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All Information is kept in strict confidence

CLIENT INFORMATION

NAME: _____

ADDRESS: _____
Street City State Zip

BIRTH DATE: _____ AGE: _____ GENDER: ___ MALE ___ FEMALE

SOCIAL SECURITY #: _____

RELATIONSHIP STATUS: ___ MARRIED ___ SEPARATED ___ SINGLE
___ DIVORCED ___ COHAB. ___ CHILD

I AGREE TO PAY MY CO-PAY OF _____ AT EACH SESSION.

IF I AM SELF PAYING, I WILL PAY _____ AT EACH SESSION. *

WHOM SHOULD I THANK FOR THE REFERRAL? _____

CONTACT INFORMATION

HOME PHONE: _____ BEST TIME TO CALL: _____
Can I leave a message? _____

CELL PHONE: _____

WORK PHONE: _____ MAY I CALL YOU IN CONFIDENCE AT WORK? _____
Can I leave a message? _____

PARENT TO CONTACT IF PATIENT IS A CHILD: _____

INSURANCE INFORMATION

NAME OF INSURANCED (if different than patient): _____

ADDRESS OF INSURED (if different that patient): _____

GENDER: _____ BIRTHDAY: _____ SS# _____

INSURANCE COMPANY: _____ PHONE: _____

ADDRESS: _____

MEMBER ID# _____ GROUP NUMBER: _____

INSURED'S EMPLOYER: _____ STATUS: EMPLOYED TERMINATED LOA

AUTHORIZATION# _____ INSURANCE TYPE: _____ DEDUCTIBLE: _____

* Usual and customary rate for providing director face-to-face psychotherapy services are \$100 per 45 to 50 min. session. You will be billed for not giving a minimum of 24 hour notification of cancellation. Insurance will not pay for missed session. You will be billed for non-covered and non routine services.

FAMILY DATA

NUMBER OF PEOPLE IN HOUSEHOLD: _____

YEARS MARRIED: _____ Years/Months Separated or Divorced _____ PREVIOUS MARRIAGES? Y N

DATE OF FORMER MARRIAGES _____

IF MARRIED, WHAT IS YOUR SPOUSE'S NAME AND AGE? _____

SIGNIFICANCE RELATIONSHIP? How long? _____ With? _____

NAME/AGES OF SIBLINGS: _____

NAME/AGES OF CHILDREN: _____

RECENT DEATHS OF FAMILY/FRIENDS (Relation/dates): _____

EDUCATION: _____

AREA OF STUDY: _____

OCCUPATIONAL DATA

EMPLOYER: _____ LENGTH OF EMPLOYMENT _____

TYPE OF WORK YOU DO: _____

Would you like to receive an email news letter 2 to 4 times a year? Y N Email: _____

Please describe your reason(s) for seeking help: _____

What would like to have happen for you as a result of counseling? _____

Patient name _____ Patient ID# _____ Patient SS# _____ Date _____

BIOPSYCHOSOCIAL HISTORY

PRESENTING PROBLEMS

Presenting problems	Duration (months)	Additional information:
_____	_____	_____
_____	_____	_____
_____	_____	_____

CURRENT SYMPTOM CHECKLIST (Rate intensity of symptoms currently present)

None = This symptom not present at this time • **Mild** = Impacts quality of life, but no significant impairment of day-to-day functioning
Moderate = Significant impact on quality of life and/or day-to-day functioning • **Severe** = Profound impact on quality of life and/or day-to-day functioning

