Sisters					

**Have you ever been abused? You may choose to discuss this section during your sessions.**

- Physically \_\_\_\_\_
- Verbally \_\_\_\_\_
- Emotionally \_\_\_\_\_
- Sexually (including rape) \_\_\_\_\_

**What are your current living arrangements?** \_\_\_\_\_

**What is the primary reason you are seeking psychotherapy at this time?** \_\_\_\_\_

### Confidentiality Statement

State law and professional ethics require therapists to maintain confidentiality except for the following situations:

1. If there is suspected child, elder, or dependent adult abuse and /or neglect
2. "Tarasoff" situations in which serious threat to a reasonably well-identified victim is communicated to the therapist.
3. When threat to injure or kill oneself is communicated to the therapist.
4. I understand that other potential limits to confidentiality include:
  - All records as well as notes on sessions and phone calls can be subject to curt subpoena under certain extreme circumstances. Most records are stored in locked filed, but some are stored in secured electronic devices.
  - Cellular phones, portable phones, fax machines, and computer-generated emails are used as communication tools on some occasions.
  - All electronic communication compromises your confidentiality.

I have read, discussed any questions, and understand the above.

\_\_\_\_\_  
 Print Name

\_\_\_\_\_  
 DOB

\_\_\_\_\_  
 Signature of Client

\_\_\_\_\_  
 Date