

# THRIVE

HEAL THRIVE GROW BEHAVIORAL HEALTH

## CLIENT INFORMATION SHEET

(Please be sure to fill out this form entirely, indicating N/A if not applicable)

Client Name \_\_\_\_\_ DOB \_\_\_\_\_ S.S. # \_\_\_\_\_  
\*Age \_\_\_\_\_ Gender \_\_\_\_\_ Marital Status \_\_\_\_\_ Sexual Orientation \_\_\_\_\_  
Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home/Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Can we leave a message?:  yes  no  
Email Address \_\_\_\_\_ Preferred contact method:  phone  email

Job Title \_\_\_\_\_ Employer \_\_\_\_\_  
Work Address \_\_\_\_\_  
Work Phone \_\_\_\_\_ Can we leave a message? \_\_\_\_\_ yes \_\_\_\_\_ no

Students: Grade \_\_\_\_\_ School \_\_\_\_\_ School Counselor \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_

Primary Physician \_\_\_\_\_ Date of last visit \_\_\_\_\_  No Primary Physician  
Address \_\_\_\_\_ Phone \_\_\_\_\_  
Emergency Medical Provider Name and Contact Number(s): \_\_\_\_\_

Psychiatric Prescriber \_\_\_\_\_ Date of last visit \_\_\_\_\_  No Psychiatric Prescriber  
Address \_\_\_\_\_ Phone \_\_\_\_\_

Who referred you to this office? \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_  
Reasons for referral? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_  
Home/Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

**\*If minor under the age of 18 years old:**

Legal Guardian Name \_\_\_\_\_ DOB \_\_\_\_\_ S.S. # \_\_\_\_\_  
Relationship to client: Parent \_\_\_\_\_ Other \_\_\_\_\_ (check one) If other, specify relationship \_\_\_\_\_  
Address \_\_\_\_\_  
Phone (home) \_\_\_\_\_ (work) \_\_\_\_\_

**Client or authorized person's signature:** I authorize Health THRIVE Grow Behavioral Health to make contact with the referral source, my physician and my prescriber, for purposes of treatment planning and coordination of care.

\_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Printed Name

## **INFORMED CONSENT STATEMENT & OFFICE POLICY**

The following statement answers important and frequently asked questions concerning the Heal Thrive Grow Behavioral Health (THRIVE). If you have further questions after reading this, or other concerns not covered here, please bring them, up with your therapist at your first appointment. Please keep one copy of this statement for your records. The original, signed and dated, will be kept in your file. It is very important that you read the entire statement carefully before signing.

### **Service Delivery Policies and Procedures**

The first step in receiving services is to complete a mental health assessment with your therapists. You will then be provided information regarding service options. After your assessment you also have the right to be informed of your mental health diagnosis, as well as the right to discontinue treatment at any time. However, we encourage you to discuss the latter choice openly with your therapist first. Similarly, your therapist may need to terminate your treatment if, in his or her judgment, you are not benefiting from treatment or are non-compliant with treatment requirements. A full copy of all our service delivery policies and procedures will be made available to you upon request.

### **Possibilities, Risks, and Benefits**

The goal of mental health treatment is to decrease targeted symptoms. There are some risks to treatment: Symptoms can worsen before they improve or may persist even after treatment is complete. New symptoms or treatment issues may emerge during the course of treatment. Progress related to mental health symptoms or issues can result in changes that have the potential to disrupt life patterns or interpersonal relationships. There are also many benefits to treatment: Individuals participating in mental health treatment often learn techniques to help cope with difficult emotions, change destructive patterns of thinking, improve functioning related to trauma or anxiety, improve interpersonal communication and demonstrate a positive impact overall behavior and personal wellness.

### **Complaints and Grievances**

Any client who has a grievance arising from their treatment at Thrive Clinic may present their grievance, verbally or in writing, to their therapist or a clinic director. This individual will investigate the nature of the grievance and seek to reach an acceptable and reasonable resolution in a timely manner. All clients and their parents (or legal guardians where appropriate), will be offered a copy of our grievance policy at the time of their first appointment. All grievances will be kept confidential unless the law requires that they be disclosed, and if disclosure is so required, they will be disclosed to as few persons as possible. The receipt, investigation and action taken regarding the grievance shall be documented in the client's chart.

