Kavita A. Hatten, MS LPC
www.phoenixcounseling.net
(480) 598-9540

# PERSONAL INFORMATION

## CLIENT INFORMATION

| | | | | |
|---|---|---|---|---|
| Last name: First: Middle: | | | Marital status (circle one)<br>Single / Married / Widowed / Divorced / Partner | |
| Best phone # to leave message on:<br>( ) | Email: | Birth date:<br>/ / | Age: | Sex:<br>❑ M ❑ F |
| Street address: | | | Contact phone:<br>( ) | |
| P.O. box: | City: | State: | ZIP Code: | |
| Occupation: | Employer: | Employer phone:<br>( ) | OK to contact at work?<br>❑ Yes ❑ No | |
| Student status: ❑ Full-time ❑ Part-time<br>Referred to by (please check one box):<br>❑ Physician ❑ Insurance Plan ❑ Hospital ❑ Family / Friend ❑ Work ❑ Internet ❑ Other | | | | |
| PCP Name: | Number: | | | |

## INSURANCE INFORMATION (RESPONSIBLE PARTY)

| | | | |
|---|---|---|---|
| Name of Primary Insurance Company or Behavioral Health Plan: | | Name of primary (subscriber): | |
| Insurance Contact#: | | Client relationship to primary: ❑ Self ❑ Spouse ❑ Child ❑ Other | |
| Sex:<br>❑ M ❑ F | Birth date:<br>/ / | Group#: | Policy#: |
| Primary Insured Employer: | | | |
| Primary Insured's Address: | | | |
| ***Please note that I only accept the following insurance providers. Alternatively, I can accept you as a self -pay client and provide an insurance receipt for you to submit to insurance for reimbursement.<br>Please indicate payment type: ❑ Aetna ❑ Lyra Health ❑ Self-Pay | | | |

## IN CASE OF EMERGENCY

| Name of local friend or relative: | Relationship to client: | Mobile/home/work phone: |
|---|---|---|
| | | |

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Kavita A. Hatten. I understand that I am financially responsible for any balance and non-covered services, including any late cancellations and no-show sessions. I also authorize Kavita A. Hatten P.C. or insurance company to release any information required to process my claims.

❑ By checking this box, I also agree to be contacted via email by the office of Kavita A. Hatten, P.C.

Client / Parent / Guardian signature: ____________________ Date: ____________

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# INFORMED CONSENT

This document contains important information about my professional services and business policies. Please read it carefully and ask questions if you have any. Once you sign this, it will constitute your consent for us to begin therapy/treatment.

## Background and Services

I am a Licensed Professional Counselor and National Board Certified Counselor and have been in field of mental health, counseling and psychotherapy for over 25 years working with individuals and families. I received my Master's degree from Wright State University in 1991, and have been in private practice in Phoenix since 1999. I primarily use cognitive-behavioral therapy approaches in my practice. I specialize in relationship issues, self-esteem, women's issues, codependency, life transitions, and the treatment of depression and anxiety. I currently work with adults and adolescents in my practice on an individual basis. Please note: I do not provide marital therapy/couples counseling or family therapy. I do not provide services related to custody, disability evaluations or provide work leave (FMLA). I do not specialize in eating disorders or substance abuse issues. Although I have many years of experience, there is a chance that my skills and expertise are not a good match for your needs. In that case, I would be happy to refer you to an appropriate resource or provider at any time if a need arises.

## Financial Terms

Payment is expected at the time of service. I accept payment by cash, check, Visa/MasterCard/Discover, and Health Savings Accounts. By signing this document, you are agreeing to pay for the services rendered and any additional expenses that may be accrued. The fee for a 60-minute initial assessment is $175.00 and the fee for a 50 to 55-minute counseling session is $150.00. The rate for teletherapy (audio/video sessions) is at the same rate as face-to-face sessions. These fees are available upon request and I reserve the right to change my fees with a 30-day notice. There is a service charge of $30.00 for all returned checks. You have the right to be informed of all fees that you are required to pay as well as my refund and collection policies. Should you have difficulty paying for sessions, please discuss it with me as we may need to meet less frequently. I do not slide my scale, however I can refer you to counseling agencies that provide therapy on a sliding scale. Please note: I cannot ethically accept "barter" for therapy.

