Intake Form

Date: _____

Name/S: _____

SS#: _____

Address: _____

City: _____State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

E-mail address: _____

Date of Birth: _____ Age: _____Sex: _____ Race: _____ Marital Status: _____

Employer: _____

Occupation: _____

Address: _____

Referral Source: _____

OK to Call Home [ ] Yes [ ] No OK to Call Work [ ] Yes [ ] No

When Was the Last Time You Examined by A Physician? _____

List Any Major Health Problems:

_____

Past Mental Health Chemical Dependency Treatment Or Counseling:

_____

_____

_____

_____

_____

The Reason For This Visit:

_____

_____

_____

_____

_____

_____

_____

Legal Problems:

_____

Emergency Notification: _____ Relationship: _____

Address: _____ Phone: _____

Name of Responsible Party: _____

Address: _____

Phone: _____ SS No. _____ Driver's License No: _____

Employer: _____

Address: _____

Phone: _____

May we contact your previous therapist? Name and city and state?

_____

The charges for my services are based on our professional training, expertise and experience and are the usual, customary and reasonable fee profiles for this area. **The Fee for individual services is $155.00 per clinical hour**. **For couples the fee is $185.00 per clinical hour. For the Addiction Recovery Intensive the fee is $700 a week. A Substance Abuse Assessment for reporting is $200 per hour.** This fee also includes our time on your behalf, including record keeping and preparation. **We encourage you to discuss fees at any time, and our clients are expected to pay for services when provided unless arrangements have been made in advance. We request payment be made out in advance so that our entire time may be spent attending to your concerns. You may pay by check, cash, Master Card or Visa**. When a psychological report is sent to a third party, there is a fee of $300 per hour, payment in full is necessary prior to release of my findings. Other charges are based on the fee discussed above. If there is an additional charge this fee will be discussed with you before a service is rendered.

_____ _____

Signature of Responsible Party Date

MOORE INSTITUTE

PLEASE SEE HIPPA REGULATIONS POSTED ON DESK IN WAITING ROM

Welcome to our practice. We are pleased to have the opportunity to serve you and hope that this handout will provide information helpful in making an informed decision concerning our services. Please ask questions at any time.

All therapists are Licensed Clinical Social Workers. They have training and experience in many areas including primary addictions, stage two recovery issues, grief, relationships, and intimacy.
If our work together leads to problems beyond our training and expertise, we will help you to obtain the necessary services from the appropriate specialist. Our resumes, licenses and credentials are available for review.

APPOINTMENTS:

Services are available by appointment only. The length of the appointment time varies on the basis of services provided. Individual therapy is generally scheduled for 45 to 50 minutes, and this is known as the "clinical hour." Because the appointment is reserved for you, it is necessary to charge for appointments which are not canceled 24 hours in advance, unless in fact they are occasioned by circumstances which we would both define as an emergency. Failure to provide a 24-hour notice of cancellation generally means that some other person is unable to use that appointment time. There are not set office hours.

We do not become Facebook friends with clients but do encourage you to like our page The Moore Institute and C3. We keep events updated to both pages regularly. We do not text with clients. This eliminates any communication confusion. It is important for you to leave a clear message with our service. We will return calls during regular business hours. We have also found it is easier to not e-mail with clients, as a phone message guarantees we will not miss information from you and we can more easily guarantee your privacy.

_____ Initial

Legal Issues

It is not the practice of The Moore Institute to provide legal testimony for our clients. We do not provide documentation or records for legal cases. We do not respond to subpoenas. Therefore, if the need for legal testimony is anticipated, we will be glad to refer you to another professional. If we do have to provide documentation or testimony for court proceedings the charge is $400 per hour door to door.

_____ Initial

INTIAL CONTACT

Our initial appointment is often called an "initial evaluation." This appointment is scheduled for you to discuss your concerns and problems from your point of view. There may be time during this appointment to obtain historical and other background data or this information may be gathered at subsequent sessions. In times of crises, the usual format of an initial evaluation is not followed in the hope that the time might be used to resolve or relieve the immediate crisis. As part of the "initial evaluation" new clients are requested to complete at least one questionnaire concerning their beliefs, experiences, thoughts and feelings. This information will help us in understanding your concerns and problems.

