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

Date of 1st 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. Please call the office at **(401) 821-6070**. If no one answers, please listen to the greeting, and you will be prompted to dial extension **3** and leave a message. It may take up to 2 hours for a call-back, but if you have not had a return call within 30 minutes, please call again. Machines and people can be imperfect, so sometimes a 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.

____

Signature of Patient/Guardian/Parent   Date

SHEEHAN PSYCHOYHERAPY 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.

____

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 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.*

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 40l-821-6070

COORDINATION OF CARE COMMUNICATION FORM

MAY WE CONTACT YOUR PRIMARY CARE PHYSICIAN? YES___ NO___

Date: _____/_____/_____

Patient: _______________________

DOB: _________________________

Primary doctor name __________________________________

Address: ____

____

____

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.

Mild	**Mod**	**Severe**		**Mild**	**Mod**	**Severe**	
			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:

____
____
____
____
____

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

____
____
____
____
____

(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? ______________________

____
____

Are you currently thinking about suicide? ____

____

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

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

Goals:

What do you hope will change by coming to therapy? ____________________________________

____
____
____
____

Client Name: ____
Substance Use

Please indicate past and present use of the following substances:

Substance	Ever used? Y/N	Age at 1st 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)

____

____

____

____

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

revised 4/24/2018