INTAKE FORM - ADULT

Our Mission Statement: To provide the client an opportunity to achieve their full potential while receiving individualized therapy services in a positive, caring environment.

Today's Date: ________________

Client Name: ____ DOB: ____________

SS#: _________-_____-_______

Address: ____

City, State & Zip: ____

Phone: ________________________________ Cell: ___________________________________

Email: ____

Emergency Contact: ____

Phone: ____

Who is the client's Primary Care Physician (PCP)? ____________________________________

Date of the client's last wellness check? ____

How did you hear about us? ____

Spouse/Partner:

Name: ____

DOB: ________________________________ SS#: ______________________________

Phone: ________________________________ Cell: ______________________________

Are there any other family members in the home currently receiving counseling services elsewhere? ☐ Yes or ☐ No

INSURANCE INFORMATION
(Please provide us with a copy of your insurance card)

Primary Insurance:

Name of Policy Holder: ____

Insurance Company: ____

Policy Number: ___________________________ Group # _________________

Effective Date: ___________________________

Secondary Insurance:

Name of Policy Holder: ____

Insurance Company: ____

Policy Number: ___________________________ Group # _________________

Effective Date: ___________________________

INFORMED CONSENT

COMPLETE INFORMED CONSENT, POLICIES AND GENERAL INFORMATION FOR THE PRACTICE OF MENTAL HEALTH CLINICIANS

GENERAL INFORMATION: We are pleased you have chosen Emerge Therapy Services...for your counseling needs. Out clinicians are licensed professionals governed by their respective state boards. We are not authorized to give medical advice or to administer prescriptions. Our office phone has a confidential voicemail at 479-250-4255. In the event of an emergency, if we are not available, please go to your nearest Emergency Room. It is important to know that as your therapist we cannot guarantee a certain outcome in therapy and in the event that the clinician is not equipped to meet your need, a referral will be provided. **It is against the ACA ethical code for a therapist to see a client concurrently with another therapist, so please be advised.**

OUR RELATIONSHIP: We are by law and ethics required not to have a dual relationship with any of our clients. Therefore, our contact will be limited to the paid sessions you have with me in my office. If we happen to encounter each other socially, it is your option to acknowledge or not acknowledge me. This is an ethical requirement, which protects your confidentiality.

PAYMENT: Being on time will ensure your full session. **Your full payment or co-pay is due upon arrival for your session; Visa/MasterCard credit cards are the only form of payment accepted.** Clients who carry insurance should remember that professional services are rendered and charged to the clients, not to the insurance company.

HEALTH INSURANCE: If we agree that Emerge Therapy Services will file your claims, Emerge Therapy Services will need a copy of your insurance card, you will be liable to pay your co-pay and Emerge Therapy Services will bill your insurance company for their portion. **While every attempt to utilize your well-earned insurance benefits, you are ultimately responsible for your bill, not your insurance company.** Emerge Therapy Services has no control or knowledge over what insurance companies do with the information submitted or who has access to that information. You must be aware that submitting a mental health claim for reimbursement carries a certain amount of risk to confidentiality, privacy, or to future eligibility to obtain health or life insurance.

COURT TESTIMONY AND SUBPOENA POLICY: Please be aware that all court appearances will be as an expert witness. As such, there is a charge ($500.00) at the time the subpoena is received for preparation, research, travel to and from the courtroom, and court testimony. Consultation with attorneys by phone or face to face will be charged separately and must be paid upfront. You have hired me as a **MENTAL**

HEALTH PSYCHOTHERAPIST/THERAPIST. Your clinician is an expert in relationships and gladly testify regarding my observations, if it is in the best interest of the client. However, **we do not provide recommendations for custody or placement of children**. If this is what you are anticipating, please hire a child custodial expert.

Please understand that court fees are not covered by third party payers and are the full responsibility of the client. A nonrefundable fee of $500.00 will be charged at the time the subpoena is received. A fee of $3,000.00 for a full day (over 4 hours), and $1,500.00 for a half-day will apply to all court appearances. Travel, meals, and lodging will be additional expenses when we are called out of town. Any telephone consultations, face-to-face meetings with your attorney or letter writing on your behalf will be charged at a rate of $250.00 per hour.

