Welcome to my practice! I will do my best to provide you with a useful and meaningful counseling experience. While the heart and soul of therapy is in the therapeutic relationship, some paperwork is required for us to get started. The forms below contain important information and client protections required by law. To make our first meeting more productive, please print, read, and fill out the following documents ahead of time:

(1) There is an AGREEMENT AND INFORMED CONSENT FOR TREATMENT, which outlines my policies and the therapy agreement. If you agree to these terms, please sign and date the document. If you would like a copy for your records, please print two copies.

(2) There is a NOTICE OF PRIVACY PRACTICES, which explains my practices and the federal regulations regarding the use and disclosure of your health information. After reviewing this document, please sign and date the ACKNOWLEDGMENT OF RECEIPT OF THE NOTICE AND PRIVACY PRACTICES.

(3) There is a PAYMENT CONTRACT FOR SERVICES, which further explains my payment policies. If you agree to these terms, please sign and date the document.

(4) Finally, there is the NEW CLIENT INFORMATION SHEET, which will help me to better understand you and make our first few sessions more productive.

Please complete these documents and bring them to your first appointment. If you have any questions, please feel free to contact me by phone or e-mail. We can also discuss your questions during our first meeting.

Before we meet it would also be helpful if you would take some time to think about what you want to get from therapy. You might even make some notes about your goals and what is most important to you, so that we can discuss these together during our first few sessions.

I look forward to meeting with you! If I can provide any additional information, please email me.

Alec Wilson, PsyD

Great Northwest Counseling
3050 SE Division #260, Portland, OR 97214
1033 SW Yamhill #202, Portland, OR, 97205
(503) 757-6259
www.therapistportlandoregon.com
alec@therapistportlandoregon.com

AGREEMENT AND INFORMED CONSENT FOR TREATMENT

Welcome to my practice! I appreciate the opportunity to work with you as a psychologist.

This document (the AGREEMENT) contains important information about my professional services and business policies, as well as summary information about the Health Insurance Portability and Accountability Act (HIPAA). HIPAA is the federal law that provides for privacy protections and patient rights regarding your Protected Health Information (PHI). HIPAA regulations require that I provide you with a NOTICE OF PRIVACY PRACTICES (the NOTICE) regarding the use and disclosure of your PHI. The law also requires that I obtain your signature acknowledging that I have provided you with this information at the start of treatment. Although these documents are long and sometimes complex, it is very important that you read them carefully before signing. You will also receive copies of this information for your records. If you have any questions or concerns about this information, please let me know so that we can address them. When you sign the AGREEMENT, it represents a formal agreement between us. You may revoke this agreement in writing at any time, and that revocation will be binding unless (1) I have already taken action in reliance upon it, (2) there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy, or (3) you have not satisfied financial obligations incurred by you.

PSYCHOLOGICAL SERVICES: Psychotherapy has both benefits and risks. While I expect that you will benefit from therapy, there is no guarantee that your condition will improve. Therapy can even cause disappointing, unexpected, or negative results or outcomes. During the therapy process, you may experience emotional discomfort, changes in your relationships, and/or a worsening of symptoms. These are normal parts of the process, and we will deal with them in therapy. On the other hand, psychotherapy has also been shown to have many benefits. Therapy can lead to better relationships, solutions for specific problems, and significant reductions in distress. To be effective, psychotherapy requires an active investment of time and energy, both during and between sessions. Our first few sessions will serve as an initial evaluation of your concerns, history, goals, and needs. By the end of this evaluation, I will provide you with my impressions of how our work might proceed and with a potential treatment plan. You should consider this information along with your own impressions and your comfort level with me, so that we can decide together whether I am the best person to provide services to meet your treatment goals. Therapy can be a big commitment, so you should select a therapist carefully. If we agree to enter into a therapy relationship, we will typically schedule one 50-minute session per week, although other arrangements are possible. Treatment duration is highly variable, depending on your presenting concerns, the treatment plan, and other factors. During our work together, we will periodically review your goals and progress. I may also request that you have a medical or psychiatric evaluation to aid in treatment. Remember, you always retain the right to request changes in treatment or to refuse treatment at any time and for any reason. However, it is my hope that you will discuss any concerns with me first. If your concerns cannot be resolved, I may be able to provide an appropriate referral to another mental health professional. Your input is always welcome, and I understand that other forms of therapy may be useful.

