PRINTING INSTRUCTIONS

Please print out these forms, carefully fill in, and bring with you. Plan on this taking approximately 30 minutes.

To print the best possible copy if received from email, click on 'file', click on 'page setup', and, where the up, down, left, and right margins are, use the down scroll arrow to reduce the margins to the lowest acceptable point (a box will probably pop up saying 'fix', click yes on this, then proceed). We look forward to seeing you! Questions? Call 732-222-1100. Thanks!

DIRECTIONS TO THE WEST LONG BRANCH OFFICE

From the parkway and all points:

Get off the parkway at Exit 105. This puts you on route 36 East. On the right, you will pass the Monmouth Mall, a Hess Station, Home Depot, Walgreens & Aldi's.

Once you pass Aldi's the next light will be Broadway. Make a right and our office will be the first building on the left, a pale green business establishment. ….1049 Broadway.

Come in the front door and we are the first door on the right, Suite 2.

Call if you are lost and we will guide you in: 732 – 222 - 1100

INSTRUCTIONS

NOTE: We realize these forms are extensive, so please bear with us. Plan on it taking between 30 – 40 minutes to complete, if done thoroughly (detail in the life history questionnaire helps Dr. Lori understand how to help quicker!) . Filling out these forms actually begins your therapeutic process. Please be sure and sign the insurance release, office policy, and patients rights /HPPA forms prior to coming in, so the valuable time of your session is not spent signing them!

Pages 2 – 4: Release of information forms: There are three of these. The first lets us BILL YOUR INSURANCE COMPANY. If you choose not to fill it out, please be prepared to pay the full session fee at the time of service. If you want us to bill your insurance company, however, you **must fill this in and sign it**. The second is for your primary care physician, as insurance companies require us to ask. You can write no contact' on the form if that is your preference. The third is for any other professional, family member, or friend you would like us to be able to contact. You only need to sign this one if you want to release to another party.

Please fill in, sign and date: Patient Information, Office Policies, Cancellation/Financial, and Privacy Forms.

Take your time with Background Information and Medical History. The more you fill in, the better we can help you.

#1: FOR YOUR INSURANCE COMPANY:

Release of Information

Your Name: _____Date: _____

NOTE: We cannot bill your insurance company if you do not sign this release. In such cases please pay in full at the time of session. Thank you!

I hereby authorize (Insurance Company)_____ to provide Billing/Mental Health information about me and on my behalf to Dr. Lori A. Sweetwood, Psy.D, for the purposes of enhancing my evaluation, treatment, and care.

I further authorize Dr. Sweetwood to provide applicable information about me and on my behalf to (Name of Insurance Company)_____ for the purposes of enhancing my evaluation, treatment, and care.

Any limitations:

_____

Signature: _____ Date: _____

Witness: _____ Date: _____

#2: Primary Care Physician:

Release of Information

Your Name: _____Date: _____

NOTE: You do not have to agree with this request. Just write 'no contact' under 'limitations' and sign.

I hereby authorize:

(Name of Profesional)_____ to provide medical/mental health information about me to Dr. Lori A. Sweetwood, Psy.D, to improve my evaluation, treatment, and care.

I further authorize Dr. Sweetwood to provide applicable information about me and on my behalf to (Name of Professional)_____ for the purposes of enhancing my evaluation, treatment, and care.

Any limitations:

_____

Signature: _____ Date: _____

Witness: _____ Date: _____

#3: Psychologist, Psychiatrist, School, Family, Friend, Other:

Release of Information

Your Name:_____ **Date:** _____

NOTE: You may not have anyone you wish us to have contact with. In that case, skip this form.

You may want to sign the form for just one specific purpose, ex. To release school records, for emergency contact, etc. and want the contact limited to that one thing.

In that case, specify the purpose below in 'Any Limitations'.

I hereby authorize

(Name of Individual/Relationship to you)_____
to provide applicable information about me and on my behalf to Dr. Lori A. Sweetwood, Psy.D, for the purposes of enhancing my evaluation, treatment, and care.

I further authorize Dr. Sweetwood to provide applicable information about me and on my behalf to (Name of Individual) _____ for the purposes of enhancing my evaluation, treatment, and care.

