Yaacov Jeffrey Kravitz, Ed.D.

101 Greenwood Ave., Suite 410, Jenkintown, PA 19046 www.dr-yjkravitz.com 215-635-3O11

Patient Name_____ Sex_____ DOB_____

Address _____City_____ State_____Zip_____

Home Phone_____Work_____Cell_____

* Confidential messages may be left at (check any that apply) ___ Home Phone __work ____cell
* If you consent to the exchange of logistic information (eg, appointments) and educational information by e-mail please give your e-mail address _____ Initials ____
PLEASE NOTE THAT E-MAIL IS NOT SECURE AND I CAN NOT GUARANTEE ITS CONFIDENTIALITY.

Marital Status: ___ Minor ___Single ___Married ___Divorced ___Widowed ____Separated

Employment: ____Full Time ____Part Time ____Minor ____Unemployed ____Disability

Employer Name:_____

Employer Address _____

If Student: ____ Full Time ____Part Time School Name: _____

Referred By: _____

Family Dr./Pediatrician: _____

Emergency Contact Person: _____Phone number _____

Responsible Party Name:_____ DOB _____

SS# _____Relationship to Patient _____

Address _____

Home Phone_____Work_____Cell_____

Employer: _____Address:_____

Primary Insurance Information: Must be completed fully in order to bill Insurance Co.:

Name of Insured: _____Relationship to Patient_____

Insured's DOB_____ Insured's S S# _____

Insurance Company Name _____Phone_____

Address _____

ID# _____Group # _____Deductible._____

Are You covered for Out-Patient Psychotherapy:___Yes___No. Max.Benefit Amount _____

Are You covered under your:_____Basic Plan or _____ Major Medical Plan .

Secondary Insurance Information: Are You covered for Out-Patient Psychotherapy:___Yes___No

Name Of Insured: _____Relationship to Patient_____

Insured's DOB_____ Insured's S S# _____

Insurance Company Name _____Phone_____

Address _____

ID# _____Group # _____Deductible._____

Assignment of insurance benefits and Release of Information for Insurance Purposes

Client's Name:_____ Date of Birth _____

Home Address _____

Home Phone: _____ Work phone: _____

Medicare Number _____ Attending Physician _____

Other Insurance_____ Policy #_____

- Specific Information To Be Released: Protected Healthcare Information
- Purpose for Releasing Information: Establishes reasons for providing insurance coverage of mental health services and for additional authorization of services.

I understand that my records are protected under Section 5100.34 of the Pennsylvania Mental Health Procedures Act and the Pennsylvania Drug and Alcohol Abuse Control Act, and under the federal regulations governing Confidentiality of Drug and Alcohol Abuse Patients Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

_____

(Specification of date, event, or condition upon which this consent expires)

Beneficiary Signature_____ Date _____

Assignment of Insurance Benefits

1. I request that payment of authorized Medicare benefits be made either to me or on my behalf to Jeffrey H. Kravitz, Ed.D. for any services rendered to me by that provider. I authorize Dr. Kravitz and his staff to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that I am liable for any balance not covered by my insurance up to the limits set by Medicare. I understand that certain psychological tests may not be covered by Medicare and that if payment is refused by Medicare I will be responsible for payment of related fees.

Beneficiary Signature_____ Date _____

2. I request that payment of authorized Medigap or other insurance benefits be made either to me or on my behalf to Jeffrey H. Kravitz, Ed.D. for any services rendered to me by that provider. I understand that I am liable for any balance not covered by my insurance up to the limits set by Medicare. I understand that certain psychological services and tests may not be covered by my insurance and that if payment is refused I will be responsible for payment of related fees. I authorize Dr. Kravitz and his staff to release to: [Please check or write in your non-Medicare insurance provider's name.]

_____ Pennsylvania Blue Cross - Blue Shield.

_____ New Jersey Blue Cross - Blue Shield

_____ AARP Heath Insurance

_____ _____

and its agents any information needed to determine these benefits payable for related services.