Additionally, clients are encouraged to take their grievance outside the program (e.g., to a licensing board, a state professional organization, a client rights advocacy group, the state insurance commissioner) if at any point they feel it is necessary to do so.

### **Confidentiality**

We abide by the laws and ethical principles that govern privilege and confidentiality. We will not disclose to

anyone anything you tell us, not even the fact that you are a client in the program, without your written permission via a signed release of information form. There are a few exceptions to this standard:

1. It is legally required of us that we act to prevent physical harm to yourself or others when there is "clear and imminent" danger of that happening.
2. We are legally required to report cases of ongoing child, elder and disabled abuse.
3. We will tell the police and courts about any crime by a client committed at our program, or against any person who works for us, or about any threat to commit such a crime.
4. We may have to release clinical information regarding you to insurance carriers as required for payment or review of a claim.
5. We may have to release your records when ordered to do so by court subpoena. However, we will discuss the details of privilege with you beforehand and request a written release from you if we judge this to be in your best interest.
6. Occasionally, we may use a fax machine or email to send treatment plans, and other evaluations to your insurance company, specific agencies or other providers. Although we make every attempt to safeguard this information, faxed and emailed information is not necessarily guaranteed confidential.
7. Thrive Clinic staff may consult internal clinical supervisors about your treatment progress. If we need to consult outside our clinic, we would obtain your permission first and be careful to conceal your name or other identifying information.

### **Appointments and Cancellations**

Individual sessions are arranged by appointment only. We will meet you at the exact time agreed upon. If we are late, we will make up the missed time or prorate your bill. If you are late, we will charge the full fee and you will lose that portion of time from your session. Cancellation of sessions should be avoided. If you need to cancel an individual therapy appointment, you will not be charged if you notify your therapist 24 hours in advance. If you no-show/no-call or late-cancel an appointment, you will be charged the full fee. Cancellations can be phoned into the office any time, day or night. Please be aware voicemail messages are date and time stamped.

### **Telephone Calls and Emergencies**

Our voice mail service enables you to call our office at any time, day or night, and leave a message for a return call. We check our phone messages at least twice a day during weekdays and return calls as soon as possible. If you are unable to reach your Thrive Clinic therapist, call the Crisis Line at 503-988-4888 (Multnomah County), 503-291-9111 (Washington County), or 503-655-8401 (Clackamas County), or go to the nearest hospital emergency room.

### **Safety Policy**

Thrive Clinic staff and client safety are of utmost importance. As such, any act of aggression to self, others or property while on site shall be reported as a critical incident to the director. A corrective action plan will be implemented to address the incident which may involve a written apology, compensation for damages, taking legal action, and/or immediate termination of Thrive services. Please note that minors must be accompanied by a responsible adult at all times while on Thrive Clinic premises and that it is his/her responsibility to monitor the

actions and whereabouts of the minor at all times.

### **Fees and Payment**

There are charges for all program services, including therapy, consultations, preparation of special reports or treatment summaries, or other services you may request. We do not have a sliding fee scale, but do offer a few low fee slots for clients in financial hardship. Financial policy and procedures including program fees will be provided to you at the point of referral and/or intake. Once informed, you will be asked to sign a form indicating acknowledgement and agreement with Thrive Clinic's financial policies and procedures. We require that you inform us immediately of any change in your contact information.

Thrive Clinic reserves the right to change terms or parts of this consent at any time. We will post any changes in our waiting room with ample notice.

By signing below, I am indicating I have read, understand, and agree to the information presented in this informed consent.

\_\_\_\_\_  
Client Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client Signature



## **TELEHEALTH INFORMED CONSENT STATEMENT & OFFICE POLICY**

The following statement answers some important and frequently asked questions concerning our use of telehealth services at Heal Thrive Grow Behavioral Health (THRIVE). In order to maintain care under certain circumstances, including during periods of office closure for any reason, THRIVE may offer to conduct individual sessions, group sessions, and assessments via telehealth service. Telehealth service is the delivery of healthcare services when the therapist and patient are not in the same physical location/site through the use of various technology. This could include video sessions via telehealth software on a computer or tablet, or phone sessions.