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
depressed mood	[]	[]	[]	[]	bingeing/purging	[]	[]	[]	[]	guilt	[]	[]	[]	[]
appetite disturbance	[]	[]	[]	[]	laxative/diuretic abuse	[]	[]	[]	[]	elevated mood	[]	[]	[]	[]
sleep disturbance	[]	[]	[]	[]	anorexia	[]	[]	[]	[]	hyperactivity	[]	[]	[]	[]
elimination disturbance	[]	[]	[]	[]	paranoid ideation	[]	[]	[]	[]	dissociative states	[]	[]	[]	[]
fatigue/low energy	[]	[]	[]	[]	circumstantial symptoms	[]	[]	[]	[]	somatic complaints	[]	[]	[]	[]
psychomotor retardation	[]	[]	[]	[]	loose associations	[]	[]	[]	[]	self-mutilation	[]	[]	[]	[]
poor concentration	[]	[]	[]	[]	delusions	[]	[]	[]	[]	significant weight gain/loss	[]	[]	[]	[]
poor grooming	[]	[]	[]	[]	hallucinations	[]	[]	[]	[]	concomitant medical condition	[]	[]	[]	[]
mood swings	[]	[]	[]	[]	aggressive behaviors	[]	[]	[]	[]	emotional trauma victim	[]	[]	[]	[]
agitation	[]	[]	[]	[]	conduct problems	[]	[]	[]	[]	physical trauma victim	[]	[]	[]	[]
emotionality	[]	[]	[]	[]	oppositional behavior	[]	[]	[]	[]	sexual trauma victim	[]	[]	[]	[]
irritability	[]	[]	[]	[]	sexual dysfunction	[]	[]	[]	[]	emotional trauma perpetrator	[]	[]	[]	[]
generalized anxiety	[]	[]	[]	[]	grief	[]	[]	[]	[]	physical trauma perpetrator	[]	[]	[]	[]
panic attacks	[]	[]	[]	[]	hopelessness	[]	[]	[]	[]	sexual trauma perpetrator	[]	[]	[]	[]
phobias	[]	[]	[]	[]	social isolation	[]	[]	[]	[]	substance abuse	[]	[]	[]	[]
obsessions/compulsions	[]	[]	[]	[]	worthlessness	[]	[]	[]	[]	other (specify) _____	[]	[]	[]	[]

EMOTIONAL/PSYCHIATRIC HISTORY

[] [] Prior outpatient psychotherapy?

No Yes If yes, on _____ occasions. Longest treatment by _____ for _____ sessions from ____/____/____ to ____/____/____
Provider Name Month/Year Month/Year

Prior provider name	City	State	Phone	Diagnosis	Intervention/Modality	Beneficial?
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

[] [] **Has any family member had outpatient psychotherapy?** If yes, who/why (list all): _____
 No Yes _____

[] [] Prior inpatient treatment for a psychiatric, emotional, or substance use disorder?

No Yes If yes, on _____ occasions. Longest treatment at _____ from ____/____/____ to ____/____/____
Name of facility Month/Year Month/Year

Inpatient facility name	City	State	Phone	Diagnosis	Intervention/Modality	Beneficial?
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

[] [] **Has any family member had inpatient treatment for a psychiatric, emotional, or substance use disorder?** If yes, who/why (list all): _____
 No Yes _____

[] [] Prior or current psychotropic medication usage? If yes:

No	Yes	Medication	Dosage	Frequency	Start date	End date	Physician	Side effects	Beneficial?
		_____	_____	_____	_____	_____	_____	_____	_____
		_____	_____	_____	_____	_____	_____	_____	_____

[] [] **Has any family member used psychotropic medications?** If yes, who/what/why (list all): _____
 No Yes _____

Patient name _____ Patient ID# _____ Patient SS# _____ Date _____

**FAMILY HISTORY
FAMILY OF ORIGIN**

Present during childhood:

	Present entire childhood	Present part of childhood	Not present at all
mother	[]	[]	[]
father	[]	[]	[]
stepmother	[]	[]	[]
stepfather	[]	[]	[]
brother(s)	[]	[]	[]
sister(s)	[]	[]	[]
other (specify)	[]	[]	[]

Parents' current marital status:

[] married to each other
 [] separated for ___ years
 [] divorced for ___ years
 [] mother remarried ___ times
 [] father remarried ___ times
 [] mother involved with someone
 [] father involved with someone
 [] mother deceased for ___ years
 age of patient at mother's death ___
 [] father deceased for ___ years
 age of patient at father's death ___

Describe parents:

Father	Mother
full name _____	_____
occupation _____	_____
education _____	_____
general health _____	_____

Describe childhood family experience:

[] outstanding home environment
 [] normal home environment
 [] chaotic home environment
 [] witnessed physical/verbal/sexual abuse toward others
 [] experienced physical/verbal/sexual abuse from others

Age of emancipation from home: _____ **Circumstances:** _____

Special circumstances in childhood: _____

IMMEDIATE FAMILY

Marital status:

[] single, never married
 [] engaged ___ months
 [] married for ___ years
 [] divorced for ___ years
 [] separated for ___ years
 [] divorce in process ___ months
 [] live-in for ___ years
 [] ___ prior marriages (self)
 [] ___ prior marriages (partner)

Intimate relationship:

[] never been in a serious relationship
 [] not currently in relationship
 [] currently in a serious relationship

Relationship satisfaction:

[] very satisfied with relationship
 [] satisfied with relationship
 [] somewhat satisfied with relationship
 [] dissatisfied with relationship
 [] very dissatisfied with relationship

List all persons currently living in patient's household:

Name	Age	Sex	Relationship to patient
_____	_____	_____	_____
_____	_____	_____	_____

List children not living in same household as patient:

_____	_____	_____	_____
_____	_____	_____	_____

Frequency of visitation of above: _____

Describe any past or current significant issues in intimate relationships: _____

Describe any past or current significant issues in other immediate family relationships: _____

MEDICAL HISTORY (check all that apply for patient)

Describe current physical health: [] Good [] Fair [] Poor

List name of primary care physician:

Name _____ Phone _____

List name of psychiatrist: (if any):

Name _____ Phone _____

List any medications currently being taken (give dosage & reason):

Is there a history of any of the following in the family:

[] tuberculosis [] heart disease
 [] birth defects [] high blood pressure
 [] emotional problems [] alcoholism
 [] behavior problems [] drug abuse
 [] thyroid problems [] diabetes
 [] cancer [] Alzheimer's disease/dementia
 [] mental retardation [] stroke
 [] other chronic or serious health problems _____

Describe any serious hospitalization or accidents:

Date _____ Age _____ Reason _____

Patient name _____ Patient ID# _____ Patient SS# _____ Date _____
 List any known allergies: _____ Date _____ Age _____ Reason _____
 Date: _____ Age _____ Reason _____

List any abnormal lab test results:
 Date _____ Result _____
 Date _____ Result _____

SUBSTANCE USE HISTORY (check all that apply for patient)

Family alcohol/drug abuse history:	Substances used: (complete all that apply)	First use age	Last use age	Current Use		
				(Yes/No)	Frequency	Amount
<input type="checkbox"/> father	<input type="checkbox"/> alcohol	_____	_____	_____	_____	_____
<input type="checkbox"/> mother	<input type="checkbox"/> amphetamines/speed	_____	_____	_____	_____	_____
<input type="checkbox"/> grandparent(s)	<input type="checkbox"/> barbiturates/owners	_____	_____	_____	_____	_____
<input type="checkbox"/> sibling(s)	<input type="checkbox"/> caffeine	_____	_____	_____	_____	_____
<input type="checkbox"/> other _____	<input type="checkbox"/> cocaine	_____	_____	_____	_____	_____
	<input type="checkbox"/> crack cocaine	_____	_____	_____	_____	_____
	<input type="checkbox"/> hallucinogens (e.g., LSD)	_____	_____	_____	_____	_____
	<input type="checkbox"/> inhalants (e.g., glue, gas)	_____	_____	_____	_____	_____
	<input type="checkbox"/> marijuana or hashish	_____	_____	_____	_____	_____
	<input type="checkbox"/> nicotine/cigarettes	_____	_____	_____	_____	_____
	<input type="checkbox"/> PCP	_____	_____	_____	_____	_____
	<input type="checkbox"/> prescription _____	_____	_____	_____	_____	_____
	<input type="checkbox"/> other _____	_____	_____	_____	_____	_____