LEGAL PROCEEDINGS: Psychotherapy is for the improvement of your psychological functioning and is not intended to be used for the purpose of current or future legal proceedings

(e.g., custody, divorce, or civil proceedings). If you are involved in or anticipate becoming involved in any legal proceeding, please notify me as soon as possible. It is important for me to understand how, if at all, your involvement in these proceedings might affect our work.

OFFICE POLICIES: (A) Phone Contact and Emergencies: I use a cellular phone as my primary business line and therefore cannot guarantee absolute privacy. (The same limitation applies to e-mail correspondence.) Email is a great way to contact me for a quick turnaround. I am generally available by phone during business hours, and I check my voice mail several times a day during the day. Phone calls are returned as soon as possible, usually within 24 hours, except on weekends and holidays. I do not answer the phone when I am with clients, and my availability at other times cannot be guaranteed. You may leave a confidential voice mail for me at any time, but messages left after 5:00 pm may not be received until the following morning. Because voice mail technology is not error proof, if you have not heard back from me by the end of the next day, please feel free to call again since it is likely that I did not receive your original message. Please be sure to state if you are calling about an urgent matter. In the case of an emergency, if you cannot reach me, you should call the Multnomah County Crisis Line (503-988-4888), dial 911, or go to the nearest hospital emergency room.

(B) Billing & Fees: Payments are due in full at the time of service, unless we have agreed to other arrangements. Please have payments ready at the beginning of each session. I reserve the right to suspend or terminate treatment if there are unpaid balances on your account. My fees are based on services provided, and my standard and customary fees are as follows. A 50-minute individual session is $165 (or $125). A 50-minute couples' session is $200 (or $150). (I offer an automatic 25% discount for payment at the time of service when there is no requirement for billing or other financial paperwork.)

Fees may also be charged on a pro-rated basis for other professional activities necessary for good clinical care or for professional services you may need or request of me. These include, but are not limited to, time spent writing letters, reports, or treatment summaries on your behalf; telephone consultations initiated by you and lasting over 10 minutes; and consultations with others on your behalf. Clients experiencing financial hardship are invited to raise their financial concerns so that we can discuss payment options. There is a $20 charge for dishonored checks. All standard and customary fees may be reviewed and revised at any time, and I will notify clients of any upcoming changes. Additional payment information can be found in the PAYMENT CONTRACT FOR SERVICES. NOTE: If you become involved in legal proceedings that require my participation, you agree to pay for all of my professional time, even if I am called to testify by another party. This includes, but is not limited to, time spent traveling, consulting with attorneys, attending depositions, reviewing materials in preparation for testimony, giving testimony, and waiting to be called to testify. Because of the difficulty of legal involvement, I charge $200 per hour for preparation and attendance at any legal proceeding.

(C) Appointments and Cancellations: Appointments are made directly with me. If we establish a regular appointment time, I will assume that that time is yours each week, and you must clarify with me if you plan to miss or need to change an appointment. With sufficient notice, appointments can often be rescheduled. Your appointment time is time I have set aside especially for you. If an appointment is cancelled with less than 48 hours notice, it is my policy to bill for that appointment at my full fee. It is important to note that insurance companies do not

reimburse for cancelled or missed appointments, so you will be personally responsible for this fee. If you are late for your session and have not called me, I will keep your time free until 15 minutes after the scheduled start time.

(D) Drugs and Alcohol: A client who attends an appointment under the influence of drugs or alcohol may not be seen. Such an incident will be treated as a missed appointment, and the client may be billed.

