# 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: <u>Psychologist, Psychiatrist, School, Family, Friend, Other:</u>

## Release of Information

**Your Name:**_____ **Date:** _____

**<u>NOTE</u>:** 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)** **LORI A. SWEETWOOD, Psy.D.**

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 do not get involved with these situations. If this is your reason for treatment we will refer you elsewhere. We will not provide letters or clinical notes or testimony to courts, insurance companies, attorneys, or any other agency public or private. Your signature below waives your request for any of the above, and designates that you understand and 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 and employers, preparation of records, treatment summaries, or time performing any other written/spoken service which you may request 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.

**AIMS AND GOALS:** Dr. Sweetwood may give you 'homework assignments' to help you learn and grow in an expedient manner. It is likely that the content of your next session will be based upon the completion of this assignment. Try and get it done! Your progress in therapy depends as much on what you do between sessions as what happens in sessions.

I have carefully read, understand, and accept this contract.

_____ _____

**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

# Background Information

This questionnaire will give us information about your past history and present situation, helping us move more quickly and effectively toward helping you solve your problems. Please answer thoroughly, and don't rush! Your answers will be kept confidential. If a question does not apply to you, simply write 'N/A' and skip it.

**Name: _____ Date: _____ Date of Birth: _____**

**Presenting Problem *(MUST be filled out!):* Why are you here today?**

_____

_____

_____

_____

## Symptom Checklist:

Please check any symptoms you are experiencing.

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

**Current Issues:**

Are anxiety or depression troubling you? **What do you feel? How does it affect your life?**
_____

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

Are you bored? _____ Lonely? _____ Overwhelmed?_____
Please explain:_____

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

Have you ever suffered from a significant trauma? (Example: Serious illness, accident, prolonged physical, emotional, or sexual abuse) If so, please explain: _____

If you have been in therapy before, with whom? Dates? (include hospitalizations and medications) _____
_____

Did it help? If yes, then how did it help? If no, why not?
_____

Do you know your diagnosis? _____

Have you ever attended anger management, parenting, AA, or any other self-help/support group or class? List:
_____

If you have eating issues, please describe: _____

Do you exercise regularly? What and how often? _____

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:

---

If you have trouble sleeping, is it: (Circle all that apply)

- Trouble Falling Asleep?
- Staying Asleep?
- Waking Early?
- Nightmares?
- Sleep Apnea?

Do you know why you are having this trouble? What is on your mind?
_____
_____

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 anyone else? Y ____ N ____

When? Do you have a plan now?:
_____
_____

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

Have you ever been arrested? Y ____ N ____
Been in jail? Y ____ N ____
Had a Restraining Order against you? Y ____ N ____
Been sued? Y ____ N ____
For what and when? _____

Have you ever been in trouble for drugs/alcohol? Y ____ N ____ If yes, please explain: _____
_____

## 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? _____

## Social History

Where did you grow up? _____

Did your family move around a lot? Y ____ N ____ If Yes, please describe:
_____

Describe your childhood:
_____
_____

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

If deceased, your and her ages at time of death: You _____ Her _____ Cause of death: _____

How would you describe your mother? _____
_____

How do (did) you get along with her? _____
_____

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

If deceased, your and his ages at time of death: You _____ Him _____ Cause of death: _____

How would you describe your father? _____
_____

How do (did) you get along with him? _____
_____

How do (did) your parents get along? _____

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

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

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

Is there anyone else in your family you are close to? _____
_____

## School History:

What was/is your highest level of education? _____

Your spouse's? _____

Are you in school now? Y ____ N ____ If yes, where? _____

How well did/do you do in school? _____

Best subjects? _____ Worst? _____

If you dropped out, why? _____

What was/is your behavior like in school? _____

Did/do you have friends? _____

Did/do other kids pick on you? Y ____ N ____ If Yes, for what? _____
How do you react to the teasing?_____

**Military History:**

Did you or do you serve in the military? Y ____ N ____

What branch? _____

Dates of service? _____

Were you stationed in a combat or other high-risk zone? _____

Type of discharge _____

**Work Status:**

Occupation: _____ How long at current job? _____

Employer: _____ Work Schedule? _____

What do you like about your job? _____

Are there any current job stressors you are experiencing? _____

Have you ever been laid off or fired? _____

Do you get along with your co-workers? _____

Is there a different job you would like? What? _____

## Relationship Status:

If married/living with someone, how long? _____ Spouse's Name: _____

Spouse's Age: _____ Spouse's Occupation: _____

Have you been married/seriously involved before? _____

With whom? _____ For how long? _____

What happened? _____
_____

How do you get along with your current partner? Strengths of relationship? Weaknesses? _____

Is infidelity an issue? _____

Is there current conflict between you and your ex-partner or their new partner? _____

Between you and your new partner's old partner? Please explain: _____

_____

| Children/Stepchildren's Names | Age | Where do they live? |
|---|---|---|
| _____ | ___ | _____ |
| _____ | ___ | _____ |
| _____ | ___ | _____ |

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

Are there step children living elsewhere? Please give their names and ages, and who they live with: _____
_____

How do your children get along with divorced/separated parents and/or stepparents? _____
_____

Do your children have any behavior /emotional problems? If so what?
At home? _____
At school? _____
In public? _____

Child's school, teacher, counselor: _____

Child study team evaluation? _____

Learning disability? _____ Special services/classes? _____



Others currently living in your household and their relationship to you:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Are you responsible for your parents/other family members in any way? _____

How? _____

Are you currently worried about a loved one? If so, who and why?
_____

Are addictions to alcohol, food, drugs, porn, shopping, social media, 'love', etc affecting you or those you love?
_____

## You

What are your strengths? _____

What are your weaknesses? _____

Briefly describe what kind of person you are:
_____
_____

Do you currently have a best friend(s)? If so, what is their first name? _____

How long have you known them? _____ 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? _____

Have you ever gotten involved with an on-line romance or chat room? _____

Are/were you active with a church or religion? _____

Does your spirituality help you? _____ Please describe: _____
_____

Do you do or have you done any type of volunteer work? (Coaching, fund raising, etc.) _____
_____

How would you describe your support system? Good ____ Fair ____ Poor

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

_____

_____

_____

What skills would you like to get out of therapy?_____

_____

_____

Is there anything else you would like us to know? _____

_____

_____

# 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 Other:_____ | | | | |
| **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? |

**Lori A. Sweetwood, Psy.D.**