Any limitations:

_____

Signature: _____ Date: _____

Witness: _____ Date: _____

(Form 4)

DATE_____

PATIENT INFORMATION

PATIENT NAME _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HOME #:_____WORK#:_____CELL #:_____

EMERGENCY CONTACT/PHONE: _____

SEX: M/F/O: _____ MARITAL STATUS S/M/D_____ Cell Carrier for Texting:_____

EMAIL_____ SS# _____ REFERRAL _____

PRIMARY INSURANCE COVERAGE

TYPE OF INSURANCE COVERAGE:

HMO _____ PPO _____ POS _____ WORKMANS COMP _____

MVA _____ MEDICARE _____ SELF PAY _____ OTHER _____

NAME OF INSURANCE _____ PHONE _____

CLAIM ADDRESS _____

SUBSCRIBER NAME _____ ADDRESS _____

-

PHONE _____ DOB _____SS# _____ SEX M_____ F _____

RELATIONSHIP TO PATIENT _____ ID#_____GROUP _____

EMPLOYER NAME _____PHONE _____

IN NETWORK ____ OUT OF NETWORK ____ MAX VISITS _____ EXTENSION _____

DEDUCTIBLE _____ PATIENT RESPONSIBILITY (% OR COPAY) _____ DX _____

PERSON FILLING OUT FORM AND RELATIONSHIP TO PATIENT _____

OFFICE POLICIES – PLEASE READ!

- If someone is working in the office, come on in and say hello – if not, have a seat and we will be w/ u shortly!
- Cell phones **OFF** in session please! (not just vibrate – let's make *you* what's important! Worried about kids/family while in session? Give them our number for EMERGENCY use – 732 – 222 – 1100.
- **NOTE**: there are animals on the premises. They are non-allergic therapy dogs. If this is a problem, let us know!
- When responding to texts and phone messages, PLEASE leave you response on the phone at 732-222-1100 rather than texting or emailing or caller ID'ing back! 😊 (Otherwise we may not get it!)
- Please have your co-pay ready at the START of the session, and pay/reschedule at that time. (Cash or Checks).
- Prior to your visit try to learn from your insurance company what your co-pay or deductible may be. In many cases, we cannot accurately answer this question until we are paid, and this can take up to six weeks. To avoid co-pays/deductibles adding up, have this information prior to your first visit!
- RELEASES: The first release in your packet allows us to bill your insurance company on your behalf. *If it is not signed, or if you write 'no contact', we cannot bill your insurance company, and you will be responsible for full payment at the conclusion of all sessions.*
- Sessions are 45 minutes long.
- ***Beginning with the first session,* there is a minimum 24 hour cancellation fee.** If you do not give us 24 hours prior to cancelling, you are responsible for the **FULL FEE, not just your co pay.** Our number for cancellations **is 732-222-1100**. Also note: **For Monday Appointments, 48 hours is required.**
- Excessive cancelations (3+) may result in termination of treatment. This will be discussed and decided between you and the Doctor, should the need arise.
- If for any reason you decide not to continue with treatment, PLEASE give us a courtesy call to explain the situation, so that we do not keep you as 'active' on our patient list, or keep calling to schedule an appointment.
- It's fine to bring children to sessions. They can wait in the waiting room or, if small, can play in our office with their toys or the toys we have available. Feel free to bring well-behaved pets as well! ☺
- We do make courtesy reminder calls/texts whenever possible – however, it is your responsibility to keep track of the time. Please ask for an appointment card or put in your phone at the time of scheduling 😊. If you do not schedule an appointment at the time of your last session, we will call to reschedule. If a message is left with a new appointment time, please let us know, otherwise we will assume it is a good time and is confirmed.
- Please be SURE and fill out the 'presenting problem' on the first page of 'Background Information'.

I have received a copy of this policy.

_____

Signature **Date**

CANCELLATION/FINANCIAL/CLINICAL POLICIES

Welcome! Thank you for choosing us as your psychological health care provider. We would like to take this opportunity to acquaint you with information relevant to treatment, confidentiality, and office and financial policies. Our staff and/or your therapist can answer any questions. We require you read and sign this statement prior to beginning treatment.