HEALTH INSURANCE: I am primarily an out-of-network provider. Please check with your insurer, many plans have coverage for out-of-network psychologists. If you are using health insurance to pay for psychotherapy services, you need to be aware of what this means. Your health insurance plan requires cooperation between the client, provider, and insurance company to provide services as efficiently as possible. In many cases, I will be required to provide information about your treatment as well as a diagnosis. I may also be required to provide additional clinical information, such as treatment plans or summaries, or even copies of your entire Clinical Record. Released information will become part of the insurance company records, and while all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. Health insurance companies may not cover all services or conditions, and they may only cover a limited number of sessions. Some insurance plans require pre-authorization or they will not cover your first meeting, and many require periodic reauthorizations for ongoing treatment. You are responsible for obtaining the initial pre-authorization, if necessary. It would also be very helpful if you would check the specifics of your insurance benefits, if any, prior to our first meeting. You remain responsible for your entire bill regardless of whether insurance covers treatment costs or whether you are the primary insured person. You always have the choice to pay for my services out-of-pocket rather than utilize insurance. While much can be accomplished in short-term therapy, some clients feel that they need more services after insurance benefits end. If you exhaust your benefits but wish to continue therapy with me, we will need to determine whether we can make this happen. If we cannot, I will attempt to help you find treatment that you can afford.

CONFIDENTIALITY AND THE LIMITS OF CONFIDENTIALITY: Confidentiality is the obligation not to disclose any client information obtained during a professional relationship without permission. Confidentiality is a cornerstone of effective psychotherapy, and the law protects confidential communications between a client and a psychologist. Information is never released to anyone, including your spouse/partner or family, without your written consent, except as required by law or ethical guidelines. In the event that there are two or more clients in therapy at one time (e.g., couples or family therapy), written consent must be given by all participating clients before records are released. I will make every effort to protect your confidentiality when I call you by phone. If you have special instructions for how I should leave messages, please let me know. Otherwise, I will generally state my name
and leave a brief message. If we happen to meet outside of therapy, I will not reveal our therapy relationship, and unless otherwise arranged, I will not even acknowledge that I know you. HIPAA allows me to use or disclose confidential information, including but not limited to your Protected Health Information (PHI), for the purposes of treatment, payment, and health care operations, as long as I have your informed written consent, signified by signing this document. For purposes outside of treatment, payment, and health care operations, I can only release your

information if you sign an AUTHORIZATION. However, you should be aware that there are some additional legal and ethical exceptions or limits to confidentiality and some situations in which I am permitted or required to disclose information without your consent or AUTHORIZATION. For more information, please consult the NOTICE OF PRIVACY PRACTICES. I will try to disclose only information that is necessary to meet the needs of the situation.

CONSULTATION: Alec Wilson, Psy.D. consults regularly with other professionals regarding his clients; however, each client's identity remains completely anonymous and confidentiality is fully maintained.

CLINICAL RECORD: As a psychologist, I maintain confidentiality in creating, storing, accessing, transferring, and disposing of records in any medium. Your Clinical Record includes your reasons for seeking therapy, how your life is being impacted, your diagnosis, the goals that we have set for treatment, your progress toward those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. By submitting a written request, you may examine and/or receive a copy of your Clinical Record, except in circumstances where disclosure would be injurious to you or would constitute an immediate and grave detriment to your treatment. In such circumstances, I may provide you with an accurate and representative summary of your Clinical Record, if requested. Professional records can be very confusing and/or upsetting to an untrained reader. For this reason, I recommend that you review them in my presence or with another mental health professional. In most circumstances, I will charge a copying/printing fee of $15 plus 50¢ per page plus any postage. If you wish to review your Clinical Record, please address your request to me, so that we can discuss the best way to make this happen. In addition to your Clinical Record, I may also keep a set of Psychotherapy Notes for my own use. Psychotherapy Notes vary from client to client, but they may include the contents of our conversations, as well as sensitive information that is not required to be included in your Clinical Record. While insurance companies can request and receive a copy of your Clinical Record, they cannot receive a copy of your Psychotherapy Notes without your written AUTHORIZATION. Insurance companies also cannot require such an AUTHORIZATION as a condition of coverage nor penalize you in any way for your refusal. You may request to examine and/or receive a copy of your Psychotherapy Notes unless I determine that such disclosure would be injurious to you. All records and notes are kept double-locked or password protected, and all records are retained for a minimum of seven years as required by law. In the event of your death, the privilege to access your record passes to your estate. In the event of my own incapacitation, withdrawal, or death, another licensed psychologist will assume responsibility for my records.