## Insurance

I am a preferred provider for Aetna and Lyra Health. If you are using one of these insurance providers to pay for your treatment, the terms that govern the plan will apply such as copayments, deductibles, and coinsurances. I will bill your insurance carrier on your behalf and they will pay me directly under the terms of your plan. I only bill primary insurance which I'm in-network, not secondary. You will be responsible for any co-pays/deductibles/coinsurances at the time of service. In cases that I do not accept your insurance or you prefer to pay "out-of-pocket", I can provide you a receipt that you can submit to your insurance for reimbursement. In all cases however, payment for services is ultimately your responsibility, not the insurance company. Your insurance company may limit the number of sessions based on their assessment of medical necessity or other factors. Their determination may or may not match what you want or feel you need in therapy. In the event that they will not authorize additional sessions or you exhaust the sessions your insurance authorizes, you understand that you will be responsible to pay for any additional services rendered. Using a third party for services implies that some information will be released (such as clinical information and a diagnosis code) in order to obtain payment for services or authorization for treatment. See the HIPAA Notice of Privacy Practices for more information.

## Appointments

Regular attendance at your scheduled appointments is one of the keys to a successful outcome in therapy. A scheduled appointment means that a time is reserved only for you. I reserve 50-55 minutes for each client. I ask that you notify me with one business day (24 hours) prior to your appointment if you need to cancel or reschedule. You will be charged for appointments that you fail to cancel in accordance with this policy, including clients that use their insurance benefits for therapy. I am unable to bill the insurance company for missed visits and may be unable to fill the time that was reserved for you. The fee for a missed or late canceled appointment is $50.00. You are responsible for paying the missed appointment fee prior to your next appointment. Repeated late cancellations or missed appointments may result in termination of treatment. Please speak with me if you are having difficulty keeping your appointments.

## Emergency Procedures

My practice does not have the capability to respond immediately to counseling emergencies. True emergencies should be directed to the community emergency services (911) or to any of the following crisis hotlines: **Empact – 480 –784 – 1500 or Maricopa County Crisis Line – 602 – 222 – 9444** If you need to contact me, leave a message at my office (480 - 598 - 9540) and your call will be returned at the first opportunity. Please note that an immediate response is not guaranteed as I may be in session or out of the office. Urgent calls will be taken for true crisis matters and lengthy phone consultations will be billed at the rate of $150.00 per hour.

## Records

This protocol applies only to the records of clients of Kavita A. Hatten, MS, LPC, PC. This protocol does not apply to records that are not medical in nature, including records of business transactions, consultations, presentations, training in all forms, and other records generated in the normal conduct of the business of the corporation. Please review this section carefully.

Secure Storage: Client records will be protected from access by unauthorized persons at all times. Records of clients will be secured at all times in a locked filing cabinet in the counseling office of Kavita A. Hatten. The content of client records will include personal data, dates of service, types of fees, credit card authorizations, reports, assessments, and basic clinical information about the session – commonly referred to as a "progress note". If you are an adult, records will be kept for 7 years after our last contact. Records involving children will be kept for 6 years after the minor child has turned 18, or 6 years after the last date of service, whichever is later. When records are destroyed, they will be shredded to maintain confidentiality of the protected health information. Beginning April 15, 2020, we will be transitioning to a "paperless" office and new client files will be stored electronically in software that is HIPAA compliant.

Access: Access to client records is restricted to the primary therapist, Kavita A. Hatten. Clients have the right to access their records upon written request in accordance with the state law and federal HIPAA regulations. After review of the written request and signed release of information, to ensure compliance with all ethical requirements, I will provide the requested information to the client and/or requestor. I reserve the right to deny requests for written reports or copies of the clinical records within the limits of the law, and in situations where it such a release may create danger to the client or others.

Transfer: In the event of death or incapacity of the primary therapist, the clients that are actively receiving services (seen in the last three months) will be given to another designated licensed behavioral health professional to facilitate the continuation of treatment. In such a situation, the client has the right to continue treatment with this professional, discontinue treatment or ask for a referral. Records for inactive clients will also be handled by a designated behavioral health professional and will be responsible for satisfying record requests and destroying records within legal timeframes.

