Anne M. Patti, PhD, LLC
200 West Center Street, Suite C-3
Manchester, Connecticut 06040
Telephone: 844-428-8728
E-mail: AnneMPatti@gmail.com
Anne M. Patti, PhD, Licensed Psychologist

Informed Consent & Agreement For Psychotherapy Services

Introduction. This document is intended to provide important information to you regarding your treatment. Please read the entire document carefully and be sure to ask me any questions that you may have regarding its contents before signing it. You may have questions about me, my qualifications, therapy, or anything not addressed here. It is your right to have a complete explanation for any questions you may have, now or in the future. Please feel free to ask questions or share any concerns that may arise. Although I know this may be uncomfortable at times, your openness and honesty will allow me to better serve you.

Information about Your Therapist. Whenever you wish, I will discuss my professional background with you and provide you with information regarding my experience, education, special interests, and professional orientation. You are free to ask questions at any time about the above, and anything else related to your therapy or other concerns.

Anne M. Patti, PhD, LLC is owned by Anne M. Patti, PhD, Licensed Psychologist, State of Connecticut Licensure #002091. The therapists in this office share space and some advertising. Each therapist's practice is separate, and each is solely and entirely responsible for any liabilities resulting from his/her own practice.

Fees. The fee for service is $280.00 for the initial intake session and $180.00 for each subsequent 55-minute therapy session. I reserve the right to periodically adjust the fee. You will be notified of any fee adjustment in advance. Fees are payable at the time that services are rendered. Please ask me if you wish to discuss a written agreement that specifies an alternative payment procedure.

If there is a need for telephone contact, with you or a third-party, other than for scheduling purposes, you understand that you are responsible for payment of the agreed-upon fee (on a pro rata basis) for any calls lasting longer than 10 minutes.

Appointment Scheduling and Cancellation Policies. Sessions are typically scheduled to occur one time per week at the same time and day if possible. I may suggest a different amount of therapy depending on the nature and severity of your concerns. Your consistent attendance greatly contributes to a successful outcome. Scheduled appointment times are reserved especially for you. **If an appointment is missed, or canceled with less than 24 hours notice, you (not your insurance company) will be charged a $85.00 fee for that missed session. Exceptions may be made if you are sick or have an unavoidable emergency.**

Insurance. Please inform me if you wish to utilize health insurance to pay for services. I will discuss the procedures for billing your insurance. Although I am happy to assist your efforts to seek insurance reimbursement, I am unable to guarantee whether your insurance will provide payment for the services provided to you. The amount of reimbursement and the amount of any co-payments or deductible depends on the requirements of your specific insurance plan. You should be aware that insurance plans generally limit coverage to certain diagnosable mental conditions, which then become part of your medical record. You should also be aware that you are responsible for verifying and understanding the limits of your insurance coverage. You are responsible for obtaining prior authorization for treatment from your insurance carrier. Please discuss any questions or concerns that you may have about this with me. If for some reason you find that you are unable to continue paying for your therapy, please inform me. I will help you to consider any other options that may be available to you at that time.

Risks and Benefits of Therapy. Psychotherapy is a process in which we will discuss a myriad of issues, events, experiences and memories for the purpose of creating positive change so that you can experience your life more fully. It provides an opportunity to better and more deeply understand oneself, as well as any problems or difficulties you may be

experiencing. Psychotherapy is a joint effort between us. Progress and success may vary depending upon the particular problems or issues being addressed, as well as many other factors.

Participating in therapy may result in a number of benefits to you, including, but not limited to, reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, work, and family settings, increased capacity for intimacy, and increased self-confidence. Such benefits may also require substantial effort on your part, including an active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts and behaviors. There is no guarantee that therapy will yield any or all of the benefits listed above.

During the therapeutic process, many people find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times, but may also be slow and frustrating. Please discuss with me any concerns you have regarding your progress in therapy. Due to the varying nature and severity of problems and the individuality of each client, I am unable to predict the length of your therapy or to guarantee a specific outcome or result.

