GoodLife Journey
INCORPORATED

Jana Zeedyk, Ph.D., Clinical Psychologist
2549 Cottonwood Street • Anchorage, AK 99508
P: (907) 222.2670 • F: (907) 222.2671

CLIENT INFORMATION

Please Print Clearly

Today's Date: ______________________________

Name: ______________________________

Address: ______________________________

City / State: ____________________ Zip: __________

Phone HOME: ______________________________

Phone WORK: ______________________________

Phone CELL: ______________________________

Age: ____________________

Birth date: ____________________

Social Sec. #: ____________________

Marital Status: ____________________

OK to leave a general message? Y N

OK to leave a general message? Y N

OK to leave a general message? Y N

EMPLOYMENT

Your employer & position: ______________________________

Highest education completed: ______________________________

How did you hear about me? ______________________________

To whom will the bills be sent (after insurance)? ______________________________

Address / Phone (if different than client's): ______________________________

Who should I contact in case of an emergency (name / phone)? ______________________________

____

INSURANCE

Effective Date: ____________________

Policy #1

Who is the insured party? ______________________________

Date of birth of insured party: ______________________________

Insurance Co: ______________________________

Address for Claims: ______________________________

____

Phone #: ______________________________

Relationship to you: ____________________

Social Security #: ____________________

Policy/ID #: ____________________

Group #: ____________________

Employer: ____________________

Effective Date: ____________________

I authorize ***GoodLife Journey, Inc.*** to release information necessary to process my claim. I authorize any insurance benefits be paid directly to ***GoodLife Journey, Inc.***

____
Signature

____
Date

____
Print Name

MENTAL HEALTH HISTORY

Are you currently in counseling or receiving mental health or substance abuse services from any other provider?

____

Have you received psychotherapy in the past? Y N If yes, please indicate:

Name of Counselor 1: ______________________

Age at the Time: ______________________

Length of Therapy: ______________________

Reason for Therapy: ______________________

Name of Counselor 2: ______________________

Age at the Time: ______________________

Length of Therapy: ______________________

Reason for Therapy: ______________________

Have you ever been admitted to a psychiatric hospital? Y N If yes, please indicate:

Where 1: ______________________

Age at Admission: ______________________

Length of Stay: ______________________

Reason for Hospitalization: ______________________

Where 2: ______________________

Age at Admission: ______________________

Length of Stay: ______________________

Reason for Hospitalization: ______________________

Have you ever received substance-abuse treatment? Y N If yes, please indicate:

Where 1: ______________________

Age at the Time: ______________________

Inpatient or Outpatient: ______________________

Where 2: ______________________

Age at the Time: ______________________

Inpatient or Outpatient: ______________________

Have you ever been charged with a crime? Y N If yes, please indicate:

Charge 1: ______________________

Were you arrested?: ______________________

Age at the Time: ______________________

Outcome: ______________________

Charge 2: ______________________

Were you arrested?: ______________________

Age at the Time: ______________________

Outcome: ______________________

Are you currently on probation? Y N If yes, explain: ______________________

____

Are you currently involved in any legal proceedings (eg: a civil suit, divorce, custody case, bankruptcy, etc.) Y N

If yes, explain: ______________________

Is an evaluation or participation in psychotherapy required of you by anyone (eg: court or employer)? Y N

If yes, who? ______________________

Have you ever taken medication for psychiatric reasons in the past? Y N If so, please list below:

Approximate Dates	Name of Medication	Reason

MENTAL HEALTH HISTORY (continued)

Have you ever had Psychological Testing? Y N If yes, approximately when and where?

Name of Counselor 1: ______________________________ Name of Counselor 2: ______________________________

Age at the Time: ______________________________ Age at the Time: ______________________________

Length of Therapy: ______________________________ Length of Therapy: ______________________________

Reason for Therapy: ______________________________ Reason for Therapy: ______________________________

MEDICAL INFORMATION

Current Primary Physician: ______________________________

Date of Last Exam: ______________________________

Primary Physician Phone: ______________________________

May I contact your primary physician to coordinate care, if necessary? Y N

If yes, please sign here to authorize: ______________________________

Have you ever been medically hospitalized? Y N If yes, please indicate:

Where 1: ______________________________ Where 2: ______________________________

Age at the Time: ______________________________ Age at the Time: ______________________________

Length of Stay: ______________________________ Length of Stay: ______________________________

What for? ______________________________ What for? ______________________________

Have you ever received a head injury? Y N

If yes, please indicate:

What happened? ______________________________

Age at the Time: ______________________________

Have you ever lost consciousness? Y N

If yes, please indicate:

What happened? ______________________________

Age at the Time: ______________________________

Do you have any current health problems? Y N

If yes, explain: ______________________________

____

List all current medications:

Name	Dose	Times Per Day	Reason for Medication

Thank you for completing this form