

HEALTH AND WELLNESS INTAKE AND ASSESSMENT  
THE OFFICE OF MICHAEL BRANT DEMARIA, PH.D.

Today's Date: \_\_\_\_\_

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

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Place of Birth: \_\_\_\_\_

Marital Status: \_\_\_ M \_\_\_ D \_\_\_ S \_\_\_ W

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

May we leave a message at your work number? \_\_\_\_\_

Current Occupation: \_\_\_\_\_

Employed with or student at: \_\_\_\_\_

How did you learn about Dr. DeMaria? \_\_\_\_\_

Circle last education grade level completed:

Elementary/High School 1 2 3 4 5 6 7 8 9 10 11 12 College: 1 2 3 4

Current Treatment (Medical and/or psychological-and by whom):

\_\_\_\_\_

Are you currently on medication? yes\_\_\_ no\_\_\_ If yes, what is the dosage and frequency taken:

\_\_\_\_\_

Previous Treatment? yes\_\_\_ no\_\_\_ If yes, please give name of provider and location:

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Is there any legal case pending, regarding the problem for which you are now seeking help? Yes \_\_\_ No\_\_\_

Names and Ages of Children \_\_\_\_\_

Disability Status: Totally Disabled \_\_\_ Partially Disabled \_\_\_ Not Disabled \_\_\_

Are you in good health: Yes\_\_\_ No\_\_\_ If no, please describe condition:

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Please give brief description of concerns:

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History of Main Concern: In your words briefly describe how and when your main concern started, how it has progressed over time, and how it is now affecting your life.

Date of Onset \_\_\_\_\_

History of Main Concern:

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How do you feel about your main concern? (for example, "I'm afraid I'll never get better?")

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Please rate 1-12 below the areas of your life you are most interested in focusing on and improving at this time in your life.

Health and Fitness \_\_\_\_

Self-Esteem \_\_\_\_

Relationships \_\_\_\_

Job and Career \_\_\_\_

Feelings \_\_\_\_

Thoughts \_\_\_\_

Money and Finances \_\_\_\_

Spirituality \_\_\_\_

Overall Lifestyle \_\_\_\_

Personal Organization \_\_\_\_

Personal/Spiritual Growth \_\_\_\_

Quality of Life \_\_\_\_

The following questions will help you become more mindful of how you are living at present and help me get a better understanding of your world.

**Nutrition:**

My overall diet could be described best as:

Eat anything and everything: \_\_\_\_

Everything except red meat \_\_\_\_

Vegetarian w/fish \_\_\_\_

Vegetarian wo/fish \_\_\_\_

Vegan \_\_\_\_

Do you eat dairy?

Yes \_\_\_\_

No \_\_\_\_

If you eat red meat do you eat it

Daily \_\_\_\_

More than 3 times a week \_\_\_\_

Less than 1x a week \_\_\_\_

I eat raw fruits, vegetables and nuts:

Daily \_\_\_

3-5 times a week \_\_\_

Rare to never \_\_\_

I consume sugar and sweets:

Daily \_\_\_

Less than once per week \_\_\_

I drink an average of \_\_\_ 8 oz. glass of water

Per day:

5 or more \_\_\_

4 or less \_\_\_

I overeat:

Rarely \_\_\_

Occasionally \_\_\_

Frequently \_\_\_

I consume aspartame (nutrasweet, diet Coke, diet Pepsi, Equal, Spoonful, etc.)