### **Risks and Benefits of Telehealth Sessions**

Generally speaking, the risks and benefits of telehealth are similar to those of in-person sessions. There are additional risks, however. First, although we will use secure platforms (e.g., Zoom) with industry-standard encryption and security, there is no way to guarantee that this software is completely failure-proof. As with any technology, there is a chance of a security breach that would affect the privacy of personal and/or medical information. Second, since you will be completing sessions in your own home, we cannot guarantee the same level of privacy that you have when you are in our clinic. This means that you are responsible for making sure that you are in a private area where disruptions (e.g., others coming into the room or hearing what you say in another room) are minimized as much as possible. Third, in the event of group sessions conducted via video, it is possible that your confidentiality could be breached if others in the group are not in a confidential setting.

In order to reduce risks to confidentiality, we suggest that all video or telephone sessions occur in a private room with no one else present and that you wear headphones to limit the possibility of other people overhearing confidential information. In group video sessions, you have the option to turn off your camera so that others may not see you.

**Since this may be different than the type of sessions with which you are familiar, it is important that you understand, acknowledge, and agree to the following statements:**

- You understand that you have undertaken to engage in a telehealth encounter for yourself that will contain personal identifying information as well as protected health information
- You understand that the therapist/assessor will be at a different location from you.
- You understand that you have the right to withhold or withdraw your consent to the use of telehealth services at any time in the course of your care, without affecting your right to future care or treatment.
- You have been informed of and accept the potential risks associated with telehealth, such as

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failure of security protocols that may cause a breach of privacy of personal and/or medical information.

- You understand that the laws that protect privacy and the confidentiality of medical information also apply to telehealth, and that no information obtained in the use of telehealth which identifies you will be disclosed to other entities without your consent or as may be allowed by law.
- You have been given the opportunity to ask your provider at THRIVE questions relative to your Telehealth encounter, security practices, technical specifications, and other related risks.

**By signing this form, you certify:**

- That you have read or had read and/or had this form explained to you;
  - That you fully understand its contents including the risks and benefits of telehealth services;
- and
- That you have been given ample opportunity to ask questions and that any questions have been answered to your satisfaction.

\_\_\_\_\_  
**Signature of Client**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Printed Name of Client**

\_\_\_\_\_  
**Signature of Person Obtaining Consent**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Name of Person Obtaining Consent**

Revised 3.13.20

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## LYRA HEALTH INFORMATION FORM

*Please complete the following information if you have coverage under Lyra Health and would like Thrive Clinic to bill Lyra Health for covered services. Please fill out completely, do not leave any fields blank.*

Client Name \_\_\_\_\_ DOB \_\_\_\_\_

Lyra code: \_\_\_\_\_

Subscriber Name \_\_\_\_\_ DOB \_\_\_\_\_

Name of Subscriber's Employer \_\_\_\_\_

Subscriber Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Subscriber Phone Number: \_\_\_\_\_

Client's Relation to Subscriber \_\_\_\_\_

Heal Thrive Grow Behavioral Health has my permission to bill Lyra Health. I authorize the clinic to release any information necessary to process my claims. Payments from Lyra Health made on my behalf will be paid directly to Thrive Clinic.

Name: \_\_\_\_\_ Relation to Client: \_\_\_\_\_

Signature: \_\_\_\_\_ Date \_\_\_\_\_



Updated 3.7.18

## FINANCIAL POLICY

In the interest of a cooperative working relationship between Heal Thrive Grow Behavioral Health (THRIVE) and our clients, please carefully read the financial policy as described below. If you have any questions or concerns regarding this policy, we encourage you to speak with your therapist at your first appointment.

**Billing and Client Fees:** Client out-of-pocket expenses are due at the time of service. We do not bill insurance. However, we will be happy to provide you with a statement to submit to your health plan should you wish to recover your out-of-pocket expenses directly from them.

**Client Delinquent Balances:** Client balances are due in full within 30 days of receiving your monthly statement. During treatment, clients that have patient balances exceeding \$500.00 must be paid in full in order to continue receiving services. You will be given adequate notice and referral options should your treatment at Thrive Clinic need to be postponed until delinquent patient balances have been resolved. Please be advised that accounts past due by 90 days, unless payment arrangements have been made with the billing department, may be sent to collections. As a courtesy to clients, a collections warning letter is sent indicating the status of your account. You will be given 10 working days to respond to this notice before action is taken. If you discontinue treatment at any time and your account is delinquent or assigned to collections, you will not be allowed to return to treatment until your balance has been paid in full. Further, if you name Thrive Clinic, or its clinicians, as a debtor when filing bankruptcy you will not be able to return for services.

