BE WELL COUNSELING LLC
4000 SOUTHLAKE PARK SUITE 150
BIRMINGHAM, AL35244

Privacy Notice Form

Notice of Be Well Counseling Policies and Practices to Protect the Privacy of Your Health Information

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

We may *use* or *disclose* your ***protected health information (PHI)***, for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

· "*PHI*" refers to information in your health record that could identify you.

·"*Treatment" is* when we provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when your therapist consults with another health care provider, such as your family physician or another doctor or therapist.

· "*Payment*" is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility for coverage.

· *"Health Care Operations"* are activities that relate to the performance and operation of our 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.

· "*Use*" applies only to activities within our office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

· "*Disclosure*" applies to activities outside of our office, such as releasing, transferring, or providing access to information about you to other parties.

· *"Business Associate"* refers to a person or entity that provides certain functions, activities, or services on our behalf pursuant to a written agreement that contains terms regarding protection of your PHI. In the event of an emergency or planned time off, we may use or disclose your PHI to a business associate in order to provide an appropriate level of care.

· *Our Contact with You.* We may us or disclose your PHI to provide you with appointment reminders (such as sending postcards, e-mailing, or leaving a voicemail message, etc.), to provide you information regarding treatment alternatives or other health-related benefits and services that may be of interests to you.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment, or health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your Psychotherapy Notes. "*Psychotherapy Notes*" are notes your therapist has made about your conversation during a private, group, joint, or family counseling session, which your therapist has kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

Your therapist may use or disclose PHI without your consent or authorization in the following circumstances:

· ***Child Abuse* – If a therapist is treating a child or adolescent under the age of 18 and knows or suspects that child or adolescent to be a victim of child abuse (physical or sexual abuse, this includes statutory cases) or neglect, the therapist is required to report the abuse or neglect to a duly constituted authority, usually the Alabama Department of Human Resources. Once such a report is filed, we may be required to provide additional information.**

· *Adult and Domestic Abuse* – If a therapist has reasonable cause to believe an adult, who is unable to take care of himself or herself, has been subjected to physical abuse, neglect, exploitation, sexual abuse, or emotional abuse, the therapist must report this belief to the appropriate authorities, usually the Alabama Department of Human Resources. Once such a report is filed, we may be required to provide additional information.

· *Health Oversight Activities* – If the Alabama Board of Examiners in Counseling or other government agency is conducting an investigation into your therapist's practice, then your therapist is required to disclose PHI upon receipt of a subpoena from the Board.

· *Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and your therapist will not release information without the written authorization of you or your legally appointed representative or a court order.

The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case. If you enter into a legal or administrative proceeding in which you raise the issue of your mental status (e.g., worker's compensation claim, a sanity hearing, raising "mental distress" as a result of an accident or injury, or defending yourself from a criminal charge by pleading insanity), then we may be ordered by the court to testify about matters discussed in confidence whether or not you give permission for us to testify. **If the custody/visitation of your child (ren) or future child (ren) becomes a legal issue, a court may, in the best interest of the child, obtain your or your child's treatment records through a court order.** If a patient files a complaint or lawsuit against a therapist, a therapist may disclose relevant information regarding that patient in order to defend oneself.

· *Serious Threat to Health or Safety* – We may disclose PHI to the appropriate individuals if we believe in good faith that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of you or another identifiable person(s).

· *Worker's Compensation* – Your therapist may disclose PHI as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and/or Therapist's Duties

Patient's Rights:

· *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of PHI. However, your therapist is not required to agree to a restriction you request.

· *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing a provider in our office. On your request, we will send your bills to another address.)

· *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in your therapist's mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. Your therapist may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. You may inspect and copy Psychotherapy Notes unless your therapist makes a clinical determination that access would be detrimental to your health. On your request, your therapist will discuss with you the details of the request and denial process.

· *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. Your therapist may deny your request. On your request, your therapist will discuss with you the details of the amendment process.

· *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI. On your request, your therapist 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 your therapist upon request, even if you have agreed to receive the notice electronically.

