

**Richard D. Recor, Ph.D.**  
**200 Newport Center Drive, Suite 203**  
**Newport Beach, CA 92660**  
**(949) 720-0167**  
**(949) 720-1151 Fax**  
**www.DrRecor.com**

**ADULT PERSONAL HISTORY FORM**

Name \_\_\_\_\_ Date: \_\_\_\_\_

Gender \_\_\_ M \_\_\_ F Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security No: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Ethnicity: \_\_\_\_\_ Family Size: \_\_\_\_\_

Referral Source(s): \_\_\_\_\_

Occupation: \_\_\_\_\_ Education level: \_\_\_\_\_

Current Employment Status: \_\_\_ Unemployed \_\_\_ Part Time \_\_\_ Full Time

Marital Status: \_\_\_ Single \_\_\_ Married (how long) \_\_\_ \_\_\_ Separated (how long) \_\_\_

\_\_\_ Unmarried, living together (how long) \_\_\_ \_\_\_ Widowed (how long) \_\_\_

\_\_\_ Divorced (how long) \_\_\_ Total Number of Marriages \_\_\_\_\_

Assessment of current relationship (if applicable): \_\_\_ good \_\_\_ fair \_\_\_ poor

Primary reason(s) for seeking services:

\_\_\_ Anger management \_\_\_ Anxiety \_\_\_ Addictive behaviors \_\_\_ Alcohol/Drugs  
\_\_\_ Eating disorders \_\_\_ Fear/phobias \_\_\_ Coping \_\_\_ Depression  
\_\_\_ Sleeping problems \_\_\_ Mental Confusion \_\_\_ Sexual Concerns \_\_\_ Other (specify) \_\_\_\_\_

Do you feel suicidal at this time: \_\_\_ Yes \_\_\_ No

If yes, explain: \_\_\_\_\_

Please check behaviors and symptoms that occur to you more than you would like them to take place:

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Aggression                  | <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Irritability        | <input type="checkbox"/> Sleeping Problems     |
| <input type="checkbox"/> Alcohol Dependence          | <input type="checkbox"/> Drug Dependence     | <input type="checkbox"/> Judgment Errors     | <input type="checkbox"/> Speech Problems       |
| <input type="checkbox"/> Anger                       | <input type="checkbox"/> Eating Disorder     | <input type="checkbox"/> Loneliness          | <input type="checkbox"/> Suicidal Thoughts     |
| <input type="checkbox"/> Antisocial Behavior         | <input type="checkbox"/> Elevated Mood       | <input type="checkbox"/> Memory Impairment   | <input type="checkbox"/> Thoughts Disorganized |
| <input type="checkbox"/> Anxiety                     | <input type="checkbox"/> Fatigue             | <input type="checkbox"/> Mood Shifts         | <input type="checkbox"/> Trembling             |
| <input type="checkbox"/> Avoiding people             | <input type="checkbox"/> Gambling            | <input type="checkbox"/> Panic Attacks       | <input type="checkbox"/> Withdrawing           |
| <input type="checkbox"/> Chest Pain                  | <input type="checkbox"/> Hallucinations      | <input type="checkbox"/> Phobias/Fears       | <input type="checkbox"/> Worrying              |
| <input type="checkbox"/> Computer/Internet Addiction | <input type="checkbox"/> Heart Palpitations  | <input type="checkbox"/> Recurring Thoughts  | <input type="checkbox"/> Other (Specify below) |
| <input type="checkbox"/> Depression                  | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sexual Addictions   | _____  |
| <input type="checkbox"/> Disorientation              | <input type="checkbox"/> Hopelessness        | <input type="checkbox"/> Sexual Difficulties | _____  |
| <input type="checkbox"/> Distractibility             | <input type="checkbox"/> Impulsivity         | <input type="checkbox"/> Sick Often          | _____  |

What are your goals for therapy? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### COUNSELING/PRIOR TREATMENT HISTORY

Information about client (past and present):

	No	Yes	When	Where	Reason
Counseling/Psychiatric Treatment					
Suicidal Thoughts/Attempts					
Drug/Alcohol Treatment					
Hospitalizations					
Involvement with self-help Groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)					

