The Wholeness Institute
Dr. Beth Sikora, Ph.D.
6501 E. Greenway Parkway, #103-529, Scottsdale AZ 85254
602-508-9190

CONFIDENTIAL INFORMATION (page 1 of 2)

Welcome to my practice. Please fill out the following questions as completely as possible.
PLEASE PRINT OR WRITE LEGIBLY.

Marital Status:
___ Single
___ Married
___ Committed Relationship
___ Separated
___ Divorced
___ Widowed
___ Other

Name:	Ms. Mrs. Mr. Last First Middle
Parent/ Guardian	(if client is a minor) Last First
Address	Street:
	City: State: Zip Code:
Phone	Home: ( ) Work: ( ) Cell: ( ) Email:
	Age: Birthdate: Birthplace: Ethnicity:
Education	No. of years: Degree: Field:
Employment	Job Position: For How Long?
Spirituality	Religious Background: Current Religion:
Spouse/ Partner	Name: Age: Occupation: Years Married/ Together:

Children M F Name: Age: M F Name: Age: M F Name: Age:

Were you raised by: Both Parents? Single Parent? Relative? Adoption? Other?

Father's Name: Age: Occupation:

Mother's Name: Age: Occupation:

Brothers and Sisters (including yourself) in birth order: Name: Age: Name: Age:

Name: Age: Name: Age: Name: Age:

In your family was there a history of: Alcoholism? Substance Abuse? Mental illness?
Sexual abuse? Other abuse?
Prolonged physical illness? What kind?

Major accident, head injury, or concussion: If so, when?

Current Medications:
Prescribed by: Phone number:

Significant medical problems: Are you currently being treated by a physician? If so, for what?

Have you had previous psychiatric care and/or counseling: Yes No
If yes, give: Name of clinician Sessions from to

Have you ever been hospitalized for substance abuse, alcoholism, eating disorders, or other psychiatric disorders?
Yes No Details:

Referred to us by: May we send them a thank you? Yes No

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Name: Date:

Mailing address for billings: City: State: Zip:

Telephone numbers which we may call and leave messages:

Bill insurance? Yes No Insurance phone:

Insurance name:

Insurance billing address:

Social security No: Group No.

ID No:

Insured's Name: Employer:

Relationship to insured? Patient's date of birth:

Spouse's name:

Working? Yes (full or part time? ___) No

In school? Yes (full or part time? ___) No

Treatment due to accident? Yes No Date of accident:

I, _____, understand and agree to pay The Wholeness Institute the amount of $_____ at the conclusion of each _____-minute consultation.

I understand that I am responsible for payment for consultations not canceled 24 hours in advance. Payment for services rendered is due at the conclusion of the consultation unless other arrangements have been made.

Signature: _____ Date: _____

Spouse's Signature: _____ Date: _____

Parent/Guardian's Signature: _____ Date: _____

I will be happy to discuss my fees, schedule of payments, or any other questions relating to billing or insurance. Please do not hesitate to ask.

FOR OFFICE USE ONLY

Fee: _____ CPT: _____ Diagnostic Code: _____

Signature: _____

Billing instructions:_____
_____