Therapist's Duties:

· Your therapist is required by law to maintain the privacy of protected health information regarding you and to provide you with notice of the therapist's legal duties and privacy practices with respect to PHI.

· We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, your therapist is required to abide by the terms currently in effect.

V. Complaints

If you are concerned that your therapist or anyone in our office has violated your privacy rights or you disagree with a decision your therapist made about access to your records, you may contact the Alabama Board of Examiners in Counseling. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. One of the parties listed above can provide you with the appropriate address upon request.

VI. Social Media, texting, and emails- Be Well Counseling and its employees do not accept friend requests or contact requests from current or former patients on any social networking sites (Facebook, Linkedin, Pinterest, Twitter, Instagram, etc). Communication on these sites can compromise confidentiality and negatively impact the patient/therapist relationship. The American Counseling Association Code of Ethics prohibits soliciting testimonials by patients. At this time Be Well Counseling does not offer text or email service for direct communication. Texts reminders and emails are sent through a third party service and by signing the contact form you are agreeing to this service and waiving your right to keep appointment information (PHI) completely private.

BE WELL COUNSELING, LLC
HOLLIE ANNA WHITE, LPC, NCC
4000 SOUTHLAKE PARK SUITE 150
BIRMINGHAM, AL 35244
(205)821-2979

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge I have read and received Be Well Counseling Notice of Privacy Practices

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature (if applicable) Date

_____ _____
Witness Signature Date

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PATIENT REGISTRATION FORM PAGE 1

Patient Information

First Name: _____ Middle Name: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

Employer: _____ Social Security #: _____

Birth Date: _____ Age: ____ Gender: _____ Marital Status: _____

Legal Guardian Information (If patient is less than 18 years old)

Legal Guardian Name: _____ Relationship to Patient: _____

Home Phone #: _____ Work Phone #: _____ Living Arrangement: _____

Responsible Party Information

Responsible Party is Patient: Yes No

First Name: _____ Last Name: _____ Relationship to Patient: _____

Address: _____

City: _____ County: _____ State: _____ Zip: _____

Home Phone #: _____ Work Phone #: _____

Financial and Policy Holder Information

Primary Insurance:

Insurance Company: _____ Contract #: _____ Group #: _____

Effective Date: _____ Policy Holder Name: _____

Policy Holder SS#: _____ Birth Date: _____ Relationship to Patient: _____

Policy Holder Address: _____ City, State & Zip: _____

Policy Holder Telephone #: _____ Sex: M or F

Secondary Insurance: Yes No

Insurance Company: _____ Contract #: _____ Group #: _____

Effective Date: _____ Policy Holder Name: _____

Policy Holder SS#: _____ Birth Date: _____ Relationship to Patient: _____

Policy Holder Address: _____ City, State & Zip: _____

Policy Holder Telephone #: _____ Sex: M or F

PATIENT REGISTRATION FORM PAGE 2

Tertiary Insurance (If Applicable):

Insurance Company: _____ Contract #: _____ Group #: _____

Effective Date: _____ Policy Holder Name: _____

Policy Holder SS#: _____ Birth Date: _____ Relationship to Patient: _____

Policy Holder Address: _____ City, State & Zip: _____

Policy Holder Telephone #: _____ Sex: M or F

Authorization to Release Information: The undersigned authorizes Be Well Counseling and any physician rendering service to release medical or other information about the patient which may be necessary for the completion of insurance claims, review of services, or receipt of benefits. Such information may include current medical records. The information may be released to third-party payors, including the third-party payor's agent and/or representative or anyone responsible for payment of services.

Authorization to Release Information to Referring Physician: I hereby authorize Be Well Counseling to release information concerning my treatment to the referring physician.

Assignment of Benefits: The undersigned assigns to and authorizes direct payment of benefits (including insurance benefits, otherwise payable with respect to the patient) to Be Well Counseling The undersigned agrees to assist in processing claims for benefits.