**Client Refunds:** Client refunds are issued the 15th of every month once your account has been cleared. In other words, refunds will not be issued until your account has a zero balance and has been closed by your therapist.

**Receipts:** Receipts will be provided at the time of payment. We recommend that you maintain a record of your visits and payments for any reimbursement that your employer or health plan may require.

**Returned Checks:** There is a \$25.00 processing fee on returned checks. We require that your returned check amount plus the processing fee be paid in full on or before your next scheduled appointment.

**Appointments:** Individual sessions are arranged by appointment only. We will meet the client at the exact time agreed upon. If we are late we will make up the missed time or prorate your bill. If the client is late we will charge the full fee and he/she will lose that portion of time from their session. Cancellation of sessions should be avoided. If the client needs to cancel an individual therapy appointment, he/she will not be charged for the appointment if he/she notifies their therapist 24 hours in advance of the scheduled appointment. If the client no-show/no-call or late-cancels an individual therapy or medication management appointment, they will be charged the full fee. Where 24 hours notice is given, the charge for a missed group session is \$30.00. No show/no call or late cancelled group sessions are charged at the full rate. Fees charged for missed sessions are not reimbursable by insurance companies.

**Fees:** Assessment sessions are \$275.00 per hour. The fee for individual therapy services is \$250.00 per hour. Psychological testing is paid at \$185.00 per hour. Case management/coordination of care services are billed in 15-minute increments based on \$100/hour fee. Medication management fees are as follows: Medication Evaluation; \$275.00, Medication Management, \$250.00 per 30 min session. For individuals in a financial hardship situation, we have a few low fee slots available.

*Signing below indicates 1) I have read Thrive Clinic's financial policy, 2) I understand Thrive Clinic's financial policy, and 3) I agree to Thrive Clinic's financial policy.*

Financially Responsible Party:

Name: \_\_\_\_\_ Relation to Client: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



PATIENT EMAIL AND TEXT MESSAGE CONSENT FORM

Patient Name:

Email Address:

Text message number(s):

1. RISK OF USING EMAIL AND/OR TEXT MESSAGE

Transmitting patient information by email or text has a number of risks that patients should consider before using email or text. These include, but are not limited to, the following risks:

- a) The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") recommends that E-mail that contains protected health information be encrypted. Emails and text messages sent from Heal Thrive Grow Behavioral Health (THRIVE) are not encrypted, so they may not be secure. Therefore, it is possible that the confidentiality of such communications may be breached by a third party.
b) Email/texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
c) Senders can easily misaddress an email/text.
d) Email /text is easier to falsify than handwritten or signed documents.
e) Backup copies of email/text may exist even after the sender or the recipient has deleted his or her copy.
f) Employers and on-line services have a right to inspect email or text transmitted through their systems.
g) Email/text can be intercepted, altered, forwarded, or used without authorization or detection.
h) Email/text can be used to introduce viruses into computer systems.
i) Email/text can be used as evidence in court.

2. CONDITIONS FOR THE USE OF EMAIL/TEXT

THRIVE cannot guarantee but will use reasonable means to maintain security and confidentiality of email/text information sent and received. Patients must acknowledge and consent to the following conditions:

- a) Email is not appropriate for urgent or emergency situations. THRIVE cannot guarantee that any

particular email will be read and responded to within any particular period of time.

- b) Text messages may be used (at the therapists discretion) to initiate coaching calls with the therapist. However, the content of urgent phone coaching typically occurs over direct voice-to-voice communications.
c) All clinically relevant email/text will typically be printed and filed in the patient's medical record.
d) Practice will not forward patient identifiable emails/texts outside of the Practice without the patient's prior written consent, except as authorized or required by law.
e) In the event that the patient does not comply with the conditions herein, Practice may terminate patient's privilege to communicate by email/text with Practice.
f) Appointment reminders via email or text message can only be done after the patient consents to receiving such messages, in compliance with the Telephone Consumer Protection Act (TCPA).

3. PATIENT ACKNOWLEDGMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email/text between THRIVE and me, and consent to the conditions and instructions outlined, as well as any other instructions that the THRIVE may impose to communicate with patient by email/text. If I have any questions, I may inquire with the Practice Privacy Officer.