_____ Initial

TREATMENT:

We expect and encourage you to obtain knowledge of the procedures, goal and possible side effects of psychotherapy. We expect to make our professional contact one where you receive the maximum benefit and will also keep you informed about alternatives to psychotherapy. Psychotherapy may be tremendously beneficial for some individuals while at the same time, there are some risks. The risks may include the experience of intense and unwanted feelings, including: sadness, anger, fear, guilt or anxiety. It is important to remember these feeling may be natural and normal and are an important part of the therapy process. Other risks of therapy might include: recalling unpleasant life events, facing unpleasant thoughts and beliefs, increased awareness of feelings, values, and experiences, alteration of an individual's ability or desire to deal effectively and harmoniously with others in relationships. In therapy, major life decisions are sometimes made, including: decisions involving separation within families, development of other types of relationships, changing employment settings and changing lifestyles. These decisions are a legitimate outcome of the therapy experience because of an individual's calling into question many of their beliefs and values. As your therapists, we will be available to discuss any of your assumptions, problems, or possible negative side effects of our work together.
_____ Initial

Confidentiality:

We respect your legal right to confidentiality and will protect your information with the proper care. All records are maintained in a confidential manner. Consent forms will be required for the release of any information except in the following specific situations =:
Medical or Mental health Emergency
2. Clients become a danger to themselves or others (suicidal thoughts/behaviors/attempts, severe depression, etc.)
A client becomes a danger to others (homicidal thoughts/ behavior/attempts). The person threatened and the police will be notified
Any reported or suspected child abuse or neglect (physical or sexual)
A court order or subpoena directing the release of information or testimony in a court proceeding
Any litigation initiated be the client related to treatment or complaints
Any abuse of the elderly with mental illness or those who cannot care for themselves properly
_____ Initial

ASSESSMENT:

In addition to the intake administered as a part of the "initial evaluation," it is often beneficial to conduct a "formal" assessment in the early stages of therapeutic services or in consultation for others. If requested, the assessment will be discussed. A written report can also be provided; however written assessments require additional time to prepare and are more expensive to the client.

------- Initial

CHARGES:

The charges for my services are based on our professional training, expertise and experience and are the usual, customary and reasonable fee profiles for this area. The fee for individual therapy is 145.00 per clinical hour, the fee for couple's therapy is $175.00 per clinical hour, and $700 a week for the Addiction Recovery Intensive morning program and $475 for the evening program. These fees also include our time on your behalf, including record keeping and preparation. We encourage you to discuss fees at any time, and our clients are expected to pay for services when provided unless arrangements have been made in advance. Payment can be made by cash, check, Master card or Visa. When a psychological report is sent to a third party, a fee of $400 per hour, payment in full is necessary prior to release of my findings. We will be glad to give you the forms to file for insurance reimbursement, but payment is due at the time of service. Other charges are based on the fee discussed above.
_____ Initial

Credit Card Authorization

Your information is confidential and protected by federal and state confidentiality laws. This form is not intended for primary method of payment. Our office is happy to accept cash or checks. Our primary goal is to have expenses paid during your visit.

We keep a copy of this form in your confidential record for the reasons stated below:

To bill **any unpaid charges** that may accrue as a result of having a deductible, co-payment, or coinsurance and or any other fees agreed upon that were not paid at the time-of-service delivery. To collect fees for individual, family, marital or assessment procedures that were not paid in full at the time of service or that were not paid by your insurance company or an EAP program or managed care company. Additionally, these charges may include: failure to keep appointment fees or late cancellation fees, and any NSF or returned unpaid check amount plus returned check fees from any bank.

By providing the information below you agree to allow our offices to charge unpaid fees in the Financial Policy and any other agreed upon fees not paid by you at the time-of-service delivery, in person, or by regular billing. Your signature is authority to release your billing statement to your credit card company/bank for the purpose of collecting the appropriate fees charged to your credit card. Please note refunds take 3-4 days to process.