Several times a day \_\_\_

Daily \_\_\_

Once a week or less \_\_\_

Never \_\_\_

**EXERCISE:**

I would describe my job as

Physically demanding \_\_\_

Partly physical/partly sedentary \_\_\_

Primarily sedentary \_\_\_

I exercise in aerobic, non-work related activities (jogging, swimming, biking):

Daily-almost daily \_\_\_

3-5 times per week \_\_\_  
Less than 1 day per week \_\_\_

I do light exercise

Daily-almost daily \_\_\_  
3-5 times per week \_\_\_  
Less than 1 day per week \_\_\_

When I exercise I do so for:

30-45 minutes \_\_\_  
15-29 minutes \_\_\_  
Less than 15 minutes \_\_\_

Check all that apply:

I enjoy the exercise that I do \_\_\_  
I dislike the exercise I do \_\_\_  
I consider myself to be in good physical shape \_\_\_  
I consider myself to be in fair physical shape \_\_\_  
I consider myself to be in poor physical shape \_\_\_

Toxic Exposure:

I have been exposed to heavy metals, such as lead, mercury, cadmium, nickel, aluminum \_\_\_  
I have \_\_\_mercury fillings.  
I have had \_\_\_mercury fillings removed.  
I have been exposed to excessive amounts of petrochemicals, pesticides, or other known toxic compounds. \_\_\_\_

**ENVIRONMENT:**

My home environment is:

Clean \_\_\_  
Moderately clean \_\_\_  
Dirty \_\_\_  
Moldy \_\_\_  
Full of chemicals or pesticides \_\_\_  
Has lots of fresh air \_\_\_

My work environment is:

- Clean \_\_\_
- Moderately clean \_\_\_
- Dirty \_\_\_
- Moldy \_\_\_
- Full of chemicals or pesticides \_\_\_
- Has lots of fresh air \_\_\_

**ADDICTIONS:**

An addiction is anything that causes negative life consequences and you want to either totally eliminate or reduce. Which of the following do you at present struggle with:

- Alcohol \_\_\_
- Cigarettes \_\_\_
- Illegal drugs \_\_\_
- Prescription drugs \_\_\_
- Anger \_\_\_
- Sex \_\_\_
- Gambling \_\_\_
- Eating \_\_\_

**CREATIVE OUTLETS:**

- I have a hobby, art form, or creative outlet that I enjoy or love \_\_\_
- I engage in a creative activity daily \_\_\_
- I engage in a creative activity at least once a week \_\_\_
- I engage in a creative activity at least once a month \_\_\_
- List your creative outlets in order of preference

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**CHILDHOOD, DEVELOPMENT AND RELATIONSHIPS:**

Check all those that apply

- I was breast fed \_\_\_
- My childhood was ideal and happy \_\_\_
- I got along well with my mother while growing up \_\_\_
- I get/got along well with my mother as an adult \_\_\_
- I got along well with my father while growing up \_\_\_

I was physically abused as a child Mild \_\_\_ Moderate \_\_\_ Severe \_\_\_  
I was emotionally abused as a child Mild \_\_\_ Moderate \_\_\_ Severe \_\_\_  
I was sexually abused as a child Mild \_\_\_ Moderate \_\_\_ Severe \_\_\_  
I was neglected as a child Mild \_\_\_ Moderate \_\_\_ Severe \_\_\_  
I have been physically abused as an adult \_\_\_  
I have been emotionally abused as an adult \_\_\_  
I have been sexually abused as an adult \_\_\_  
I have been attacked, beaten, or raped as an adult \_\_\_  
I have a pet at home \_\_\_  
I need to resolve conflicts I still have with my Mother \_\_\_ Father \_\_\_  
Brother(s) \_\_\_ Sister(s) \_\_\_ Spouse \_\_\_ x-spouse \_\_\_ Employer (s) \_\_\_  
Co-workers \_\_\_  
I am currently in romantically involved or married \_\_\_  
I gain comfort and love from this relationship \_\_\_  
I can share my deepest secrets with my spouse or partner \_\_\_  
My romantic relationships are chaotic \_\_\_  
I have at least one close friend \_\_\_  
I can share my deepest secrets with my friend(s) \_\_\_  
My friendships are chaotic \_\_\_  
I am a loner \_\_\_  
I love to be around people \_\_\_  
I am more introverted than extroverted \_\_\_  
I am more extroverted than introverted \_\_\_  
My adult life is free from the chains of the past \_\_\_  
My relationships at work are comfortable and gratifying \_\_\_  
My work relationships are chaotic \_\_\_  
My social life is complete and fulfilling \_\_\_  
I give and receive as much love in my life as I need \_\_\_

