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:
pjd@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:

_____

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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

Do you have a history of severe or repetitive trauma? ❒ Yes ❒ No

Please indicate your spiritual/religious status:

❒ Atheist ❒ Agnostic ❒ Buddhism ❒ Christian ❒ Islam ❒ Judaism

❒ Traditional Native American ❒ Other: _____

Is there anything else you think we should know or that you want to be sure we know about you or your situation to help us evaluate your case?

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For Office Use

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