GROUP THERAPY (if applicable): In group therapy, it is of utmost important that all members maintain confidentiality and neither disclose the content of sessions nor the identity of fellow group members. It is highly recommended that any meaningful exchange outside the group also be discussed in the group. In group therapy, the other members of the group are not therapists. They are not regulated by the same ethics and laws that bind your therapist. The limits of confidentiality and the reporting laws have been outlined earlier in this document. While the expectation is that all group members will maintain confidentiality regarding anything said in the

group, you cannot be certain that they will. You are ultimately responsible for what you say and what you think, feel, or do with the feedback you receive in the group.

Agreement and Consent to Treatment

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ, UNDERSTOOD, AND AGREED TO THE TERMS OF THIS DOCUMENT. YOUR SIGNATURE ALSO SERVES AS AN ACKNOWLEDGMENT THAT YOU HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES DESCRIBED ABOVE.

_____	_____	_____
Client Name	Signature	Date
_____	_____	_____
Client Name	Signature	Date
_____	_____	_____
Parent/Guardian Name (if minor)	Signature	Date

This form has been discussed and a copy given to the client.

_____	_____
Alec Wilson, PsyD	Date

NOTICE OF PRIVACY PRACTICES

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

Understanding the contents of your Clinical Record and how that information is used will (1) help you to better understand when others may have access to your health information and (2) assist you in making more informed decisions when authorizing disclosures. Your record is the physical property of Dr. Alec Wilson; the information within the record belongs to you. In using and disclosing your health information, it is my policy to be in compliance with the Privacy Standards of the federal Health Insurance Portability and Accountability Act (HIPAA).

1. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your Protected Health Information (PHI) for treatment, payment, and health care operations purposes with your consent. To help clarify this statement, the following definitions are provided: "**Use**" applies to activities within my office such as utilizing, examining, and analyzing your PHI. "**Disclosure**" applies to activities outside my office, such as releasing, transferring, or providing access to your PHI. "**Protected Health Information (PHI)**" refers to any individually identifiable health information maintained or transmitted by me that relates to (1) the past, present, or future physical or mental health or condition of an individual; (2) the provision of health care to an individual; or (3) the past, present, or future payment for the provision of health care to an individual. "**Treatment**" is when I provide, coordinate, or manage your health care and other services related to your health care. This includes when I consult with other health care providers, such as your family physician or another psychologist, and when I make referrals. "**Payment**" includes what a health care plan does to collect premiums, determine eligibility and coverage, and provide payments. This includes when I disclose your PHI to your health insurer to determine eligibility or coverage or to obtain reimbursement. "**Health Care Operations**" are activities that relate to the performance, operation, and maintenance of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination. "**Consent**" refers to your consent and agreement, which you indicate by your signature on the ACKNOWLEDGMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES or the AGREEMENT AND INFORMED CONSENT FOR TREATMENT.

2. Uses and Disclosures Requiring Authorization

I may use or disclose confidential information, including but not limited to PHI, for purposes of treatment, payment, and health care operations when your written informed consent has been obtained. I may also use or disclose your PHI for purposes outside of treatment, payment, and health care operations only with your written AUTHORIZATION. An AUTHORIZATION will also be needed before releasing any Psychotherapy Notes. An "**Authorization**" is specific, written permission above and beyond general consent. When information is requested for purposes other than treatment, payment, and health care operations, I will obtain an

AUTHORIZATION from you before releasing the information. "**Psychotherapy Notes**" are notes I may have made about our conversations during therapy, which I have kept separate from the rest of your Clinical Record. These Notes are given a greater degree of protection than your PHI. You may revoke an AUTHORIZATION at any time, provided the revocation is in writing. You may not revoke an AUTHORIZATION to the extent that (1) I have relied on the AUTHORIZATION or (2) the AUTHORIZATION was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

3. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose your PHI without your consent or authorization in the following circumstances. If any of these situations arise, whenever possible, I will make every effort to discuss it with you before taking action, and I will limit my disclosures to what is minimally necessary.

