Christopher D’Amato, Psy.D., MPA
280 Madison Avenue, Suite 305
New York, NY 10016
Phone: 917-225-8381 cdamato708@gmail.com

Welcome to my practice. I look forward to serving you. The following pages include a brief history form, disclosure/consent for treatment, and a release of information form. Please try to be as detailed as possible when filling out the forms. Please sign and bring these forms with you on the day of your appointment.

I look forward to meeting you!

The following forms are confidential. Rediscolsure or transfer is expressly prohibited by law.

Please mail to:

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HISTORY FORM

Patient's Name: _______________________________________

Date of Birth: ___________Age: ___ Sex: ___ Race: ___ Marital Status: ____________

Address: ____

Phone #s: Home: _________________ Work: _______________ Cell:_________________

Briefly explain the main concern or problem that brings you here.
____
____
____
____
____

When did these problems begin?
____

Did they begin: Abruptly ____ Gradually ____
Have they gotten: Better ____ Worse ____ Stayed the Same ____
Have you or others noticed changes in your:
Memory? No ___ Yes ___
Speech? No ___ Yes ___ (explain) __________________________________
Appearance? No ___ Yes ___ (explain) __________________________________
Mood or personality? No ___ Yes ___ (explain) __________________________________
Movements or motor functioning? No ___ Yes ___
(explain)__________________________________

Medical History:
Do you know if your mother had any difficulty during her pregnancy with you?
No _____ Unknown _____ Yes _____ (explain)
____
Were you born prematurely or were there any complications at the time of your birth?
No _____ Unknown _____ Yes _____ (explain)
____
Were there any problems with your development during childhood?
No _____ Unknown _____ Yes _____ (explain)
____

Have you ever had?

Brain Surgery No ___Yes ___
Meningitis No ___Yes ___
Encephalitis No ___Yes ___
Cancer No ___Yes ___
High blood pressure No ___ Yes ___
Low blood pressure No ___ Yes ___
Heart Disease No ___ Yes ___
Heart Attack No ___ Yes ___
Diabetes No ___ Yes ___
Multiple Sclerosis No ___ Yes ___
Parkinson's Disease No ___ Yes ___
Head Injury No ___ Yes ___
Seizures No ___ Yes ___
CPR/artificial respiration? No ___ Yes ___
Fibromyalgia No ___ Yes ___
Chronic Fatigue No ___ Yes ___
Lupus No ___ Yes ___
Chronic Pain No ___ Yes ___
Sleep Apnea No ___ Yes ___
Lyme's Disease No ___ Yes ___
Emphysema No ___ Yes ___
Lead or Other Poisoning No ___ Yes ___
Migraine Headaches No ___ Yes ___
Tension Headaches No ___ Yes ___
Vision Problems No ___ Yes ___

Have you ever had?
EEG No ___ Yes ___
CT scan No ___ Yes ___
MRI scan No ___ Yes ___
PET scan No ___ Yes ___
SPECT scan No ___ Yes ___
Spinal Tap No ___ Yes ___
Psychological Testing No ___ Yes ___
Neuropsych. Testing No ___ Yes ___ Date or Age ______ By

Current medication(s) and reason for taking: Dosage (if known)
____
____
____
____
____
____

____ ____________________

Caffeine Use
Do you drink caffeinated beverages on a daily basis (e.g., coffee, tea, soda)?
No _____ Yes _____

If yes, specify the type and amount per
day:____

Tobacco Use
Do you currently use tobacco? No _____ Yes _____
If yes, specify the type and quantity per day:

____

How long have you used tobacco?

____

If you currently do not use tobacco, but have in the past, describe how much and how long you used tobacco:

____

____

Alcohol / Drug Use
Do you currently drink alcohol? No _____ Yes _____
If yes, specify the type and number of drinks per day or per week:
For how long (since what age)?