CONFIDENTIALITY AND PRIVILEGED COMMUNICATION: As licensed professionals, we are bound by Arkansas law (Act 593 of 1979 and Act 244 of 1997) to maintain your privileged communication as that of an Attorney-Client. We will keep confidential who clients are and anything a client shares with the therapist with the following exceptions: 1) the client [legal custodial parent or guardian] directs me to give information to another, verbally and/or in writing, andreleases me to disclose specific information for a specific purpose. 2) There is a threat of life by homicide, suicide or a clear and imminent danger to human life. 3) I have a strong suspicion of abuse to children, the elderly or the handicapped; I am by law (Act #1208) a mandated reporter. 4) If court-ordered. I/we do consult with other professionals regarding cases in order to better serve the client. Your signature on this document gives us permission to do this.

We maintain counseling information that is beneficial to your treatment. This information typically includes symptoms, medications, progress, test results, diagnoses and a summary of our session, this will continue during the course of your treatment with Emerge Therapy Services.

In accordance with ethical code, Emerge Therapy Services will keep your records for a period of seven (7) years, In maintaining the chart, the clinician, the owner of the chart; but you are the owner of the information, You must sign a release of information for Emerge Therapy Services to share your information with anyone other than yourself. If this is a child, the custodial parent HAS and the non-custodial MAY HAVE a right to review the records. These are considered medical records. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal to provide it. In the event of the clinician's death your records will be in a guardianship status with another appointed Mental Health Professional. Disclosure may be required to a legal proceeding. If you place your mental status as an issue in litigation initiated by you, the defendant may have the right to obtain the records and/or testimony by your therapist. Emerge Therapy Services will not release records to any

outside party unless we have been authorized to do so by all adult family members who were part of the treatment. If you request a copy of the records, please be aware that there is a charge per page for copied medical records. Emerge Therapy Services must advise you that records read by anyone other than the author are easily misinterpreted. A written summary is more appropriate and less likely to be misread.

ELECTRONIC COMMUNICATION AND SOCIAL MEDIA: Electronic communications such as FAX, e-mail, and cell phone are not protected; therefore, your therapist will limit these communications regarding clients. Your therapist is also bound by confidentiality restraints and relationship constraints that forbid our connecting with clients through social networks. You can become a member of the Emerge Therapy Services professional Facebook page.

BENEFITS AND POTENTIAL RISKS TO THERAPY/LENGTH OF TREATMENT: Psychotherapy carries with it potential benefits and benefits and risks, be advised that therapy may produce emotional discomfort, as well as positive change. **You may end the therapy relationship at any point, but we ask you to do so in person in session because this will have the greatest benefit to your mental health**. You and the therapist will work together to decide the length of treatment. We will work with you as long as we believe it is beneficial to you.

CANCELLATION: Because we hold the scheduled appointment time for you only, we must have 24 hours notice for cancellation. Unless it is a true emergency, you will be charged $50.00 (Intake/therapy appointment).

NOTICE OF PRIVACY POLICIES: As required by Federal Regulations: THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Policy: This information is provided to you in response to federal regulations that took effective April 14, 2003. These regulations were issued by the Department of Health and Human Services of the US Government in response to a law called “HIPAA” which was passed in 1996. Emerge Therapy Services cares about your privacy and will always do whatever is necessary to protect it. These regulations are about the privacy of your health and personal information known in the regulations as “Protected Health Information” or PHI. In the process of providing you with proper counseling/therapy, Emerge Therapy Services will collect, use and share certain information you have provided. This policy explains how Emerge Therapy Services collects and would use it if complying with federal regulations. It also describes your rights as they relate to PHI and states how Emerge Therapy Services will protect the security and confidentiality of your information.

SHARING INFORMATION: Emerge Therapy Services can disclose PHI per federal regulations without an authorization from you under these circumstances.