Patient

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Would you like to receive automated appointment reminders...

via e-mail? Yes No

via text (SMS)? Yes No

via voicemail? Yes No

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5200 SW Macadam Ave., Suite 580  
Portland, OR 97239  
Voice: (503) 290-3261 Fax: (503) 231-8153

Therapist: \_\_\_\_\_

- Thrive is **SENDING** Records
- Keep Release on **FILE** for Future Use
- Thrive is **REQUESTING** Records

## AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

A. By signing this form, I, (client's full name) \_\_\_\_\_ authorize the use and disclosure of my individually identifiable health information to/from:

\_\_\_\_\_  
Person and Agency Represented (if applicable)

\_\_\_\_\_  
Address and Phone/Fax Number

B. **Purpose of Disclosure:** Mental Health Treatment Planning and Continuity of Care. Health information that may be used or disclosed through this authorization is as follows:

- Assessment/Treatment/Coordination of Care
- Eligibility Determination
- Legal/Court/Corrections/Probation
- At the request of the client
- Other: \_\_\_\_\_

C. **Specific Information to be Disclosed:** By **initialing** next to a category listed below, I specifically authorize use of confidential information.

- Psychiatric and Mental Health information as included in the records.
- Alcohol and Drug Treatment information (Specifically protected under law)
- AIDS/HIV/ other STD testing information (Specifically protected under law)
- All health information about me as described above, *excluding* the following: \_\_\_\_\_
- Specific health information including only: \_\_\_\_\_
- Mail records certified if indicated by Thrive Clinic

D. I give permission to release my records from the following dates:

\_\_\_\_\_  
(approximate start date of treatment from provider above)

\_\_\_\_\_  
(approximate end date of treatment from provider above)

E. I understand that my records are protected under the federal and state confidentiality regulation, including HIPAA, CFR 42 Part 2, RCW 71.05, 70.02, 71.34, 74.04, 13.50.100(4)(b) and WAC 388-865-0436 or its successor, and can not be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent in writing at any time, but that in any event this consent expires automatically in **180 days** or shall remain in effect for the period of time reasonably needed to complete the request. I understand that I may refuse to sign this authorization and that such refusal will not affect my ability to obtain treatment from Thrive.

I have read and understand the terms of this authorization. I have had an opportunity to ask questions about the use or disclosure of my health information. I understand that, except when I am receiving health care solely for the purpose of creating information for disclosure to a third party, I may refuse to sign this authorization.

Date \_\_\_\_\_ Signature of Client \_\_\_\_\_

Print Client's Full Name \_\_\_\_\_

Client's Birth Date \_\_\_\_\_ SS#: \_\_\_\_\_

Date \_\_\_\_\_ Signature of Parent/Legal Representative\* \_\_\_\_\_

\*When client is not of legal age or competent to give consent, the signature of Parent or Legal Representative: \_\_\_\_\_

F. **Redisclosure:** If you give us permission to share your information with others, they may share your information without your consent. We cannot ensure that your information will be protected by others. However, some instances of State and/or Federal law may protect your information from being shared with others if it is information about HIV/AIDS, mental health, genetics, or drugs/alcohol.

G. **Information about treatment, payment, and insurance:** If your written permission to release health information about you is needed to determine your eligibility for medical programs and you do not give us permission to release your health information, then you may not be able to show that you are eligible. If another health care provider has asked us to provide a health care service to you, such as a test or evaluation, and you do not give us written permission to release your information to them, then we may not provide you with that health care service.

To the recipients of protected health care information: The information that has been disclosed to you from this authorization is protected by State laws (ORS 179.505, 192.525) and Federal regulations (42 CFR Part 2, 45 CFR Parts 160-164). You are instructed that you may not re-disclose this information with the written authorization from the person to whom the information pertains, or otherwise in accordance with the law.