Discussion of Treatment Plan. It is my intention to provide services that will assist you in reaching your goals. Within a reasonable period of time after the initiation of treatment, I will discuss with you my working understanding of the problem, treatment plan, therapeutic objectives and my view of the possible outcomes of treatment. Sometimes more than one approach can be helpful in dealing with a certain situation. During the course of therapy, I will draw on various treatment approaches according, in part, to the problem that is being treated and my assessment of what will best benefit you. These approaches may include but are not limited to behavioral, cognitive, psychodynamic, interpersonal, system/family, developmental, and/or psycho-educational techniques.

I believe that therapists and clients are partners in the therapeutic process. You have the right to agree or disagree with my recommendations. If you have any unanswered questions about any of the procedures used in the course of your therapy, their possible risks, my expertise in employing them, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment that I do not provide, I have an ethical obligation to assist you in obtaining those treatments.

Termination of Therapy. The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination, in collaboration with me. I will discuss a plan for termination with you as you approach the completion of your treatment goals. You may discontinue therapy at any time. If you or I determine that you are not benefiting from treatment, either of us may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy. It is best to discuss this in a planned termination session if at all possible.

Professional Consultation. Professional consultation is an important component of a healthy psychotherapy practice. As such, I regularly participate in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, I will not reveal any personally identifying information regarding you or your situation.

Collaboration with Other Professionals. In order to provide quality services, I often need to collaborate with other professionals, such as your physician, psychiatrist, past therapists, and/or other mental health professionals. You will be asked to complete a release of information authorizing these exchanges; in some cases, I may not be able to provide services without this.

Records and Record Keeping. I will write notes and keep records regarding your treatment. These notes constitute my clinical and business records, which by law, I am required to maintain. Such records are the sole property of the therapist. Should you request a copy of my records, such a request must be made in writing. I reserve the right, under Connecticut law, to provide you with a treatment summary in lieu of actual records. I also reserve the right to refuse to produce a copy of the record under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider. Following the termination of therapy, I maintain records for seven years for adults and 10 years for minors. After the respective number of years, your records may be destroyed in a manner that preserves your confidentiality.

Confidentiality. The information disclosed by you is generally confidential and will not be released to any third party without written authorization from you, except where required or permitted by law. Exceptions to confidentiality include, but are not limited to, situations where you pose a threat of serious harm to yourself or someone else; cases involving suspected child, elder or dependent adult abuse; cases in which I am court-ordered to testify or produce records.

If you participate in family therapy, I will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release such information. **However, it is important that you know that I utilize a "no secrets" policy when conducting family therapy**. This means that I do not keep secret information gathered in individual conversations (whether on the phone or in an individual session) if the information revealed in some way violates the integrity of the family. Such information will need to be revealed to the other participants for therapy to effectively continue. Please feel free to ask me about my "no secrets" policy and how it may apply to you.

Psychotherapist-Client Privilege. The information disclosed by you, as well as any records created, is subject to the psychotherapist-client privilege. The psychotherapist-client privilege results from the special relationship between Therapist and Client in the eyes of the law. It is akin to the attorney-client privilege or the doctor-client privilege. Typically, the client is the holder of the psychotherapist-client privilege. If I receive a subpoena for records, deposition testimony, or testimony in a court of law, I will assert the psychotherapist-client privilege on your behalf until instructed, in writing, to do otherwise by you or your representative. **You should be aware that you might be waiving the psychotherapist-client privilege regarding your entire treatment if you make your mental or emotional state an issue in a legal proceeding.** You should address any concerns you might have regarding the psychotherapist-client privilege with your attorney.

Client Litigation. I will not voluntarily participate in any litigation or custody dispute in which you and another individual, or entity, are parties. I have a policy of not communicating with clients' attorneys and will **generally not write or sign letters, reports, declarations, or affidavits to be used in any client's legal matter**. I will generally not provide records or testimony unless compelled to do so. Should I be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving you, you agree to reimburse me for any time spent for preparation, travel, or other time in which I have made myself available for such an appearance at my usual and customary hourly rate for such services of $450.00 per hour.