Substance use status:
 no history of abuse
 active abuse
 early full remission
 early partial remission
 sustained full remission
 sustained partial remission

Treatment history:	Consequences of substance abuse (check all that apply):			
<input type="checkbox"/> outpatient (age[s] _____)	<input type="checkbox"/> hangovers	<input type="checkbox"/> withdrawal symptoms	<input type="checkbox"/> sleep disturbance	<input type="checkbox"/> binges
<input type="checkbox"/> inpatient (age[s] _____)	<input type="checkbox"/> seizures	<input type="checkbox"/> medical conditions	<input type="checkbox"/> assaults	<input type="checkbox"/> job loss
<input type="checkbox"/> 12-step program (age[s] _____)	<input type="checkbox"/> blackouts	<input type="checkbox"/> tolerance changes	<input type="checkbox"/> suicidal impulse	<input type="checkbox"/> arrests
<input type="checkbox"/> stopped on own (age[s] _____)	<input type="checkbox"/> overdose	<input type="checkbox"/> loss of control amount used	<input type="checkbox"/> relationship conflicts	
<input type="checkbox"/> other (age[s] _____) describe: _____	<input type="checkbox"/> other _____			

Tobacco Use: Cigarettes Chewing Other How much _____

DEVELOPMENTAL HISTORY (check all that apply for a child/adolescent patient)

Problems during mother's pregnancy:	Birth:	Childhood health:	
<input type="checkbox"/> none	<input type="checkbox"/> normal delivery	<input type="checkbox"/> chickenpox (age _____)	<input type="checkbox"/> lead poisoning (age _____)
<input type="checkbox"/> high blood pressure	<input type="checkbox"/> difficult delivery	<input type="checkbox"/> German measles (age _____)	<input type="checkbox"/> mumps (age _____)
<input type="checkbox"/> kidney infection	<input type="checkbox"/> cesarean delivery	<input type="checkbox"/> red measles (age _____)	<input type="checkbox"/> diphtheria (age _____)
<input type="checkbox"/> German measles	<input type="checkbox"/> complications _____	<input type="checkbox"/> rheumatic fever (age _____)	<input type="checkbox"/> poliomyelitis (age _____)
<input type="checkbox"/> emotional stress	birth weight ____lbs ____oz.	<input type="checkbox"/> whooping cough (age _____)	<input type="checkbox"/> pneumonia (age _____)
<input type="checkbox"/> bleeding		<input type="checkbox"/> scarlet fever (age _____)	<input type="checkbox"/> tuberculosis (age _____)
<input type="checkbox"/> alcohol use	Infancy:	<input type="checkbox"/> autism	<input type="checkbox"/> mental retardation
<input type="checkbox"/> drug use	<input type="checkbox"/> feeding problems	<input type="checkbox"/> ear infections	<input type="checkbox"/> asthma
<input type="checkbox"/> cigarette use	<input type="checkbox"/> sleep problems	<input type="checkbox"/> allergies to _____	
<input type="checkbox"/> other	<input type="checkbox"/> toilet training problems	<input type="checkbox"/> significant injuries _____	
		<input type="checkbox"/> chronic, serious health problems _____	

Delayed developmental milestones (check only those milestones that did not occur at expected age):

- sitting
- rolling over
- standing
- walking
- feeding self
- speaking words
- speaking sentences
- controlling bowels
- sleeping alone
- dressing self
- engaging peers
- tolerating separation
- playing cooperatively
- riding tricycle

Emotional / behavior problems (check all that apply):