- For treatment purposes, such as to your physician, or hospital, or another therapist who may be involved in your treatment.
- For payment purposes, such as to your insurance company or other third-party payer. For healthcare operations, such as to set up or confirm appointments, or share your PHI with our secretary who is directly involved in the business aspect of billing and payment.
- To communicate with family members or friends who you designate as being allowed to receive this information. For public health reporting purposes.
- For worker's compensation purposes.
- To business associates, such as answering services, collection agencies, etc. These organizations are required to sign agreements with Emerge Therapy Services…to safeguard and protect your PHI.
- As otherwise provided by law.

In all other cases, we will disclose your PHI only upon receipt of a proper authorization signed by you or your legal representative. Because state law that is more stringent, privilege-keeping law binds me, Emerge Therapy Services will continue to ask you to sign consent for all disclosures.

YOUR RIGHT REGARDING YOUR PHI: Although your PHI is the therapist's legal property, you have certain rights regarding your PHI. You have the right to:

- Obtain a paper copy of this notice of information, policy and procedures and informed consent. I will give you a copy at the end of our first session if you would like one.
- Inspect and request a copy of your counseling record. There will be a charge per page for copying your record.
- Request to amend your counseling record.
- Obtain an accounting of disclosures of your counseling information from 01/01/2018 forward.
- Request a restriction on certain uses and disclosures of your information.
- Authorize individuals, including family and friends, access to your counseling information as it pertains to treatment, payments and/or healthcare operations. Revoke your authorization to use or disclose counseling information except to the extent that it has already been disclosed.

MY RESPONSIBILITIES: Emerge Therapy Services has the following responsibilities regarding your PHI:

- Maintain the privacy of your counseling information.
- Provide you with this notice of my legal duties, privacy practices with respect to information I collect and maintain about you.
- Abide by the terms of this notice.
- Notify you if I am unable to agree to a requested restriction.

I reserve the right to change my practices and to make new provisions effective for all PHI I maintain. Should my privacy policies change, I will provide you with an updated copy of such information. I will discontinue to use or disclose your counseling information after I have received a written revocation of the authorization according to the procedures included in the authorization.

For more information or to report a problem: If you have a question, you may contact me. If you believe your rights have been violated, you can file a complaint with the Office of Civil Rights, US Department of Health and Human Services. There will be no retaliation for filing a complaint:

Office of Civil Rights
US Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201

If you would like to file a complaint against me or my counseling practice:

Emerge Therapy Services
2713 SE I Street Ste #5
Bentonville, AR 72712

I acknowledge that I have read the statement of disclosure, the complete informed consent, policies and procedures, general information and Notice of Privacy Policies per Federal Regulations. I understand it and I will take responsibility to speak with my clinician if I do not.

CONSENT TO TREATMENT

In order to assist you in the best way possible, Emerge Therapy Services gathers information about you and maintains records of our work with you. All information you provide and records we maintain will be considered confidential, and you have the right to give consent before information can be shared with others. However, there are some limitations to confidentiality and situations in which we might be required to disclose information without your consent.

We are required by law to report suspected child or elder abuse or neglect. We also must take steps to insure safety of clients that are an imminent danger of harm to themselves or others. In cases of emergence, we may disclose information for the purpose of securing emergency medical treatment and/or preventing injury, death, or substantial property destruction. Only information specifically needed to address the emergency will be disclosed. In some cases, the courts may subpoena your records and we would be required to provide the record. Records are also available to staff members; agency legal counsel; reviewers for licensing/accreditation/certification/ and/or human rights purposes; and insurance companies and other third party payors. We may also disclose information to the extent required or permitted by any other state or federal statute or regulation.

You have the right to see your own record and to insert information and/or a statement in your record. You also have the right to discuss any concerns you have about the services of this group with your therapist, the therapist's supervisor, and/or the CEO in accordance with the groups Grievance Policy.

By signing below, I hereby voluntarily and knowingly consent to allow Emerge Therapy Services and any of its therapists, employees and/or agents, to use and/or disclose my health information as deemed appropriate to carry out treatment, payment and/or other health care operations of the organization.

I hereby do/do not (please circle one) consent to appointment reminders. If I do consent, unless otherwise specified, messages may be left on my voicemail and/or with anyone answering the phone at my contact location.