____

If you currently do not drink alcohol, but did in the past, describe how much and how long you drank in the past:

____

____

Have you ever tried or taken recreational or street drugs? No ___ Yes ___ (if yes circle all below)

____

First use / frequency / last use of circled drugs:

____

Have you ever received treatment to help you stop taking drugs or abusing alcohol?
No ___ Yes ___ (explain)

____

____

____

Have you ever had any of the following because of your use of alcohol and/or drugs?
Relationship problems No ___ Yes ___ (explain)

____

Job problems No ___ Yes ___ (explain) ____
Legal problems No ___ Yes ___ (explain) ____

Mental Health
Have you ever experienced significant anxiety, depression, suicidal or homicidal feelings or attempts in the past or
presently? No ___ Yes ___ (explain below)
Have you ever had a mental health evaluation; treatment from a counselor, social worker, psychologist, psychiatrist,
or church leader; or related hospitalization? No ___ Yes ___ (explain below)
Please describe any past or current psychological or psychiatric treatment below:

Type of Treatment Age at that time/Reason

Parental Information:
Mother's highest level of education: _____________ Occupation: _______________________________
Medical/Psychiatric Problems: ____
Father's highest level of education: _____________ Occupation: _______________________________
Medical/Psychiatric Problems: ____

Educational History:
Highest grade completed: _________________________ GED?: ________________________________
College or University Education: No _____ Yes _____ (if yes specify below)
Degree: ________ Major/Area: ___________________ Years: ______ Semester Hours: _______
Institution Name: _________________________ Location: ________________________________
Technical or Vocational Training (if any): ____
Typical Grades on Report Card:
____
Skipped any grades? No _____ Yes _____ (explain) _______________________________________
Repeated any grades? No _____ Yes _____ (explain) _______________________________________
Special education classes, tutoring, or alternative school placement (if any):
____
Easiest subjects: _________________________Difficult subjects:
____

Employment History
Are you currently employed?
No ___ How long? _________ Reason for unemployment: _______________________________

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CONSENT FOR TREATMENT

The undersigned consents to any evaluation or therapy rendered to the patient by staff in my practice, which in the judgment of Christopher D’Amato, Psy.D., MPA, is advisable during the course of diagnosis and treatment.

The undersigned certifies that he/she has read the foregoing, and is the patient or the legally authorized representative of the patient.

____
Patient Signature

____
Date

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NOTICE OF PRIVACY PRACTICES

My practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. I am also required by law to keep your information private.

I will use the information about your health which we get from you or from others mainly to provide you with treatment, to arrange payment for services, and for some other business activities which are called, in the law, health care operations.

After you have read this please sign Consent Form to let us use and share your information. If you do not consent and sign this form, we cannot treat you.
If we or you want to use or disclose (send, share, release) your information for any other purposes we will discuss this with you and ask you to sign an Authorization form to allow this.

Of course, I will keep your health information private but there are some times when the laws require us to use or share it. For example:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We
will only share information with a person or organization, which is able to help prevent or reduce the threat.
2. Some lawsuits and legal or court proceedings.
3. If a law enforcement official requires us to do so.
4. For Workers Compensation and similar benefit programs.

Your rights regarding your health information

1. You can ask me to communicate with you about your health and related issues in a particular way or at a certain place which is more private to you. For example, you can ask me to call you at home, and not at work to schedule or cancel an appointment.

2. You have the right to ask me to limit what I tell people involved in your care or the payment for your care, such as family members and friends. While I do not have to agree to your request, if I do agree, I will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you.
3. You have the right to look at the health information I have about you such as your medical and billing records. You can even get a copy of these records, at any time.

4. If you believe the information in your records is incorrect or missing important information, you can ask me to make some kinds of changes (called amending) to your health information.

5. You have the right to a copy of this notice.

6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with the Secretary of the Department of Health and Human Services below. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

U.S. Dept. of Health and Human Services
HIPAA Complaint
7500 Security Boulevard, C5-24-04
Baltimore, MD 21244

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AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Christopher D'Amato, Psy.D., MPA to use or disclose the specific information described below, only for the purposes and parties also described below.

Information Description:
____

Person or entity requesting the information and authorized to make the requested use or disclosure:
____

Recipient of the information: ____

This information is being requested for the following reasons:
____

This authorization shall remain in effect from the date signed below until: _________________I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office at the address above, attention Privacy Officer.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA.
- I may refuse to sign this authorization and that you will not condition treatment or payment on me providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment).

  ____ If this line is checked, I understand that you will receive compensation from a third party for the use or disclosure of my information.

Patient Name:___________________________Signature:___________________________

Relationship to Patient
(if signed by personal representative of Patient):_________________Date:_____________