## Privacy Practices and Confidentiality

Sessions between a client and therapist are strictly confidential. No information will be released without the client's written authorization and consent. An authorization for release of information is written permission allowing information to be disclosed to a specific party. Protected Health Information (PHI) is information that identifies you in a medical or mental health record. I may use or disclose PHI for purposes of treatment, payment or healthcare operations with your consent. When mandated by law, I may disclose your PHI without your consent or authorization in certain circumstances. Please review the HIPAA Notice of Privacy Practices (included in this packet) which details the considerations regarding confidentiality, privacy and your records.

## Peer Consultations

I sometimes participate in peer consultations where client cases are discussed with professional colleagues to facilitate my continued professional growth and to give you the benefit of a variety of professional expertise. While no identifying information is revealed during this peer consultation process, the individual and dynamics of the problem are discussed along with treatment approaches.

## Legal Considerations

In efforts to provide a safe and unbiased therapy environment, it is important that you agree not to call me as a witness or to attempt to subpoena clinical records in the event you are involved in a legal proceeding (divorce, custody, civil litigation etc.). I am not an expert witness or provide expert testimony. If you need an evaluation for legal reasons, I will make a referral to an outside professional who can assist you in this service. In signing this agreement, you agree that you will not call me as a witness to testify or to expect recommendations or other involvement in your legal proceedings. In the event that client records are requested via a court order, I will review the request first with you. In the event that law requires disclosure of your record, you will be responsible and shall pay any costs involved in producing the records and for the time involved in preparing for and giving testimony. Such payments, at the rate of $300.00 per hour, are to be made at the time or prior to the time I render these services.

## Purposes, Limitations and Risks of Treatment

While the ultimate purpose of therapy is to reduce your distress through a process of personal change, there are no guarantees that the treatment provided will be effective or useful. Moreover, the process of therapy usually involves working through difficult personal struggles that can result in some emotional or psychological pain for the client. Attempting to resolve the issues that brought you to therapy may result in changes that were not originally intended and could include decisions about changing behaviors, employment, education, relationships, or virtually any other aspect of your life. Sometimes, a decision that is positive for one family member may be viewed negatively by another. Often, growth cannot occur until you confront the issues that may induce sadness, fear or anxiety. The success of our work depends on the quality of both our efforts and the realization that you are responsible for lifestyle choices and change that may result from therapy.

## The Therapeutic Relationship

The client/therapist relationship is unique and exclusively therapeutic. In other words, it is inappropriate for a client and therapist to spend time together socially, to bestow gifts or to attend family functions. The purpose of these boundaries is to ensure your privacy, limit misunderstanding or misinterpretations and that our roles in the treatment process are clear. If there is ever a time when you believe you have been treated unfairly or disrespectfully, please talk with me. It is never my intention to cause this to happen, but sometimes misunderstandings can inadvertently result in hurt feelings. I want to address any issues that might get in the way of therapy as soon as possible. This includes financial and administrative issues as well. I will not terminate the therapeutic relationship before first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason, I will provide you a list of therapists that can treat you.

## Treatment Process and Rights

Your therapy will begin with one or two sessions devoted to an initial assessment so that I can get a good understanding of your issues, your background, any other factors that may be relevant, and your goals for treatment. We will then begin therapy and discuss ways to treat the problem(s). You have the right to participate in treatment decisions and the development of your treatment plan. You also have the right to refuse any recommended treatment or to withdraw consent to treatment or be advised of the consequences of such refusal or withdrawal. I request that you discuss with me your concerns before discontinuing treatment.

## Office Policies

The best way to reach me is to call my office **(480-598-9540)** and leave a message on my confidential voicemail or send an email to kavita@phoenixcounseling.net. I do not send or reply to text messages. I keep email communication limited to scheduling purposes. Also, on occasion I may email information regarding books, groups or other resources that I may think would be helpful to you in the course of your treatment. Please note that email communication is not an entirely confidential form of communication. I may use electronic transmission, such as fax to send treatment plans, reports or releases to another provider or to you, and you may also fax information to me. To ensure the privacy and confidentiality of the client, I do not accept friend requests from current or former clients on any social networking site.