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## CLIENT SELF-REPORT FORM

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Please check items that you consider problematic:**

<input type="checkbox"/>	Distractibility	<input type="checkbox"/>	Panic attacks	<input type="checkbox"/>	Impulsivity	<input type="checkbox"/>	Reoccurring nightmares
<input type="checkbox"/>	Sadness/depression	<input type="checkbox"/>	Fear of being away from home	<input type="checkbox"/>	Compulsive behavior	<input type="checkbox"/>	Intrusive thoughts/images
<input type="checkbox"/>	Hopelessness	<input type="checkbox"/>	Anxiety/worry	<input type="checkbox"/>	Hyperactivity	<input type="checkbox"/>	Sleep difficulties
<input type="checkbox"/>	Sleep problems	<input type="checkbox"/>	Obsessive thoughts	<input type="checkbox"/>	Irritability/anger	<input type="checkbox"/>	Hypervigilance
<input type="checkbox"/>	Change in appetite	<input type="checkbox"/>	Social discomfort	<input type="checkbox"/>	Aggression	<input type="checkbox"/>	Flashbacks
<input type="checkbox"/>	Loss of pleasure	<input type="checkbox"/>	Suspicion/paranoia	<input type="checkbox"/>	Frequent arguments	<input type="checkbox"/>	Avoidance of certain people, places, situations
<input type="checkbox"/>	Crying spells	<input type="checkbox"/>	Visual hallucinations	<input type="checkbox"/>	Sexual Problems	<input type="checkbox"/>	Increased startle response
<input type="checkbox"/>	Seasonal mood changes	<input type="checkbox"/>	Racing thoughts	<input type="checkbox"/>	Computer addiction	<input type="checkbox"/>	Feeling detached/unreal
<input type="checkbox"/>	Thoughts of death	<input type="checkbox"/>	Hearing voices	<input type="checkbox"/>	Relationship problems	<input type="checkbox"/>	Losing time/dissociation
<input type="checkbox"/>	Low self worth	<input type="checkbox"/>	Poor memory/concentration	<input type="checkbox"/>	Problems with pornography	<input type="checkbox"/>	Wide mood swings
<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	Homicidal thoughts	<input type="checkbox"/>	Gambling problems	<input type="checkbox"/>	Excessive energy
<input type="checkbox"/>	Withdrawal from people	<input type="checkbox"/>	Self-harm	<input type="checkbox"/>	Work/school problems	<input type="checkbox"/>	Alcohol/drug abuse
<input type="checkbox"/>	Guilt/shame	<input type="checkbox"/>	Loneliness	<input type="checkbox"/>	Eating problems	<input type="checkbox"/>	Other:
<input type="checkbox"/>	Lack of motivation	<input type="checkbox"/>	Boredom	<input type="checkbox"/>	Parenting problems		

**Additional symptoms or problems:**

**Previous or current diagnoses:**

**Please check areas that are affected by the above items:**

<input type="checkbox"/> Hygiene	<input type="checkbox"/> Finances/ housing	<input type="checkbox"/> Sexual activity	<input type="checkbox"/> Recreational activities
<input type="checkbox"/> Relationships	<input type="checkbox"/> Work/school	<input type="checkbox"/> Health	<input type="checkbox"/> Handling daily tasks

**History of problem:**

Time period	Details of problem
Childhood	
Adolescence	
Young adulthood	
Adulthood	

**Current treatment:**  No current treatment

Provider	Name	Contact information	Summary of treatment (e.g. length of time, progress thus far)
Therapist			
Prescriber			
Treatment programs			
Community resources			

**Previous treatment:**  No previous treatment

Provider/program	Dates seen	Outcome

**Psychiatric hospitalizations:**  No psychiatric hospitalizations

Hospital	Dates	Reason

**High risk behavior:**

Suicidal behavior:  No suicidal behavior

<input type="checkbox"/>	Frequent and severe
<input type="checkbox"/>	Mild/moderate and occasional
<input type="checkbox"/>	Frequent morbid, but not suicidal thoughts/images
<input type="checkbox"/>	Current plan for suicide including timeline. Details:
<input type="checkbox"/>	Gun in home or easy access

Suicide attempt (date/age)	Circumstances?	Treatment received

**Self-harm behavior**  No self-harm behavior

Type of self harm behavior	<input type="checkbox"/> Cutting <input type="checkbox"/> Burning <input type="checkbox"/> Head banging <input type="checkbox"/> Hitting self <input type="checkbox"/> Scratching <input type="checkbox"/> Other:
Circumstances?	