Beneficiary Signature _____ Date _____

CONSENT FOR RELEASE OF MEDICAL RECORDS AND CONFIDENTIAL INFORMATION

This form when completed and signed by you, authorizes Dr. Kravitz to release to and/or obtain from the person or entity you designate certain protected information from your clinical record.
I, (patient Name)_____, (Birth date): _____ authorize my psychologist, Yaacov Jeffrey Kravitz, Ed.D. and/or his administrative and clinical staff, to
_____Disclose or release only to
_____obtain from

_____
(Person/Organization to/from whom information is to be disclosed/obtained) (phone number) (fax number)

_____
(Street address, city, state, .zip code)

records and information relevant to the mental health professional services that I have received from him. Such release or disclosure shall be limited to the following specific types of information: (*Provide a description of the information that you want disclosed. Your description should be as specific and detailed as possible.*)
_x_ History and evaluation _____
_x_ Test results (Specify) _____
_x_ Other ___*progress*_____

I am requesting this release of information for the following reasons: ("at the request of the individual" is all that is required if you are my patient and you do not desire to state a specific purpose.)
__*Coordination of care*_____
_____
_____

It is understood that information disclosure may be made through written documents, telephone conversation, or other electronic means.

I issue this authorization with knowledge of the contents of the material or communication and understanding of the consequences, and do so voluntarily and free from duress or undue influence.

By signing this consent to release confidential information / medical records, I am expressly consenting to release of information / medical records that may contain information concerning alcohol abuse, drug abuse, psychiatric treatment, or HIV-related information.

I hereby hold harmless the above named practitioner from any liability relevant to the release of the confidential information or privileged information.

The patient signing this form has the right to revoke this authorization, in writing, at any time by sending such written notification to Dr. Kravitz's office address. However, such revocation will not be effective to the extent that action has been taken in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

This authorization is valid today, and remains in effect until
(*fill in expiration date)* _____ or event _____.
If no date or event is specified this authorization remains in effect for one (1) year from today.

I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

Patient's Signature _____ Date _____

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided: _____
_____
_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below I,_____, acknowledge that I received a copy of the "Notice of Privacy Practices."

_____ _____
Signature of client (or personal representative) Date

If this acknowledge is signed by a personal representative on behalf of the client, complete the following:
Personal Representative's Name:_____

Relationship to Client: _____
_____

ACKNOWLEDGEMENT OF RECEIPT OF PSYCHOTHERAPIST-PATIENT AGREEMENT and CONSENT TO TREATMENT

By my signature below , I acknowledge that I received a copy of the Psychotherapist-Patient Agreement indicating that I have been informed of the policies and practices of Dr. Kravitz and that I consent to treatment.

_____
(Signature) (Date) (Please print Name)

_____
(Witness) Date

This form will be retained in your medical records

FOR OFFICE USE ONLY

I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

__ Individual refused to sign
__ Communications barriers prohibited obtaining the acknowledgement
__ An emergency situation prevented us from obtaining acknowledgement
__ Other (Please Specify)

_____

_____

YAACOV J. KRAVITZ, Ed.D.,Licensed Psychologist
101 Greenwood Ave., Suite 410, Jenkintown, PA 19046 www.dr-yjkravitz.com 215-635-3O11

PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT

Welcome to my practice. This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. A HIPAA Notice of Privacy Practices (the Notice) is attached to this Agreement .It is very important that you read these documents carefully. We can discuss any questions you have about the procedures. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES Psychotherapy varies depending on the personalities of the psychologist and patient, and the particular problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home. Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience. Our first few sessions will involve an evaluation of your needs. I will then be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

TREATMENT SESSIONS We will usually schedule one 45-minute session (one appointment hour of 45 minutes duration) per week at a time we agree on, although some sessions may be longer or more frequent. If you miss a scheduled appointment**,** you will be expected to pay a cancellation fee of $70 for it unless you provide 24 hours advance notice of cancellation. It is important to note that insurance companies do not provide reimbursement for cancelled sessions. This fee will be waived by Dr. Kravitz if he and you agree that the situation was an emergency.

PROFESSIONAL FEES My hourly fee for individual therapy is $130 for a 45 minute session; $160 for a 60 minute session; and $175 for an initial assessment. I charge $150 for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services may include, but are not limited to report writing, telephone conversations lasting longer than 10 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. [Because of the difficulty of legal involvement, I charge $200 per hour for preparation and attendance at any legal proceeding, with a minimum of 4 hours, payable in advance.] Other services are often not eligible for insurance reimbursement and are your responsibility.

CONTACTING ME Due to my work schedule, I am often not immediately available by telephone. While I am in my office, I probably will not answer the phone if I am with a patient. When I am unavailable, my telephone is answered by an answering machine that I monitor frequently. I will make every effort to return your call within 24 hours, with the exception of weekends and holidays when calls will be returned on the next work day. If you are difficult to reach, please inform me of some times when you will be available. In serious emergencies only you can call my cell at 267-626-9115. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

LIMITS ON CONFIDENTIALITY - Please see the attached Notice of Privacy Practices for details.