E-mail and Text Message Communication. I recognize that some clients prefer to communicate about appointment times or other administrative issues via e-mail or text. To make email more secure, I use encryption software to send email that only the intended participant can open. Although this does make the emails I send much more secure, no security measures are 100% effective and e-mail **should NOT be considered a completely confidential means of communication**. **Text messaging is also not a secure means of communication**. For that reason, please do NOT communicate via email or text about clinical or other sensitive information. In addition, **please do NOT use email for anything urgent or time-sensitive**, as I cannot guarantee that I will see an emergency email.

Therapist Availability / Emergencies. You may leave a message for me at any time on my confidential voicemail at 855-521-1015. If you wish me to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call. Non-urgent phone calls are generally returned within 24 hours during normal workdays (Monday through Friday).

Please understand that as a solo, outpatient practitioner, I am unable to personally provide continuous 24-hour crisis services. In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance or go to the nearest emergency room. For other types of urgent situations, please follow any instructions that are provided on my main voicemail at 855-521-1015 and leave your message there. **The main voicemail is where I also provide on-call information in the event I am on vacation or unexpectedly called away.** I will do my best to return your call promptly. Please do not use email for urgent situations.

Acknowledgement
By signing below, Client(s) acknowledge that Client(s) have reviewed and fully understand the terms and conditions of this Agreement. Client(s) have discussed such terms and conditions with the therapist, and have had any questions with regard to its terms and conditions answered to Client(s)' satisfaction. Client(s) agree to abide by the terms and conditions of this Agreement and consent to participate in psychotherapy with the Therapist. Moreover, Client(s) agree to hold Therapist free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

_____ _____
Client Name (please print) Signature of Client (or authorized representative) Date

_____ _____
Client Name (please print) Signature of Client (or authorized representative) Date

I understand that I am financially responsible for payment for all services rendered and that I am obligated to pay all charges denied by my insurance carrier. Any assignment and authorization in no way releases me from said responsibility and imposes no obligation on my therapist to collect money on my behalf.

_____
Name of Responsible Party (Please print) Date

_____
Signature of Responsible Party Date

Consent to Treatment of Minors
This section must be completed by the parent or legal guardian of each child who attends session. Some custody agreements require the signatures of both parents for treatment. Because of this, it is generally my policy to require the signature of both parents in any divorce situation.

Confidentiality with Minors
The State of Connecticut provides significant confidentiality to minors seeking mental health treatment. In fact, minors under the age of 16 years of age have many privacy rights similar to those of adults. Therefore, I am not obligated to share all the information your child discloses in session and will not do so without your child's consent, unless it is an emergency situation. My role as a therapist is to help minors learn to communicate openly and directly with their parents, and thus, I do typically involve parents in the counseling process. That said, when children are making poor and dangerous decisions, parents will be brought into the conversation as soon as possible, which in the case of many situations – such as suicidal ideation or attempts – is immediately.

I hereby consent to treatment of my child(ren) per the terms outlined in the above pages of this document

Name _____ Birthdate _____

Name _____ Birthdate _____

_____
Signature Date

Confidentiality & HIPAA Practices Form	Anne M. Patti, PhD, LLC Anne M. Patti, PhD, Licensed Psychologist State of CT Licensure: 002091

The Health Insurance Portability and Accountability Act (HIPAA) establishes patient rights and protections associated with the use of protected health information. HIPAA provides patient protections related to the electronic transmission of data ("the transaction rules"), the keeping and use of patient records ("privacy rules"),and storage and access to health care records ("the security rules"). HIPAA applies to all health care providers, including mental health care providers. Providers and health care agencies are required to provide patients a notification of their privacy rights as it relates to their health care records.

This Patient Notification of Privacy Rights informs you of your rights. Please carefully read this Patient Notification. It is important that you know and understand the patient protections HIPAA affords you as a patient.

In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship; therefore, we will do all we can do to protect the privacy of your mental health records. Please contact your counselor if you have questions regarding matters discussed in this Patient Notification.

Please print, sign, and date this form below acknowledge that you have familiarized yourself with Confidentiality/HIPAA practices.

I, _____, have been provided a copy of The Patient Notification of Privacy Rights. My signature below indicates that I had opportunity to review this document prior to signing it.