Financial Responsibility: In consideration of the services provided or to be provided, the undersigned agrees to pay Be Well Counseling for the services rendered or to be rendered to above-said patient within 90 days. In failing to do so, I hereby waive all claims or rights to exemption and agree to pay the reasonable cost of collection, including a reasonable attorney's fee for the collection of the account if assigned to an attorney for collection.

I acknowledge that I have read this form and understand its purpose and content.

_____ _____

Signature of Guarantor/responsible party Patient (or authorized Representative/Relationship to Patient)

_____ _____

Date Date

BE WELL COUNSELING, LLC
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How You Wish to Be Contacted by Our Office

Unless you direct us not to, we will call your home, work or cell phone or write to you at your home address regarding appointments or other aspects of your care. Please circle "Yes" or "No" to the following questions:

May we leave messages with detailed information on your home phone? Yes or No

Work Phone? Yes or No

Cell phone? Yes or No

Would you prefer to receive reminder texts or emails? If yes, please provide the phone number or email address in which we may send for reminders_____

REMINDER TEXTS AND EMAILS ARE SENT BY A THIRD PARTY SERVICE. THESE MESSAGES WILL STATE "PATIENT HAS AN APPOINTMENT WITH HOLLIE WHITE ON DATE AND TIME." PLEASE TO DO NOT ATTEMPT TO CONTACT THERAPIST BY REPLYING TO THESE TEXTS OR EMAILS.

May we write to you at your address? Yes or No

Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above. **PLEASE SIGN** _____

Who May Bring Your Child to in Your Absence? I hereby authorize the person(s) below to bring my child/children to Be Well Counseling LLC for their scheduled appointments in my absence. Furthermore, I assume full responsibility for any medical costs incurred as a result. This authorization shall remain valid until revoked by me.

1._____

2. _____

_____ _____

Client Signature Date

_____ _____

Parent/Guardian Signature (if applicable) Date

_____Witness Signature and date

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Insurance and Financial Agreement

If you wish to file your insurance, I must provide a diagnosis to your insurance provider. By signing this consent, you are giving me your permission to provide that information for billing purposes. Please know that Be Well Counseling respects your right to privacy and confidentiality, but in order to bill insurance please know that records are subjected to audits by insurance companies.

Additionally, by signing this document you are agreeing to timely payment to Be Well Counseling if your insurance does not cover counseling services provided by this practice. By signing this form you are also agreeing to pay for deposition or court fees, if this becomes necessary. Please note that copays and other fees are due at the time of service. I ask that you give a 24 hour notice if you are unable to keep your appointment.

Extra fees include:

NO SHOW FEES- NOT SHOWING FOR THE APPOINTMENT AND NOT CONTACTING THERAPIST PRIOR TO THE APPOINTMENT -
BETWEEN 9AM AND 3PM -$25.00
BETWEEN 4PM-7PM AND SATURDAYS $45.00

Letters - $20
Document preparation including record requests – starts at $50 and will be billed according to time spent.
Phone calls with clients/guardians (after 15 min) - $25 for each 15 min increment
Phone calls with third parties (except healthcare workers) - $20+
Returned check fee per check- $ 35

BE WELL COUNSELING DOES NOT PROVIDE RECOMMENDATIONS, LETTERS, OR EVALUATIONS FOR CUSTODY OR VISITATION. IF A VALID SUPEONA OR COURT ORDER IS ISSUED DOCUMENTS WILL BE PROVIDED BASED ON COURT ORDER (SEE DOCUMENTATION PREP FOR CHARGES RELATED TO PROVIDING RECORDS). COURT FEES IF REQUIRED TO APPEAR IN COURT START AT $150 AN HOUR INCLUDING TRAVEL TIME AND MILEAGE.

We will keep a credit card number on file in the instance that you do not pay your balance within 60 days. By signing this agreement, you are accepting the financial responsibility to pay your fees in a timely manner or Be Well Counseling will charge your card the necessary funds. Note, this card will not be used for any other circumstances.