Name exactly as it appears on card: _ ____

Type of Card: Visa ☐ MC ☐ Amer Express ☐ Debit ☐

Card Number: _

Expiration Date: Month__________ Year_________ CCV/Security # _ _ _ _(3 digits on back of card)

Billing address for card:

Street Address: _

City, _ _ _ _ _ _ _ _ _ _ _ _ _ _ State,_ _ _ _ _ _ Zip:_ _ _ _ _ _

Phone number for card: _

Cardholder Signature _

Date _

Social Media: We do not text with clients unless it's absolutely necessary. This eliminates any communication confusion. It is important for you to leave a clear voice message with our answering service. We have also found it is easier to not e-mail with clients, as a phone message guarantees we will not miss information from you and we can more easily guarantee your privacy..

We do not become Facebook friends with clients but do encourage you to like our page The Moore Institute and C3. We keep events updated to both pages regularly. We do not text with clients. This eliminates any communication confusion. It is important for you to leave a clear message with our service. We will return calls during regular business hours. We have also found it is easier to not e-mail with clients, as a phone message guarantees we will not miss information from you and we can more easily guarantee your privacy

______ **Initial**

I consent to receive email and text messages for appointment reminders and clinician communication

_____ Initial

TERMINATION:

Termination of psychotherapy may occur any time and may be initiated by either the client or the therapist. We request that if a decision is being made to terminate, that there be a minimum of a seven Termination itself can be a constructive, useful process. If any referral is warranted, it may be made at that time.

_____ Initial

CLIENTS WHO ARE DEPENDENTS:

If you are requesting our services as the guardian or parent of a child, or the guardian of a dependent adult, the same general practice as outlined above will apply. However, as your child's therapist, it is important that our child be able to completely trust us. As such, we keep confidential what your child says in the same way that we keep confidential what an adult says. As the parent or guardian, you have the right and responsibility to question and understand the nature of my activities and progress with your child, and we must use our clinical discretion as to what an appropriate disclosure is. In general, we will not release specific information that the child provides to us; however, we feel it appropriate to discuss with you, the parent or guardian, your child's progress and your participation in their treatment.

_____ Initial

CLIENT RIGHTS AND RESPONSIBILITIES

CLIENT RIGHTS

Confidentiality: Everything you say to your provider is confidential, which means that it is private and cannot be shared with anyone outside this office without your permission. Your provider cannot release any information about you without a signed consent for release of information, except in emergencies or when there is a Court order requiring the information be released. Please note that information about dangerous behaviors, including serious thoughts of hurting yourself or another person, as well as information about possible child abuse, is not confidential and will be reported by your provider to the appropriate authorities to keep you and other people safe. Also, if you were referred to counseling by a Court order, information about your treatment is not confidential and can be release without your consent.

Informed Consent: You have the right to an explanation of your condition and treatment in language that you can understand. You have the right to consent or agree to treatment and you also have the right to refuse treatment. You have the right to consent to release of records if you want someone else to be informed about your treatment, and you have the right to refuse to release records if you do not want someone else to know about your treatment. If you do not consent to treatment or if you do not consent to release of information, this does not affect your other rights as listed on this sheet.

Input into Treatment: You have the right to provide input into your treatment. You have the right to share in the treatment planning process, determining what options you choose for your treatment. You have the right to file complaints and compliments related to your treatment. You may also have the right to file grievances and appeals related to this treatment.

Respect and Non-Discrimination: You have the right to be treated with respect and dignity by all the staff. You have the right to be treated equally regardless of your race, ethnic origin, religion, creed, gender, age, disability status, sexual orientation, or source of payment.

Other Information and Options: You have the right to information concerning your provider. You also have the right to know about other treatment options, regardless of their cost or if they are covered by your insurance. You have the right to know what clinical guidelines or standards are used in providing your treatment. You may have other rights and responsibilities as provided by Alabama Law. Information about these can be obtained by contacting the Alabama Board of Examiners for Psychologist/Psychiatrist.

CLIENT RESPONSIBILITIES

Cancellation Policy: 24-hour notice (one business day) is required for cancellations since your provider reserves time for you when you schedule an appointment. If you do not cancel 24 hours in advance, you will be charged the full fee. Insurance will not cover a failed appointment or late cancellation.

Billing Agreement: Payment for services rendered is due at the time of your session. We must remind you that you are responsible for payment of professional services rather than your insurance company.