#### PERSONAL BELIEFS AND PRACTICES

Check all those that apply:

I believe in God or a Higher Power \_\_\_  
God is a positive resource for me \_\_\_  
My illness or problem has a meaning or purpose \_\_\_  
There is a solution for my problem \_\_\_  
I believe in miracles \_\_\_  
I believe I deserve a miracle \_\_\_  
I believe in the power of prayer \_\_\_  
I pray 3 or more times a day \_\_\_ 1-2 times a day \_\_\_ During crises \_\_\_  
I believe in meditation \_\_\_ I meditate daily \_\_\_ weekly \_\_\_ monthly \_\_\_  
I am basically a good person \_\_\_  
I feel as if I am in control of my life \_\_\_  
I feel as if others are in control of my life \_\_\_

I feel that my Main Concern (illness, problem) is in control of my life \_\_\_\_  
I understand why bad things happen to good people \_\_\_\_  
I understand why good things happen to bad people \_\_\_\_  
I believe human nature is basically bad or evil \_\_\_\_  
I believe human nature is basically good \_\_\_\_  
I believe human nature is neutral \_\_\_\_  
My life has a purpose \_\_\_\_  
I know what that purpose is \_\_\_\_  
I consider myself religious \_\_\_\_  
I consider myself spiritual \_\_\_\_  
My spiritual beliefs relate to my healing \_\_\_\_  
My thoughts and feelings contribute to my health \_\_\_\_  
My religion I was raised in was \_\_\_\_  
My current religion is \_\_\_\_

**TREATMENT MODALITIES:**

Check those treatment modalities which you have already tried. Mark those that have been most helpful with an asterisk:

|                                   |                                     |
|-----------------------------------|-------------------------------------|
| Acupuncture/Acupressure ____      | Aromatherapy ____                   |
| Biofeedback ____                  | Ayurveda ____                       |
| Chiropractic ____                 | EMDR ____                           |
| Group Therapy ____                | Herbal Medicine ____                |
| Homeopathy ____                   | Hypnosis ____                       |
| Iridology ____                    | Light Therapy ____                  |
| Massage ____                      | Medication ____                     |
| Meditation ____                   | Vitamin/Mineral Therapy ____        |
| Mental Imagery/Visualization ____ | Mindfulness ____                    |
| Music/Sound Therapy ____          | Naturopathy ____                    |
| Energy Work ____                  | Breath Work ____                    |
| Psychotherapy ____                | Qigong/Tai Chi ____                 |
| Reflexology ____                  | Reiki ____                          |
| Pranic Healing ____               | Structured Integration/Rolfing ____ |
| Spiritual/faith healing ____      | Shamanic Healing ____               |
| Yoga ____                         | Other ____                          |

## THE STORY OF MY LIFE

Of course your life story is a subtle, multilayered sacred story and can never be fully captured in any amount of words or pages. However, to help me better understand your world at the present time I would like you to share your life story in a few brief sentences if possible. Try to distill down to the essential/central theme(s) you feel your life revolves around. For this purpose sometimes it is helpful to include, "I always", or "I never," if they apply. You can even begin with, "Once upon a time..." In this short exercise you are helping me understand if your current main concern is an isolated struggle/event or a recurrent issue and how you perceive your current chances of overcoming or mastering it. Please feel free to use extra paper if necessary.

## FINANCIAL POLICY

We are committed to providing you with the best possible care. Payment for services are due at the time services by cash, check or credit card. If you are interested in filing insurance for possible reimbursement we will provide you with an *attending physician's statement* including all the information needed for your insurance company to complete a claim (services received, payments made, and my license and provider number). You then file your own claim for possible reimbursement according to the terms of your insurance plan. In this way, we are able to practice the art of psychotherapy with our complete focus on what is in your best interests, without inappropriate restrictions by a third party. We feel strongly that, as your health and wellness professional, our focus and loyalty should be with you and not directed by your insurance company.