_____ _____ ____/____/____
Patient and/or Parent/Guardian Signature Printed Name/Relationship to Client Date

_____ _____ ____/____ _____
Card Number Security code/CVV Expiration Zip Code

_____ ____/____/____
Witness Signature Date

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Counseling Consent

Welcome to Be Well Counseling. This is a private, professional counseling practice whose primary purpose is to enhance quality of life and strengthen individuals and families. It is my primary responsibility to respect the dignity and promote the welfare of those I serve. This form serves to explain my purpose, services, and limitations. If you choose to participate in counseling, or you, as a parent/guardian, choose for your child to participate, we must have your signed permission. Please be aware that participation in counseling is voluntary, and you have the right to decline.
My primary **purpose** is to provide professional counseling for individuals and families. As you or your child begins counseling, I want you to know that I am committed to providing the highest quality of professional counseling **services** for individuals and families regardless of race, gender, religion, ability, or ethnic/national origin.

RISKS AND BENEFITS: Counseling and psychotherapy are beneficial, but as with any treatment, there are inherent risks. During counseling, you will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. The benefits of counseling can far outweigh any discomfort encountered during the process. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem solving. I cannot guarantee these benefits, of course. It is my desire, however, to work with you to attain your personal goals for counseling and/or psychotherapy.

COUNSELING: The first visit will be an assessment session or Intake in which you or you and your child, and I will determine identified concerns, and if we both agree that I can meet your therapeutic needs, develop a plan of treatment. Should you choose not to follow the plan of treatment provided, services may be terminated. My goal is to provide the most effective therapeutic experience available. If at any time you feel I am not a good fit for your or your child's therapeutic needs, please discuss this matter with me to determine if transferring to a more suitable Therapist is right for you or your child. If it is decided that other services would be more appropriate, I can be of assistance in finding a provider to meet you or your child's needs. Wellness is more than the absence of disease; it is a state of optimal well-being. It goes beyond the curing of illness to achieving health. Through the ongoing integration of our physical, emotional, mental, and spiritual self, each person has the opportunity to create and preserve a whole and happy life. My services are designed to provide my patients an integrated solution for their mind, body, spirit, and life to enhance their lives and resolve issues. I am committed to providing the highest quality of counseling services for individuals and families, regardless of race, age, ethnicity/national origin, gender, religion, sexual orientation, or ability.

APPOINTMENTS: Appointments are scheduled based on the patient's individual needs and my assessment of what is clinically indicated. Therapy sessions are approximately 53 minutes long. More frequent sessions or an intensive outpatient schedule are available if determined to be clinically appropriate. If you must cancel or reschedule an appointment, I ask that you call me at (205) 821-2979 at least 24 hours in advance, whenever possible. This will free your appointment time for another patient. **PLEASE SEE FINANCIAL AGREEMENT FOR APPLICABLE FEES REGARDING NO-SHOWS.**

EMERGENCIES: If you or your child encounter a situation which requires prompt attention, please contact me at (205) 821-2979 regarding the nature and urgency of the circumstance. You may also contact the direct office line at (205) 988-4350 and leave me a message during normal business hours. I will make every attempt to schedule you or your child as soon as possible or to offer other options. **Because patients may be scheduled back-to-back, it is not always possible to return a call immediately.** However, I will make every effort to respond to you in a timely manner. If you are experiencing a life-threatening emergency, **call the Birmingham Crisis Center at (205) 323-7777** or have someone take you or your child to the nearest emergency room for help. When I am out of town, you will be advised and given contact information for on-call procedures.

