

**Sheehan Psychotherapy Associates**  
33 College Hill Rd., Ste 30E, Warwick, RI 02886  
Telephone: (401)821-6070 Fax: 401-821-6047

Date of 1<sup>st</sup> Appointment \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender: M \_\_\_\_\_ F \_\_\_\_\_

Address \_\_\_\_\_ Soc. Sec \_\_\_\_\_

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

Telephone: Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_ Ext. \_\_\_\_\_

May we contact you at all of the numbers/address listed above regarding making/changing appointments? \_\_\_\_\_

If not, how do you prefer we reach you if necessary? \_\_\_\_\_

Marital Status: Single, Married, Divorced, Separated, Widowed, Domestic Partnership

Are you employed? \_\_\_\_\_ full or part-time? \_\_\_\_\_ Are you a student? \_\_\_\_\_ full or part-time? \_\_\_\_\_

If employed, employer name: \_\_\_\_\_ Occupation: \_\_\_\_\_

How did you find out about our agency? \_\_\_\_\_

**Insurance Information**

Primary Insurance _____	Secondary Insurance _____
Policy # _____	Policy# _____
Name of Policy Holder _____	Name of Policy Holder _____
Policy Holder Date of Birth _____	Policy Holder Date of Birth _____
Policy Holder Soc. Security # _____	Policy Holder Soc. Security # _____
Employer of Insured _____	Employer of Insured _____
Relationship: self ___ spouse ___ child ___ other ___	Relationship self ___ spouse ___ child ___ other ___

Is the condition you are seeking help for related to your employment? \_\_\_\_\_yes \_\_\_\_\_no An accident? \_\_\_\_\_yes \_\_\_\_\_no

If you answered yes to either of the questions above, please explain and let us know who is responsible for claims related to your care. \_\_\_\_\_

**Health Information**

Please describe below any mental health/psychiatric care you are currently receiving or have received in the past.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name of your Primary Care Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Please indicate any allergies: \_\_\_\_\_

Please list **all** current medications and dosages, including supplements and herbal remedies:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name of emergency contact person and their relationship to you: \_\_\_\_\_

Emergency Contact Phone: Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

**Client Signature (or Parent/Guardian Signature if Client is under 18 years of age)** \_\_\_\_\_ **Date** \_\_\_\_\_

**SHEEHAN PSYCHOTHERAPY ASSOCIATES INC.  
33 COLLEGE HILL RD., STE 30E, WARWICK, RI 02886**

**ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION**

I hereby authorize direct payment of mental health benefits to Sheehan Psychotherapy Associates, In., for services rendered. I understand that I am financially responsible for any balance not covered by my insurance.

I also authorize Sheehan Psychotherapy Associates, Inc., to release any medical/mental health information that may be necessary for either medical care or in processing applications for financial benefit. I request that payment of authorized benefits be made on my behalf. A photocopy of these assignments shall be valid as the original. I am aware and do consent and authorize Sheehan Psychotherapy Associates, Inc., to disclose information pertaining to my identity, diagnoses, and treatment to the Utilization Review Manager and/or any authorized Utilization Review/Managed Care Company or subcontractor employed by my insurance company. This information needs to be disclosed for the purpose of obtaining health insurance payments for charges incurred by the patient as a result of treatment at Sheehan Psychotherapy Associates, Inc.

I am aware that my records are protected under the Health Insurance Portability and Accountability Act of 1996 (45CFR,Parts 160 and 164), Federal regulation 42 CFR, Part 2 (Confidentiality of Alcohol and Drug Abuse Treatment), and under the General Laws of the State of Rhode Island and cannot be disclosed without my written consent except as otherwise specifically provided for by law. I understand that by law I need not consent to the release of this information. However, I choose to do so willingly and voluntarily for the purpose specified above.

\_\_\_\_\_  
Signature of Patient/Guardian/Parent

\_\_\_\_\_  
Date

**SHEEHAN PSYCHOTHERAPY ASSOCIATES, INC.**

***Rights and Informed Consent***

Welcome to our practice, Sheehan Psychotherapy Associates, Inc. This document (the Agreement) contains information about our professional services and business policies and answers some frequently asked questions. After you have had an opportunity to read it, your therapist and you will discuss it together so that any question you may have can be answered.