I consent to my own participation in evaluation, assessment, referral and treatment. I acknowledge that no explicit or implied guarantees have been made to me or my family as to the result of evaluation of treatment. I understand that treatment cannot be provided unless I sign this form. I also understand that I have the right to participate in the development of a Treatment Plan and that I may discontinue treatment at any time but agree not to hold the staff liable for any adverse consequences arising out of dropping out of treatment. In case of a medical emergency, I authorize the staff to arrange appropriate emergency medical treatment

for myself or any individual for whom I have authorized treatment. I agree to allow a follow-up questionnaire to be sent to me at termination.

PCP Collaboration Agreement (Medication Management)

In the event it is recommended that you/your child need medication management, Emerge will consult with your families Primary Care Physician who has the appropriate Prescriptive Authority to ensure quality and compliance.

____ __________________

Client Signature Date

ADULT CONSENT

CONSENT FOR TREATMENT

Client Name:_______________________________________ Age:_______ DOB:___________

Address:____

City, State, Zip:____

Phone: ________________________________ Cell: _________________________________

Spouse / Partner Name: ____

Phone: ________________________________ Cell: _________________________________

PROFESSIONAL DISCLOSURE: Emerge Therapy Services clinicians are licensed by their respective governing boards for their professional licensure. Emerge Therapy Services mental health professionals are not authorized to give medical advice or to administer prescriptions.

CONFIDENTIALITY: Federal regulations effective 4/4/03 (HIPAA) have changed the way we care for your Protected Health Information (PHI). We shall provide you with the complete consent information regarding HIPAA and general practices and policies of this center. By state law, we are also required to keep your information confidential. These are the following exceptions: 1) you direct me to give information to someone and/of give me written consent to do that; 2) I determine that there is a threat of life by homicide or suicide; 3) I have a strong suspicion of abuse to children, the handicapped or elderly; and 4) I am ordered by a judge to disclose information.

FIRST SESSION: 1) Introduction. 2) Determine if we are a good fit. 3) Begin the evaluation and assessment phase. 4) Establish a fee structure. 5) Inform you of the nature of my practice and therapy. 6) Begin to set goals.

PAYMENT CONTRACT: Our standard fee for an individual 45-50 minute counseling session is $125.00. The first session is a Diagnostic Interview and is $250.00. Fees for 45-50 minute marriage and family therapy sessions are $125.00. Additional fees shall be assessed for testing, reports, correspondence, court appearances or consultations with attorneys. Payment is expected at the end of each session. Only credit/debit Visa or MasterCard are accepted. Any concerns or issues about your payment will be discussed in this first session.

CANCELLATION: Please give 24 hours notice for cancellation of appointments. Failure to do so will result in a $50.00 no show fee.

I have read, understand and agree to consent to treatment of professional counseling at Emerge Therapy Services. I give consent for my mental health clinician to leave a brief voice mail or message on my phone. I further give consent to Emerge Therapy Services to file my insurance claims (if applicable) following federal regulations regarding my payment and healthcare operations.

PCP Collaboration Agreement (Medication Management)
In the event it is recommended that you/your child need medication management, Emerge will consult with your families Primary Care Physician who has the appropriate Prescriptive Authority to ensure quality and compliance.

____ __________________

Signature of Client Date

ROI - WAIVER

RELEASE OF INFORMATION & CONSENT FOR TREATMENT

All information provided herein is true and correct.

I am aware of my diagnosis and wish myself to receive treatment at Emerge Therapy Services. I permit its employees and all other persons caring for myself to treat me in ways they judge are beneficial to myself. I understand that this care can include an evaluation, testing, and treatment. No guarantees have been made to me about the outcome of this care.

I give permission to Emerge Therapy Services to release information, verbal and written contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related health care provider, assignees and/or beneficiaries and all other related persons to my treatment or payment for services provided.

I authorize Emerge Therapy Services to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment.

The signature below certifies that I have read and understand the above information.

