CLIENT INFORMATION FORM

Client Name ________________________________ Age _________ Birthdate ________________

If there is an additional client (i.e., spouse, relative, etc.) please fill out the following:

Additional Client Name ______________________ Age _______ Birthdate ______________

Parent/Guardian Name (if client is under 18) ____

Relationship to client _________________________ Age ________ Birthdate _____________

All information below pertains to the adult client, or the responsible party (if client is a minor)

Address ___________________________ City __________________ State _______ ZIP _________

Home Phone # ____________________ Work # ____________________Cell/Pager # _____________

Occupation ______________________ Employer ____

Highest level of Education ____

Marital Status (circle): Single Separated Divorced

Widowed Married – how many years? _________

Church Affiliation ____

How did you find out about us? ____

Physician's Name ___________________________ Phone (if available) _______________________

Is the client currently on medication? Yes *or* No *(if yes, you may let your therapist know what meds you're taking)*

In case of emergency notify ____

Relationship to client ____

Phone number(s) ____

Will we be billing insurance? YES *or* NO (If yes, fill out information below)

Name of insured (i.e.,parent, spouse, etc.) ______________________________ Birthdate___________

Client SS# (if other than insured) SS# ____

Insured's Employer _______________________________ Insured's SS# ____________________

Insurance Co. ___________________________________ Phone # __________________________

I have read and signed the attached forms: (check the last two items only if applicable)

- ☐ Limits of Confidentiality
- ☐ Insurance Billing Agreement
- ☐ Consent for treatment of a Minor

Signature ____ Date ___________________________

[Please take this signed form to the first meeting with your therapist]

NOTICE TO CLIENTS: LIMITS OF CONFIDENTIALITY/INFORMED CONSENT

The term "confidentiality" refers to your therapist's professional obligation to avoid unauthorized disclosure of information obtained during the course of your therapy. Thus, your therapist will reveal nothing about your counseling except under conditions agreed upon by you.

In order that there be no confusion in this regard, however, the Link Care Counseling Staff want you to be fully aware of certain limits to the general rule of confidential information:

• 1. While many of our therapists are licensed Psychologists, Marriage and Family Therapists (MFT), or Licensed Clinical Social Workers, your therapist may be a Psychological Assistant, MFCC Intern, or Counselor Trainee. Should this be the case, your therapist is required to receive supervision from a California-licensed Psychologist or Counselor on staff. Your case may be reviewed as a part of this supervision. This is to insure that you receive the highest quality of professional assistance. Link Care also takes a team approach to many of its cases. In addition, our philosophy of treatment is that of not working in isolation. Therefore, Link Care clinical staff will often review cases as a counseling staff. The intent of these case reviews is to insure quality, professional services; and your confidentiality is maintained by the clinical staff as a whole. Other staff members also have access to clinical information to the degree necessary to perform their job responsibilities.

• 2. There are some exceptions to the promise of confidence that your therapist is obligated to observe in accordance with California State Law: A) Confidence must be broken where there is a reasonable suspicion that you may be a danger to yourself, to someone else or their property: B) Confidence must be broken if you make a threat of violence that is communicated directly by you, or reported by a significant other; C) Confidence must be broken where there is a reasonable suspicion of abuse being inflicted upon a minor (under 18), a dependent adult, or an older adult (65 or older).

• 3. If you are involved or become involved in legal action, your legal right to prevent confidential information from being disclosed in court or other legal proceedings may not apply. This could occur, for example, if your emotional condition has been raised as an issue by you or your attorney. Disclosure of information may also be required by a superior court subpoena. Should a legal action take place Link Care will charge for therapist/staff time related to the legal action.

• 4. If part or all of your fees are being paid for through insurance coverage, then your therapist will need to supply the company with the dates of your sessions and a diagnostic number. Additional clinical information is frequently requested in order to authorize payment or additional treatment. This information may include relevant historical background, a description of current symptoms, and a current treatment plan. Additionally, your insurance company may require that they be permitted to review records for case management and quality assurance purposes. You are encouraged to discuss this issue with your therapist if you have questions about the possible disclosure of additional information.