All the therapists in this practice are licensed to practice in the State of Rhode Island. All persons are eligible for our services, regardless of race, ethnicity, gender, sexual orientation, disability, religion, or creed. We use a number of different approaches in our work and will discuss with you the strategies that we believe may best meet your needs.

Psychotherapy works best when it is a cooperative and collaborative effort. It calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home. You have the right to be informed about your therapy, any risks it might involve, and what alternatives there might be. You have the right to be informed about your therapist's qualifications to treat you. You have the right to request or to refuse any particular technique or to withdraw from therapy at any time. If you could benefit from any treatments we cannot provide, it is our ethical obligation to offer to refer you to someone who can help you. If you wish to examine your records, your therapist will go over them with you and answer any questions you may have. To do this, we request one week notice in order to review the record and prepare to discuss it with you. Your feedback about what you like or do not like about the therapy is always welcome. Should you at any time feel dissatisfied or concerned about your work with your therapist, please speak with your therapist as soon as possible. If you feel the discussion does not resolve a problem and would like further assistance, you may speak with the Director of the practice, Helen Sheehan, or your therapist will help you to find another professional.

Psychotherapy has helped many people, but success is never guaranteed. In fact, there are some risks in treatment. As problems or difficulties are faced, they sometimes seem to get worse. As people work to improve the quality of their lives, they sometimes make decisions which can lead to painful outcomes or conflict with others. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. An important part of our work together will be to discuss the benefits and risks of the choices you make. You are the final judge of the benefits and risks that therapy holds for you.

***CONTACT BETWEEN SESSIONS***

Each psychotherapist in our practice keeps a different schedule, to better accommodate the different needs of different patients. Please ask your therapist for his/her schedule. Calls are usually returned to patients on the days that the therapist is in the office. Please leave messages on the voice mail of the therapist with whom you wish to speak, or you can contact the business office to speak with the administrative staff.

**IN CASE OF EMERGENCY**, someone is on call 24 hours per day. If your therapist is unavailable when you call, please contact the therapist on call by using our pager: 401-933-4490. It may take up to 2 hours for a call-back, but if you have not had a return call within 30 minutes, please page twice more. Machines and people can be imperfect, so sometimes when people page, an incorrect number shows up on the pager or some other problem with communication has occurred. If you are unable to wait to hear from the on-call therapist, you are responsible to contact another safe adult, your prescribing physician or psychiatrist, Butler Hospital or other psychiatric facility. If you are at serious or imminent risk or have already harmed yourself, you should call 911 or go directly to an emergency room and call us again from there.

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Signature of Patient/Guardian/Parent

Date

**SHEEHAN PSYCHOHERAPY ASSOCIATES, INC.**  
**FEES AND PAYMENT**

The length of individual and family sessions is 45 minutes. That time has been specifically set aside for you. **Should you be unable to come to a scheduled appointment, we ask that you provide at least 24 hours notice of cancellation so that we have an opportunity to offer other clients the appointment time you no longer need. Since we are unlikely to fill your appointment time with less than 24-hour notice, we ask your cooperation and understanding in paying the late cancellation or missed appointment fee of \$80 if you provide less than 24 hours notice, even if you are sick. The one exception to this requirement is in the case of dangerous weather. We do not require 24 hour notice of cancellation when there is dangerous weather, but if you do not keep an appointment in bad weather, you will be charged if you have not cancelled.** Our answering machine is working 24 hours per day, so cancellations can take place on weekends for Monday appointments, as long as 24 hour notice is given. Our answering machine records the time and date of your calls.

It is expected that appointments for psychotherapy will be kept by you, as part of your commitment to treatment. Therefore, if you cancel or miss three appointments, or if there is a pattern of canceling or missing appointments, then we will talk with you about taking a break from treatment until such time as you are able to commit to regular appointments.