Signed: ____ ______________________

Client Signature Date

WAIVER FORM

I, __________________________ the client (thereafter referred to as “myself”), give permission for me to participate in Emerge Therapy Services programs and services.

I hereby release Emerge Therapy Services principal owners, therapists, employees and representatives and all other individuals or organizations acting on behalf of Emerge Therapy Services, from any and all claims which I may have, resulting from or in connection with my participation in Emerge Therapy Services programs. This includes, but without limitation, any claim, demands or causes of action for injuries to myself, including but not limited to injuries resulting from the use of any play/therapy equipment during the program at an Emerge Therapy Services center or at client’s homes.

I understand that I should be present at all times during delivery of service to myself. If I choose not to, I understand that the aforementioned statements still apply in my presence or absence during the services provided. This agreement is signed for the purpose of fully and completely releasing, discharging and indemnifying Emerge Therapy Services in connection with their programs from all liability as herein described.

Signed: ____ ______________________

Client Signature Date

PERMISSION TO SHARE

PERMISSION TO SHARE INFORMATION WITH FAMILY AND FRIENDS

If you wish to grant permission for a friend or family member to accompany you to appointments on your behalf or for us to share medical/billing information, please specify below. You may revoke this permission at any time by submitting a written statement.

I give permission to Emerge Therapy Services to share the health/billing information of the client ____, DOB ____/____/_____ with the following person or persons:

NAME	RELATIONSHIP	PHONE #
_________________________	_________________________	_________________________
_________________________	_________________________	_________________________
_________________________	_________________________	_________________________

Client Signature: ____

Client Name (Print): ____

Date: ___________________________________

OFFICE POLICIES

Please bring registration with you to the patients' first appointment. Do not send it to the office. We welcome you to the office and appreciate the opportunity to provide you with our services. To better serve you, we have established certain guidelines that should increase efficiency. Please review this information and feel free to ask any questions at your appointment.

OFFICE HOURS: Our office staff is available to receive your calls Monday - Friday, 8:00 am to 5:00 pm. The number listed is to reach our staff 479-250-4355.

AFTER HOURS CALLS: In case of an emergency after hours, please call your PCP or local emergency room.

APPOINTMENTS: If you need to change or cancel your appointment, please give at least 24 hours prior notice. **NOTE:** Failure to give this notice will result in your being financially responsible for the appointment. If a first appointment is missed with no explanation this office reserves the right to refuse to reschedule. If two appointments are either canceled without 24 hours notice or without any notice, we will be unable to schedule further appointments but will assist in finding alternative coverage.

INSURANCE: Please let our office know **immediately** if you have any changes in your insurance company, policy, billing, subscriber, etc. If you have a **secondary insurance** the office must know this information before the first appointment. Please bring copies of your insurance card(s) or have the receptionist make copies.

ADULT SUPERVISION: Due to financial constraints and issues of liability, we are unable to provide supervision for patients children during office visits. Every family is required to make arrangements to provide appropriate adult supervision during appointment times.

Clients Printed Name: ____

____ ____________________

Client Signature Date

PAYMENT POLICY

It is the policy of Emerge Therapy Services to collect payment at the time of service. If we will be filing insurance and the deductible has been met, we ask that you simply pay the co-payment required at the time of service.

