

Paulo Lazaro, LCSW, CBT, EMDR

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BASIC INFORMATION

Name: _____ Age: _____

Add.: _____

Cell #: _____ Home: _____ Work: _____

Is it OK to leave messages? () Cell () Home () Work

Authorize electronic communication (Skype, Facetime, Zoom, Whatsapp, Text, etc)? () Yes () No

Date of Birth: _____ S.S.#: **(if using insur.)** _____

Email: _____ @ _____ .com

Insur. Co.: _____ Tel: _____ ID#: _____

Acct#: _____ Grp#: _____ Plan#: _____

Referred by: _____

INSURED INFO (IF DIFFERENT THAN CLIENT)

Name: _____ Relation: _____

Date of Birth: _____ S.S.#: _____

CURRENT CONDITION

1) Reason to seek psychotherapy at this time: _____

2) Expectations in regards to this therapy: _____

3) Intensity and duration of current symptoms:

Symptoms	Intense	Moderate	Mild	< 1 mth	1 to 6 mths	> 6 mths
1) Sadness						
2) Lack of pleasure in activities that used to feel pleasant						
3) Anxiety						

4) Low energy/motivation						
5) Reduced or Increased sleep						
6) Reduced or Increased appetite						
7) Low self-esteem						
8) Frequent crying						
9) Irritability						
10) Relationship difficulties						
11) Decreased/Increased sexual desire						
12) Isolation						
13) Panic attacks						
14) Unusual weight loss						
15) Poor concentration/memory						
16) Substance abuse (alcohol, etc)						
17) Frequent, sudden episodes of anger						
18) Physical pains/problems w/out reason						
19) Episodes of breathing difficulties						
20) Periods of euphoria						
21) Suicidal thoughts						
22) Other (list):						
23) Other (list):						

4) Use of drugs, alcohol, coffee, cigarettes (past and present): _____

5) Physical health (date of last general check up): _____

MENTAL HEALTH HISTORY

1) Previous psychotherapy, reasons and results ("helpful," "not helpful"): _____

2) Psychiatric Medication used in the past or being currently used: _____

3) History of impulse control difficulties (self-destructive behavior, suicidal attempts, etc): _____

EDUCATIONAL AND PROFESSIONAL INFO

1) Professional occupation: _____

2) Highest academic degree: _____

PERSONAL AND FAMILY HISTORY

- 1) Your marital status: _____
- 2) Legal issues (arrests, DUI's, etc): _____
- 3) (Emotional) Support system (spouse, family, friends, etc): _____

- 4) Family mental health history (including mental illness, domestic violence, abuse, etc): _____

- 5) Parents' marital status (if separated, divorced and deceased, please list your age at the time):

- 6) Current relationship with your family of origin: _____

OTHER RELEVANT INFO

FOR INSURANCE PAYMENT PURPOSE, WHEN APPROPRIATE

- 1) Patient's or authorized person's signature: I authorize the release of any medical or other information necessary to process claims related to this psychotherapy treatment. I also request payment of government benefits to the party who accepts assignment below.
- 2) Insured's or authorized person's signature: I authorize payment of medical benefits to the undersigned provider described herein.

Client's Signature/Date	Paulo Lazaro, LCSW, CBT, EMDR/Date