You are financially responsible for all costs for the care you receive, except those services for which you are eligible through your insurance coverage. Clients/Patients are expected to pay any known co-payments, deductibles, co-insurances, and non-covered amounts when services are received. Our office manager is happy to answer any questions you may have about your insurance.

All requests for payments are based on estimated amounts and are not considered final billing totals, as we will adjust your bill after final payments have been received from insurance carriers. Insurance claims are submitted as a courtesy service and do not relieve you of financial responsibility.

**FEES**

We charge fees for various services as listed below. Please feel free to contact the business office for any other information you need.

- \$25            returned check fee
- \$80            late cancellation/missed appointment fee (less than 24 hour notice)
- \$135          Diagnostic Interview
- \$110          Family Psychotherapy
- \$100          Individual Psychotherapy
- \$40            Group Psychotherapy
- \$100          Telephone Psychotherapy
- 12%            annual interest charge for balances more than 30 days old

A fee is charged for other professional services you may need, such as report writing, telephone conversations lasting longer than five minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of us. If you become involved in legal proceedings that require the participation of your psychotherapist, you will be expected to pay for all of the therapist's professional time, including preparation and transportation costs, even if your therapist is called to testify by another party. Because of the difficulty of legal involvement, we charge \$120 per hour for preparation and attendance at any legal proceeding.

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Signature of Patient/Guardian/Parent

Date

**Sheehan Psychotherapy Associates**  
**NOTICE OF PRIVACY PRACTICES**

**I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

**II. WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION ("PHI")**

This notice explains how we use and disclose your protected health information ("PHI" for short). We are required by law to protect the privacy of PHI, and to provide you with this notice and follow the privacy practices described in it.

PHI includes information that we create or receive about your past, present, or future physical or mental health or condition, the provision of health care to you, or the payment for health care provided to you.

We may change the terms of this notice and our privacy practices at any time. Any change we make will apply to the PHI we already have as well as to any new PHI we create or receive. When we change our practices, we will promptly change this notice and post it in the main reception area of our office.

**III. HOW WE MAY USE AND DISCLOSE YOUR PHI**

We use and disclose PHI for many different reasons. Below, we describe the different reasons and give you some examples.

**A. Use and Disclosure of PHI for Treatment, Payment, or Health Care Operations.** We may use and disclose PHI for the following reasons:

**1. For treatment** We may use and disclose PHI in order to provide therapy, counseling, treatment, and other services to you. For example, we may use and disclose PHI about you to consult with other professionals about your care. We will obtain your consent before disclosing your PHI for treatment purposes if state law requires me/us to do so.

**2. For payment** We may use and disclose PHI in order to bill and collect payment for the treatment and services provided to you. For example, I/we may disclose PHI to your health plan to get paid for the health care services provided to you. I/We may also disclose PHI to billing companies and companies that process my/our health care insurance claims. I/We will obtain your consent before disclosing your PHI for payment purposes if state law requires me/us to do so.

**3. For health care operations.** We may use and disclose PHI in order to operate this practice. For example, we may use PHI in order to evaluate the quality of services that you receive. We may also disclose PHI to our accountants, attorneys, and others in order to make sure we are complying with the laws that affect us. We will obtain your consent before disclosing your PHI for the purposes of our health care operations if state law requires me/us to do so.

**B. Other Uses of PHI.** We may also use and disclose your PHI for the following reasons:

**1. Reports required by law.** We may disclose PHI when legally required to do so. For example, we may use PHI to make mandatory reports to various government agencies about suspected abuse, mistreatment, neglect, or exploitation of vulnerable people such as children, people with developmental disabilities and the elderly.

**2. Health oversight** We may disclose your PHI to certain government agencies authorized by law to license, audit, inspect, or investigate health and mental health care providers and the health care system.

**3. To avoid harm.** Consistent with state law, we may disclose PHI to the police or other appropriate persons, in order to avoid a serious threat to the health or safety of a client, another person, or the public.

**4. Appointment reminders, treatment alternatives, and health-related benefits or services.**

We may use PHI to give you appointment reminders; or give you information about treatment choices or other health or mental health care services or benefits we offer.