## CONSENT FOR EVALUATION AND TREATMENT / AGREEMENT

I have read this information full and completely; I have discussed any questions I have about this information, and I understand and agree to this information.

I do hereby give consent for evaluation and treatment under the terms described in this consent document and the HIPAA Notice of Privacy Practices. It is agreed that either of us may discontinue the evaluation and treatment at any time and that you are free to accept or reject the treatment provided.

Signature of Client ______________________________________________________ Date_________________

In the case of a MINOR CHILD, I/We hereby state that I am the legal parent or legal guardian of (minor child) _______________________________________________ and therefore, I am authorized to make this request for and give my consent to assessment and treatment services for my child.

Signature of Parent or Guardian __________________________________________________ Date_________________

Signature of Parent or Guardian __________________________________________________ Date_________________

## CONFIDENTIALITY WITH ADOLESCENTS (IF APPLICABLE)

When counseling adolescents, the therapy process requires information to remain confidential between the therapist and the minor child in order to develop rapport and trust. By signing this statement, I understand that some information may not be shared with me. Effort will be made by the therapist to promote open communication.

Signature of Parent or Guardian __________________________________________________ Date_________________

Signature of Parent or Guardian __________________________________________________ Date_________________

Kavita A. Hatten, MS LPC
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# NOTICE OF PRIVACY PRACTICES

This notice describes how your health information is protected and confidential. It also describes those circumstances where it may be used and disclosed in counseling and how you can get access to this information if you wish to do so. Please review it carefully.

UNDERSTANDING YOUR PROTECTED HEALTH INFORMATION (PHI)

Except in the instances described in this Notice, the information you share with your counselor is confidential to this office only. It is our objective to follow, at all times, the Federal and State laws applicable to psychological and substance abuse services under HIPAA standards or the federal Health Insurance Portability and Accountability Act, 45 CFR Part 464 (HIPAA).

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I may use or disclose your protected health information (PHI) for treatment, payment and health care operation purposes with your consent.

- PHI: refers to information in your health record that could identify you.
- I may use or disclose PHI for purposes outside of treatment, payment, or health care operation when your appropriate authorization is obtained. Authorization" is written permission above and beyond the general consent that permits only specific disclosures.
- You may revoke all authorizations of PHI at any time, provided such revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization or (2) If the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

USES AND DISCLOSURES WITH NEITHER CONSENT NOR AUTHORIZATION

I may use or disclose PHI without your consent or authorization in the following circumstances. These are exceptions to and Limitations of Client Confidentiality:

- Disclosures for threats to safety : If you communicate to me an explicit threat of imminent serious physical harm or death to a clearly identified or identifiable victim(s) and I believe you have the intent and ability to carry out such a threat, I have a duty to take reasonable precautions to prevent the harm from occurring, including hospitalization procedures. I have a duty to warn others of a threat. If you believe there is an imminent risk that you will inflict serious harm on yourself, I may disclose information in order to protect you.
- Child Abuse: I am required to report PHI to the appropriate authorities when I have reasonable grounds to believe that I minor is or has been the victim of neglect or physical and/or sexual abuse. A report may be made to the appropriate government authorities without seeking authorization.
- Adult and Domestic Abuse: If I have the responsibility for the care of an incapacitated or vulnerable adult, I am required to disclose PHI when I have a reasonable basis to believe that occurred. I am required by law to report situations in which I believe elder abuse or neglect has occurred. This report may be made to the appropriate government authorities without seeking authorization.
- Judicial and Administrative Proceedings, Court Orders, and Subpoenas : If you are involved in a court proceeding and a request is made for information about the professional services I provided you and/or the records thereof, such information is privileged under state law, and I will not release information without the written authorization of you or your legally appointed representative or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case. The mere issuance of a subpoena does not indicate that a privileged communication is now open for discussion. I must still assert the privilege until you waive it, or unless a judge orders the privilege to be waived.
- Health Oversight Activities : If the Arizona Board of Behavioral Health Examiners is conducting an investigation, then I am required to disclose PHI upon receipt of a subpoena from the Board.
- Workers Compensation : I may disclose PHI as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

I am required by law to make disclosures of your PHI upon your request and maintain the privacy of your PHI and provide you with notice of our legal duties and privacy practices with respect to your PHI. I reserve the right to change the privacy policies and practices described in this notion, unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will provide you a copy of any revised notice of Privacy Practices at your request.

