**Notice of Privacy Practices**

**This notice describes how protected health information about you may be used and disclosed and how you can get access to this information. Please read carefully.**

**Summary**

By law I am required to provide you with my Notice of Privacy Practices. This notice describes how your medical information may be used and disclosed by. It also tells you how you can obtain access to this information.

As a patient you have the following rights:

* The right to copy and inspect your information.
* The right to request corrections to your information.
* The right to request your information be restricted.
* The right to request confidential communications.
* The right to a paper copy of this notice.

I want to ensure that your health information is secure with me. This notice contains information about how I will insure that your information remains private.

If you have any questions about this, please contact my office during regular business hours.

I herby acknowledge that I have received a copy of this practice’s Notice of Privacy Practices. I understand that if I have questions or concerns regarding my privacy rights that I may contact the office. I further understand that the practice will offer me updates to this Notice of Privacy Practices should it be amended, modified, or changed in anyway.

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

Patient or Representative Name (Print) Patient or Representative Signature

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

Date Patient refused/unable to sign because

***Informed Consent for Outpatient Treatment***

|  |  |
| --- | --- |
| Client: | Date: |

By initialing and signing this document, you acknowledge that you understand and agree with the following:

\_\_\_\_\_I acknowledge that I have been given a list of local providers and choose to receive services from *Tami M. Morgan, LPC.*

\_\_\_\_\_While I expect benefits from this treatment, I understand and accept that the practice of Psychotherapy Community Based Psycho-Social Rehabilitation and/or Developmental Therapy is not an exact science and that because of factors beyond their control, the service providers at this office make no guarantees as to the outcome of my treatment.

\_\_\_\_\_I understand the importance of regular attendance and review of treatment goals and agree to play an active role in the treatment process. I also understand that I may choose to seek the services of another provider or terminate treatment at any time.

\_\_\_\_\_I understand that Tami M. Morgan, LPC is not providing emergency services and I have been informed of whom and/or where to call in emergency of during the evening, weekend, or after regular business hours.

\_\_\_\_\_I acknowledge that if I become a threat to myself or others, or if a child, adult, or elderly person in treatment discloses being neglected or abused; Tami M. Morgan, LPC will take the necessary interventions to protect me, my child and/or others.

\_\_\_\_\_I acknowledge that I have received a copy of the brochure “*Notice of Privacy Practices”* and *“Your Rights as a Client”* which includes “*Right to Voice Grievances”*. I have read them and understand them completely. I also acknowledge that I have read and signed the “*Financial Policy,”* and all other forms presented to me.

\_\_\_\_\_I acknowledge that I give permission for treatment for myself or child. I allow permission to receive services on-site, in the community, and/or in home. I also allow for transportation in the community for activities as deemed necessary.

\_\_\_\_\_I acknowledge that I give permission to Tami M. Morgan, LPC to contact the proper medical authorities for the client’s emergency medical needs. Tami M. Morgan, LPC is not and shall not be responsible for any medical expenses acquired due to the emergency.

\_\_\_\_\_I acknowledge that I herby waive any and all claims which may arise against Tami M. Morgan, LPC, its employees, volunteer and assignees. As a result of services provided in this authorization with the exclusion of any willful or intentional acts which Tami M. Morgan, LPC, its employees, volunteers and assignees may commit and which may result in harm or injury to the person(s).

\_\_\_\_\_***By signing this form, you confirm that you:*** ***(a)***have had full opportunity to read and/or have been read to and consider the contents of this consent form and the Notice of Privacy Practices, and I have received and read the Consumer Rights Form and understand its contents. It has also been explained to me the procedures for handling questions and complaints; ***(b)*** I am giving permission for treatment in the office, home, community, and school and authorize Tami M. Morgan, LPC, staff to transport to activities in the community. In addition, I understand that by signing this consent form, **I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.**

* As a licensed psychotherapist, counselors are required to participate in ongoing continuing education and/or supervision to maintain their clinical licenses as therapists and enhance their therapeutic skills.
* I also give my consent for my counselor to seek consolation and supervision as needed on my behalf.
* I have been given sufficient information to understand the nature of treatment, Tami M. Morgan, LPC, health care operations, billing and payment policies, confidentiality including legal and ethical limits, possible risks and benefits of treatment, and alternative treatments available.
* ***Right to Revoke***: You will have the right to revoke this consent at any time by giving us a written notice of your revocation. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if revoke this consent.