**5. Legal proceedings.** We may disclose PHI pursuant to a valid court order, search warrant, and, under certain circumstances, in response to a subpoena or other discovery request.

**6. As required by law.** We will disclose PHI when required to do so by federal or state law.

**C. When my/our Use or Disclosure of PHI Requires Your Prior Written Authorization.**

We must ask for your written authorization for any use or disclosure of PHI not described in sections III A or III B above. If you authorize us to use or disclose your PHI, you can later withdraw the authorization and stop any future use or disclosure of your PHI based on it. You can withdraw an authorization by written request to: *Helen Sheehan, Privacy Officer, Sheehan Psychotherapy Associates, Inc., 33 College Hill Rd., Ste30E, Warwick, RI 02886.*

**Notice of Privacy Practices (continued)**

**IV. YOUR RIGHTS REGARDING YOUR PHI.**

**A. Your Right to Request Limits on Our Use and Disclosure of PHI.** You may ask that we limit how we use and disclose your PHI. We will consider your request but are not legally required to agree to it. If we agree to your request, we will comply with your limits, except in emergency situations.

**B. Your Right to Choose How We Send PHI to You.** You may ask that we send information to you at a different address (for example, to your work address rather than your home address) or by different means (for example, by mail instead of telephone). We will agree to your request, as long as we can easily provide the information in the way you request.

**C. Your Right to View and Get a Copy of Your PHI.** You have the right to view or obtain a copy of your PHI. Your request must be in writing. However, there are some circumstances in which we may deny your request. If we deny your request, we will tell you, in writing, my/our reason(s) for the denial and explain what appeal rights, if any, you have. If you request a copy of your PHI, we may charge a fee for it if permitted to do so by law. Instead of providing the PHI you requested, we may offer to give you a summary or explanation of the PHI, as long as you agree to it, and to the associated cost, in advance. To view or obtain a copy of your PHI please send your written request to: *Helen Sheehan, Privacy Officer, Sheehan Psychotherapy Associates, Inc., 33 College Hill Rd., Ste30E, Warwick, RI 02886.*

**D. Your Right to a List of the Disclosures of Your PHI that We Have Made.** You have the right to an accounting of instances in which we disclosed your PHI to others. Some disclosures will not be listed, however. For example, the list will not include disclosures made for the purpose(s) of treatment, payment, or health care operations, or disclosures that you authorized or that were made directly to you. We will report disclosures made within the six years prior to your request, unless you request a shorter time frame. However, our obligation to account for disclosures begins with disclosures made after April 13, 2003. If you ask for more than one accounting within a twelve-month period, we may charge you a fee for every accounting provided after the first one. For a list of

disclosures you must submit a request to: *the privacy officer of the practice in which you are treated. See name and address below.*

**E. Your Right to Correct or Update Your PHI.** If you feel that there is a mistake in your PHI, or that important information is missing, you may request a correction. Your request must be in writing and include the reason for the request. Your request must be made to: *Helen Sheehan, Privacy Officer, Sheehan Psychotherapy Associates, Inc., 33 College Hill Rd., Ste30E, Warwick, RI 02886.* We may deny your request for a variety of reasons. If we deny your request, we will inform you in writing of the reason(s) for the denial and explain your rights regarding responding to the denial. If we agree to your request, we will change your PHI, inform you of the change, and tell others who need to know about the change to your PHI.

**F. Your Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice, even if you agreed to receive it electronically. You may request a paper copy at any time.

**V. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO FILE A COMPLAINT ABOUT MY/OUR PRIVACY PRACTICES.**

If you have any questions about this notice, wish to exercise any of the rights explained in it or file a complaint about my/our privacy practices, feel that I/We may have violated your privacy rights, or disagree with a decision I/We made about your PHI, please contact: *Helen Sheehan, Privacy Officer, Sheehan Psychotherapy Associates, Inc., 33 College Hill Rd., Ste30E, Warwick, RI 02886.* You also may send a written complaint to: Office for Civil Rights, U.S. Department of Health and Human Services, J.F. Kennedy Federal Building, Room 1875, Boston, MA 02203. I/We will not retaliate against you for filing a complaint.