## FAMILY INFORMATION

Relationship	Name	Age	Living		Living with you	
			Yes	No	Yes	No
Mother						
Father						
Spouse						
Children						

Information about family/significant others (past and present):

	No	Yes	Who	When	Reason
Counseling/Psychiatric Treatment					
Suicidal Thoughts/Attempts					
Drug/Alcohol Treatment					
Hospitalizations					
Involvement with self-help Groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)					

## MEDICAL /PHYSICAL HEALTH

Check all that apply:

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> AIDS/HIV       | <input type="checkbox"/> Constipation       | <input type="checkbox"/> Hepatitis                     | <input type="checkbox"/> Sore Throat      |
| <input type="checkbox"/> Alcoholism     | <input type="checkbox"/> Chicken Pox        | <input type="checkbox"/> High Blood Pressure           | <input type="checkbox"/> Scarlet Fever    |
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Dental Problems    | <input type="checkbox"/> Kidney Problems               | <input type="checkbox"/> Sinusitis        |
| <input type="checkbox"/> Abortion       | <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Measles                       | <input type="checkbox"/> Small Pox        |
| <input type="checkbox"/> Allergies      | <input type="checkbox"/> Diarrhea           | <input type="checkbox"/> Mononucleosis                 | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> Anemia         | <input type="checkbox"/> Dizziness          | <input type="checkbox"/> Mumps                         | <input type="checkbox"/> Sexual Problems  |
| <input type="checkbox"/> Appendicitis   | <input type="checkbox"/> Drug Abuse         | <input type="checkbox"/> Menstrual Pain                | <input type="checkbox"/> Tonsillitis      |
| <input type="checkbox"/> Arthritis      | <input type="checkbox"/> Epilepsy           | <input type="checkbox"/> Miscarriages                  | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> Asthma         | <input type="checkbox"/> Ear Infections     | <input type="checkbox"/> Neurological Disorders        | <input type="checkbox"/> Toothache        |
| <input type="checkbox"/> Bronchitis     | <input type="checkbox"/> Eating Problems    | <input type="checkbox"/> Nausea                        | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Bed Wetting    | <input type="checkbox"/> Fainting           | <input type="checkbox"/> Nose Bleeds                   | <input type="checkbox"/> Vision Problems  |
| <input type="checkbox"/> Cancer         | <input type="checkbox"/> Fatigue            | <input type="checkbox"/> Pneumonia                     | <input type="checkbox"/> Vomiting         |
| <input type="checkbox"/> Chest Pain     | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Rheumatic Fever               | <input type="checkbox"/> Whooping Cough   |
| <input type="checkbox"/> Chronic Pain   | <input type="checkbox"/> Headaches          | <input type="checkbox"/> Sexually Transmitted Diseases | <input type="checkbox"/> Other (describe) |
| <input type="checkbox"/> Colds/Coughs   | <input type="checkbox"/> Hearing Problems   | <input type="checkbox"/> Sleeping Disorders            | _____                                     |

List any current health concerns: \_\_\_\_\_

List any recent health or physical changes: \_\_\_\_\_

Current Prescribed Medications	Dose	Dates	Purpose	Side Effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Current Over-the-counter Meds	Dose	Dates	Purpose	Side Effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Are you allergic to any medications or drugs?  No  Yes (describe): \_\_\_\_\_

Please check if there have been any recent changes in the following:

- |  |  |                                   |  |
|--|--|-----------------------------------|--|
| <input type="checkbox"/> Sleep Pattern           | <input type="checkbox"/> Eating Patterns     | <input type="checkbox"/> Behavior | <input type="checkbox"/> Energy Level        |
| <input type="checkbox"/> Physical Activity Level | <input type="checkbox"/> General Disposition | <input type="checkbox"/> Weight   | <input type="checkbox"/> Nervousness/tension |

Describe changes in areas in which you checked above: \_\_\_\_\_

\_\_\_\_\_

## CHEMICAL USE HISTORY

Type of Drug	Quantity/Amount	Frequency of Use	Age of First Use	Used in Last 48 Hours		Used in Last 30 Days	
				Yes	No	Yes	No
Alcohol							
Barbiturates							
Valium/Librium							
Cocaine/Crack							
Heroin/Opiates							
Marijuana							
PCP/LSD/Mescaline							
Inhalants							
Caffeine							
Nicotine							
Over-The-Counter							
Prescription Drugs							
Other Drugs							