BILLING AND PAYMENTS You will be expected to pay for each session at the time it is held, unless you have insurance coverage that requires another arrangement. All insurance co-pays or private rate payments must be made at the time of the visit. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

INSURANCE REIMBURSEMENT I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers. If you have questions about the coverage, call your plan administrator. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. It may be necessary to seek approval for more therapy after a certain number of sessions.

In addition if your insurance carrier denies payment for any reason, you assume responsibility for the cost of the sessions. This agreement shall remain in effect for one year or throughout the course of treatment, whichever is longer.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS, AND THAT YOU AGREE AND CONSENT TO PARTICIPATE IN BEHAVIORAL HEALTH CARE SERVICES OFFERED AND PROVIDED BY DR. YAACOV J. KRAVITZ. YOUR SIGNATURE ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

I understand that I may revoke this authorization to release information at anytime by written notice to Dr. Kravitz and my insurance carrier.

Name (please print) _____ Signature _____ Date: _____

NOTICE OF PRIVACY PRACTICES

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. **Your signature on this Agreement provides consent for those activities, as follows**:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).
- You should be aware that I practice with other mental health professionals and that I employ administrative staff. In most cases, I need to share your protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.
- I also may have contracts with accountants, billing services and lawyers. As required by HIPAA, I have a formal business associate contract with these businesses, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, I can provide you with the names of these organizations and/or a blank copy of this contract.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.
- If a patient seriously threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.
- You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis, and, sometimes, additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier.

There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning the professional services I provided to you, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- If I am treating a patient who files a worker's compensation claim, I may, upon appropriate request, be required to provide otherwise confidential information to your employer.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice.

- If I have reason to believe that a child who I am evaluating or treating is an abused child, the law requires that I file a report with the appropriate government agency, usually the Department of Public Welfare. Once such a report is filed, I may be required to provide additional information.
- If I have reason to believe that an elderly person or other adult is in need of protective services (regarding abuse, neglect, exploitation or abandonment), the law allows me to report this to appropriate authorities, usually the Department of Aging, in the case of an elderly person. Once such a report is filed, I may be required to provide additional information.
- If I believe that one of my patients presents a –specific and immediate threat of serious bodily injury regarding a specifically identified or a reasonably identifiable victim and he/she is likely to carry out the threat or intent, I may

required to take protective actions, such as warning the potential victim, contacting the police, or initiating proceedings for hospitalization

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, I keep information about you in two sets of professional records. One set constitutes your Clinical Record (Protected Health Information). It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances that involve danger to yourself and others or where information has been supplied to me by others confidentially, or the record makes reference to another person (unless such other person is a health care provider) and I believe that access is reasonably likely to cause substantial harm to such other person, you may examine and/or receive a copy of your Clinical Record if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. [I am sometimes willing to conduct this review meeting without charge.] In most circumstances, I am allowed to charge a copying fee of at least $0.20 per page and for certain other expenses. The exceptions to this policy are contained in the attached Notice Form. If I refuse your request for access to your records, you have a right of review (except for information supplied to me confidentially by others), which I will discuss with you upon request.

In addition, I also keep a set of Psychotherapy Notes. These Notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of our conversations, my analysis of those conversations, and how they impact on your therapy. They also contain particularly sensitive information that you may reveal to me that is not required to be included in your Clinical Record. These Psychotherapy Notes are kept separate from your Clinical Record. Your Psychotherapy Notes are not available to you and cannot be sent to anyone else, including insurance companies without your written, signed Authorization. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal to provide it.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights or any complaints with you.

EFFECTIVE DATE and CHANGES TO THIS NOTICE

This Notice is effective on September 7, 2009. Revised 9/3/2014,

I may change this notice at any time. I f I change this notice I will make the new notice terms effective for all PHI that I maintain, including any information created or received prior to issuing the new notice. If I change this notice I will post the revised notice on my web site (www.dr-yjkravitz.com). You may also request a written copy. This form is educational only and does not constitute legal advice and covers only federal, not state law.

YAACOV J. KRAVITZ, Ed.D.
Licensed Psychologist

101 Greenwood Ave., Suite 410 drk@dr-yjkravitz.com
Jenkintown, PA 19046 215-635-3O11

Secure Communication addition to Privacy Practices

Limits of Confidentiality

It is important for you to be aware of the risks, including but not limited to your confidentiality in treatment, of transmitting any protected health information by unsecured means. Electronic message

s can be intercepted in two ways. One is when the message is sent unencrypted; the message may be read by third parties who monitor internet traffic, such as server administrators. The second is when the message reaches the recipient but is viewed by someone else (e.g., if someone has access to the person's phone, computer, or other devices used to read or write messages). When a work email is used for communication, employers may have access to any messages that are sent.