• 5. In the event of chronic failure to make payments for therapy, Link Care Counseling Center may utilize the services of a collection agency. While use of such an agency would involve disclosure of your identity, no additional clinical information would be released either to the agency or to small claims court.

If you should have further questions regarding any portion of this notice, please discuss it with your therapist at your earliest convenience. We look forward to working with you!

I have read and understood the above statement:

________________________________ ____________________________

Signature *Date*

________________________________ ____________________________

Signature *Date*

________________________________ ____________________________

Witness *Date*

Copy: Given / Declined *(circle one)*

New Client Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Mental Health Care Operations

I, _____________________________________, understand that as part of my health care, Link Care Center originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and treatment information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine mental health care operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Link Care Center is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me, as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Link Care Center reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Link Care Center change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:
____
____
____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand, and
❑ accept the terms of this consent.
❑ decline the terms of this consent.

____
Patient's Signature

____
Date

FOR OFFICE USE ONLY
[ ] Consent received by __________________________________ on _______________________.
[ ] Consent refused by patient, and treatment refused as permitted.
[ ] Consent added to the clinical medical record on ____.

Your Choices:

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations we describe below, talk to us. Tell us what you want us to do, and we will follow your instructions.

- **In these cases you have the right and choice to tell us to:**

1. Share information with your family, close friends, or others involved in your care.
2. Share information in a disaster relief situation.
3. Include your information in a hospital directory. If you are not able to tell us your preference. (for example, if you are unconscious), we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or Safety.

- **In these cases we never share your information unless you give us written permission**:

1. Marketing purposes
2. Sale of your information
3. Most sharing of psychotherapy notes

- **In the case of fundraising**:

1. We may contact you for fundraising efforts, but you can tell us not to contact you.

Psychologist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticecpp.html.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact Phillip Collier, Ph.D., 1734 W. Shaw Avenue, Fresno, CA 93711. E-mail: philcollier@linkcare.org.

You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date

This notice is in effect and was updated October 1, 2013

CALIFORNIA NOTICE FORM

Notice of Mental Health Provider Policies and Practices to Protect the Privacy of Your Health Information

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

I. Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information (PHI)* for certain *treatment, paym and health care operations* purposes without your *authorization.* In certain circumstance can only do so when the person or business requesting your PHI gives me a written request t includes certain promises regarding protecting the confidentiality of your PHI. To help cla these terms, here are some definitions:

- *"PHI"* refers to information in your health record that could identify you.
- *"Treatment and Payment Operations"*

-*Treatment* is when I provide or another health care provider diagnoses or treats you. example of treatment would be when I consult with another health care provider, such your family physician or another psychologist, regarding your treatment.

-*Payment* is when I obtain reimbursement for your health care. Examples of payment when I disclose your PHI to your health insurer to obtain reimbursement for your hea care or to determine eligibility or coverage.

-*Health Care Operations* is when I disclose your PHI to your health care service plan (example, your health insurer), or to your other health care providers contracting with y plan, for administering the plan, such as case management and care coordination.

- *"Use"* applies only to activities within my [office, clinic, practice group, etc.] such sharing, employing, applying, utilizing, examining, and analyzing information t identifies you.
- *"Disclosure"* applies to activities outside of my [office, clinic, practice group, etc.], such releasing, transferring, or providing access to information about you to other parties.
- *"Authorization"* means written permission for specific uses or disclosures.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and healthcare operati when your appropriate authorization is obtained. In those instances when I am asked information for purposes outside of treatment and payment operations, I will obtain authorization from you before releasing this information. I will also need to obtain authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are note have made about our conversation during a private, group, joint, or family counseling sessi which I have kept separate from the rest of your medical record. These notes are give greater degree of protection than PHI.