If our services are covered by your insurance company, we will submit your claim and wait for the reimbursement payment. We can only do this with your cooperation, however. We ask that you : (1) pay your portion – i.e. Deductible, co pay and/or co-insurance – at the time of your visit, and (2) assign the insurance benefits to us so that your insurance company pays us directly for your care. It is your responsibility to familiarize yourself with your insurance benefit.
If our services are not covered by your insurance company, payment in full will be expected at the time services are rendered, unless prior arrangements have been made with our office.

Our fees are: $125.00 for the initial evaluation, $125.00 for family therapy, and $100.00 for individual therapy. We know these rates are very low, but believe in a fair price for a fair service. Insurance co's will set their own fees.

Even though you may have insurance coverage, you must understand that **you, and you alone**, are ultimately responsible for paying your or your child's bill. To avoid billing conflicts later on, please let us know if you have a problem with assuming full responsibility for your bill.

Parents are responsible for their children's bills; if there is a divorce/custody/insurance coverage conflict between a child's parents, we must be informed before treatment begins. The parent bringing the child for treatment must agree to be responsible for the bill, even if legally another party is also responsible for this child.

Make any checks payable to 'Challenges Psychological Services' or just 'Challenges'.

CANCELLATIONS AND MISSED APPOINTMENTS: Unless cancelled at least 24 hours in advance (and 48 hours for Monday appointments), our policy is to **charge the FULL FEE directly to the patient for** any missed appointments, beginning with and including the first, initial session, **at our <u>full rate</u> of a regular office visit, $125**. There are no exceptions to this policy. We do not bill insurance for missed appointments. Our practice is very busy, and someone can take missed/cancelled appointments with proper notice! Please note that chronic cancelations will result in termination.

YOU RECEIVE THE REIMBURSEMENT CHECK FOR YOUR INSURANCE COMPANY: This is payment to us for services rendered, which you have authorized your insurance company to pay to us. Bring in or mail the check and EOB to us, endorsed by you if necessary, as soon as possible. If you are not prompt and honest in these matters, we will be forced to refer you elsewhere and, if necessary, pursue legal channels to recover monies owed us.

WORKMAN'S COMPENSATION/Legal Issues/Law Suits/Disability, etc: We will not be involved or represent you or our treatment in any way. If this is your reason for treatment we will refer you elsewhere. We will not provide letters, notes, testimony to courts, insurance companies, attorneys, or any other agency public or private. Your signature below waives any request to same, and designates that your understanding agree to our position.

TELEPHONE / EMAIL CONSULTATIONS: Brief, infrequent conversations with you, your family members, or other professionals are not billable services. However, if these become extended, i.e. over 15 minutes long, or frequent, we will bill you for this time on a pro-rated scale, based on $125.00 an hour.
OTHER PROFESSIONAL SERVICES: Authorized/requested consultations or reports with schools/employers, preparation of records, treatment summaries, or time performing any other written/spoken service is billed at $150.00

an hour. Psychological testing/reports, medical evaluations/reports, legal report writing, custody evaluations/reports will be billed at a rate of $175.00 an hour. Legal testimony is billed at $200.00 an hour, door to door.

OVERDUE ACCOUNTS: If your account is more than 60 days in arrears and suitable arrangements for payment have not been agreed to, we have the option of using legal means to secure payment, including collection agencies or small claims court (if such legal action is necessary, the cost of bringing that proceeding will be included in the claim). In most cases, the only information which we release about a client's treatment would be the client's name, the nature and date of services, and the amount due. We are typically very receptive to 'good faith' payment plans, and will not send folks to collections as long as they are making a fair and reliable effort to repay their past due accounts.

CONTACTING US: There is typically someone here to answer your call during normal business hours, 9:00 – 5:00, M, Tu, W, and F at 732-222-1100. If you cannot reach us and you feel you cannot wait for us to return your call, please call your family physician, emergency room at the nearest hospital. If we are unavailable for an extended period of time, we will provide you with the name of a trusted colleague whom you can contact if necessary.

