Rosemarie Scolaro Moser, PhD, ABN, ABPP-RP, Director
American Board of Professional Neuropsychology
American Board of Professional Psychology-Rehabilitation
NJ Psychology Lic. # SI02148
NJ Certified School Psychologist

CONFIDENTIAL
INTAKE INFORMATION

(Depending on Child or Adult, Please Complete Where Applicable)

Name_____ Date of Birth _____Today's Date_____

Please Check: Female _____ Male _____ Age _____ Social Security #: _____

Home Address _____ City/State/Zip_____

Home/Cell Phone _____Work Phone _____

Employer & Occupation-**OR**-*School & Grade & GPA*_____

Years of Education _____ Place of Birth _____ Religion, if applicable _____

Check One: Single _____; Married _____; Separated _____; Divorced _____; Widowed _____

For ADULTS: Spouse's Name, Age & Occupation_____

Children's Names & Ages_____ _____

For CHILDREN: Parents' Names & Occupations _____

Sisters'/Brothers' Names & Ages _____

Emergency Contact Name & Phone _____

Name of Primary Care Physician, Pediatrician, or Psychiatrist_____

Nature of Assistance you are seeking: (Please check)

Psychotherapy/Counseling _____	Psychological Testing _____	Neuropsychological Testing _____
Baseline Testing _____	Concussion Exam_____	Bariatric Testing_____
Spinal Cord Stim. Testing_____	Career Counseling _____	Cognitive Rehabilitation _____
Hypnosis _____	Academic Coaching_____	Biofeedback_____

Other (describe) _____

How did you hear about this service? Who referred you? _____

Describe below the difficulties or symptoms for which you are seeking assistance.

Please list any significant <u>past or present</u> medical or health related conditions, treatments, injuries or surgeries. Are you now receiving treatment for any of these conditions?

Please note if you have ever sustained a head injury, concussion, or been in a work-related, sport-related, or motor vehicle accident. Please describe and list dates.

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www.sportsconcussionNJ.com www.rsmpsychology.com

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Have you ever been hospitalized for a medical, substance/alcohol abuse, or psychiatric problem? If yes, where and when?

Are you now receiving, or have you ever in the past received, any type of mental health or psychiatric treatment or personal or career counseling? If yes, please list diagnoses, dates, type of treatment.

Have you ever been diagnosed with a learning or attention or memory disorder? If yes, please explain.

Has anyone in your family ever received psychological/psychiatric assistance or been diagnosed with a learning or attention or memory disorder? If yes, please describe:

Please list name and dosage of any medications you are taking:

Do you use other non-prescription drugs or substances? If yes, please describe:

Do you drink alcohol? If yes, how many drinks per week?

Do you smoke? If yes, how many cigarettes per day?

Are you [*or for children*- is/are your parent(s)] a present or past military member? Yes__ No__

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I agree to accept responsibility for all fees and payments of any services rendered to me by RSM PSYCHOLOGY CENTER, LLC/SCCNJ and its providers. I understand that payment is expected at the time services are rendered. I also understand that I will be charged for any appointments that I do not cancel 24 hours prior to my scheduled appointment.

_____ _____
Signature Date

ONLY For: Medicare, Personal Injury, Workers Comp, TriCARE, Princeton Univ. Student Aetna
I permit RSM PSYCHOLOGY CENTER, LLC/SCCNJ to bill my Third Party Payer/Insurance company and its affiliates/contractors for services provided and to provide those entities with the necessary information to process my bills. I agree to pay all co-pays promptly and to take responsibility for payment of any services that may not be covered by my health care/insurance plan. I understand that I am responsible to know my plans' coverage prior to treatment.

_____ _____
Signature Date

Insurance Carrier & Address:_____ _____

Insurance ID/Claim # _____ Group # _____

Name of Insured _____Adjuster Name & Contact Info _____

Form Date 9/1/18)