For those concerned about coverage, we suggest that you call and verify which services they will be covered and how to submit your claim before you appointment since coverage of specific services varies by insurance company and health care plan.

We will gladly discuss your treatment and answer any questions relating to your insurance – you must realize however that:

- 1) Your insurance is a contract between you, your employer and the insurance company. We are NOT a party to that contract.
- 2) Most insurance companies base their fees on a percentage of the UCR (usual, customary and reasonable) fees for this region. Our fees do not always fall within this range, thus, the balance will be the patients responsibility.
- 3) Not all services are covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
- 4) Also be aware that even if you file on your own – your insurance company can request a copy of your records, letter of medical necessity and/or treatment updates. In this case, there will be an additional charge for our time.

We must emphasize that as your health and wellness provider our relationship is with you, not your insurance company. If you have any questions about the information or are uncertain regarding insurance information, please don't hesitate to ask us. We are here to help you.

I understand and agree that, regardless of my insurance, I am ultimately responsible for the balance on my account for any professional services rendered. I give my consent to release any pertinent information to my insurance company and/or my referring healthcare professional. I have read all the above information and agree.

I agree to pay all costs of collection or attempting to collect the balance due, including court costs and attorney fees, whether the same be collected by suit or otherwise.

I agree to give Michael B. DeMaria, Ph.D., P.A. a 24 hour notice for any cancellation. Failure to give a 24 hour notice will result in a cancellation charge not to exceed the normal charge of the service. Payment for the cancellation is due prior to the next scheduled appointment for all missed appointments.

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

\*Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

Responsible Party Information:

Name: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Employed with \_\_\_\_\_ Work Phone: \_\_\_\_\_

**Please be aware that a responsible party needs to accompany a minor to each visit for payment or an arrangement must be made with our office to send payment with the minor or provide our office with credit card information.**

**Prior to services being rendered a credit card is required - this information can be provided over the phone to doctor DeMaria prior to the time of service.**

*\*Typing your name serves as legal signature.*

# CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by **MICHAEL B. DEMARIA, PH.D., PA/ONTOS** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **MICHAEL B. DEMARIA, PH.D., PA/ONTOS**. I understand that diagnosis or treatment of me by **MICHAEL B. DEMARIA, PH.D.** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **MICHAEL B. DEMARIA, PH.D./ONTOS** is not required to agree to the restrictions that I may request. However, if **MICHAEL B. DEMARIA, PH.D./ONTOS** agrees to a restriction that I request, the restriction is binding on **MICHAEL B. DEMARIA, PH.D./ONTOS** and **MICHAEL B. DEMARIA, PH.D.**

I have the right to revoke this consent, in writing, at any time, except to the extent that **MICHAEL B. DEMARIA, PH.D./ONTOS** or **MICHAEL B. DEMARIA, PH.D./ONTOS** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review **MICHAEL B. DEMARIA, PH.D./ONTOS'** Notice of Privacy Practices prior to signing this document. The **MICHAEL B. DEMARIA, PH.D./ONTOS'** Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the **MICHAEL B. DEMARIA, PH.D./ONTOS**. The Notice of Privacy Practices for **MICHAEL B. DEMARIA, PH.D./ONTOS** is also provided on the **MICHAEL B. DEMARIA, PH.D./ONTOS'** website at [www.ontos.org](http://www.ontos.org). This Notice of Privacy Practices also describes my rights and the **MICHAEL B. DEMARIA, PH.D./ONTOS'** duties with respect to my protected health information.

**MICHAEL B. DEMARIA, PH.D./ONTOS** reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the **MICHAEL B. DEMARIA, PH.D./ONTOS'** website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

\_\_\_\_\_ Date \_\_\_\_\_  
\*Signature of Patient or Personal Representative

\_\_\_\_\_ \*Typing your name serves as legal signature.  
Name of Patient or Personal Representative (description of personal representative authority)