MINORS: We will typically adhere to strict limits regarding your participation in treatment, unless we feel there is a high risk that you may seriously harm yourself or another. Aside from risk issues, before giving your parents any information, we will discuss the matter with you and will do the best we can to resolve any objections you may have about what we are prepared to discuss in the rare case that Dr. Lori feels it is priority.

PROFESSIONAL RECORDS: Both law and the standards of our profession require that we keep appropriate treatment records describing your condition, treatment, progress, dates and fees for sessions, and clinical notes. Both active and inactive charts are locked and kept on site. These are not typically shared with anyone, including the client, as they can be emotionally damaging or distressing or misinterpreted, as they are professionally geared. If you feel strongly about reviewing them we can discuss this and make appropriate arrangements, and we can provide a summary and forward it to the professional of your choice. We do find verbal communications with fellow clinicians even more productive. Clients will be charged a rate of $175.00 an hour for any time necessary to comply with an information request.

LENGTH OF SESSION: Sessions are typically approximately 45 minutes long. They may be somewhat longer or shorter, as deemed clinically appropriate by your therapist. Please note that if you are late, we cannot extend the time of your session. If Dr. Lori runs late, you will typically receive your full time, by running the session longer at the end.

_____ _____

Signature of Patient or Parent/Guardian **Date**

PATIENT'S PARTICIPATION: I am aware that the practice of psychotherapy is not an exact science and that results cannot be guaranteed. No promises have been made to me about results of treatment. I have had opportunity to ask any questions needed for my clarification. I understand that active participation in my treatment is a very important part of solving problems and feeling better. I will attend scheduled appointments, apprise you of upcoming vacations or breaks, follow thru with prescribed homework assignments, and give 24 hours notice of cancellation. I know I can discontinue therapy at anytime. If I decide to discontinue treatment, I may discuss this decision directly with Dr. Sweetwood, so that she can help us end therapy in a clinically appropriate manner. I know I have the right to have any complaints heard and resolved in a timely manner, and I may discuss any concerns with Dr. Sweetwood &/or her staff. I understand and agree with all of the above statements, and I give consent for evaluation and treatment to be provided to myself/my child by Lori A. Sweetwood, Psy.D. I have received a copy of this contract.

_____ _____

Signature: (client / parent) **Date** **Signature: (child)** **Date**

Challenges Psychological Services

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
If you have any questions about this Notice please contact: Gina Russomanno

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by, calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information Based Upon Your Written Consent

You will be asked by your physician to sign a consent form; this will be your consent disclosure of your protected health information for treatment, payment and health care operations. Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice.

Following are examples of the types of uses and disclosures of your protected health care information that the physician's office is permitted to make once you have signed our consent form.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained our permission to have access to your protected health information.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that our health insurance plan may undertake before it approves or pays for the health care services we recommend for you.

Healthcare Operations: We will share your protected health information with third party "business associate's" that perform various activities (e.g., billing, transcription services) for the practice.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object

You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to

agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in you best interest based on our professional judgment.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment

Communication Barriers: We may use and disclose your protected health information if your physician or another physician in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the physician determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

Other Permitted and Required Uses and Disclosures That May be Made Without Your Consent, Authorization or Opportunity to Object: We may use or disclose your protected health information in the following situations without your consent or authorization, including:
Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Your Rights: You have the right to be treated with dignity and respect, regardless of race, religion, gender, ethnicity, age, disability, or source of payment. You have the right to have your treatment and other information private. You have the right to timely care, to know about your treatment choices, a clear explanation of your condition, and share in the development of your care plan in a language you can understand. You have the right to understand Dr. Sweetwood's credentials and level of expertise in given areas.
Dr. Sweetwood is not required to agree to a restriction that you may request. If she believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If Dr. Sweetwood does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with Dr. Sweetwood. You may request a restriction by written notice to the office.

Your Responsibilities: To provide accurate information, follow through with treatment plans, adhere to the cancelation policy, pay in a timely manner, respond with courtesy calls as requested and let us know if you are terminating treatment. You are also responsible for letting the doctor know of any medical changes, speak up if you need something or if you are experiencing any level of discomfort with our practice, and generally work with us as a partner to help you.