You may revoke or modify all such authorizations (of PHI or psychotherapy notes) at any ti however, the revocation or modification is not effective until I receive it.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstanc

- **Child Abuse**: Whenever I, in my professional capacity, have knowledge of or observ child I know or reasonably suspect has been the victim of child abuse or neglect, I m immediately report such to a police department or sheriff's department, county probat

department, or county welfare department. Also, if I have knowledge of or reasonably suspect that mental suffering has been inflicted upon a child or that his or her emotional well-being is endangered in any other way, I must report such to the above agencies.

- **Adult and Domestic Abuse**: If I, in my professional capacity, have observed or have knowledge of an incident that reasonably appears to be physical abuse, abandonment, abduction, isolation, financial abuse, or neglect of an elder or dependent adult, or if I am told by an elder or dependent adult that he or she has experienced these or if I reasonably suspect such, I must report the known or suspected abuse immediately to the local ombudsman or the local law enforcement agency.

  I do not have to report such an incident if:

  1) I have been told by an elder or dependent adult that he or she has experienced behavior constituting physical abuse, abandonment, abduction, isolation, financial abuse, or neglect;
  2) I am not aware of any independent evidence that corroborates the statement that the abuse has occurred;
  3) the elder or dependent adult has been diagnosed with a mental illness or dementia, or is the subject of a court-ordered conservatorship because of a mental illness or dementia; and
  4) in the exercise of clinical judgment, I reasonably believe that the abuse did not occur.
- **Health Oversight**: If a complaint is filed against me with the California Board of Psychology, the Board has the authority to subpoena confidential mental health information from me relevant to that complaint.
- **Judicial or Administrative Proceedings**: If you are involved in a court proceeding and a request is made about the professional services that I have provided you, I must not release your information without 1) your written authorization or the authorization of your attorney or personal representative; 2) a court order; or 3) a subpoena *duces tecum* (a subpoena to produce records) where the party seeking your records provides me with a showing that you or your attorney have been served with a copy of the subpoena, affidavit and the appropriate notice, and you have not notified me that you are bringing a motion in the court to quash (block) or modify the subpoena. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. I will inform you in advance if this is the case.
- **Serious Threat to Health or Safety**: If you communicate to me a serious threat of physical violence against an identifiable victim, I must make reasonable efforts to communicate that information to the potential victim and the police. If I have reasonable cause to believe that you are in such a condition, as to be dangerous to yourself or others, I may release relevant information as necessary to prevent the threatened danger.
- **Worker's Compensation**: If you file a worker's compensation claim, I must furnish a report to your employer, incorporating my findings about your injury and treatment, within five working days from the date of your initial examination, and at subsequent intervals as may be required by the administrative director of the Worker's Compensation Commission in order to determine your eligibility for worker's compensation.
- **To Run Our Organization:** We can use and share your health information to run our practice, improve your care, and contact you when necessary. For example we use health information about you to manage your treatment and services.
- **Bill for Services:** We can use and share your health information to bill and get payment from health plans or other entities.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- ***Right to Request Restrictions*** - You have the right to request restrictions on certain uses and disclosures of PHI about you. However, I am not required to agree to a restriction y request.
- ***Right to Receive Confidential Communications by Alternative Means and at Alterna Locations*** - You have the right to request and receive confidential communications of I by alternative means and at alternative locations. (For example, you may not wan family member to know that you are seeing me. Upon your request, I will send your b to another address.) We will say yes to all reasonable requests.
- ***Right to Inspect and Copy*** - You have the right to inspect or obtain a copy (or both) PHI in my mental health and billing records used to make decisions about you for as lo as the PHI is maintained in the record. I may deny your access to PHI under cert circumstances, but in some cases you may have this decision reviewed. Upon y request, I will discuss with you the details of the request and denial process. You can to see or get an electronic copy or paper copy of your medical record and other hea information we have about you. Ask us how to do this. We will provide a copy c summary of your health information, usually within 30 days of your request. We n charge a reasonable, cost-based fee. You have the right to see or get an electronic copy your medical record for those records stored electronically.
- ***Right to Amend*** - You have the right to request an amendment of PHI for as long as PHI is maintained in the record. You can ask us to correct health information about y that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to y request, but we'll tell you why in writing within 60 days. Upon your request, I will disc with you the details of the amendment process.
- ***Right to Ask Us to Limit What We Share*** – You can ask us not to use or share cert health information for treatment, payment, or our operations. We are not required to ag to your request, and we may say "no" if it would affect your care. If you pay for service health care item **out-of-pocket** in full, you can ask us not to share that information for purpose of payment or our operations with your health insurer. We will say "yes" unl the law requires us to share that information.
- ***Right to an Accounting*** - You generally have the right to receive an accounting disclosures of PHI for which you have neither provided consent nor authorization described in Section III of this Notice). Upon your request, I will discuss with you details of the accounting process. You can ask for a list (accounting of the times we ha shared your health information for six years prior to the date you ask, who we share with and why). We will include all the disclosures except for those about treatme payment and health care operations, and certain other disclosures (such as any you ask us to make). We'll provide one accounting a year for free but will charge a reasonal cost-based fee if you ask for another one within 12 months.
- ***Right to Get a Copy of This Privacy Notice*** – You can ask for a paper copy of this not at any time, even if you have agreed to receive the notice electronically. We will prov you with a paper copy promptly.
- ***Right to Choose Someone to Act for You*** – If you have given someone medical power attorney or if someone is your legal guardian, that person can exercise your rights a make choices about your health information. We will make sure the person has t authority and can act for you before we take any action.
- ***Right to File a Complaint*** – You can complain if you feel that we have violated y rights by contacting us using the information on the back page. You can file a compla with the U.S. Department of Health and Human Services Office for Civil Rights sending a letter to 200 Independence Avenue, S.W. Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