CONFIDENTIALITY: I follow all ethical standards prescribed by state and federal law. I am required by practice guidelines and standards of care to keep records of your counseling. These records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to you. Discussions between a Therapist and a patient are confidential. To ensure patient confidentiality, recording audio or video in your session without the written consent of your therapist is prohibited. No information will be released without the patient's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: **reports of child abuse (physical, sexual, and statutory cases) and neglect**; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation, AIDS/HIV infection and possible transmission; criminal prosecutions; **child custody cases (this would be in the event of a subpoena or court order)**; suits in which the mental health of a party is in issue; situations where the Therapist has a duty to disclose, or where, in the Therapist's judgment, it is necessary to warn or disclose; fee disputes between the Therapist and the patient; a negligence suit brought by the patient against the Therapist; or the filing of a complaint with the licensing or certifying board. If you have any questions regarding confidentiality, you should bring them to my attention when we discuss this matter further. **By signing this Consent Form, you are giving consent to the undersigned Therapist to share confidential information with all persons mandated by law and with the agency that referred you and the insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding harmless the undersigned Therapist from any departure from your right of confidentiality that may result.** You may give permission for the therapist to provided limited information to third parties including but not limited to schools, employers, doctors, psychiatrists, spouses/family members, etc. You can do this by signing a RELEASE OF INFORMATION. Releases must be signed in person and can be revoked at any time by the patient or parent with a written request. Information will be released at the discretion of the therapist. Patients over the age of 14 years of age should sign giving consent along with the parent/guardian.

SOCIAL MEDIA, TEXTING, AND EMAILS- Be Well Counseling and its employees do not accept friend requests or contact requests from current or former patients on any social networking sites (Facebook, Linkedin, Pinterest, Twitter, Instagram, etc). Communication on these sites can compromise confidentiality and negatively impact the patient/therapist relationship. The American Counseling Association Code of Ethics prohibits soliciting testimonials of patients. At this time Be Well Counseling does not offer text or email service for direct communication. Texts reminders and emails are sent through a third party service and by signing the contact form you are agreeing to this service and waiving your right to keep appointment information (PHI) completely private.

DUTY TO WARN/DUTY TO PROTECT: If the Therapist believes that I (or my child if child is the patient) am in any physical or emotional danger to myself or another human being, I hereby specifically give consent to my Therapist to contact any person who is in a position to prevent harm to me or another, including, but not limited to, the person in danger. I also give consent to my Therapist to contact the following person(s) in addition to any medical or law enforcement personnel deemed appropriate:

EMERGENCY CONTACT Name and Number:_____

INCAPACITY OR DEATH: I understand that, in the event of the death or incapacitation of my Therapist, my case can be assigned to another Therapist which will have possession of my treatment records. I hereby consent to another licensed mental health professional, selected by the undersigned Therapist, to take possession of my records and provide me copies at my request, and/or to deliver those records to another therapist of my choosing.

I understand the information provided above, and I freely give my consent for myself/my child to receive counseling services as offered and provided Be Well Counseling. I also understand that I may withdraw my consent at any time by written request, effective at the time and date received by Be Well Counseling.

_____	_____	____/____/____
Patient Signature (14 yrs and older)	Print Client Name	Date
_____	_____	____/____/____
Parent/Guardian Signature (if applicable)	Print Name and Relationship to Client	Date

_____ Witness Signature and date

BE WELL COUNSELING LLC
4000 SOUTHLAKE PARK SUITE 150
HOOVER, AL 35244

Authorization for the Release of Protected Health Information

This completed form authorizes and requests BE WELL COUNSELING LLC to **release** the following patient's information:

Patient's Name: _____ DOB: _____ SS#: _____

I, the undersigned, authorize and request Hollie White to release the following **specific** patient information: (include dates of service, type of service, etc.)

1. School/work excuses
2. _____
3. _____
4. _____

I understand that this authorization will result in the release of clinical information regarding the patient's diagnosis, behavioral or mental health condition, substance abuse history, and psychiatric and/or counseling services. I understand that these records are strictly confidential and solely for the information of the person to whom addressed.

This information is to be released to: (**specific name and address of school or employer**)

_____

_____

This information is to be released for the **specific** purpose(s) of: (if authorization requested by the patient, put "at the request of the individual") school/work excuses