Patient Signature: _____

Date: _____

I. Preamble
Records are kept documenting your care as required by law, professional standards, and other review procedures. HIPAA clearly defines what kind of information is to be included in your "designated medical record" or "case record" as well as some material, known as "Psychotherapy Notes" which is not accessible to insurance companies and other third-party reviewers and in some cases, not to the patient himself/herself.

HIPAA provides privacy protections about your personal health information, which is called "protected health information (PHI)" which could personally identify you. PHI consists of three (3) components: treatment, payment, and health care operations.

Treatment refers to activities in which we provide, coordinate or manage your mental health care service or other services related to your health care. Examples include a counseling session or communication with your primary care physician about your medication or overall medical condition.

Payment is when Anne M. Patti, PhD, LLC obtains reimbursement for your mental health care or other services related to your health care. Health care operations are activities related to our performance such as quality assurance. The use of your protected health information refers to activities our agency conducts for scheduling appointments, keeping records, and other tasks related to your care. Disclosures refer to activities you authorize such as the sending of your protected health information to other parties (i.e., your insurance company).

II. Uses and Disclosures of Protected Health Information Requiring Authorization
If you request Anne M. Patti, PhD, LLC to send any of your protected health information of any sort to anyone outside its offices, you must first sign a specific authorization to release information to this outside party.

A copy of that authorization form is available on the Anne M. Patti, PhD, LLC upon request.
In recognition of the importance of the confidentiality of conversations between therapist and patients in treatment settings, HIPAA permits keeping "psychotherapy notes" separate from the overall "designated medical record". "Psychotherapy notes" are the therapist's notes "recorded in any medium by a mental health provider documenting and analyzing the contents of a conversation during a private, group, or joint family counseling session and that are separated from the rest of the individual's medical record."
"Psychotherapy notes" are private and contain information about you and your treatment. "Psychotherapy notes" are not the same as "progress notes" which could include any of the following: medication prescriptions and monitoring, assessment/treatment start and stop times, the modalities of care, frequency of treatment furnished, and any summary of your diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date.

III. Business Associates Disclosures
HIPAA requires that we train and monitor the conduct of those performing ancillary administrative services for our office and refers to these people as "Business Associates". In our office, "business associates" include any secretaries who provide such services as typing and billing-all activities which bring them into some measure of contact with your protected health information. Our other "business associates" may include student interns or certain volunteers, who have signed a formal contract which very clearly spells out to them the importance of protecting your mental health information as an absolute condition for their placement at our agency. We train them in our privacy practices, monitor their compliance, and correct any errors, should they occur.

IV. Uses and Disclosures Not Requiring Consent or Authorization
By law, protected health information may be released without your consent or authorization under the following conditions:
• Suspected or known child abuse or neglect
• Suspected or known sexual abuse of a child
• Abuse of an elderly or disabled person
• Judicial or administrative proceedings (i.e. you are ordered here by the court)
• Serious threat to health or safety (i.e. "Duty to Warn" and Threat to NationalSecurity)

V. Patient's Rights and Our Duties
You have a right to the following:
• The right to request restrictions on certain uses and disclosures of your protected health information which I may or may not agree to but if I do, such restrictions shall apply unless our agreement is changed in writing
• The right to receive confidential communications by alternative means and at alternative locations. For example, you may not want forms mailed to your home address so we will send them to another location of your choosing.
• The right to inspect and copy your protected health information in the designated record and any billing records for as long as protected health information is maintained in the record.

• The right to insert an amendment in your protected health information, although the therapist may deny an improper request and/or respond to any amendment(s) you make to your record of care.
• The right to an accounting of non-authorized disclosures of your protected health information.
• The right to a paper copy of notices/information from Anne M. Patti, PhD, LLC, even if you have previously requested electronic transmission of notices/information.
• The right to revoke your authorization of your protected health information except to the extent that action has already been taken.
For more information on how to exercise each of these aforementioned rights, please do not hesitate to ask your therapist for further assistance on these matters. Anne M. Patti, PhD, LLC is required by law to maintain the privacy of your protected health information and to provide you with a notice of your Privacy Rights and our duties regarding your PHI. Anne M. Patti, PhD, LLC reserves the right to change its privacy policies and practices as needed with these current designated practices being applicable unless you receive a revision of these policies when you come for future appointment(s). Our duties in these matters include maintaining the privacy of your protected health information, to provide you with a notice of your rights and our privacy practices with respect to your PHI, and to abide by the terms of the notice unless it is changed and you are so notified.