Child Abuse: If I have reasonable cause to believe that a child has been abused, I may be required to report the abuse and turn over PHI. Regardless of whether I am required to disclose PHI, I also have an ethical obligation to prevent harm to my clients and others. I will use my professional judgment to determine whether it is appropriate to disclose PHI.

Abuse of Mentally Ill or Developmentally Disabled Adults: If I have reasonable cause to believe that a mentally ill or developmentally disabled adult has been abused, I may be required to report the abuse and turn over PHI. Regardless of whether I am required to disclose PHI, I also have an ethical obligation to prevent harm to my clients and others. I will use my professional judgment to determine whether it is appropriate to disclose PHI.

Other Abuse: If I have reasonable cause to believe that other forms of abuse have occurred, I may have an ethical obligation to disclose PHI in order to prevent harm to my clients and others. I will use my professional judgment to determine whether it is appropriate to disclose PHI.

Clear and Immediate Danger: If I believe that there is a clear and immediate danger to others or society, I may report relevant information to the appropriate authorities.

Future Crimes: If I believe there is a clear and serious intent to commit a future crime involving physical injury, threat to physical safety of anyone, sexual abuse, or death; and if I believe there is a danger of the crime being committed; then I may report information to the authorities.

Medical Emergency: I may disclose PHI that would facilitate treatment in the case of a medical emergency or involuntary commitment. This includes situations where a person poses a danger to self or others. Such disclosures may also be covered under HIPAA.

Legal Proceedings and Court Orders: I may have to release your PHI if (1) you become involved in a lawsuit and your mental or emotional condition is an element of your claim, or (2) a court orders your PHI to be released or orders your mental evaluation.

Worker's Compensation Claim: If you file a Worker's Compensation claim, this authorizes me to release all relevant records to involved parties and officials. This includes any past history of complaints or treatment of conditions similar to those involved in the claim.

Legal Defense: If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.

Government Health Oversight: If the Oregon State Board of Psychologist Examiners or a government agency requests PHI for health oversight activities, I may be required to provide it.

While this summary of the exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In specific situations, formal legal advice may be needed.

4. Client's Rights

HIPAA provides you with the following rights with regard to your Clinical Record and disclosures of your Protected Health Information. I will be happy to discuss any of these rights with you upon request. Should you wish to utilize any of these rights, please make your request in writing. If necessary, I can provide you with the proper form or procedure.

Right to Request Restrictions: You have the right to request restrictions on the uses and disclosures of your PHI. However, I am not required to agree to a restriction that you request.

Right to Receive Confidential Communications: You have the right to request that I communicate with you in certain ways or at certain locations. For example, you can ask that I only contact you at work or by mail. All reasonable requests will be accommodated.

Right to Inspect Records: You have the right to inspect and/or receive a paper copy of your PHI in my mental health and billing records for as long as the PHI is maintained in the record. You may be charged a copying/printing fee of $15 plus 50¢ per page plus any postage. I may deny access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

Right to Amend: You have the right to request an amendment of your PHI for as long as the PHI is maintained in the record. However, I am not required to agree to your amendment. On your request, I will discuss with you the details of the amendment process.

Right to an Accounting: You have the right to receive an accounting of disclosures of your PHI for which you have neither provided consent nor authorization (as described in Section 3 of this NOTICE). I am not required to account for disclosures for treatment, payment, health care operations, or pursuant to an authorization, among other exceptions. On your request, I will discuss with you the details of the accounting process.

Right to a Paper Copy: You have the right to obtain a paper copy of the NOTICE from me

upon request, even if you have agreed to receive the NOTICE electronically.