Email or text should never be used to request assistance for emergencies. Electronic communication is never a substitute for face-to-face therapy; detailed or sensitive conversations should be reserved for in-person meetings. If you send any insecure communications, please be advised that I will respond only by phone or in person at our next scheduled session. While I will try to return secured/encrypted messages in a timely manner, I cannot guarantee an immediate response.

In order to insure that all of your communications with me are private, safe and secure I have established the following procedures for ALL communications. These procedures will take a few minutes for you to set up on your phone and computer, but will ensure that we are following all HIPAA requirements for the security of your information.

1. **Telephone and cell phone**. This is the most secure means of communication for voice calls as there is no data that is recorded so it can't be compromised. If you leave a message on my answering machine I am able to delete the message after it has been listened to. Any important information will be recorded in your record. Phones calls and encrypted texts are the best way to communicate information regarding scheduling and appointment times.

2. Text communication. If you wish to send me a text message from your cell phone **please do not use the basic SMS text app on your cell phone.**

Please go to https://whispersystems.org/ and install the "Signal Private Messenger" app. You can use this app to send totally secure encrypted texts. Signal is free and easy to set up. If you have any difficulty I will be happy to help you set it up. You will still be able to use your regular text app if you like for communicating with other people. You can also use Signal to send unencrypted texts to anyone who is not using Signal.

3. **E-mail**. E-mail is the least secure mode of communication. E-mail accounts may be hacked. Emails may remain on your (or my) e-mail provider's servers even after you have deleted them from your account. **I am requesting that you NEVER use regular e-mail for communication with me**.

As an **alternative** to regular e-mail I have established a Patient Portal which you may use to send secure communications to me, including uploading or downloading of any confidential documents. If you agree to use the Patient Portal I will send you a link from **Patient Ally** which you may use to set up a free account.

If in any event you wish to use regular email or text you must submit a written request using a "Request for non-Secure Communication" form that I can provide to you.

Name_____ INTAKE QUESTIONNAIRE
Date _____ Yaacov Jeffrey Kravitz, Ed.D., Licensed Psychologist

Please complete these questions as fully and as accurately as you can. Case records are strictly confidential.

I. PERSONAL INFORMATION

Birth date: ____/_____/_____ Age:___ Sex____ Race_____

Religion_____ Church/Synagogue member: yes __ no __

Education: Years or grade completed_____ Degrees earned_____

Occupation_____ How long in present job?_____

Have you had any counseling and/or psychiatric care? yes[ ] No[ ] If yes, when and under what circumstances:

Name of Dr. or counselor	Approximate Dates	What problem were you treated for?		

Who referred you to this psychologist or this group? _____

IN EMERGENCY PLEASE NOTIFY:

Name_____ Relationship _____Phone _____

Address_____Zip_____

MARITAL INFORMATION

Present Marital Status: (check one): single [ ] engaged [ ] married [ ]
separated [ ] divorced [ ] widowed [ ] unmarried couple [ ]

How long in present status?_____

Present mate: First name_____ Age _____

Occupation_____ religion_____ Hobbies _____

Comments about mate _____

_____

Prior marriage length was _____years. From 19____ to 19____

Prior mate: First name_____

Occupation _____ religion_____ Hobbies_____

(comments about mate _____

Was this marriage broken by divorce [ ] or by the death [ ] of mate?

Give information about additional marriages on the reverse side of page.

CHILDREN:

First name: Sex Age Descriptive comments

_____ ___ ___ _____

_____ ___ ___ _____

_____ ___ ___ _____

_____ ___ ___ _____

_____ ___ ___ _____

Who is currently living in your household? _____

_____

Name_____ INTAKE QUESTIONNAIRE
Date _____ Yaacov Jeffrey Kravitz, Ed.D., Licensed Psychologist

FAMILY HISTORY

Parents (names) Mother _____ Father _____
Occupation_____ _____
Education _____ _____
Religion_____ _____
How do you get along? _____ _____
Parent's current marital status _____ _____
Current age or age at death _____ _____
If deceased, what was your age then? _____ _____
Comments _____ _____

Sisters and brothers in chronological order (include yourself)

First name Sex Age Descriptive comments

_____ ___ ___ _____
_____ ___ ___ _____
_____ ___ ___ _____
_____ ___ ___ _____

Give any other information about your family that seems important (include suicide, chemical abuse, diagnosed mental illness, etc.) _____
_____
_____