____ ______________________

Client Signature Date

PATIENT RIGHTS

PATIENT / FAMILY RIGHTS

Client Name: ____ DOB: _____________

1. You have the right to be treated with dignity and respect, as an individual who has personal needs, feelings, and preferences.
2. You have the right to privacy in your treatment, in your care and in the fulfillment of your personal needs, and of protected health information.
3. You have the right to be informed of services available to you in Emerge Therapy Services and of any charges for those services.
4. You have the right to be informed of your rights as a client and of all rules and regulations governing your conduct as a client in these facilities.
5. You have the right to know about your physical condition unless your provider, for medical reasons, chooses not to inform you and so indicates in your records. You have the right to participate in the development of your treatment plan.
6. You have the right to receive information necessary to give informed consent prior to the start of any procedure and/or treatment.
7. You have the right to refuse treatment to the extent permitted by law and to be informed of the consequences of your choices.
8. You have the right to voice opinions, recommendations, complaints, and grievances in relation to and your rights, without fear of restraint, interference, coercion, discrimination, or reprisal.
9. You have the right to be free from physical, chemical and mental abuse.
10. You have the right to confidential treatment of your person and medical records. Information from these sources will not be released without your prior consent, except in an emergency, or as required by law, or under third party payment contract. Emerge Therapy Services utilized electronic medical records (EMR) in compliance with HIPPA regulations.
11. You have the right to be assessed for pain and have evaluation and management of pain if indicated.
12. You have the right to file a complaint if you feel you have been discriminated against because of race, color, sex, religion, national origin, or disability.
13. You have the right to request the opinion of a consultant at your expense or to request an in-home review of the individual treatment plan, as provided in specific procedures of the facility.

The safety of health care delivery is enhanced by the involvement of the patient and/or family, as appropriate to his/her condition, as a partner in the healthcare process. Emerge Therapy

Services has identified the following patient and family responsibilities and educates the patient and/or family about these responsibilities during the admission process and as needed thereafter.

Responsibilities include at least the following:

1. **Providing Information**

    - The patient and/or family are responsible for providing, to the best of their knowledge, accurate and complete information about present complaints, past illness, hospitalizations, medications, and other matters relating to the patient's health
    - The patient and family are responsible for reporting perceived risks in their care and unexpected changes in the patient's condition.

2. **Asking questions:**

    - Patients and/or family are responsible for asking questions when they do not understand what they have been told about their care or what they are expected to do.

3. **Following instructions:**

    - The patient and family are responsible for following the care, service, of treatment plan developed. Further, patients and family are responsible for following the program rules and guidelines. They should express any concerns they have about their ability to follow and comply with the proposed care plan of course treatment. Every effort is made to adapt the plan to the patient's specific needs and limitations.

4. **Accepting Consequences:**

    - The patient and family are responsible for the outcomes if they do not follow the care or treatment plan.

5. **Following Rules and Regulations:**

    - The patient and family are responsible for following the rules are regulations concerning patient care and conduct. This includes helping control noise, and disturbances, following smoking policies and respecting others.

6. **Showing Respect and Consideration:**

    - Patients and families are responsible for being considerate of Emerge Therapy Services personnel and property and other patients, their family members, and their personal property.

7. **Meeting Financial Commitments:**

    - The patient and family are responsible for promptly meeting any financial obligation agreed to with Emerge Therapy Services.

8. **Legal Issues:**

    - Subpoenas are to be served in person, preferable at least a week in advance, but no later than 72 hours in advance. Any court appearances or legal documentation are subject to fees.

____ ____________
Client Signature Date

CANCELLATION POLICY

Dear Client:

Each time a patient misses an appointment without providing proper notice another patient is prevented from receiving care.

We at Emerge Therapy Services understand that sometimes you need to cancel, reschedule your appointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible (with at least 24 hours notice) at (479) 250-4355. There is a waiting list to see the therapists at Emerge Therapy Services, and whenever possible, we like to fill the cancelled spaces to shorten the waiting periods for our patients.

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality treatment, it is very important for each patient to attend their visit on time.

Emerge Therapy Services will impose a $50.00 fee to patients who:

- ❏ Do not show for their appointments;
- ❏ Are more than 15 minutes late for their appointments; or
- ❏ Attempt to cancel their appointments with less than 24 hours notice.

This fee will be billed directly to the patient, as it is not covered by insurance; it must be paid prior to your next appointment. Multiple “no shows” in any 12 month period may result in termination of services from our clinic.

Thank you for your understanding and cooperation as we strive to best serve the needs of all our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

_______________________________________	_______________
Client Name (Printed)	Date of Birth
_______________________________________	_______________
Client Signature	Date

MENTAL HEALTH QUESTIONNAIRE - ADULT

Please complete this questionnaire prior to your first appointment. Your answers will allow the therapist to have a better understanding of your current concerns. Feel free to ask questions if you need assistance. Thank you for your time and effort in completing this questionnaire.