5. Psychologist's Duties:

I have a legal duty to maintain the privacy of your PHI.
I will abide by the terms of the current NOTICE.
I will not disclose your PHI for any other purpose without your AUTHORIZATION.
I will make sure that all business associates comply with HIPAA regulations and procedures.
If I revise the NOTICE, I will post a summary of the revised NOTICE in my office.
Upon request, I will provide you with a copy of the current NOTICE.
If state or federal law prohibits or further restricts disclosure of your PHI, I will follow the more stringent law.

6. Complaints

If you believe that your privacy rights have been violated, please contact me immediately, so that we can attempt to address your concerns together. If you are not satisfied with our resolution of your concerns, you may file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services. I can provide you with the appropriate form and address upon request, and you will not experience any retaliation from me for filing a complaint.

7. Effective Date, Restrictions, and Changes to Privacy Practices

The effective date of this NOTICE is 1/1/14. I reserve the right to change the terms of this NOTICE and to make the revised or changed NOTICE effective for all PHI that I maintain, including PHI collected previously. I am not obligated to tell you when the NOTICE has changed, but I will post a summary of the revised NOTICE in my office, with its effective date in the bottom right corner. You are entitled to request and receive a copy of the current NOTICE at any time.

ACKNOWLEDGMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

By my signature below, I acknowledge that I have received a copy of the NOTICE OF PRIVACY PRACTICES for Dr. Alec Wilson, and I agree to the procedures and policies described therein. Specifically, I agree that my PHI may be used and disclosed by Dr. Wilson to carry out treatment, payment, and health care operations as specified in the NOTICE. (For more information on uses and disclosures, please refer to the NOTICE.) I understand that I have the right to review the NOTICE before signing this consent. I understand that I have the right to request restrictions on the uses and disclosures of my PHI. I also understand that Dr. Wilson does not have to agree to my requested restrictions, but if he does agree, that agreement is binding. I understand that I can revoke consent in writing, but I cannot revoke consent retroactively.

_____ _____ _____
Client (or personal representative) Signature Date

_____ _____ _____
Client (or personal representative) Signature Date

_____
Relationship to Client (if a personal representative)

For Office Use Only

I, Dr. Alec Wilson, have attempted to obtain written acknowledgment of receipt of the NOTICE OF PRIVACY PRACTICES from the client named above, but acknowledgment could not be obtained because:

¨ The client or personal representative refused to sign.
¨ Communications barriers prohibited obtaining the acknowledgment.
¨ An emergency situation prevented us from obtaining acknowledgment.
¨ Other (specify below):

_____
_____

_____ _____
Alec Wilson, PsyD Date

PAYMENT CONTRACT FOR SERVICES

This document is intended to clarify the payment policies for services contracted with Dr. Alec Wilson.

The Person Responsible for Payment is required to sign this document before any services are provided.

Your insurance policy, if any, is a contract between you and the insurance company. I am not part of the contract between you and your insurance company, and you are responsible for knowing what your insurance covers.

Clients are responsible for payments at the time of service. The parent or guardian accompanying a minor is responsible for payments for the minor at the time of service. Your appointment time is time I have set aside especially for you. Cancellations with less than 48 hours notice will be billed at my full fee. Please note that insurance companies do not reimburse for cancelled or missed appointments, so you will be held responsible for this fee.

Payment methods include cash or check, unless other arrangements have been made. For more information on Billing & Fees or on Health Insurance, please review the AGREEMENT AND INFORMED CONSENT FOR TREATMENT.

If you have any questions regarding this document, please be sure to ask me. YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ, UNDERSTOOD, AND AGREED TO THE TERMS OF THIS DOCUMENT.

_____	_____	
Client Name(s)		
_____	_____	_____
Person Responsible for Payment	Signature	Date
_____	_____	_____
Co-Responsible Person	Signature	Date

CLIENT INFORMATION

Please provide the following information as honestly and completely as possible. If you do not feel comfortable answering a question, leave it blank and we will discuss it during the first session. If you need more space, feel free to use the margins or attach an additional page. All answers are strictly confidential in accordance with the NOTICE OF PRIVACY PRACTICES.