**VI. EFFECTIVE DATE OF THIS NOTICE.**

This notice is effective as of April 14, 2003, and supersedes any and all prior versions of this notice.

\_\_\_\_\_  
Signature of Patient Date

\_\_\_\_\_  
Signature of Parent, Guardian or Personal Rep Date

\_\_\_\_\_  
If Pt. Refuses to Acknowledge Receipt, Staff member sign and date.

**SHEEHAN PSYCHOTHERAPY ASSOCIATES**  
33 College Hill Road, Suite 30E, Warwick, Rhode Island 02886 401-821-6070  
**COORDINATION OF CARE COMMUNICATION FORM**

**MAY WE CONTACT YOUR PRIMARY CARE PHYSICIAN? YES \_\_\_ NO \_\_\_**

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Primary doctor name \_\_\_\_\_  
Address: \_\_\_\_\_  
Patient: \_\_\_\_\_  
DOB: \_\_\_\_\_ Doctor's Phone: \_\_\_\_\_

This information is provided to facilitate coordination of treatment/continuity of care.

This patient was seen by me on \_\_\_\_/\_\_\_\_/\_\_\_\_.

DSM V Diagnoses: \_\_\_\_\_

The recommended treatment/medication regimen is:

\_\_\_\_\_  
\_\_\_\_\_

Please call me if you need to discuss this case further or if you require additional information.

\_\_\_\_\_  
Signature of psychotherapist                      Name (Printed)                      Degree/License

**PATIENT AUTHORIZATION FOR RELEASE OF INFORMATION**

I, \_\_\_\_\_, do hereby authorize Sheehan Psychotherapy Assoc. to release and exchange medical/psychiatric and psychological information pertaining to me/my child with my primary care physician. This authorization is for the exchange of information between the primary care physician and behavioral health clinician, and vice versa. This information will include information concerning diagnosis, treatment plan, tests, and medications. This authorization will expire no later than one year from the date of signature.

Signed (patient/guardian) \_\_\_\_\_ Date \_\_\_\_\_

Notice to Recipient: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR,Part2) and/or state law. In accordance with Federal and State law requirements, the information received pursuant to this document is confidential and recipient is prohibited from making further re-disclosure of this information to any other person or entity, or to use it for any purpose other than as authorized herein, without the written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug patients.

**Client Name:** \_\_\_\_\_

Please describe the problem(s) that prompted you to make this appointment:  
 \_\_\_\_\_  
 \_\_\_\_\_

**Please check off any of the following symptoms that you have experienced overt the past two months.**

<u>Mild</u>	<u>Mod</u>	<u>Severe</u>		<u>Mild</u>	<u>Mod</u>	<u>Severe</u>	
___	___	___	low energy or fatigue	___	___	___	loss of interest/pleasure
___	___	___	impulsiveness	___	___	___	low self-esteem
___	___	___	inertia, moving very slowly	___	___	___	marked mood swings
___	___	___	restlessness	___	___	___	difficulty speaking
___	___	___	trouble going to school/work	___	___	___	diminished thinking ability
___	___	___	behaving with aggression/rage	___	___	___	distractibility
___	___	___	behaving compulsively	___	___	___	indecisiveness
___	___	___	being deceitful or stealing	___	___	___	impaired memory
___	___	___	acting destructively	___	___	___	talking much more than usual
___	___	___	disorganized	___	___	___	talking much faster than usual
___	___	___	behaving recklessly	___	___	___	jumping from topic to topic
___	___	___	injuring yourself purposely	___	___	___	racing thoughts
___	___	___	violating rules/rights of others	___	___	___	poor concentration/attention
___	___	___	anxiety/fearfulness	___	___	___	self-critical, negative thoughts
___	___	___	sensitive to rejection by others	___	___	___	thinking about distressing events
___	___	___	feeling jittery	___	___	___	hallucinations
___	___	___	panic attacks	___	___	___	obsessive thoughts
___	___	___	phobias	___	___	___	paranoid thoughts
___	___	___	excessive worry	___	___	___	thoughts of suicide
___	___	___	anger	___	___	___	dissatisfaction with body/looks
___	___	___	not caring anymore	___	___	___	binge/excessive eating
___	___	___	feeling numb	___	___	___	self-induced vomiting
___	___	___	depressed mood	___	___	___	excessive use of laxatives
___	___	___	excessive/inappropriate guilt	___	___	___	excessive exercising
___	___	___	feeling helpless	___	___	___	gain/loss of weight > five pounds
___	___	___	feeling worthless	___	___	___	trouble getting to sleep
___	___	___	feeling hopeless	___	___	___	waking up during the night
___	___	___	tearfulness	___	___	___	waking up too early in the A.M.
___	___	___	irritability	___	___	___	sleeping more than usual