This notice went into effect on April 14, 2003.

Kavita A. Hatten, MS LPC
www.phoenixcounseling.net
(480) 598-9540

## ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I have read, understood, and agreed to the information stated in this document.

____________________________________ ______________
Client signature Date

____________________________________ ______________
Client signature Date

____________________________________ ______________
Parent/guardian signature Date

____________________________________ ______________
Parent/guardian signature Date

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# TELETHERAPY CONSENT

I ________________________________________(name of client) hereby consent to participate in teletherapy with Kavita Hatten, MS, LPC as part of my psychotherapy. I understand that teletherapy is the practice of delivering clinical health services via technology assisted media or other electronic means (interactive video, audio or electronic communications) between a practitioner and a client who are located in two different locations.

I understand that I have the following rights with respect to teletherapy.

1) I have the right to withdraw consent at any time without affecting my right to future care or treatment, services, or program benefits to which I would otherwise be entitled.

2) The laws that protect the confidentiality of my protected health information (PHI) also apply to teletherapy unless an exception to confidentiality applies. I understand that the information disclosed by me during the course of my therapy is confidential. However, there are mandatory exceptions to confidentiality, including, but not limited to reporting child, elder, or vulnerable adult abuse, danger to self or others; and where I make my emotional/mental health an issue in a legal proceeding.

3) There will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization/consent, except where the disclosure is permitted and/or required by law.

4) I understand that there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of the psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons, and/or limited ability by the psychotherapist to respond to emergencies.

5) I understand that teletherapy services and care may not be as complete as face-to-face services. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services, higher levels of care etc.) due to suicidal/homicidal thoughts or if I'm experiencing a mental health crisis, I will be referred to a psychotherapist who can provide such services in the area.

6) I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and efforts of my psychotherapist, my condition may not improve, and in some cases may even get worse. I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured.

7) If during a teletherapy session we encounter technical difficulties resulting in service termination and we are unable to restart the session within 10 minutes, please call 480-598-9540 to discuss how to reschedule.

8) I will ask you a few questions at the beginning of each session to include your location and emergency contact person and their telephone number in the event of a life-threatening emergency.
(24 hour Maricopa County Crisis: 602-222-9444; Empact Crisis Line: 480-784-1500)

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

____________________________________ ______________________
Signature of Client/Parent/Legal Guardian Date

____________________________________ ______________________
Signature of Therapist Date

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## CREDIT CARD AUTHORIZATION AGREEMENT

By completing and signing this form, I authorize Kavita A. Hatten, MS, LPC/Kavita A. Hatten, P.C. , to charge my credit card for outpatient counseling services, missed sessions, sessions cancelled with less than 24 hours notice, and any unpaid balances.

- I understand that my credit card will be charged for any applicable co-pays, or deductibles/co-insurance if I am using my insurance for services.
- I understand that my credit card will be charged $175 per session for the initial evaluation and $150 per session for follow-up counseling sessions if I am a self-pay client.
- I understand that my credit card will be charged for appointments cancelled less than 24 hours in advance and for any no-show sessions. The charge for this is $50 per appointment missed. This applies to all clients - insurance and self-pay clients.
- I understand that my credit card will be charged for services provided for scheduled counseling appointments on the day of the scheduled appointment, as will my credit card for any late canceled appointments and no-shows sessions.
- My credit card statement will be my sole receipt, but I will be provided with a printed copy of the transaction upon request at the next scheduled appointment.

Credit Card Type: ________ Visa ________ Master Card ________ Discover

Credit Card Number: ____________________________________________________________

Card Verification Code: (Last 3 digits after the credit card number in the signature area on the back of the card.):
___________

Expiration Date: _____ /_____

Billing Address (for which the credit card statements are mailed to, including house number and zip code.):

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

---

Client's Name (Please print): ______________________________________________________

Cardholder's Name (Please print): __________________________________________________

Cardholder's Signature ________________________________ Date ____________________

Contact telephone number for Cardholder ____________________________________________

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# ADULT INTAKE

## Problem Inventory

Below is a list of concerns commonly reported by people seeking counseling. To facilitate the best assessment of your current situation, please circle the number indicating the degree to which each item is presently a concern for you.