Participation in Treatment: In order to benefit from treatment, you must participate by giving your provider information needed to guide the treatment process and to deliver the best possible care. This includes telling your provider about any medication you are taking, and informing your provider about any changes in medications prescribed by another doctor. It also includes asking your provider any questions you have about your care, so that you can understand your care and your role in it. Any questions you have about the procedure or process are always legitimate. You always have the right to decline participation in or the use of certain therapeutic techniques. Psychotherapy sessions will be fifty (50) minutes, unless otherwise specified by your psychologist.

Risk: Psychotherapy involves change. Processing areas of your life and learning new ways of thinking, feeling and behaving can cause discomfort for you and those around you. However, if you are committed to your psychotherapy process, you can expect benefits from your psychotherapy time. Please ask for any clarification that may help you feel more comfortable. You are responsible for avoiding any actions that could harm yourself or others. This includes being responsible for telling your provider if you feel that you might harm yourself or any other person, so that your provider can take actions to keep you safe.

Emergency Services and After Hours Contact: Although your Psychologist will do their best to assist and coordinate your care in the event of an emergency, they do not provide emergency services. In the event of an emergency, call or go to the nearest emergency room, contact the Crisis Center or contact the designated individual on your Safety Plan.

My signature below indicates that I have been informed of my rights and responsibilities, and that I understand this information. I understand that it is my sole responsibility to request clarification or additional information concerning my rights and responsibilities.

Client Signature (or Legal Guardian) _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Date _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice is effective as of May 1, 2019:
This notice describes how health related information about you may be used and disclosed and how you can access this information. This notice describes our policies, which extend to: All employees, staff and other personnel that work for or with us. All office areas (front desk, waiting room, etc.) and our business associates (billing service, clearinghouse, covering therapists, etc.).

We are required by law to:

Make sure that medical information that identifies you is kept private, except in certain situations where we are allowed to disclose information under the protection or direction of state or federal law.
Give you this notice of our legal duties and privacy practices with respect to medical information about you.
Follow the terms of this notice now in effect.

Responsibilities:
Maintain the privacy of your health information as required by law, provide you with a notice of our duties and privacy practices as to the
information we collect and maintain about you, abide by the terms of this notice and notify you if we cannot accommodate a requested restriction or request. Accommodate your reasonable requests regarding methods to communicate health information with you. We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. We will keep a posted copy of the most current notice in our office containing the effective date. In addition, each time you visit our office for treatment, you may obtain a copy of the current notice in effect upon request. We will not use or disclose your health information without your authorization except as described in this notice or in situations that can be reasonably inferred from the intended uses listed in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

Patient Health Information Rights:
The health record we maintain and billing records are the physical property of the practice. The information in it, however, belongs to you. You have the right to:
Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted; Request that you be allowed to inspect and copy your health record and billing record– you may exercise this right by delivering the request in writing to our office; File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information; Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care; Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office; and revoke authorizations that you made previously to use or disclose information except to the extent of information or action has already been taken by a written revocation to our office. With your consent, the practice is permitted by federal privacy laws to make use and disclosure of your health information for purposes of treatment, payment and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, assessment and test results, diagnoses, treatment and future care or treatment. You have a right to review this notice before signing the consent authorizing use and disclosure of your protected health information for treatment, payment and health care operations purposes.

How we use and disclose health information:
For Treatment: We may use your health-related information to you to provide initial, ongoing, or referral services for you. This may mean discussing your case or collecting records from a previous provider or disclosing your records to collaborate with a previous, current or future provider, such as psychiatrists, psychiatric hospitals and or doctors or other healthcare professionals. The owners of the practice, management, and or clinical supervisors may collaborate with your clinician(s) and review your information for supervision, customer services, payment collections or other purposes. If you are a minor healthcare information may be disclosed to your parents or guardian during or after treatment.

For Payment: We may use and disclose health related information in billing and insurance operations needed to collect payment for the services you have received. This information may be shared with your insurance, EAP, and or managed care company and will be viewed by our billing department. You may receive a bill at your address for services rendered.

Your healthcare plan may require ongoing and updated detailed information of your treatment in order to provide payment as permitted by AL and USA laws. Individuals involved in your care or in payment of your care may also be informed of your healthcare.

