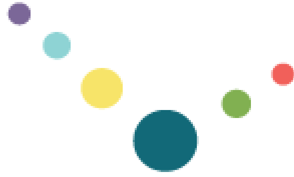

JOCIE SWEENEY, PHD

Your Charlotte Psychologist

Licensed Psychologist
980.236.0734
801 East Morehead Street, Suite 103
Charlotte, NC 28202
drsweeney@sweeneypsych.com
www.sweeneypsych.com

Welcome! Please complete the following information sheet to provide me with your contact information, medical and personal history, and help me understand your current concerns. Leave blank any items that do not apply. Thank you! Also, please provide your insurance card (if applicable), a photo ID, and a credit card for your records.

Basic Information
Legal Name: ____ Date of birth: _____/_____/________
Preferred name (if any): __________________________ Last 4 of SSN: ___________

Home Address: ____
____
____
____

HIPAA Agreement:
Did you receive a copy of the Privacy Policy describing how personal health information is used?
□ Yes □ No

PCP Release:
Would you like me to be able to communicate with your medical doctor regarding concerns we discuss in counseling? □ Yes □ No
If yes, please provide their name(s) and phone number(s) ___________________________________
Signature ____

Referral Information (Optional)
Who referred you to Dr. Sweeney? _____________________________
Is it ok to thank this person/office for their referral? □ Yes □ No

Contact Information
Mobile Phone: _________________________ Ok to leave messages at this number? □ Yes □ No
Home Phone: __________________________ Ok to leave messages at this number? □ Yes □ No
Work Phone: __________________________ Ok to leave messages at this number? □ Yes □ No

E-mail Address:
____ OK to contact? □ Yes □ No

Would you like to get appointment reminders?

- ☐ No reminders
- ☐ E-mail reminders

Emergency Contact

Name: ____

Relation to you: ___________________________________

Phone: ______________________________ ☐ Mobile ☐ Home ☐ Work

Alt. Phone: ___________________________ ☐ Mobile ☐ Home ☐ Work

E-mail Address: ____

Home Address: ☐ Same as client, or:

____

____

____

Contact Release:

Would you like me to be able to communicate with your emergency contact regarding your attendance in counseling? ☐ Yes ☐ No

If yes, please provide the date in which you would like to terminate this release (enter date in MM/DD/YYYY format please)_____________________

Signature ____________________________________

Would you like me to be able to communicate with your emergency contact regarding concerns we discuss in counseling? ☐ Yes ☐ No

If yes, please provide the date in which you would like to terminate this release (enter date in MM/DD/YYYY format please)____________________

Signature ____________________________________

Identity Information

Relationship Status:

- ☐ Single
- ☐ Partnered
- ☐ Married
- ☐ Separated
- ☐ Divorced

Gender: ____

Preferred pronouns: ____

Racial and/or ethnic identity: ____________________________________

Sexual identity/orientation: ______________________________________

Religious/spiritual identity: ______________________________________

Have you ever experienced any stress or discrimination based on any aspect of your identity? If yes, please explain:

____

____

____

____

____

Education and Work Information

Highest level of education completed:

- ☐ Grade _______
- ☐ GED
- ☐ High school
- ☐ some college
- ☐ Associate's degree
- ☐ Bachelor's degree
- ☐ Grad/Prof. degree

Current job status:

- ☐ Employed ---> Job title: ___________________________________
- ☐ Part-time Student Work hrs./week: _______
- ☐ Full-time Student Employer _________________________________
- ☐ Unemployed

Job/work stress:	☐ Always	☐ Often	☐ Sometimes	☐ Rarely	☐ Never
Financial stress:	☐ Always	☐ Often	☐ Sometimes	☐ Rarely	☐ Never

Have you served in the military? ☐ Yes ☐ No

If "Yes" to military service, what branch? ____________________________

When? ________________________________

Deployed? ☐ Yes ☐ No

Where? _____________________________

Legal History

Have you ever been arrested?	☐ Yes	☐ No
Convicted of a crime?	☐ Yes	☐ No
Are you involved in any litigation currently?	☐ Yes	☐ No

Medical Conditions and History

Have you had any of the following medical concerns?

- ☐ Thyroid problems
- ☐ Low iron (anemia)
- ☐ Head injury or TBI
- ☐ Chronic pain
- ☐ Concussion
- ☐ Seizure
- ☐ Migraines
- ☐ Other (specify): ____

Do you have a documented or diagnosed disability? ☐ Yes ☐ No

If "Yes," please indicate which type of disability (check all that apply):

- ☐ Deaf or Hard of Hearing
- ☐ Visual Impairment
- ☐ Mobility Impairment
- ☐ Chronic Pain
- ☐ ADD/ADHD or Learning Disability
- ☐ Mental Health Disorder
- ☐ Physical/health-related Disorders
- ☐ Other (specify): ______________________________________

Please list all current medications (including hormones, if applicable):

____

____

Name of your Primary Care doctor: ____
Practicing at what agency/hospital: ____
Phone: ____________________________________

Do you see a psychiatrist? ◻ Yes ◻ No
Name of psychiatrist: ____
Practicing at what agency/hospital: ____
Phone: ____________________________________

Mental Health History
Have you had previous counseling? ◻ Yes ◻ No
When? ____
For what? ____
Was it helpful? ____

Are you aware of any family history of mental health concerns (e.g., anxiety, depression, substance use, suicides)?
◻ Yes ◻ No *If "Yes," please list the relation to you and the type of concern:*
____
____
____

Presenting Concerns
Which of the following have been a concern for you lately (check all that apply):

- ◻ Unhappiness
- ◻ Irritability or anger
- ◻ Mood swings
- ◻ Worrying
- ◻ Anxiety or stress
- ◻ Fear of avoidance
- ◻ Discrimination
- ◻ Traumatic event
- ◻ Accident or injury
- ◻ Social anxiety
- ◻ Panic attacks
- ◻ Eating/appetite
- ◻ Body image or weight
- ◻ Sleep
- ◻ Substance use
- ◻ Legal problems
- ◻ Family problems
- ◻ Suicidal thoughts
- ◻ Work or school
- ◻ Spirituality
- ◻ Grief or loss
- ◻ Identity
- ◻ Sexuality
- ◻ Gender
- ◻ Romantic break-up
- ◻ Divorce
- ◻ Recent changes in life

Briefly describe your reason(s) for seeking therapy now:
____
____
____
____
____
____
____
____
____
____

Thank you! Please have your credit card and photo ID ready for Dr. Sweeney's records. Please also provide your insurance card if you're planning to file a claim for your sessions.

↓ Please leave this section blank ↓

Hx of PP and curr. sxs

Soc. hx/supp./coping

Fam of origin/Devel. Hx

Trauma/IPV/SA

SU

Sleep
App

SI/HI

Goals