**Health Information:** Please check off any of the following physical symptoms you have experienced during the last **three months**:

headache	___	loss of desire	___	sexual dysfunction	___
abdominal pain	___	painful intercourse	___	menstrual irregularity	___
diarrhea/constipation	___	heart palpitations	___	muscle/joint pain	___
nausea	___	food sensitivity	___	twitching muscles	___
bloating	___	hearing loss	___	stiff back/neck	___
vomiting	___	vision loss	___	tremor	___
dry mouth	___	hair loss	___	double/blurry vision	___
difficulty swallowing	___	swollen glands	___	lightheadedness	___
shortness of breath	___	fever/chills	___	poor balance	___
fainting	___	sore throat	___	difficulty concentrating	___
seizures/convulsions	___	urinary problems	___	confused thinking	___
number of pregnancies	___	number of live births	___		



**Client Name:** \_\_\_\_\_

Do you now have, or have you in the past had any of the following conditions? (Please check **all** that apply)

Condition	Have Now	In Past	Condition	Have Now	In Past	Condition	Have Now	In Past
Immune System Disorder			Chronic Fatigue Syndrome			Service Related Injury		
Allergies			Heart Disease			Fibromyalgia		
Asthmas			Arthritis			Lyme Disease		
Brain Injury			Tuberculosis			Liver Disease		
Cancer			Thyroid Disorder			Hepatitis		
Diabetes			Stroke			Kidney Disease		
Digestive Disorder			High Blood Pressure			Seizure Disorder		
Sexually Transmitted Disease			Multiple Sclerosis			Other (please specify)		

Please describe your medical problems:

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Names of any physicians (or health care professionals) who are currently treating you, and for what problems:

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(Contact with other health professionals for the purpose of coordination of care would only take place with your written authorization.)

### **Risk Assessment**

Have you ever or are you currently engaged in self-harming behaviors such as cutting? \_\_\_\_\_

Have you ever thought about or attempted suicide? If so, when and by what means? \_\_\_\_\_

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Are you currently thinking about suicide? \_\_\_\_\_

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If you are contemplating suicide, are there things in your life that would hold you back (e.g., family, friends, or religious beliefs)? \_\_\_\_\_

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Are you having thoughts about seriously hurting or killing someone else? If so, about whom are you having these thoughts? \_\_\_\_\_

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### **Goals:**

What do you hope will change by coming to therapy? \_\_\_\_\_

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

**Substance Use**

Please indicate past and present use of the following substances:

Substance	Ever used? Y/N	Age at 1 <sup>st</sup> use?	How much per day/week?	Currently Using? Y/N	Amt. used at one time?	Length of time used?
Caffeine						
Alcohol						
Tobacco						
Marijuana						
Ecstasy						
Cocaine/Crack						
Heroin						
Methamphetamines						
PCP/LSD/Mushrooms						
Pain killers						
Steroids						
Tranquilizers						
Sleeping Pills						
Diet Pills						
Inhalants						
Other (specify)						

Have you ever believed that substance use/abuse has caused problems in your life? \_\_\_\_\_

Has anyone else expressed concern over your use/abuse of certain substances? \_\_\_\_\_

Have you ever experienced withdrawal symptoms when attempting to stop using substances? \_\_\_\_\_

Have you ever experiences blackouts related to substance use? \_\_\_\_\_

Have you ever had problems with relationships, work, or the law related to your use/abuse of substances? \_\_\_\_\_

Have you ever participated in drug or alcohol treatment? \_\_\_\_\_ If so, please describe:

**Family Information**

Please list the people living in your household, and the names and ages of children even if out of house.