- drug use
- alcohol abuse
- chronic lying
- stealing
- violent temper
- fire-setting
- hyperactive
- animal cruelty
- repeats words of others
- not trustworthy
- hostile/angry mood
- indecisive
- immature
- bizarre behavior
- self-injurious threats
- frequently tearful
- distrustful
- extreme worrier
- self-injurious acts
- impulsive
- easily distracted
- poor concentration
- often sad
- breaks things

Patient name _____ Patient ID# _____ Patient SS# _____ Date _____
[] controlling bladder [] riding bicycle [] assaults others [] frequently daydreams [] other _____
[] other _____ [] disobedient [] lack of attachment _____

Social interaction (check all that apply):

- normal social interaction
- inappropriate sex play
- isolates self
- dominates others
- very shy
- associates with acting-out peers
- alienates self
- other _____

Intellectual / academic functioning (check all that apply):

- normal intelligence
 - authority conflicts
 - mild retardation
 - high intelligence
 - attention problems
 - moderate retardation
 - learning problems
 - underachieving
 - severe retardation
- Current or highest education level _____

Describe any other developmental problems or issues: _____

SOCIO-ECONOMIC HISTORY (check all that apply for patient)

Living situation:

- housing adequate
- homeless
- housing overcrowded
- dependent on others for housing
- housing dangerous/deteriorating
- living companions dysfunctional

Social support system:

- supportive network
- few friends
- substance-use-based friends
- no friends
- distant from family of origin

Sexual history:

- heterosexual orientation
 - currently sexually dissatisfied
 - homosexual orientation
 - age first sex experience _____
 - bisexual orientation
 - age first pregnancy/fatherhood _____
 - currently sexually active
 - history of promiscuity age ___ to _____
 - currently sexually satisfied
 - history of unsafe sex age ___ to _____
- Additional information: _____

Employment:

- employed and satisfied
- employed but dissatisfied
- unemployed
- coworker conflicts
- supervisor conflicts
- unstable work history
- disabled: _____

Military history:

- never in military
- served in military - no incident
- served in military - **with** incident

Cultural/spiritual/recreational history:

cultural identity (e.g., ethnicity, religion): _____
describe any cultural issues that contribute to current problem: _____
currently active in community/recreational activities? Yes No
formerly active in community/recreational activities? Yes No
currently engage in hobbies? Yes No
currently participate in spiritual activities? Yes No
if answered "yes" to any of above, describe: _____

Financial situation:

- no current financial problems
- large indebtedness
- poverty or below-poverty income
- impulsive spending
- relationship conflicts over finances

Legal history:

- no legal problems
 - now on parole/probation
 - arrest(s) not substance-related
 - arrest(s) substance-related
 - court ordered this treatment
 - jail/prison _____ time(s)
- total time served: _____
describe last legal difficulty: _____

Please describe your reason(s) for seeking help: _____

What would like to have happen for you as a result of counseling? _____

PATIENT NOTIFICIATION OF PRIVACY RIGHTS

The Health Insurance Portability and Accountability Act (HIPAA) has created new patient protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law", HIPAA provides patient protections related to the electronic transmission of data ("the transaction rules"), the keeping and use of patient records ("privacy rules"), and storage and access to health care records ("the security rules"). HIPAA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide patients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you don't have formal legal training. My Patient Notification of Privacy Rights is my attempt to inform you of your rights in a simple yet comprehensive fashion. Please read this document, as it is important you know what patient protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship and as such, you will find I will do all I can to protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask me for further clarification.

By law, I am required to secure your signature indicating you have received this Patient Notification of Privacy Rights Document. Thank you for your thoughtful consideration of these matters.

I, _____, understand and have been provided a copy of Patient Notification of Privacy Rights Document, which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand I have the right to review this document before signing this acknowledgment form.

Patient Signature or Parent if Minor or Legal Charge Date
If Legal Charge, describe representative authority: _____