For Healthcare Operations: We may use or disclose information about you for practice operations. These uses and disclosures are necessary to run the operations efficiently and increase the quality of care we provide. For example, we may use your healthcare information to review our treatment and service and to evaluate the performance of our staff in providing your care. We may also use this information to determine the need for new services and to train students, billing personnel and other employees of the practice. We may remove data that identifies you personally before others view it or use it to study healthcare delivery without identifying patients.

Appointment Reminders: We may send reminders by text or email, both of which could be intercepted by others. If you do not wish for us to leave messages please let us know by indicating so on the forms provided in this packet.

Emergency Situations: We may disclose medical information about you to an organization assisting with an emergency medical or mental health condition or crisis so that you may receive the proper health care and or so that your family can be notified about your condition.

Law Enforcement: We may release healthcare information if asked to do so by a law enforcement official in response to a court order, to protect an individual or yourself from imminent harm or danger, in emergency situations to report a crime or in the process of facilitating a transfer to a hospital of any kind.

Department of Community Based Services:: We may disclose records as required by AL law in order to report suspected abuse of children, elderly individuals or adults who cannot care for themselves.

Judicial/Administrative Proceedings, Probations Officers, Court designated Workers, Parole offices and Judges: Healthcare information may be disclosed to these individuals with a written consent, court order, or subpoena to do so. We disclose detailed information including date and time of appointments, clinical progress and treatment compliance as well as other information requested and listed on the consent. This may include privileged information.

Complaints/Lawsuits: Your information will be used to defend any complaint, lawsuit, liability or similar claim brought on by you and/or a family member on your behalf.

To report a problem please notify our Privacy Officer:
We have designated a Privacy Officer, Steve Moore, to answer your questions about our privacy practices and to ensure that we comply with applicable laws and regulations. The Privacy Officer also will take your complaints and can give information about how to file a complaint. If you believe your privacy rights have been violated, please contact Steve Moore 205-967-3277..

You can also file a complaint with the Office for Civil Rights or email to www.hhs.gov. There will be no retaliation for filing a complaint. The address for OCR is listed below:

Office for Civil Rights:
U.S. Department of Health and Human
Services 200 Independence Ave., S.W.
Room 509F, HHH
Building Washington,
D.C. 20201

We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment.

I acknowledge that I have received a copy of your privacy practices and that I understand them.

Client Signature _

Date_____

Parent/Legal Guardian Signature (for Minor)_____

Informed Consent for Teletherapy Services

This Informed Consent for Teletherapy contains important information about providing and receiving psychotherapy using the telephone or internet. Please read this carefully and ask any questions that you may have. When you sign this document, you are consenting to receive psychotherapy services via audio/visual interactive technology or by telephone after being fully informed of the risks, benefits, and limitations involved. Once signed, it becomes an agreement between us.

POTENTIAL BENEFITS AND RISKS OF TELETHERAPY
Teletherapy refers to the provision of mental health services by the provider (therapist) to recipient (client) of services being in separate locations, and the services are delivered over electronic media using the internet or telephone. To be effective, Teletherapy requires both client and therapist to be comfortable with the technology used.

One of the benefits of teletherapy is that the client and therapist can engage in therapy services without being in the same physical location. This can ensure continuity of care if the client or clinician moves to a different location, takes an extended vacation, or is otherwise unable to continue meeting in person. Teletherapy provides the opportunity for clients to receive services in the comfort of their own space with access to favorite things that may be calming or soothing to them. It can also provide convenience and save driving time. Several validated studies have shown teletherapy to be as effective as in-person therapy. In addition to the many benefits of teletherapy, there are also some potential risks.

RISKS TO CONFIDENTIALITY
Because teletherapy sessions take place outside of the therapist's private office, there can be potential for other people to overhear sessions. This could happen if you choose to use a public Wi-Fi network. It is important that you plan ahead, proactively log onto to a reliable, secure internet connection. It is also important for you to find a private place for your session that is free of interruptions, distractions and others who could overhear.

RISKS RELATED TO TECHNOLOGY
There are many ways that technology might impact teletherapy. Technology may stop working during an important moment in session due to a low battery, power outage or poor internet connection/cell service. Also, since we are relying on a technology platform hosted and managed by a third party, there is a risk that someone (Cloud-based service personnel, IT assistant, or malicious hacker) could accidentally or intentionally gain access to our conversation in progress. I am only using technology that is private, secure and compliant with HIPAA laws and who have agreed to take all reasonable measures to protect your confidentiality and privacy. They certify that they will not record the sessions.