_____

This authorization is valid for one year from the date listed below. You may revoke this authorization at any time by notifying BE WELL COUNSELING LLC in writing, but such revocation will have no effect on disclosures of information already made under this authorization prior to receipt of the revocation. This authorization is voluntary and you may refuse to sign the authorization and the patients' treatment or payment obligations will not be affected by this authorization unless (i) the treatment is related to research and the use and/or disclosure is related to such research, or (ii) the treatment is solely for the purpose of creating protected health information for disclosure to a third-party. Upon signature, you may receive a copy of this authorization. The information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by state or federal law. BE WELL COUNSELING LLC will not receive financial or in-kind compensation or remuneration in exchange for the use and/or disclosure of the patient's information unless an applicable legal exception applies. This authorization is continuing in nature and is to be given full force and effect to release any and all of the foregoing information learned or determined after the date hereof until the expiration date. I hold BE WELL COUNSELING, its employees, directors, officers, agents and representatives harmless from any and all damages which might result to myself, the patient, our representatives, heirs, and/or assigns from the disclosure of this information. A copy or facsimile of this authorization shall be valid and effective, just as the original.

_____ **Date:** _____
Patient Signature

_____ _____ **Date:** _____
Parent/Patient Representative Signature (If Applicable) **Printed Name and Relationship to Patient (If Applicable)**

_____ **Date:** _____
Witness Signature

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Adult Patient questionnaire page 1

Patient Name: _____ **Date:** _____

Please read the following questions and answer to the best of your ability by placing a checkmark in the appropriate boxes or fill in the blank as directed. Your cooperation is appreciated.

Please state in your own words why you have come to _____ today:

_____

_____

_____

_____

_____

_____

_____

Please check ALL of the following symptoms or thoughts that apply to you **AT THIS TIME or during the past six months:**

Depressed mood
Diminished interests or pleasure
Sleep disturbance
Fatigue
Change in appetite
Hopelessness
Pleasure in few activities
Weight change
Agitation
Excessive worry
I feel like I am losing control.
Irritability
Poor Concentration
Tension
Feelings of panic
Socially withdrawn
Use of alcohol
Use of illicit drugs
Use of tobacco
Anxiety in social settings
Makes careless mistakes
Does not complete tasks
Difficulty organizing
Forgetful
Confusion
Disorientation
Compulsive checking / counting
Indecisiveness
People talk about me.
Some people want to hurt me.
I feel emotionally distant from others.
I hear voices or sounds others do not hear.
I see things others do not see.
I smell things others do not smell.
Racing thoughts
I do risky or dangerous things.
Little interest in sexual activity
Sexual problems
Gender concerns
I don't like my body.
Binge eating
Self induced vomiting
Laxative abuse
Excessive fasting
Intense fear of weight gain
Impulsive
I think about hurting myself.
I have trie to hurt myself.
Sometimes I wish I were dead.
I think about hurting someone else.
Exposed to a significant traumatic event
Recurrent distressing dreams

Social and Family History:

Who lives in the home with you:_____

_____

Marriages:_____

Children:_____

Family Supports:_____

Social Supports:_____

Work/Education History:

Highest level of education completed:_____

Schools attended (high school, college, technical schools):_____

_____

Work history current/past:_____

_____

Legal Involvement:

History of arrests:_____

Current charges pending:_____

DHR involvement:_____

Psychiatric History:

I have received treatment for: Substance abuse □ Mental health issues □ Both □

The treatment occurred at:

□ Other private psychiatrist □ Mental Health Center
□ Hospital □ Other counseling service □ Other facility

Are you presently being treated? Yes □ No □ If yes, by whom? _____

_____

Name of your primary care doctor _____

Phone: _____ Date last seen: _____

Do you have a history of any medical problem? Yes □ No □ If so, what? _____

_____

Are you presently being treated for any medical problem? Yes □ No □ If so, what?

_____

Past surgeries: _____

_____

_____

Have you ever received treatment for any of the following medical conditions?

Neurological impairment
Seizure disorder
Visual loss / impairment
Hearing loss / impairment
Dementia
GI disorder
Obesity
Significantly underweight
Cirrhosis
Hepatitis
Heart condition
Hypertension
Asthma
Emphysema
Chronic bronchitis
Tuberculosis / +PPD
Cancer
Thyroid disease
Diabetes
Pregnancy
Irregular menstrual periods
Musculoskeletal condition
HIV / AIDS / Related condition
Other

Please list any medications you are presently prescribed.

_____

_____

_____

_____