Name	Relationship to you	Age	Other info (e.g. shared custody)

**Client Name:** \_\_\_\_\_

**Family of Origin**

Please indicate members of the family in which you were raised and indicate if there is a history of any of the conditions listed.

Relation	Name	Age(or age at death)	Cause of death (if deceased)	History of: alcohol/substance/gambling problems, anxiety/depression, eating disorder, bi-polar, psychosis, suicidal behavior, or trauma history. Please specify.
Father				
Mother				
Stepfather				
Stepmother				
Sibling				
Sibling				
Sibling				
Sibling				
Other				
Other				

Were you adopted? \_\_\_\_\_ If so, what was your age at time of adoption? \_\_\_\_\_  
Did your parents ever divorce? \_\_\_\_\_ If so, how old were you at the time of the divorce? \_\_\_\_\_  
Were you ever in foster or residential care growing up? \_\_\_\_\_

**Trauma/Abuse**

Have you ever been a victim of or witnessed any of the following types of abuse? If so, please briefly describe who was involved and when this took place.

Physical abuse (hitting, kicking etc.) by a spouse/partner/parent/sibling? \_\_\_\_\_  
Sexual abuse (such as unwanted touching or rape)? \_\_\_\_\_  
Emotional abuse (such as threats, name-calling, intimidation)? \_\_\_\_\_  
Financial abuse (such as withholding child support, gambling)? \_\_\_\_\_  
If you have experienced any of the above, is the abuse still going on? \_\_\_\_\_

**Educational/Occupational Information** Please check all degrees received.

Number of years of education completed? \_\_\_\_\_ High School Diploma \_\_\_\_\_ G.E.D. \_\_\_\_\_  
Vocational/Trade School \_\_\_\_\_ Associate's \_\_\_\_\_ Bachelor's \_\_\_\_\_ Master's \_\_\_\_\_  
Doctorate \_\_\_\_\_ Other Program \_\_\_\_\_  
Are you currently enrolled in school? \_\_\_\_\_ If so, what type of program? \_\_\_\_\_  
Are you currently employed? \_\_\_\_\_ If so, what type of work do you do? \_\_\_\_\_  
If you are not currently employed, is it by choice? \_\_\_\_\_

**Legal Concerns**

Have you ever been arrested and do you have any pending legal problems?  
\_\_\_\_\_  
\_\_\_\_\_

**Client Name :** \_\_\_\_\_

**Financial Concerns:**

Is your current financial situation causing you serious concern? Do you have a lot of debt or have arguments with family about bills? \_\_\_\_\_

**Spiritual Considerations**

Do you feel that your religious or spiritual beliefs help you in life? Are you currently affiliated with a faith community (e.g., church, temple, mosque) or spirituality-based group?

\_\_\_\_\_  
\_\_\_\_\_

**Your wishes:** Would you please list the most important things you want to have improve or change for you (such as: Less depressed, able to make decision, improved finances, less anxious, able to sleep)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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*Thank you for taking the time to fill out this form to help us to understand your situation better.*

*-----Information below to be completed by Psychotherapist-----*

Long-term goals: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Short-term goals: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Diagnoses

Axis I: \_\_\_\_\_

Axis II: \_\_\_\_\_

Axis III: (Medical) \_\_\_\_\_

Axis IV (severity of stressors): \_\_\_\_\_

Axis V (GAF): \_\_\_\_\_

Does Client agree with the treatment plan? \_\_\_\_\_ Yes \_\_\_\_\_ No

\_\_\_\_\_  
Therapist's Signature