INSURANCE BILLING AGREEMENT

Link Care agrees to bill your primary insurance company and all insurance benefits from primary insurance will be collected by Link Care. Link Care will verify insurance benefits; however, **this is only an estimate until we receive payment and an explanation of benefits from your primary insurance company.**

If for any reason your insurance company does not pay what was quoted at the time of the insurance verification, full payment is the responsibility of the client.

There are some self-funded insurance plans and some companies that require special handling that Link Care is not equipped to bill. You will be informed of these special circumstances at the time of your insurance verification.

Link Care does not bill secondary insurance. We will, however, assist by providing information necessary for secondary insurance billing. Payment from your secondary insurance will be paid to the client as the difference between primary insurance and the total fee will be the responsibility of the client at the time of each visit. If there is an insurance write-off, it will be applied at the time of the visit.

If needed, Link Care is authorized to contact my place of employment and/or insurance carrier to obtain any and all additional information necessary to submit a claim for benefits to the insurance carrier.

I acknowledge by my signature below my agreement to all the terms contained in this Insurance Billing Agreement and acknowledge that I have received a copy of this agreement (when requested).

______________________________________ ______________________

Signature of Client Date

LINK CARE CENTER

General Information for Clients/Informed Consent

The following document will provide you with general information, as well as some specific procedures, relative to your receiving counseling services at Link Care Center. If you have any questions or need clarification regarding this information, please discuss this with your counselor.

Urgent Calls

If you have ***a life-threatening emergency, it is important that you immediately dial 911*** for assistance. This will ensure the most immediate response to your situation.