Name: ______________________________________ Today's Date: ______________

Street Address: ____

City, State, Zip Code: ____

Date of Birth: _____________________ Current Age: ________________________

Gender: ☐ Male or ☐ Female Social Security Number: ______________

Home Phone: _______________________ May we leave a message? ☐ Yes or ☐ No

Work Phone: ________________________ May we leave a message? ☐ Yes or ☐ No

Cell Phone: _________________________ May we leave a message? ☐ Yes or ☐No

Who referred you to Emerge Therapy Services? _______________________________

____

Race: ☐ African / American ☐ Asian ☐ Hispanic
☐ Native / American ☐ Caucasian ☐ Other

Are there ethnic / cultural / lifestyle / gender / religious considerations you would like us to be aware of during your care? ☐ Yes or ☐ No

If yes, please describe: ____

____

____

____

____

Relationship Status

☐ Single ☐ Married ☐ Separated ☐ Divorced
☐ Widowed ☐ Committed Relationship with Significant Other

Do you have children? ☐ Yes or ☐ No

Do your children live with you? ☐ Yes or ☐ No

Please indicate gender and ages of your children: ________________________________

____

____

____

____

____

Residence

☐ Reside Alone
☐ Reside with Spouse/Significant Other
☐ Reside in Foster Care
☐ Reside with Parents
☐ Reside with Roommate(s)
☐ Reside in Group Home

Employment History

Current Employment Status:

☐ Unemployed ☐ Leave of Absence ☐ Employed Part Time
☐ Employed Full Time ☐ Student ☐ Temporary Employment

Employer: ____

Position / Title: ____

Length of Time with Employer: ____

Education

Please check the highest grade level you completed:

☐ GED ☐ High School Diploma ☐ BA / BS Degree
☐ Doctorate Degree ☐ Some College CourseWork Completed
☐ AA Degree or 2 Year Program Completion ☐ Other: ____________________

Concerns for Yourself

What are the concerns that cause you to seek our services at this time? _____________

____

____

____

____

____

____

Medical Information

Name of primary care physician or medical group: _______________________________

____

Approximate date you last saw your primary care physician: _______________________

Please list all the prescription medications you are currently taking: _________________

____

____

____

Please list other over the counter medications you regularly take (aspirin, laxatives, vitamins, supplements and herbal remedies): ___________________________________

____

____

____

____

Please list any allergies: ____

____

____

____

____

____

Please check if you have been treated for any of the following:

- ☐ High Blood Pressure
- ☐ Stroke Problem
- ☐ Ulcers
- ☐ Organic Brain Dysfunction
- ☐ Tuberculosis
- ☐ Meningitis
- ☐ Hepatitis Seizures
- ☐ Other ________________________________
- ☐ Diabetes
- ☐ Heart Problem
- ☐ Cancer

Please list any other medical conditions we should be aware of (surgeries, auto accident injuries, etc): ____

____

____

____

____

____

Current / Previous Mental Health Services

Name of current Psychiatrist / Clinic: ____

Prior Psychiatrist: ____________________________________ Years Treated: ______

- Medications: ____
  ____
  ____
  ____
  ____
  ____
- Date of most recent psychiatric hospitalization: __________________________

  Hospital Name: ____
- Approximate number of psychiatric hospitalizations: ______________________
- Prior Therapist: __________________________________ Years Treated: ____
- Issues: ____
  ____
  ____
  ____
  ____
  ____
  ____
  ____

If members of your family have been treated for a mental illness, please indicate relationship to you and diagnosis: ____

____

____

____

____

____

____

____

____

____

Please list any other background information you feel may be helpful to the therapist in understanding you: ____

____

____

____

____

____

____

____

____

____

ADULT BEHAVIOR CHECKLIST

Please answer the following questions the best you can.