Please use the following scale: Not at all – 1 A little bit – 2 Quite a bit – 3 Extremely – 4

| Concern | Rating |
|---|---|
| Dealing with stress or pressure | 1 2 3 4 |
| Feeling sad, depressed or blue | 1 2 3 4 |
| Easily emotional or drastic mood changes | 1 2 3 4 |
| Feeling unmotivated or low energy | 1 2 3 4 |
| Problems with memory or difficulty concentrating | 1 2 3 4 |
| Procrastination or difficulty completing home/work tasks | 1 2 3 4 |
| Difficulty with organization | 1 2 3 4 |
| Feeling irritable or tense | 1 2 3 4 |
| Feeling angry or hostile | 1 2 3 4 |
| Feeling isolated and uncomfortable around others | 1 2 3 4 |
| Feeling anxious, worried or panicky | 1 2 3 4 |
| Fear of crowds or public places | 1 2 3 4 |
| Worried about money and finances | 1 2 3 4 |
| Problems in relationship with partner or spouse | 1 2 3 4 |
| Abuse in relationship with partner or spouse | 1 2 3 4 |
| Problems with children or family relationships | 1 2 3 4 |
| Concern over values, beliefs, religion or spirituality | 1 2 3 4 |
| Physical, Emotional or Verbal abuse in childhood | 1 2 3 4 |

| Concern | Rating |
|---|---|
| Sexual Abuse in childhood | 1 2 3 4 |
| Concerned about own habits or behaviors | 1 2 3 4 |
| Concerned about someone else's habits or behaviors | 1 2 3 4 |
| Troubled by painful memories/traumatic events | 1 2 3 4 |
| Struggling with self-esteem/self worth issues | 1 2 3 4 |
| Preoccupied with sexual thoughts or urges | 1 2 3 4 |
| Sleep problems – insomnia or oversleeping | 1 2 3 4 |
| Difficulties relating to sexual orientation/identity | 1 2 3 4 |
| Sexual concerns | 1 2 3 4 |
| Somatic complaints – headaches, stomachaches | 1 2 3 4 |
| Physical health problems | 1 2 3 4 |
| Feeling helpless about eating habits | 1 2 3 4 |
| Body image concerns | 1 2 3 4 |
| Grief and Loss of someone or something close to you | 1 2 3 4 |
| Problems on the job | 1 2 3 4 |
| Thoughts of harming yourself | 1 2 3 4 |
| Thoughts of harming others | 1 2 3 4 |
| Concerns about my alcohol or drug use | 1 2 3 4 |

Presenting Problems:

Why are you seeking counseling? Describe the main problem as well as other problems.

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

How long have you known about the problem(s)?

______________________________________________________________________________

What have you tried to do to deal with the problem(s)?

______________________________________________________________________________

List possible causes of the problems or contributing factors.

______________________________________________________________________________

______________________________________________________________________________

What are you goals for therapy?

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Family Members and Others currently living in your Household:

| Name | Relationship | Age | Marital Status |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Education and Employment History:

Education: ______________________________________________________________________

Employer:_____________________________ Occupation:_________________________________

How many hours per week are you employed? ____________________________________________

How long have you worked at your current job? __________________________________________

Have you ever been fired or let go from a job? ___________________________________________

If so, please explain circumstances: __________________________________________________

Has there been a major change in your income in the past 12 months or has your income stopped? ❑ Yes ❑ No

Legal History:

Have you ever been arrested? ❑ Yes ❑ No Circumstances_________________________________

Are you presently on probation? ❑ Yes ❑ No

If yes, please explain:________________________________________________________

______________________________________________________________________________

Are you currently, or have been involved in legal proceedings? ❑ Yes ❑ No

If yes, please explain:________________________________________________________

______________________________________________________________________________

Marital/Partner History:

Are you married? ❑ Yes ❑ No Do you have a partner? ❑ Yes ❑ No
Length of present marriage or relationship:_______________________________________________
How many times have you been married, including current marriage? ___________________________