Complaints: You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. You may contact our Privacy Contact, Gina Russomanno, 732 222 1100, for further information about the complaint process.

I have read and understand Challenges / Dr. Lori Sweetwood's (herein referred to as Challenges) Notice of Privace Practices. I consent to the use or disclosure of my protected health information by Challenges for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Challenges. I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Challenges is not required to agree to the restrictions that I may request. I have the right to revoke this consent, in writing, at any time, except to the extent that Challenges has taken action in reliance on this consent.

_____

Signature of Patient or Personal Representative Date

CHILD BACKGROUND AND HISTORY

If the child is old enough to do independently, please allow them to. There may be some questions the parents need to answer. If the child is younger, you may ask them the questions and record their answers. *If the parent is filling out/helping to fill out this questionnaire, please answer questions from the child's perspective.*

Date: _____ Person completing this form, relation to child: _____
Name of Child: _____ Date of Birth: _____ Age: _____

PRESENTING PROBLEM:
Describe the problems you/your child is having and when they started: _____
_____
_____
_____
_____
_____
_____

SYMPTOM CHECKLIST:
Please check any symptoms you/your child is experiencing.

__ Aggression/Anger Outbursts	__ Difficulty Thinking	__ Judgment	__ Sexual Difficulties
__ Alcohol Abuse	__ Distractibility	__ Legal Problems	__ Stressed Out
__ Anxiety	__ Dizziness	__ Loneliness	__ Substance Abuse Problems
__ Appetite Change	__ Drug Abuse	__ Loss of Interest in People /Activities	__ Suicidal Thoughts
__ Attitude	__ Eating Disorder	__ Low Energy	__ Trembling
__ Avoidance of People	__ Elevated Mood	__ Marital Conflict	__ Victim of Abuse:
__ Behavior Disturbance	__ Fear	__ Memory Problems	__ Physical
__ Breathing Problems	__ Fatigue	__ Mood Swings	__ Emotional
__ Chest Pains	__ Financial Problems	__ Muscle Tension	__ Sexual
__ Compulsive/Obsessive	__ Gambling	__ Panic Attacks	__ Weight Gain/Loss
__ Computer Addiction	__ Hallucinations	__ Paranoia/Suspicious	__ Withdrawal
__ Conflict with Children	__ Headaches	__ Poor Peer Relations	__ Worrying
__ Conflict with Other Family	__ Health Problems	__ Problems at School	__ Worthlessness
__ Conflict with Parents	__ Helplessness/Giving Up	__ Problems at Work	__ Fears: (List)
__ Conflict with Siblings	__ Housing Problems	__ Racing Thoughts	_____
__ Conflict with Spouse	__ Hopelessness	__ Recent Death/Grief	_____
__ Confused	__ Impulsivity	__ Recent Move	_____
__ Crying	__ Indecisiveness	__ Restlessness/On Edge	Other Symptoms: (List)
__ Depression	__ Irritability	__ Self-Esteem	_____
__ Despair	__ Isolation	__ Separation/Divorce	_____
__ Difficulty Concentrating	__ Job Loss or Change	__ Sexal Addiction	_____

PREGNANCY AND BIRTH HISTORY:

Was the pregnancy _____planned or _____unplanned? Was it full-term? ____Yes ____No
How did the mother feel about this pregnancy? _____
How did the father feel? _____
Was any alcohol, drugs, or medications used during pregnancy? ____Yes _____No
If yes, please describe: _____
Were there any problems with the pregnancy? _____
Were there any problems with the birth? _____

Were there any significant delays in your child's development (smiling, speaking, walking, toilet training, dressing self, etc.)?
_____
_____
_____

Were there any behavioral difficulties or discipline problems during early childhood? _____
_____
_____

Did your child have temper tantrums? _____Yes _____No Describe: _____
_____
_____

PARENTING AND FAMILY:

What discipline techniques have been used? _____
_____

What are parents' strengths and weaknesses in parenting?_____
_____
_____

Mother's Name: _____ Age: _____ Occupation: _____

How would you/the child describe their mother? _____
_____

How do you get along with her? _____
_____

Father's Name: _____ Age: _____ Occupation: _____

How would you/the child describe their father?
_____
_____

How do you get along with him? _____
_____

Is infidelity an issue? _____

Have parents been married/seriously involved before? With whom, for how long, what happened? _____
_____

How do (did) your parents get along? Strengths? Weaknesses? _____
_____
_____

Is there conflict between your parents and stepparents? Between you and your stepparents? Please explain: _____
_____
_____

Brothers/Sisters	Age	How do you get along?	Do they drink/use drugs?	How often in contact?

Do the children have the same parents? If not, please give us the breakdown: _____
_____

Any others currently living in your household and their relationship to you:

Name: _____ Relationship: _____
Name: _____ Relationship: _____

Do you have pets? Tell me about them: _____
_____

Any abuse going on? (physical, mental emotional) _____
_____

Have either of your parents ever been arrested, had Restraining Order, etc.? _____
_____
_____

Do (did) either of your parents drink/do drugs? Explain: _____
_____

Has anyone in your family been treated for depression/anxiety/mental illness? If so, who, for what, and when?
_____
_____

YOU
Does anxiety or depression trouble you? How? _____
_____

How have you tried to get rid of these feelings? _____
_____

Is there something on your mind a lot? What? _____
_____

Are you grieving or have you suffered a serious loss in the last year or so? Please explain: _____

What is the worst thing that ever happened to you? _____
_____

Do you have any fears? What? _____

_____

What are your strengths? _____

What are your weaknesses? _____

Briefly describe what kind of person you are: _____

Do you have any trouble with memory?	Y ____ N ____
Concentration?	Y ____ N ____
Preoccupied/running thoughts?	Y ____ N ____

If you answered Yes to any of these questions, please describe: _____

_____

Have you ever heard voices others didn't hear, or seen things others didn't see?	Y ____ N ____
Are these active?	Y ____ N ____
Have you ever been suicidal?	Y ____ N ____
Thought seriously about it?	Y ____ N ____
Made an attempt, gesture, or cut on yourself?	Y ____ N ____
Thought seriously about hurting someone else?	Y ____ N ____

Please describe, give dates, and state whether you currently feel this way: _____

_____

_____

If you have eating issues, please describe: _____

_____

Do you have a history or anger and/or violence/fights? Please describe: _____

_____

Have you ever been in trouble with the law? How? _____

_____

Have you ever been involved in drugs or alcohol? _____

_____

SUBSTANCE USE: Please indicate both current and past use.

Substance	Current Use		Past Use				
	Yes	No	Yes	No	Amount Used	Frequency	Date Last Used
Tobacco	___	___	___	___	_____	_____	_____
Caffeine	___	___	___	___	_____	_____	_____
Alcohol	___	___	___	___	_____	_____	_____
Marijuana	___	___	___	___	_____	_____	_____
Cocaine/Crack	___	___	___	___	_____	_____	_____
Heroin	___	___	___	___	_____	_____	_____
Amphetamines	___	___	___	___	_____	_____	_____
LSD	___	___	___	___	_____	_____	_____
Ecstasy	___	___	___	___	_____	_____	_____
Inhalants	___	___	___	___	_____	_____	_____
IV Drug Use	___	___	___	___	_____	_____	_____
Prescription Drugs	___	___	___	___	_____	_____	_____
(Please List: _____)							

Do you have any financial problems? If so, what? _____

Any history of fire setting, bed wetting, or hurting animals? _____
_____

If you have been in therapy before, with whom? (include school-based programs, guidance counselors, etc., approximate dates, and did it help?) _____
_____

How did it help? _____
_____

Do you know your diagnosis? _____
_____

EDUCATION:

School: _____ Grade: _____ Like about school? _____

Dislike about school? _____ Special classes? _____

Ever skip a grade/ been left back? _____ Behavior? _____

Any attendance problems? _____

Are you respectful to teachers? _____

Any bullying or being bullied? _____

What is your behavior like in school? _____

Any discipline problems in school? Detention, suspension, expulsion? _____

Child Study Team evaluation? Learning disability? Special services? _____
_____

Child's teacher, counselor: _____How much time do you spend on homework each day? _____