For the following check: • Yes for behaviors that are a concern for you, • Sometimes for behaviors that are sometimes a concern for you. • No for behaviors that are not a concern for you.	**Date symptoms began**	**Yes**	**Sometimes**	**No**
ATTENTION				
Careless mistakes				
Poor attention span				
Trouble listening				
Trouble finishing tasks				
Problems organizing				
Avoid tasks requiring concentration				
Lose needed items				
Easily distracted				
Trouble remembering / forgetful				
Fidget, squirm				
On the go, seem driven				
Excessive restlessness				
Talk all the time				
Interrupt others				
Lose train of thought while talking				
Other ________________________________				
MOOD				
Sleep disturbance				

Difficulty concentrating				
Crying spells				
Loss of interest/pleasure				
Hopeless feelings				
Guilty feelings				
Isolate self				
Low self-esteem / self-hate				
Give things away				
Wish to be dead				
Injure self				
Think about death/violence often				
Rage outbursts				
Bizarre behavior, hallucinations				
Rapid, hard to follow speech/thoughts				
Think you are the smartest, best person in the world				
Other ________________________________				
CONDUCT				
Intimidate/threaten others				
Use of weapon				
Start fights				
Physically cruel to people/animals				
Forcibly stolen from victim				
Stolen without confronting victim				

Force sexual activity				
Deliberately set fires to cause damage				
Gambling				
Difficulty controlling anger				
Other ___________________________				
ANXIETY / WORRY				
Worry something terrible will happen to self/others				
Frequently refuse or are reluctant to go somewhere				
Avoid being alone				
Fear of going to sleep without someone else near				
Fearfulness of new situations, people or objects				
Engage in repeated behaviors (counting, cleaning, Force sexual activity organizing, hand washing, etc,) or rigid rituals				
Excessive worry about everyday things				
Excessive nervousness for no reason				
Flashbacks/Nightmares				
Numbness				
Feeling disconnected				
Difficulty remembering/memory lapses				
Uncomfortable in social situations				
Panic Attacks				

Other ________________________________				
OCCUPATION / WORK				
Conflict with C0-Worker(s)				
Conflict with Employer / Supervisor				
Poor Work Performance				
Absent / Late				
Inadequate Training / Skills				
Learning Disabilities - Explain ___________ ________________________________				
Other ______________________________				
RELATIONSHIPS / COMMUNICATION				
Parent / Child Conflict				
Partner / Spouse Conflict				
Conflict with Friends				
Social Isolation				
Inadequate Social Support				
Lack of Assertiveness				
Fear of Social Situations				
Other ______________________________				
PHYSICAL HEALTH SELF CARE				
Excessive Fatigue / Energy				
Too Much / Too Little Sleep				
Poor Hygiene				

Alcohol / Use Substance				
Loss of Appetite / Anorexia / Binge Eating				
Housing Problems				
Little or No Exercise				
Energy Level Change				
Weight Change				
Other________________________________				

Further comments about any of the above: _____________________________________

____

____

____

____

____

____

____

____

____

____

____

____

____

Please answer the following questions honestly.

Question	Yes	No	Explain
LEGAL			
Arrested in the Past			
Incarcerated in Jail / Workhouse / Etc			
Legal Charges / Court Appearance Scheduled			
Currently on Probation For: ___________________			
Other ______________________________________			

CHEMICAL HEALTH			
Do you smoke?			If yes, how much?
Do you drink alcohol?			If yes, how much?
Number of drinks per time? ______________			Last use?
Have you felt you ought to cut down on your drinking or drug use?			
Have you felt bad or guilty about your drinking or drug use?			
Have you ever had a drink or use drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye opener)?			
Other			
Please indicate the date of LAST USE of the following chemicals.			
Chemical Type	**Yes**	**No**	**Date Last Used**
Cocaine			
Marijuana			
Sleeping Pills			

Heroin			
Stimulants/Pep Pills/ Diet Pills			
Tranquilizers/Acid/Angel Dust/LSD			
Pain Pills/Amphetamines/Methamphetamines			
Other ________________________________			

Number of times you have participated in Chemical Dependency Treatment? ________

____

Name and date of last treatment program: ______________________________

____

____

____

YOUR STRENGTHS:

In work setting: ____

____

____

____

____

____

____

____

In social setting: ____

____

____

____

____

____

____

In home setting: ____

____

____

____

____

____

____

Special Interests / Hobbies: ____

____

____

____

____

____