

DAVIS CONSULTANTS, PC
APPLICATION FOR PSYCHOTHERAPY SERVICES

To help us understand your situation, the services you are seeking, and whether or not we may be able to provide the services you are seeking we ask that you complete this Application for Services and email or fax it to our office so that we can evaluate whether or not we are a good fit for your needs.

For either Dr. Davis or Ms. Richards you can fax this form to: 406-543-1290

If emailing the form would be easier you may email it as an attachment to:

pdj@dcpcmt.com for Dr. Davis, or
srichardslcsw@gmail.com for Ms. Richards

Once we have received and reviewed your application we will contact you to schedule an initial intake appointment or to let you know that we don't think that we are a good fit for your needs

Date: _____

Demographic Information

Name: _____

Age: _____

Gender: Male Female Other/Please Ask

What is your mailing address?

What is the best way for us to contact you?

Telephone: _____

Do you give us permission to leave messages identifying our clinic on your voice mail? Yes No

Please initial here to signify your authorization: _____

Email: _____

Do you give us permission to send you email messages containing information which identifies our clinic? Yes No

Please initial here to signify your authorization: _____

Other/ Please provide any special contact instructions: _____

How did you find out about our clinic?

Primary Care Provider: _____

Please provide Name and Phone Number of Primary Care Provider

Other: _____

Please tell us who referred you to our clinic

Self: How did you find out about us? _____

For Example: Yellow Pages, Psychology Today website, Davis Consultants website, etc.

What is the primary issue you are seeking psychotherapy for?

For Example: Anxiety, Depression, Substance Use, Pain, etc.

How long have you had this issue?

- Less than 1 month 1-3 months 3-6 months 6-12 months More than 12 months

Have you received services for this issue from other providers in the past? Yes No

If yes, please estimate the number of previous providers you have seen: _____

Which of the following treatments have you received for this issue in the past?

- Counseling/Psychotherapy Biofeedback Medication
 Psychiatric Hospitalization Other: _____
-

How will you be paying for services? Out of Pocket Health Insurance Other

If Health Insurance, what company? _____

If Health Insurance, have you met your deductible for 2016 Yes No

If not, what is your deductible? _____

If Other, please provide details: _____

Are you currently involved in any lawsuits? Yes No

If Yes, please briefly describe the nature of the litigation:

Are you currently applying or considering applying for Social Security disability benefits? Yes No

Have you been Court Ordered to seek mental health treatment? Yes No

Are you currently under any type of legal supervision? Yes No

If Yes, nature of supervision: _____

Psychosocial Functioning Questions

In general, do you have difficulty making and keeping friends? Yes No

Would you normally describe yourself as a loner? Yes No

In general, do you trust other people? Yes No

Do you normally lose your temper easily? Yes No

Are you normally an impulsive sort of person? Yes No

Are you normally a worrier? Yes No

In general, do you depend on others a lot? Yes No

In general, are you a perfectionist? Yes No