If you have an urgent need during normal business hours, contact the counseling office at (559) 439-2647 and dial “0” to speak with the receptionist. Every effort will be made to contact your counselor who will return your call as soon as reasonably possible. If you have an urgent need outside of normal business hours or on a holiday and wish to speak with your counselor, call the Link Care answering service at (559) 490-6389. Inform the answering service operator that you have an urgent need and indicate that you desire to speak with your counselor as soon as possible. The answering service operator will attempt to contact your counselor so that he or she can return your call. In the event that the answering service operator is unable to contact your counselor, an on call counselor will be contacted and return your call as soon as possible. Urgent calls placed to your counselor may be billed at your standard hourly rate.

Session Length

Counseling sessions involve 45 to 50 minutes of face-to-face time with your counselor. Please make every effort to arrive on time for your sessions since your counselor, in most cases, will be unable to extend your session time to make up for a late arrival.

Missed Appointments

Appointments must be cancelled 24 hours prior to their scheduled time. Failure to provide 24 hours notice of cancellation will result in a $25.00 cancellation fee. This fee will not be covered by your insurance company and will need to be paid prior to attending your next session.

Concerns Regarding The Therapeutic Process

It is our desire that your therapeutic experience at Link Care Center will be positive and healing. Unfortunately, we cannot guarantee that a favorable outcome will result and in some cases things could get worse. If you have concerns about the counseling process, it is important to immediately discuss this with your counselor. If you are unable to resolve your concerns, you may wish to ask your counselor to assist you by providing a referral to another counselor. If you wish to speak with a Link Care Center administrator, you may contact the Executive Director (Phillip M. Collier, Ph.D.; phone: (559) 439-2647, Ext. 135) to discuss your concerns.

PLEASE TURN OVER AND COMPLETE OTHER SIDE

Email Policy

Link Care Counseling Center does not provide counseling services on line. Email should not be viewed as a reliable means of communicating with your counselor. In the event that you choose to email your counselor, your counselor may or may not respond to your email. While all email accounts at Link Care Center are secure, Link Care is unable to assume any responsibility for email responses maintained by your computer or personal email providers.

Public Contact

Maintaining confidentiality is a high priority of all counselors of Link Care Center. In the event that you encounter your counselor in a public place, your counselor will not acknowledge you or approach you. This is to maintain your confidentiality in the counseling relationship. If you choose to approach or greet your counselor in a public setting your counselor is then free to respond.

Ending Counseling

In the event that you choose to discontinue counseling, it is important that you discuss ending counseling with your counselor. If you elect to discontinue counseling and do not inform your therapist, he or she will leave you a message requesting that you contact him or her regarding the status of your counseling. Should you elect not to contact your counselor, it will be assumed that you have chosen to discontinue the counseling relationship. You are strongly encouraged to contact your counselor so he or she can assist you by providing referrals to other counselors and establish an appropriate conclusion of the counseling relationship.

oOo

I have received a copy of and reviewed the ***General Information for Clients*** form.

____________________________________ _______________________
Name Date

____________________________________ _______________________
Witness Date

FINANCIAL RESPONSIBILITY AGREEMENT

In consideration of services received from Link Care Center, I hereby agree to pay the full amount of all charges and fees rendered by Link Care Center to me or to someone for whom I am responsible. I understand I will be required to pay for counseling services prior to each appointment. The fee will be collected by the receptionist. The fee collected will be either the full fee or the full amount of any co-pay.

I hereby agree and understand that for all services rendered to me or to someone for whom I am responsible I am responsible to pay the amount of $__________ per hour. Whether or not an insurance company is billed and/or pays insurance benefits, I understand that I will remain responsible for all charges. My copay before each session is $__________ after $__________deductible is met. When we bill insurance, the above co-pay is an estimate until we receive payment and an explanation of benefits from your insurance company.

As a courtesy, Link Care agrees to bill insurance companies on my behalf, and I agree that all insurance benefits to which I am entitled may be collected by Link Care. I hereby assign to Link Care all insurance benefits to which I am entitled for the services rendered by Link Care. I agree to provide sufficient information of insurance coverage to allow Link Care to contact my insurance carrier and obtain insurance benefits to which I or someone for whom I am responsible is entitled. I authorize Link Care to provide the insurance carrier information necessary to verify entitlement to insurance benefits. In the event the information I provide to Link Care is insufficient to contact the insurance carrier and obtain benefits or is insufficient to satisfy the requirements of the insurance carrier, Link Care is authorized to contact my place of employment and/or insurance carrier to obtain any and all additional information necessary to submit a claim for benefits to the insurance carrier.