Substance of preference:

1. \_\_\_\_\_ 2. \_\_\_\_\_

Describe when and where you typically use substances \_\_\_\_\_

Describe any changes in your use patterns \_\_\_\_\_

Describe how your use has affected your family or friends (include their perceptions of your use) \_\_\_\_\_

Reason(s) for use:

Addicted                       Build Confidence                       Escape                       Self-medication  
 Socialization                       Taste                       Other (specify) \_\_\_\_\_

How do you believe your substance use affects your life? \_\_\_\_\_

Who or what has helped you in stopping or limiting your use? \_\_\_\_\_

Does (has) someone in your family (present/past) have (had) a problem with drugs or alcohol?

No  Yes (describe) \_\_\_\_\_

Have you had withdrawal symptoms when trying to stop using drugs or alcohol?

No  Yes (describe) \_\_\_\_\_

Have you had any adverse reactions or overdose to drugs or alcohol? (describe) \_\_\_\_\_

Have drugs or alcohol created a problem for your job?  No  Yes (describe) \_\_\_\_\_

## LEGAL

### Current Status

Are you involved in any active or prior cases (traffic, civil, criminal, child protective services)? \_\_\_ No \_\_\_ Yes  
If yes, please describe and indicate the court and hearing/trial dates and charges \_\_\_\_\_

---

---

Are you presently on probation or parole \_\_\_ No \_\_\_ Yes

If yes, please describe \_\_\_\_\_

---

### Past History

Criminal involvement: \_\_\_ No \_\_\_ Yes

DWI, DUI, Etc.: \_\_\_ No \_\_\_ Yes

Civil involvement: \_\_\_ No \_\_\_ Yes

If you responded Yes to any of the above, please complete the following information:

Charges	Date	Where (City)	Results

## MILITARY

Military Experience: \_\_\_ No \_\_\_ Yes    Combat Experience: \_\_\_ No \_\_\_ Yes    Where: \_\_\_\_\_  
Issues pertaining to Military experience? \_\_\_ No \_\_\_ Yes (describe)

---

---

## LEISURE/RECREATIONAL

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

Activity

How often now?

How often in the past?

---

---

---

---

---

---

---

---

---

---

---

---

## SPIRITUAL/RELIGIOUS

How important to you are spiritual matters? \_\_\_ Not \_\_\_ Little \_\_\_ Moderate \_\_\_ Much

Are you affiliated with a spiritual or religious group? \_\_\_ No \_\_\_ Yes (describe) \_\_\_\_\_

Were you raised within a spiritual or religious group? \_\_\_ No \_\_\_ Yes (describe) \_\_\_\_\_

Additional Religious Issues/Experiences? \_\_\_ No \_\_\_ Yes (describe) \_\_\_\_\_

## SOCIAL RELATIONSHIPS

Check how you generally get along with other people: (check all that apply):

\_\_\_ Affectionate    \_\_\_ Aggressive    \_\_\_ Avoidant    \_\_\_ Fight/argue Often    \_\_\_ Follower  
\_\_\_ Friendly    \_\_\_ Leader    \_\_\_ Outgoing    \_\_\_ Shy/Withdrawn    \_\_\_ Submissive  
\_\_\_ Other (specify) \_\_\_\_\_

## DEVELOPMENT

Are there special, unusual, or traumatic circumstances that affected your development? \_\_\_ No \_\_\_ Yes

If yes, were you a victim of child abuse? \_\_\_ Sexual \_\_\_ Physical \_\_\_ Verbal

Other childhood issues: \_\_\_ Neglect \_\_\_ Inadequate Nutrition \_\_\_ Other (specify) \_\_\_\_\_

Comments re: Childhood development: \_\_\_\_\_

Any additional information you would like to note:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ASSIGNMENT OF INSURANCE BENEFITS**

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Primary Insurance Co:**

Name & Phone Number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Policy Holder Name, Social Security # & Employer: \_\_\_\_\_