**Aggressive behavior**  No aggressive behavior

Type of aggressive behavior	<input type="checkbox"/> Physical aggression toward others <input type="checkbox"/> Verbal aggression toward others <input type="checkbox"/> Destruction of property <input type="checkbox"/> Cruelty toward animals <input type="checkbox"/> Other:
Circumstances?	

**Trauma:**  No trauma

Type of trauma	<input type="checkbox"/> Sexual abuse <input type="checkbox"/> Physical abuse <input type="checkbox"/> Emotional abuse <input type="checkbox"/> Neglect <input type="checkbox"/> Other:
Circumstances?	

**Legal history:** **No legal history**

<input type="checkbox"/> On probation	<input type="checkbox"/> Convicted of felony	<input type="checkbox"/> Involved in custody case	<input type="checkbox"/> Legal charges
<input type="checkbox"/> Convicted of misdemeanor	<input type="checkbox"/> Involved in divorce	<input type="checkbox"/> DUII	<input type="checkbox"/> Other:
Circumstances?			

**Substance use/abuse:** **No substance use/abuse**

Current substance use/abuse	<input type="checkbox"/> Alcohol <input type="checkbox"/> Marijuana <input type="checkbox"/> Cocaine <input type="checkbox"/> Methamphetamines <input type="checkbox"/> Ecstasy <input type="checkbox"/> Heroin <input type="checkbox"/> Inhalants <input type="checkbox"/> LSD <input type="checkbox"/> Steroids <input type="checkbox"/> Prescription medications, Type:
Quantity of substance use/abuse	Amount and frequency:
History of substance use/abuse	When started and how long:
Previous treatment	<input type="checkbox"/> Outpatient <input type="checkbox"/> Residential <input type="checkbox"/> Day Treatment <input type="checkbox"/> Other:
Family history	<input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Siblings <input type="checkbox"/> Grandparents <input type="checkbox"/> Aunts/Uncles <input type="checkbox"/> Other:

Do you have withdrawal symptoms when not using substance (e.g. physical cravings, illness, anxiety)?

 No  Yes, details:

Have you built tolerance for the substance (i.e. do you need to use more to get the same effect)?

 No  Yes, details:

Do you have problems due to substance use (e.g. work, relationships, health, legal)?

 No  Yes, details:**Medical History:**

Height:	Weight:
Childhood illnesses:	<input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Polio
Immunizations and date of last vaccinations:	<input type="checkbox"/> Tetanus <input type="checkbox"/> Influenza <input type="checkbox"/> Pneumonia <input type="checkbox"/> Hepatitis <input type="checkbox"/> Chickenpox <input type="checkbox"/> MMR (Measles, mumps, rubella)
General medical concerns (e.g. cancer, arthritis, heart, thyroid, neurological disease)	<input type="checkbox"/> No <input type="checkbox"/> Yes, details:
Prenatal complications	<input type="checkbox"/> No <input type="checkbox"/> Yes, details:
History of head trauma	<input type="checkbox"/> No <input type="checkbox"/> Yes, details:
History of major accidents/illnesses	<input type="checkbox"/> No <input type="checkbox"/> Yes, details:
Allergies (i.e. to food or medications)	<input type="checkbox"/> No <input type="checkbox"/> Yes, details:
General medical illnesses that run in your family	
Other notes about your health	
Primary care provider	Name: _____ Last visit: _____

**Please list all prescription medications you are taking:** **No prescription medications**

Medication	Dosage	Duration	Prescribed by



<b>Caffeine</b>	<input type="checkbox"/> None <input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Cola/Energy Drinks # of drinks per day?	
<b>Alcohol</b>	Do you drink alcohol? How many drinks per week? Are you concerned about the amount you drink? Have you considered stopping? Have you ever experienced blackouts when drinking?	<input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Tobacco</b>	Do you use tobacco? <input type="checkbox"/> cigarettes. ___ Packs/day <input type="checkbox"/> Chew ___ times/day <input type="checkbox"/> Pipe ___times/day <input type="checkbox"/> Cigars___#/day ___ Number of years of tobacco use   ___ Year quit	
<b>Drugs</b>	Do you currently use recreational or street drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No What recreational or street drugs do you use? How long have you used this drug?          When was the last time you used any drug? Have you ever given yourself street drugs with a needle? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Is there anything else you want your therapist to know about you?

What are your goals for treatment?