From:_____________ To:_______________ From:______________ To:___________________
From:______________ To:______________ From:______________ To:___________________

Have you ever been separated? ❑ Yes ❑ No Yes, how many times? ________________________
If yes, for how long were you separated?
_____________________________________________________________________________

How many children do you have? __________

# of Biological children:______ Age: _____ Sex: _____
# of Step-children:__________ Age: _____ Sex: _____
# of Adopted children:_______ Age: _____ Sex: _____

How many children live currently in the household? ________________

Are you currently in legal proceedings over custody or divorce? ❑ Yes ❑ No
If yes, please explain:___________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

Counseling History:
Currently in counseling? ❑ Yes ❑ No Have you been in counseling in the past? ❑ Yes ❑ No
Have those issues been resolved? ❑ Yes ❑ No

Therapist Name:______________________________ Dates of counseling:______________________________

Therapist Name: ______________________________ Dates of counseling:______________________________

Therapist Name: ______________________________ Dates of counseling:______________________________

Mental Health History:
Have you ever been hospitalized for a psychiatric reason? ❑ Yes ❑ No
If yes, please indicate where and when:_____________________________________________

Do you presently have a psychiatrist that you are seeing? ❑ Yes ❑ No
If so, please indicate name/address/telephone number of psychiatrist:
_____________________________________________________________________________
_____________________________________________________________________________

Substance Abuse/Compulsive Behavior History:

Have you ever been hospitalized for a substance abuse problem or any type of compulsive behavior or addiction?
❑ Yes ❑ No If yes, please indicate where and when:
_____________________________________________________________________________
_____________________________________________________________________________

Are you or have you ever been concerned that you might have a compulsive problem or addiction?
❑ Yes ❑ No Please explain:__________________________________________________
_____________________________________________________________________________

Childhood Trauma History:
Experienced physical abuse as a child? ❑ Yes ❑ No Emotional/psychological/verbal abuse? ❑ Yes ❑ No
Sexual abuse? ❑ Yes ❑ No

Other Traumatic Events : ____________________________________________________________

____________________________________________________________

Family History :

| Paternal Side | |
|---|---|
| Depression | ❑ Yes ❑ No |
| Anxiety | ❑ Yes ❑ No |
| Alcohol/Drug Addictions | ❑ Yes ❑ No |
| ADHD | ❑ Yes ❑ No |
| Other Mental Health Issues | ❑ Yes ❑ No |

| Maternal Side | |
|---|---|
| Depression | ❑ Yes ❑ No |
| Anxiety | ❑ Yes ❑ No |
| Alcohol/Drug Addictions | ❑ Yes ❑ No |
| ADHD | ❑ Yes ❑ No |
| Other Mental Health Issues | ❑ Yes ❑ No |

Medical History/Medication :
Please include all medication including over-the-counter medication and vitamins/supplements.

| Current Medication | Dose/Frequency | Prescribing Physician | Start Date |
|---|---|---|---|
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Health History:

| | | | | |
|---|---|---|---|---|
| Cardiovascular Disease | ❑ Yes ❑ No | | Neurological Disorders | ❑ Yes ❑ No |
| Thyroid Abnormalities | ❑ Yes ❑ No | | Cancer | ❑ Yes ❑ No |
| Hypertension | ❑ Yes ❑ No | | Tuberculosis | ❑ Yes ❑ No |
| Diabetes | ❑ Yes ❑ No | | Respiratory Disease | ❑ Yes ❑ No |
| Liver Disease | ❑ Yes ❑ No | | Head Injuries | ❑ Yes ❑ No |
| Allergies | ❑ Yes ❑ No | | Other: | ❑ Yes ❑ No |

Major Surgeries including dates:____________________________________________________________

____________________________________________________________

____________________________________________________________

Your Strengths :____________________________________________________________

____________________________________________________________

The purpose of this questionnaire is to obtain a comprehensive picture of your background. By completing these questions as fully and accurately as you can, you will facilitate your therapeutic program. You benefit by completing these questions in your own time instead of using your actual consulting time. Case records are strictly confidential. No outsider is permitted to see your case without your written permission. If you do not desire to answer any question, merely write "Do not care to answer."

Signature of Client____________________________ Date______________________________________________