Policy & Group #'s: \_\_\_\_\_

**Secondary Insurance**(If Applicable)

Name & Phone Number: \_\_\_\_\_

Claims Mailing Address: \_\_\_\_\_

Policy Holder Name, Social Security # : \_\_\_\_\_

Employer, Policy & Group #'s: \_\_\_\_\_

***We suggest you confirm your insurance benefits with your insurance company(s) to assure your understanding of specific policy provisions. Your insurance Company may not pay for services they consider nonefficacious, not medically or therapeutically necessary, or ineligible. If the insurance company(s) denies payment for any provided services, the Person Responsible for Account will be responsible for the balance of account.***

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. ***I further expressly agree and acknowledge that my signature on this document authorizes my health care provider to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned has personally signed the particular claim.***

**I** \_\_\_\_\_ hereby authorize

\_\_\_\_\_  
(Insurance Co. and/or third-party payer)

to pay and hereby assign directly to Richard D. Recor, Ph.D., all benefits, if any, otherwise payable to me for his services as described on the attached forms. ***I understand that I am financially responsible for all charges incurred. I also understand upon 75 days default, I am liable for any and all costs associated in the collection process of said debt as well as 15% interest on balance at time of default.*** I further acknowledge that any insurance benefits, will be credited to my account, in accordance with the above said assignment.

\_\_\_\_\_  
**Patient or Parent/Legal Guardian Signature** **Date**

\_\_\_\_\_  
**Witness** **Date**

**Financially Responsible Party Information**

**Dr. Recor is committed to providing caring and professional mental health care to all his patients. As part of the delivery of mental health services we have established a financial policy which provides payment policies and options to all consumers as further described in the Patient Consent and Rights Form.** The financial; policy is designed to clarify the payment policies as determined by the management of Richard D. Recor, Ph.D.

Your insurance policy, if any, is a contract between you and the insurance company, we are not part of the contract with you and your insurance company. As a service to you, we will bill insurance companies and other third-party payers, but can not guarantee such benefits or the amounts covered and are not ultimately responsible for the collection of such payments. In some cases, insurance companies or other third-party payers may consider certain services as not reasonable or necessary or may determine that services are not covered. In such cases the Person Responsible for Payment of Account is responsible for payment of these services. Dr. Recor charges the usual customary rates for these services provided in our area. *Person Responsible for Payment of Account is responsible for payments of any insurance company's arbitrary determination of usual and customary rates or denial of payment for services.*

The Person Responsible for Payment of Account is financially responsible for paying funds not paid by insurance companies or third-party payers after 45 days. *Payments not received after 75 days are subject to collections. A 15% interest fee effective the date the account became delinquent, as well as all collection fees associated in collecting the debt.*

*Insurance deductibles and co-payments are due at the time of service.* Although it is possible that mental health coverage deductible amounts may have been met elsewhere (e.g. if there were previous visits to another mental health provider during the current benefit year), this amount will be collected by our office until the deductible payment is verified by the insurance company or third-party payer. *All insurance benefits will be assigned to Dr. Recor by the insurance company or third-party payer unless the Person Responsible for Payment of Account pays the entire balance each session.*

Patients or their parent/legal guardian are responsible for payment at the time of service. Unaccompanied minors will be denied non-emergency services unless charges have been preauthorized by the parent/legal guardian of the minor by either credit card or other payment source at the time of service.

*Missed appointments or cancellations less than 24 hours prior to the appointment are charged \$125.00 and will need to be paid in full before another appointment can be scheduled.* Questions regarding this agreement can be directed to either the Office Manager or Dr. Recor.

- **I (we) have read, understand, and agree with the provisions of the Financially Responsible Party Information.**
- **Patient Name:** \_\_\_\_\_
- **Person (s) Responsible for Account:** \_\_\_\_\_
- ***Person Responsible Address:*** \_\_\_\_\_
- ***Person Responsible Social Security #*** \_\_\_\_\_ ***Phone Number:*** \_\_\_\_\_
- **Signature of Person(s) Responsible for Account:** \_\_\_\_\_



**Preferred Payment Method:**    Check                      Cash                      Visa                      MasterCard

**Credit Card:** \_\_\_\_\_ **Expiration Date:** \_\_\_\_\_ **Sec Code:** \_\_\_\_\_

**Signature(s) of Authorized Credit Card Holder:** \_\_\_\_\_