If payment expected from an insurance company or any other person or group is not received by Link Care within sixty (60) days from billing by Link Care, I hereby agree to pay the full amount of any remaining balance. I agree to pay the remaining balance within thirty (30) days of the date Link Care mails to me at my last known address a request for payment. Should any balance remain unpaid thirty (30) days after Link Care mails a request for payment to me at my last known address, I agree to pay attorneys' fees, all collection expenses, interest at the legal rate from the date the services were rendered and incidental expenses associated with collection activities.

CANCELLATION OF APPOINTMENTS

I agree to notify Link Care Center at least 24 hours in advance of my scheduled appointment of the need to cancel or reschedule. Failure to provide 24 hours notice of cancellation will result in a $25.00 missed appointment fee. This fee will not be covered by my insurance company and will need to be paid prior to attending my next session.

I acknowledge by my signature below my agreement to all of the terms contained in this Financial Responsibility Agreement and acknowledge that I have received a copy of this Agreement.

____ ____________________

Signature of Client *Date*

____

Printed Name

____ ____________________

Signature of Witness *Date*

____

Printed Name

LINK CARE COUNSELING CENTER

LIFE HISTORY QUESTIONNAIRE

The purpose of this questionnaire is to obtain a comprehensive picture of your background. By completing these questions as fully and as accurately as you can, you will facilitate your own therapeutic program at Link Care. You are requested to answer these routine questions in your own time instead of using up your actual consulting time. Please try to answer all of the questions. However, if a question does not apply to you or if you do not wish to reply at this time, please indicate so and then continue on. If you need more space to answer, please use the back of the page or use a blank piece of paper and attach it to this questionnaire.

If a spouse or other family member is also to be in therapy with you, please complete separate questionnaires and do not consult about your answers. Remember, we want to know how you think and feel, and not how you believe someone else would want you to respond.

It is understandable that you might be concerned about what happens to the information you give, because much or all of this information is highly personal. Consequently, your care records are kept strictly within professional confidence.

PERSONAL HISTORY

Your name: ______________________________

Ethnicity: ____________ Birth date: ____________ Birth place: ____________

Mother's condition during pregnancy (e.g., drug use, prematurity, difficult delivery, etc.):

____

Check any of the following that apply to your childhood:

Night terrors	Bed-wetting	Sleep walking	Often called a liar
Nail biting	Loneliness	Abuse/sexual abuse	Unhappy childhood
Happy childhood	Fears	Stammering	Ran away from home
Poor health	Fighting	Memory gaps (after age 5)	Frequent moves/ relocations

Other:

____

List any significant events or crises that occurred to you and/or your family as you were growing up:

____

____

____

What is the last grade of schooling that you completed? ____________

What sort of student were you (i.e., C student, A student, etc.)? ____________

What did you do for fun (including extracurricular activities)? ____________

____

How did you get along with your teachers? ____________

How did you get along with your peers? ____________

Did you make friends easily? ____________ Did you keep them? ____________

Briefly describe your dating history (include age at first date): ____

____

____

Please give a brief outline of your sexual history (include parents' attitudes, when you first became aware of sex and your own sexual impulses, any anxieties or guilt regarding sexual orientation, and satisfaction with present sex life): ____

____

____

____

Are you employed; if so, what do you do? ____

How long have you been employed there? ______________ Do you enjoy it? Why? __________________

____

What was your previous job? ____

Why did you leave? _____________________________________ How long were you there? _____________

What ambitions do you have? ____

____

MEDICAL HISTORY

Please list any medications you are currently taking: ____________________________________