VI. Complaints
The Managing Partner is the appointed “Privacy Officer” for our agency per HIPAA regulations. If you have any concerns of any sort that your privacy rights may have been somehow compromised, please do not hesitate to speak to the appointed privacy officer immediately about this matter. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

VII. Effective Date
This notice shall go into effect January 3, 2017 and remain so unless new notice provisions effective for all protected health information are enacted accordingly.

DBWS PROFESSIONAL MEDICAL BILLING, LLC

P.O. BOX 806

JEWETT CITY, CT 06351

TELEPHONE: 860-376-6878

FAX: 860-376-5878

FOR OFFICE USE ONLY

First Date of Treatment: _____

DSM Code: _____

ICD-10 Code: _____

☐ **Check here is this is a returning patient**

A FULL SERVICE AGENCY FOR MENTAL HEALTH PROVIDERS

Intake Form For: Anne M. Patti, PhD, LLC

Anne M. Patti, PhD, Licensed Psychologist

CLIENTS: Please complete sections A, B, C, G & H

A. PERSONAL INFORMATION:

Patient Name: _____Date of Birth: _____

Address: _____

City/State/Zip: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____ Office Phone: ( ) _____

E-mail:_____ Gender: _____

Primary Care Physician: _____ Office Phone: _____

B. RESPONSIBLE PARTY: (Fill in if under 18 or someone other than patient is responsible for payment):

Name: _____Date of Birth: _____

Address: _____

City/State/Zip: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____ Office Phone: ( ) _____

Relationship to patient: _____

Second Responsible Party: _____

C. INSURANCE INFORMATION:

Primary Insurance Company: _____

Address: _____

City/State/Zip: _____

Phone: ( ) _____

Name of Insured (If different from patient): _____

Insurance ID#: _____

Secondary Insurance Company: _____

Address: _____

City/State/Zip: _____

Phone: ( ) _____

Name of Insured (If different from patient): _____

Insurance ID#: _____

D. INSURANCE COVERAGE INFORMATION:

Annual Deductible: _____

Insurance Coverage per session:

- ☐ 100%
- ☐ 80%
- ☐ 50%

Other: _____

How much coverage per calendar year: _____ or number of sessions: _____

Co-payment per session: _____ Other: _____

E. AUTHORIZATION INFORMATION:

Authorization #: _____Number of sessions authorized: _____

Date authorization starts: _____ Date Authorization ends: _____

For authorization call: ( ) _____ Ext: _____ Fax:

_____ Billing Codes:

- ☐ 90791 Diagnostic Interview Examination
- ☐ 90834 45 (38-52) Minute Individual Psychotherapy
- ☐ 90837 60 (53+) Minute Individual Psychotherapy
- ☐ 90846 Family Psychotherapy
- ☐ 90853 Group Psychotherapy
- ☐ 90839 Psychotherapy for Crisis
- ☐ ***** Other

F. BILLING INFORMATION:

- ☐ Send Claims to Primary Insurance
- ☐ Send Claims to Secondary Insurance
- ☐ Send Bills for Copayments/Deductible to (circle one): Patient or Responsible Party
- ☐ Patient or Responsible Party Pays in Full Each Session
- ☐ Send Claims to Insurance but Collect in Full from (circle one): Patient or Responsible Party

G. FINANCIAL POLICY

- ✓ Appointments cancelled with less than 24 hours' notice will be charged to me at a $60.00 fee per session.
- ✓ I am responsible for the entire balance of services performed regardless of whether there is insurance coverage. Secondary Insurance will be billed as a courtesy.
- ✓ I understand and agree to the above state financial policy.