How well do you do in school? _____

Best subjects? _____ Worst? _____

If you dropped out, why? _____

SOCIAL:
Do you have friends? _____

Do other kids pick on you? For what? How do you react to the teasing? _____
_____

Has your family moved around a lot? _____

Do you currently have a best friend(s)? If so, what is their first name, how long have you known them, and what is special about this person? _____
_____
What are your hobbies? Do you get enough time to do them? _____

Do you have a computer? How much time do you spend on it? _____

How much combined time do you spend on TV, Play Station, Game Boy, and computer each day? _____
_____

Do you have a girlfriend or boyfriend? What is this relationship like? _____
_____

Do you play any sports? On any teams? _____

Are you in any activities or clubs? Which ones? _____

Do you spend time outside? Doing what? _____

Do you go to church? How do you feel about this? _____
_____

Are you bored? Lonely? Please explain: _____

Do you have a job? If so, describe. If not, how do you get money? _____
_____

Describe how your life would be different – what you and your life would be like – if the problems got better? _____

_____

_____

_____

_____

Medical History Form

Please answer the following questions to the best of your knowledge. Use the back of this page if you need more room. Your records are considered confidential. Your records will not be released to any party without your written consent.

PATIENT INFORMATION				
Last Name	**First Name**	**Sex** ☐ **Male** ☐ **Female**	**Main Phone #**	**Okay to Call?**
Birth date	**Marital Status:** ☐ Single without partner ☐ Single with partner ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			
Sexual Orientation	☐ Heterosexual ☐ Homosexual ☐ Bisexual			
Children: ☐ Yes ☐ No How many?		**Number of Persons Living in Your Home?**		**Race/Ethnicity**
Emergency Contact Person		**Phone Number**	**Relationship**	

PRIMARY PHYSICIAN	**NAME**	**ADDRESS**	**PHONE**
PSYCHIATRIST	**NAME**	**ADDRESS**	**PHONE**

Rate your overall health: ☐ Poor ☐ Fair ☐ Good ☐ Excellent Height _____ Weight _____
Medication Allergies? ☐ Yes ☐ No Substance or Food Allergies? ☐ Yes ☐ No
If yes, what medication(s) _____ If yes, what substance(s) _____

HEALTH HISTORY: Please ☐ if you have a history of:					
☐ Diabetes	☐ High Blood Pressure	☐ Heart Attack, Heart Disease	☐ Stroke	☐ Breathing Problem	☐ Head Injury
☐ Cancer	☐ Alzheimer's	☐ Family History Unknown	☐ Mental Illness	☐ Tuberculosis	☐ Chronic Pain
☐ Anxiety	☐ Depression	☐ Sexually Transmitted Disease	☐ Urinary Track Infection	☐ Epilepsy/Seizure	☐ PMS/Hysterectomy

Any other major conditions? Surgeries? Hospitalizations? _____
_____
_____
If you answered Yes to any of the above, please explain: _____
_____
Are you currently being treated for medical conditions? ☐ Yes ☐ No If yes, please list: _____

MEDICATIONS (Include over-the-counter and herbal treatments)					
Current Medications	**For what condition?**	**Dosage**	**Frequency**	**Date started**	**Comments / Problems / Concerns**

Past Medications / For what condition? (list sedatives, pain medications, sleeping pills, antidepressants, etc.)			

Social/Sexual Risk History	
☐ Yes ☐ No	Do you smoke? If yes, how many cigarettes per day?
☐ Yes ☐ No	Do you use alcohol? If yes, how often, how much?
☐ Yes ☐ No	Do you or your partner(s) use drugs? If yes, how much, how often? Ever injected drugs? (explain)
☐ Yes ☐ No	Have you ever had or would you like help now with an alcohol or drug problem?
☐ Yes ☐ No	Would you like to discuss problems related to a rape or emotional/physical/sexual abuse?
☐ Yes ☐ No	Are you now or have you ever been in a relationship where you have been physically hurt or threatened?