Alexandria Moretti, LCSW
8079 N. 85th Way
Scottsdale, AZ 85258
480-261-5015

Client Name: ____

May I call you at:

Home: ______________________ Y N Work: ______________________ Y N
Cell: ______________________ Y N E-mail: ______________________ Y N

Address:

____

City State Zip

Appointment Reminder Preference (circle one) Email Phone Text

Social Security No: ______________________ Age: __________ Date of Birth: ____________

In case of emergency notify: ____

Relationship to you: ___________________________ Phone: ________________________

Primary Care Physician: ________________________ Phone: _________________________

Referred by: ____

If you would like us to bill your insurance company, we need the following information:

Insurance name: _______________________________ Phone number: ___________________________

Insured's name: _______________________________ Relationship to you: _______________________

Insured's address: ____

Insured's date of birth: _______________ Insured's Social Security No: __________________________

Member ID: _____________________________________ Group ID: ___________________________

Effective date of coverage: ____________ Deductible: ___________ Ded. Amount met: ____________

Copay/Coinsurance: ____

Out-of-pocket max: __________________ Out-of-pocket max met: ____________________________

Authorization required: Y N *If YES, authorization number: _______________________________

INTEGRATED MENTAL HEALTH ASSOCIATES

EDUCATION/CAREER

School completed?

High School _____ Vocational _____ College _____ Graduate _____

Are you currently in school or a training program? Y N

If yes, where? ________________________ Area of study? ______________________________

Are you currently employed? Y N

Employer? ____

Job/Occupation: ____

Other jobs, last five years? ____

____

INTEGRATED MENTAL HEALTH ASSOCIATES

RELATIONSHIP BACKGROUND

	Name	Age (or deceased)	Level of Education	Occupation
Spouse/ Partner				
Children				

	Yes/No	When?	What/Whom?
Have you ever been separated/divorced?			
Have you ever been in a physically or sexually hurtful or abusive relationship?			
Has your partner had a problem with alcohol or drugs?			

FAMILY BACKGROUND (include step-parents if applicable)

	Name	Age (or deceased)	Level of Education	Occupation
Father				
Mother				
Siblings				

	Yes/No	When?	Whom?
Have your parents ever been divorced?			
Have either of your parents ever had a problem with alcohol or drugs?			
Was there any physical or sexual abuse in your family?			
Are you in contact with your parents?			
Are you in contact with your siblings?			

INTEGRATED MENTAL
HEALTH ASSOCIATES

Describe any medical or psychiatric conditions of your parents and siblings (including substance abuse):

____

MEDICAL HISTORY

Describe your physical health (circle one): excellent good fair poor very poor

What prescription/non-prescription medications/drugs do you take or use?

Name	Dose	Start Date	Side Effects?

Please list any past or present condition for which you are being or have been treated:

____

____

Do you have allergies? Y N If yes, please list: ___________________________________

When did you last have a physical examination? ______________________________________