Signed: _____ Date: _____

H. AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGMENT OF BENEFITS FOR INSURANCE:

I authorize the use or disclosure of my individually identifiable health insurance information necessary to process insurance claims. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations.

Signed: _____ Date: _____

I authorize payment of medical benefits to my provider for services performed.

Signed: _____ Date: _____

Anne M. Patti, PhD, LLC
200 West Center Street, Suite C-3
Manchester, Connecticut 06040
Telephone: 844-428-8728
E-mail: AnneMPatti@gmail.com

Anne M. Patti, PhD, Licensed Psychologist

CLIENT DATA FORM

Today's date: ____/____/____

Note: If you were a client here before, please fill in only the information that has changed.

A. Identification

Your legal name: _____ Date of birth: ____/____/____

Other names you have used (maiden, nicknames, aliases): _____

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

Primary phone number: _____Voicemail OK: ☐ Text Message OK: ☐

Other phone number:_____ Voicemail OK: ☐ Text Message OK: ☐

Email: _____Ok to send email: ☐

❑ Gender identity: _____ ❑·Talk about later

❑ Sexual orientation: _____ ❑·Talk about later

❑ Racial/ethnic identities: _____ ❑·Talk about later

❑ Religious/spiritual traditions or identity: _____ ❑·Talk about later

Other ways you identify yourself and consider important:

B. Emergency information

If some kind of emergency arises and we cannot reach you, whom should we call?

Name: _____ Phone: _____ Relationship: _____

C. Referral

Who gave you my name to call? Name: _____

Address: _____ Phone: _____

How did this person explain how I might be of help to you? _____

Is this person's relationship with you ❑·personal or ❑·professional?

If professional, may I let this person know that you have come to see me? ❑·Yes ❑·No

D. Current problems or difficulties

Please describe the main difficulties that led to your coming to see me: _____

_____

_____

When did these problems start? _____

_____

What makes these problems worse? _____

_____

What makes these problems better? _____

_____

E. Your medical care

From whom, or where, do you get your medical care? Clinic/doctor's name: _____

_____

Address: _____ Phone: _____

Rate your general level of health: ❑·Excellent ❑·Good ❑·Fair ❑·Poor ❑·Extremely poor

Current medications/Dose	For what condition?	Prescribed and supervised by:

F. Your education and training

How many years of school have you had (including elementary and high school)? ____ years

Degrees/certificates: _____ Field(s) of study: _____

G. Employment experiences

Current occupation: _____

Current employer: _____ Date hired: ____/____/_____

Address: _____

City: _____ State: _____ Zip: _____

Previous employment history

From (date)	To (date)	Name of employer	Job title or duties	Reason for leaving

H. Military experiences

Have you ever been in the military? ❑·No ❑·Yes:

If yes:

What branch? _____

From: _____ to: _____ Highest rank held? _____

Were you ever deployed? ❑·No ❑·Yes:

If yes, please list location and duration of each deployment.

Date of deployment	Length of deployment	Location

I. Family-of-origin history

1. Members of your family as you grew up

Relative	Name	Current age (or age at death)	Illnesses (or cause of death, if deceased)	Education	Occupation
Parent/Guardian 1					
Parent/Guardian 2					
Stepparents					
Brothers					
Sisters					

Grandparents					
Uncles/aunts					

If you were adopted or raised by other than your biological parents, how old were you when this started? _____

Briefly describe your relationship with your brothers and/or sisters: _____

_____

Which of the following best describes the family in which you grew up? ❑·Warm/accepting ❑·Average
❑·Hostile/fighting ❑·Other: _____

2. Parent/Guardian 1 Name: _____

Please describe this caregiver: _____

_____

How much time did this person spend with you when you were a child? ❑·A lot ❑·Average ❑·Little

How did you get along with this person when you were a child? ❑·Poorly ❑·Average ❑·Well

How do you get along with this person now? ❑·Poorly ❑·Average ❑·Well ❑·Does not apply

Did this person have any problems (e.g., alcoholism, violence) that may have affected your childhood development? ❑·Yes ❑·No ❑·Don't know

If yes, please specify:

3. Parent/Guardian 2 Name: _____

Please describe this caregiver: _____

_____

How much time did this person spend with you when you were a child? ❑·A lot ❑·Average ❑·Little

How did you get along with this person when you were a child? ❑·Poorly ❑·Average ❑·Well

How do you get along with this person now? ❑·Poorly ❑·Average ❑·Well ❑·Does not apply

Did this person have any problems (e.g., alcoholism, violence) that may have affected your childhood development? ❑·Yes ❑·No ❑·Don't know

If yes, please specify:

J. Your significant nonmarital relationships (past and present)

Name of other person	Person's age when started	Your age when started	Your age when ended	Reasons for ending

K. Marital/couple relationship history

	Spouse's/partner's name	His/her age at marriage	Your age at marriage	Your age when divorced/widowed	Has he/she remarried?
First					
Second					
Third					

L. Children

In the last column below, indicate those from your current marriage with "Y," those from a previous marriage or relationship with "P," and your current stepchildren with "S.")

Name	Current age	Sex	School	Grade	Adjustment problems?	Yours? Previous? Step?

M. Treatment history

Have you ever received inpatient or outpatient psychological, psychiatric, drug/alcohol treatment, medications, or counseling services before? ❑·No ❑·Yes. If yes, please describe:

When (dates)?	For what (diagnosis)?	What kind of treatment?	Where or from whom?	With what results?

Has any relative had inpatient treatment for a psychiatric, emotional, or substance use disorder? ❑·No ❑·Yes. If yes, please describe:

Name/relationship	For what (diagnoses)?	What kind of treatment? Where or from whom?	When (dates)?	With what results?

N. Abuse history

You may leave this section blank for discussion later.

❑ I was not abused in any way. ❑·I may have been abused in some way.

❑ I was abused. Please indicate the following. For kind of abuse, use these letters: P = physical, such as beatings; S = sexual, such as touching/molesting, fondling, or intercourse; N = neglect, such as failure to feed, shelter, or protect; E = emotional, such as humiliation, etc.

Your age	Kind of abuse	By whom? Intimate partner? Relative? Sibling? Other (specify)?	Effects on you?	Whom did you tell?	Consequences of telling?

O. Chemical use

1a. How many caffeine drinks (coffee, tea, colas, energy drinks, etc.) do you use each day? _____

1b. How often each week do you use medications (prescription or over-the-counter) or chemicals to be more alert or sharper? ___

2a. How much tobacco do you smoke or chew each week? Amount: _____ Kind: _____

2b. Do you use vapor or e-cigarettes? ❑·No ❑·Yes. How many per week? _____

3. How many drinks of beer, wine, or hard liquor do you consume in a typical week? _____

4. Have you ever felt the need to cut down on your drinking? ❑·No ❑·Yes
6. Have you ever felt guilty about your drinking? ❑·No ❑·Yes
7. Did you ever drink to unconsciousness, or run out of money because of drinking? ❑·No ❑·Yes
8. Which drugs (not medications prescribed for you) have you used in the last 10 years?_____
9. Do you think that you have a drug or alcohol problem? ❑·No ❑·Yes

P. Legal history

1. Are you presently being sued, suing anyone, or thinking of suing anyone? ❑·No ❑·Yes. If yes, please explain:____

_____

2. Is your reason for coming to see me related to an accident or injury? ❑·No ❑·Yes. If yes, please explain: _____

_____

3. Are you required by a court or probation/parole officer to have this appointment? ❑·No ❑·Yes. If yes, please explain:

_____

4. List all the contacts with the police, courts, and jails/prisons you have had. Include all open charges and pending ones.

Date	Charge/arrest	Jurisdiction	Sentence Time/Type

5. Your current attorney's name: _____ Phone: _____
6. Have you had any other legal involvements? ❑·No ❑·Yes. If yes, please explain:

Q. Religious concerns

What role, if any, does faith or spirituality play in your life? _____

_____

What is your present religious affiliation, if any? _____

R. Other

Is there anything else that is important for me to know about, and that you have not written about on any of these forms? ❑·No ❑·Yes

If yes, please say more:

SUBMIT FORMS