____

When were you last examined by a medical doctor? ____________________________________

Please list any significant physical conditions you have: _________________________________

____

Please give dates of any previous hospitalizations and reasons (physical and/or emotional) for these hospitalizations: ____

____

MARITAL HISTORY

How long have you been married? ______ How long did you know your spouse before engagement? ________

Spouse's name: ______________________________ Age: ________ Occupation: ______________________

Names and ages of natural children: ____

Names and ages of stepchildren: ____

Have you had any other pregnancies? If so, what happened to these pregnancies (e.g., miscarriages, stillbirths, abortions)? ____

Please describe the personality of your spouse: ______________________________

In what areas is there compatibility? ______________________________

In what areas is there incompatibility? ______________________________

Please give details of any previous marriage(s), including name of spouse, years married, children, and reasons for any divorces: ______________________________

SPIRITUAL HISTORY

What is your religion and/or denomination? ______________________________

Check the word which best describes how often you attend worship services:

Regularly Occasionally Rarely Never

Please describe the type of religious training you received growing up: ______________________________

What image comes to mind when you think of God? ______________________________

Briefly describe how your religion influences your daily life now: ______________________________

Are there significant differences within your family (spouse, children, parents, etc.) concerning religious preferences or beliefs? Give details. ______________________________

FAMILY HISTORY

Name of father: ______________________ Age (current or at time of death): __________

If deceased, cause of death: ______________________________

Your age at the time of his death: __________ Father's occupation: ______________________

Please describe your past and present relationship to your father: ______________________________

____

____

____

Name of mother: ______________________________ Age (current or at time of death): __________

If deceased, cause of death: ______________________________

Your age at the time of her death: __________ Mother's occupation: ______________________________

Please describe your past and present relationship to your mother: ______________________________

____

____

____

Please provide details regarding stepparents, if any: ______________________________

____

Names and ages of brothers: ______________________________

____

Names and ages of sisters: ______________________________

____

Stepbrothers and stepsisters: ______________________________

____

Describe the atmosphere of the home in which you grew up (e.g., quality of your parents' marriage, how you were disciplined, whether you could confide in your parents, etc.):

____

____

____

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____

Has any member of your family suffered from alcoholism or a serious emotional difficulty? Please give details:

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HISTORY OF DIFFICULTIES

Briefly describe the nature and development of your concerns: ______________________________

Approximately how long ago did these problems arise (if less than two years, please include months and weeks)?

Years: ____________ Months: ____________ Weeks: ____________

Check any of the following that have applied to you recently:

- Poor appetite
- Trouble sleeping
- Significant weight loss or gain
- Decreased sex drive
- Suicidal thoughts
- Fatigue
- Guilt feelings
- Worthless feelings
- Trouble concentrating
- Thoughts racing
- Sickly
- Defiant
- Increased sex drive
- Explosive
- Tense
- Anxious
- Heart pounding
- Irrational fears
- Unwanted recurring thoughts or behaviors
- Restlessness
- Jitteriness
- Irritable
- Nauseous
- Worrisome
- Dizziness
- Physical pain
- Physical problems
- Easily distracted
- Sexual problems
- Sexual confusion
- Impulsiveness
- Unusual experience
- Nightmares or recurring dreams
- Drug use
- Excessive drinking
- Extra energy
- Feel unreal, as in a dream
- Time loss
- Flashbacks
- Blank spells
- As if another person is inside
- Withdrawn
- Suspicious
- Perfectionist
- Fear of being alone
- Aggressive
- Misunderstood
- Difficulty making friends
- Stubborn
- Overly criticized
- Helpless
- Angry
- Unappreciated
- Difficulty keeping job

Other: ______________________________

ADDITIONAL INFORMATION

Please add any information not asked in this questionnaire that may help your therapist to understand and help you: ____

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What benefits do you hope to obtain from therapy? ______________________________________

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