EFFICACY
Most research shows that teletherapy is as effective as in-person psychotherapy. However, it is different and can present limitations of a therapist's ability to fully observe and understand nonverbal communication.

Please provide the name and telephone number of someone that you trust whom I may contact if you have an emergency

Name _

Relation to you_ _ _ _ _ _ _ _ _ _ _ _ Telephone Number ____________________________

If a session is interrupted for any reason, and you are having an emergency, please do not put your safety at risk by calling me back first. Instead, call 911 or go to your nearest emergency room. Call me back after you have called or obtained emergency services.

If the session is interrupted and you are not having an emergency, disconnect from the session and try to reconnect; I will do the same. If that is not successful, I will text or call you at the phone number you have designated as your preferred contact.

As always, if you should have an urgent need to speak to someone due to a crisis between sessions and you cannot reach me, here are other options:
The Birmingham Crisis Center: 205-323-7777
National Suicide Prevention Lifeline: 1-800-273-8255

FEES
The same fees/rates will apply for both in-person and teletherapy. However, insurance or other managed care providers may not cover sessions conducted via telecommunication. If your insurance does not cover electronic psychotherapy sessions, you will be solely responsible for the entire session fee. Please contact your insurance company prior to beginning teletherapy sessions to determine your coverage for teletherapy sessions. Private- pay fees are the same for teletherapy as for in-person therapy.

RECORDS
Teletherapy sessions shall not be recorded in any way unless agreed to in writing by our mutual consent. I will maintain a record of the session in the same way I maintain records of in-person sessions in accordance with my policies.

INFORMED CONSENT
This agreement is intended as a supplement to the Informed Consent and Permission for Treatment. It does not amend any terms of that agreement. Your signature below indicates that you have read this document entirely and that you consent to the terms and conditions included.

Your signature, below, also represents your agreement to adhere to the following expectations: I

will choose a secure internet network and private place for all teletherapy sessions.
I will be fully, appropriately dressed for all teletherapy sessions.
I will ensure that no other person is in the room with me during teletherapy sessions unless my therapist and I have mutually agreed to include someone.
I will not record any portion of teletherapy sessions without my therapist's knowledge and consent.

Signature _____ Date _____

Adult Intake Form

Name: _____ _____

PRESENTING PROBLEMS AND CONCERNS

Describe the problem that brought you here today: _____

_____

Please check all the behaviors a symptom that you consider problematic:

Distractibility	Change in appetite	Suspicion/paranoia
Hyperactivity	Lack of motivation	Racing thoughts
Impulsivity	Withdrawal from people	Excessive energy
Boredom	Anxiety/worry	Wide mood swings
Poor memory/confusion	Panic Attacks	Sleep problems
Seasonal mood changes	Fear away from home	Nightmares
Sadness/ Depression	Social Discomfort	Eating problems
Loss of pleasure/interest	Obsessive Thoughts	Gambling problems
Hopelessness	Compulsive Behavior	Computer addiction
Thoughts of Death	Aggression/fights	Problems with pornography
Self-harm behaviors	Frequent Arguments	Parenting problems
Crying spells	Irritability/anger	Sexual problems
Loneliness	Homicidal Thoughts	Relationship problems
Low self-worth	Flashbacks	Work/school problems
Guilt/shame	Hearing Voices	Alcohol/D rug use
Fatigue	Visual Hallucinations	Recurring Disturbing memories

Other:_____

Are your problems affecting any of the following?

Handling everyday tasks Self-esteem Hygiene

Work/School Housing Recreational Finances

Sexual Relationships Legal Matters Health

Yes No Have you ever had thoughts, made statements, or attempted to hurt yourself? If yes, please Describe:

_____

_____

_____

Yes No Have you ever had thoughts, made statements, or attempted to hurt someone else? If yes, please Describe.:

_____

_____

_____

Yes No Have you recently been physically hurt or threatened by someone else? If yes, please Describe:

_____

_____

_____

Name: _____

FAMILY AND DEVELOPMENTAL HISTORY

Relationship	Name	Age	Quality of Relationship	Family Mental Health Problems	Who?
Mother					
Father				Hyper-activity	
				Sexually Abused	
Stepmother				Depression	
Stepfather				Manic Depression	
Siblings				Suicide	
				Anxiety	
				Panic Attacks	
				Obsessive-Compulsive	
Spouse/partner				Anger/Abusive	
Children				Schizophrenia	
				Eating Disorder	
				Alcohol Abuse	
				Drug Abuse	

_

Parents legally married or living together: Yes No Mother remarried : Yes No Number of times _____
Parents temporarily separate Yes No Father remarried : Yes No Number of times _____
Parents' divorce or permanently separate Yes No

Please circle if you have experience any of the following types of trauma or loss:

Emotional abuse	Neglect	Lived in a foster home
Sexual abuse	Violence in the home	Multiple family moves
Physical abuse	Crime Victim	Homelessness
Parent substance abuse	Parent Illness	Loss of a loved one
Teen pregnancy	Placed a child for adoption	Financial problems

PREVIOUS MENTAL HEALTH TREATMENT

		Type of Treatment	When?	Name of /Program	Reason for Treatment
Y	N	Outpatient Counseling			
Y	N	Medication (mental health)			
Y	N	Psychiatric Hospitalization			
Y	N	Drug/Alcohol Treatment			
Y	N	Self-help/Support Groups			

Yes No Have you gamble in the past 6 months? If yes, let us know the following
Yes No Have you ever felt the need to bet more and more money?
Yes No Have you ever had to lie to people important to you about how much you gamble?

Name: _____

SUBSTANCE USE HISTORY

Substance Type			Current Use (last 6 months)		Past Use			
	Y	N	Frequency	Amount	Y	N	Frequency	Amount
Tobacco								
Caffeine								
Alcohol								
Marijuana								
Cocaine/crack								
Ecstasy								
Heroin								
Inhalants								
Methamphetamines								
Pain Killers								
PCP/LS								
Steroids								
Tranquilizers								

Yes No Have you had withdrawal symptoms when trying to stop using any substances?
Describe:_____
_____
_____
_____
_____

Yes No Have you ever had problems with work, relationships, health, the law, etc. due to your substance use? If yes, please

Describe:_____
_____
_____
_____
_____

MEDICAL INFORMATION

Date of last physical exam:_____

Have you experience any of the following medical conditions during your lifetime?

Allergies Asthma Headaches Stomach aches
Chronic pain Surgery Serious Accident Head injury
Dizziness/fainting Meningitis Seizures Vision problems
High fevers Diabetes Hearing Problems Miscarriage
Sexually transmitted Disease_____ Abortion Y N Sleep Disorder
Other:_____ **Please list any CURRENT health concerns:**_____
_____

Name: _____

Medication	Dosage	Date First Prescribed	Prescribed By

Current over-the-counter medications (including vitamins, herbal remedies, etc.)

_____

_____

_____

Allergies and/or adverse reactions to medications: None

If yes, please list: _____

INTERPERSONAL/SOCIAL/CULTURAL INFORMATION

Please Describe your social support network (check all that apply):

Family Neighbors Friends Students Co-workers Support/Self-Help Group

Community Group Religious/Spiritual Center (which one?) _____

To which cultural or ethnic group do you belong? _____

If you are experiencing any Difficulties due to cultural or ethnic issues, please Describe:

_____

_____

How important are Spiritual matters to you?

Not at all Little Somewhat Very much

Yes No Would you like spiritual/religious beliefs to be incorporate into your counseling?
Please Describe your strengths, skills, and talents?

_____

_____

_____

Describe any special areas of interest or hobbies (art, books, physical fitness, etc.): _____

_____

_____

Employment

Employer: _____ **Position:** _____

Length of time in this position: _____ **Job duties:** _____

Stress level of this position: Low Medium High

Name: _____

Education

Yes No Are you currently school of any kind? Highest Degree Attained_____

Military Service

Yes No Have you been/are you currently in the military? (If no, skip remainder of this section)
Branch_____ Date of Discharge____Type of Discharge_____ Rank_____
Yes No Were you in combat?

Legal

Have you ever been convicted of a misdemeanor or felony? Yes No If yes, please explain _____
_____
_____
_____

Are you currently involve in any divorce or child custody proceedings? Yes No
If yes, please explain _____
_____
_____
_____