Is there any history of abuse in your life? Yes [ ] No [ ]
If yes, was it verbal [ ] emotional [ ] physical [ ] sexual [ ]

II. GENERAL CURRENT HEALTH data.

1) How much caffeine do you consume each day? (Give number of cups, size of typical cup, and amount of sugar per cup)

Coffee ___ cups _____ Oz/CUP _____ sugar
tea _____ cups _____ Oz/CUP _____ sugar
sodas/colas_____ Type _____

2) Cigarette use per day equals _____ cigarettes, or _____ packages.

a) Alcohol and drug consumption equals

Substance	Amount	How often ?	Age began	Last used
Wine				
Beer				
Hard liquor				
Drug(specify)				

4) List all known allergies (food, medications, environmental factors) including the reactions you experience. Please include any treatment and/or medications that you use to deal with your allergies:

5) What kind of exercise do you get? What is the frequency of your exercise?

What is the effect on you of this exercise?

How is most of your free time occupied?

6) What is your current height?_____Weight_____
In the last six months have you gained ___ weight or lost_ weight?
How much? ____ lbs. Reason

7) Describe your daily diet. Include foods, drinks, snacks:
Breakfast:

Lunch:

Dinner:

Snacks:

8) Please list any medical conditions that you have now or have had in the past:

Medical Condition	Approximate Dates	Name of Dr. or counselor

9)List all medications you currently take. Please include dosage and condition being treated.
Please list all current medications (prescription/non-prescription/vitamins/herbs/other):

Name of medication	Dosage	Date started	What is it for?

What is the date of your last physical exam?_____

III. INFORMATION ABOUT CURRENT CONCERNS
Why did you choose this time to seek counseling?

Has life been satisfying to you? Explain.

Additional thoughts or comments:

Name_____Date: _____

Below is a list of the ways you might have felt or behaved. Please check the boxes to tell me how often you have felt this way in the past week or so	Not at all	Less than 1 day/ Week	1-2 days this week	3-4 days this week	5-7 days this week	Nearly every day for 2 weeks	Do not write in this column
1. My appetite was poor.							
2. I could not shake off the blues.							
3. I had trouble keeping my mind on what I was doing.							
4. I felt depressed							
5. My sleep was restless							
6. I felt sad.							
7. I could not get going.							
8. Nothing made me happy							
9. I felt like a bad person							
10. I lost interest in my usual activities							
11. I slept much more than usual.							
12. I felt like I was moving too slowly.							
13. I felt fidgety.							
14. I wished I were dead							
15. I wanted to hurt myself							
16. I was tired all the time							
17. I did not like myself							
18. I lost a lot of weight without trying to.							
19. I had a lot of trouble getting to sleep							
20. I could not focus on the important things.							
21. Feeling nervous, anxious, or on edge .							
22. Not being able to stop or control worrying .							
23. Worrying too much about different things							
24 Trouble relaxing .							
25. Being so restless that it's hard to sit still							
26. Becoming easily annoyed or irritable							
27. Feeling afraid as if something awful might happen							
28. Panic attacks							
29. Hearing voices							
30. Inability to control thoughts							
31. Can't make decisions							
32. Difficulty concentrating							
33. Racing thoughts							
34. Stomach problems							
35. Binge eating							
36. Pain							
37. Periods of confusion or disorientation							
38. Memory lapses, forgetfulness							
39. Thoughts of loss or trauma							
40. Fear of going crazy or out of control							

YAACOV J. KRAVITZ, Ed.D.
Licensed Psychologist

101 Greenwood Ave. Suite 410
Jenkintown, PA 19046-2603

drk@dr-yjkravitz.com
215-635-3O11

Office Information

My office is located at
101 Greenwood Ave.
Suite 410
Jenkintown, PA 19046-2603

My business phone number: 215-635-3011.

Office Hours are by appointment only:
Monday: 10:00am -7:00pm; Tuesday 10:00am - 7:00pm ; Thursday 10:00am -5:00pm

Directions and parking:

101 Greenwood Ave. is located at the intersection of Greenwood Ave., West Ave. and Township Line Road in Jenkintown. We are directly across the street from the SEPTA Regional Rail – Jenkintown Station.

There is a large parking lot on the east side of the building with direct access to the building. Please use the upper level.

There are parking spaces for individuals with disability tags in three locations:

1. off of Greenwood Ave at the corner of the building near the entrance to the lot
2. one space behind the building
3. three spaces on the parking lot level (no wheel chair access on this level).