Today's Date: _____ Referred By: _____

Full Name of Client: Social Security #:

Home Address: Date of Birth:

Age:

Home Phone: May I leave messages at this number? c Yes c No

Cell Phone: May I leave messages at this number? c Yes c No

May I send you a text message? c Yes c No

Email Address: May I send you an email? c Yes c No

Marital/Relationship Status:

Work/School Address: Nation of Origin:

Employment:

Work Phone: May I leave messages at this number? c Yes c No

Highest Educational Degree:

Emergency Contact: Relationship:

Emergency Contact Address: Emergency Phone #1:

Emergency Contact/Phone #2:

Family & Relationship History

1. Family: Please list the members of your family of origin (parents, brothers, sisters, etc.):

Name	Relationship	Age	Occupation/School	Lives w/ you?

2. Is there any family history of mental health or substance abuse issues?

3. Are there any special circumstances related to your childhood? (adoption, separation, divorce, etc.)

4. Were you raised with any particular religious or cultural beliefs?

5. What are your current relationships like with your family of origin?

6. Current Family: Please list the members of your current/immediate family (if different from above):

Name	Relationship	Age	Occupation/School	Lives w/ you?

7. How would you describe your social and relationship history? (active, isolated, etc.)

8. Who do you consider to be your primary social supports right now?

9. Are you currently in a romantic relationship? If so, for how long?

10. Have you ever been abused or witnessed abuse? (physical, sexual, emotional, etc.)

11. What are some of your most important hopes and dreams for your life?

Physical & Mental Health History

12. Past Hospitalizations or Major Medical Problems:

13. Current Medical Conditions or Allergies:

14. Current Prescription Medications:

15. Date of Last Complete Physical:

16. Primary Physician/Phone:

17. Current Non-Prescription Medications (vitamins, supplements, diet pills, etc.):

18. Have you ever had a head injury?

19. Do you experience any serious concentration or memory problems?

20. Have you ever worked with a therapist before? If so, when, where, and with whom?

21. Have you ever received substance abuse services? If so, when, where, and with whom?

22. Do you have any history of suicidal thoughts or attempts? If so, when?

23. Do you have any other history of self-harm? (cutting, burning, etc.)

24. Do you have any history of harming others?

25. Do you have any history of substance use problems? (excessive use, dependency, etc.)

26. Is there anything else I should know about your physical or mental health?

Other Relevant History

27. Describe any relevant work or school issues:

28. Describe any relevant legal history:

29. Anything else I should know about your history?

Symptom Checklist

Please check any of the symptoms that you are having or have had recently:

c Fatigue c Stress c Sadness/Depression c Anger c Worrying

c Memory Difficulties c Low Energy c Eating Behavior Issues

c Nervousness c Social/Family Conflicts c Mood Swings

c Low Self-Esteem c Hopelessness c Irritability

c Poor Concentration c Anxiety c Sleep Difficulties

c Perfectionism c Sexual Difficulties c Panic Attacks

c Hallucinations c Suicidal Thoughts c Muscle Tension

c Intrusive Thoughts c Dizziness c Weight Change

c Violent Behavior c Loneliness/Isolation c Speech Difficulties

c Physical Pain c Work Difficulties c Poor Judgment

c Obsessive/Compulsive c Chest Pain c Elevated Mood

c Nightmares	c Impulsiveness	c Feeling Worthless
c Excessive Sweating	c Body Image Concerns	c Heart Palpitations
c Sick Often	c Avoiding People	c Headaches
c Easily Distracted	c Disorganized Thoughts	c Trembling
c Thoughts of Harming Others		

Please add any useful details about your checked items above:

I certify that the above information is accurate. I understand that this information will be included in my Clinical Record and will be used and disclosed only as described in the AGREEMENT AND INFORMED CONSENT FOR TREATMENT and the NOTICE OF PRIVACY PRACTICES.

_____	_____	_____
Name	Signature	Date