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

Name of Client

­­­­­­­­­­­­­­­

Signature of Client/Parent/Guardian Date

*By signing this agreement, I acknowledge that I have had the opportunity to full discuss all aspects of treatment, have my questions answered, and understand the outpatient treatment process. Therefore, I agree to comply with treatment and authorize my designated provider to administer treatment to me and/or my child.*

Tami M. Morgan, MA., LPC Date

I ***revoke*** my consent for your use and disclosure of my protected health information for treatment, payment activities and health care operations. I understand that revocation of my consent will *not* affect an action in reliance on my consent before you revived this written notice of revocation. I also understand that you may decline to treat or continue to treat me after I have revoke my consent.

**(Only sign this line if you *revoke* your consent).**

Signature of Client/Parent/Guardian Date

***AUTHORIZATION FOR EXCHANGE OF INFORMATION***

|  |  |  |  |
| --- | --- | --- | --- |
| Client: | | Date: | |
| Parent/Guardian | | Phone: | |
| Mailing Address: | | | |
| City: | State: | | Zip: |
| Clients DOB: | | | |

Completion of this document authorizes the use of disclosure of individual identifiable health information, as set forth below, consistent with State and Federal law concerning the privacy such information.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ herby authorize the use of disclosure of my mental health information, or my child’s mental health information (if under 18) between Tami M. Morgan, MA., LPC and:

|  |  |  |  |
| --- | --- | --- | --- |
| Primary Care Doctor: | | | |
| Address: | | | |
| City: | State: | | Zip: |
| Phone: | | Fax: | |

**Expiration Date of Authorization:\_\_\_\_/\_\_\_\_/\_\_\_\_**

**(**Indicate date, or an event relating to you or to the purpose of authorization.)

The following information is requested (**Client needs to initial next to each that applies):**

\_\_\_\_\_Psychosocial History/Intake \_\_\_\_\_Dates of Treatment

\_\_\_\_\_Psychiatric Evaluation \_\_\_\_\_Treatment Plan(s)

\_\_\_\_\_Psychological Education/Testing \_\_\_\_\_Aftercare Plan

\_\_\_\_\_Diagnoses \_\_\_\_\_Financial obligations

\_\_\_\_\_Assessments \_\_\_\_\_Verbal/Written Exchange

\_\_\_\_\_Medical Records/H&P \_\_\_\_\_ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The purpose of this exchange is to facilitate treatment, summarize treatment and/or coordinate aftercare planning. I understand that I may revoke this consent at any time, expect information already released. If not revoke in writing this consent will expire in one year after the date below at my request.

Signature of Client/Parent/Guardian Date

Witness Date

**I *revoke* my consent for your use and disclosure of my protected health information for treatment.**

*Disclosure: This information has been disclosed to you from the records whose confidentiality is protected by law. Federal regulations, (42CFR part 2) prohibit you form making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another part is not sufficient for this purpose/ Federal regulations state that nay person who violates any provision of this law shall be subject to fines.*

Signature of Client/Parent/Guardian Date

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

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

Clinician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CLIENT HISTORY, SYMPTOM, AND TREATMENT BACKGROUND**

PRESENTING PROBLEMS: (Why are you here today?)

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

WHEN DID THIS START:

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

HOW LONG DOES THIS LAST:

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

HOW OFTEN DOES THIS HAPPEN:

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

EMOTIONAL SYMPTOM CHECKLIST (Rate intensity of symptoms currently present)

**None**= this symptom not present at this time **Mild=**impacts quality of life, but no significant impairment of day-to-day functioning **Moderate**=Significant impact on quality of life and/or day-to-day functioning **Severe**=Profound impact on quality of life and/or day-to-day functioning.

None Mild Moderate Severe None Mild Moderate Severe None Mild Moderate Severe

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Depressed mood |  |  |  |  | Bingeing/purging |  |  |  |  | Guilt |  |  |  |  |
| Appetite disturbance |  |  |  |  | Laxative/diuretic abuse |  |  |  |  | Elevated mood |  |  |  |  |
| Sleep disturbance |  |  |  |  | anorexia |  |  |  |  | Hyperactivity |  |  |  |  |
| Elimination disturbance |  |  |  |  | Paranoid ideation |  |  |  |  | Dissociative states |  |  |  |  |
| Fatigue/low energy |  |  |  |  | Circumstantial symptoms |  |  |  |  | Somatic complaints |  |  |  |  |
| Psychomotor retardation |  |  |  |  | Loose associations |  |  |  |  | Self-mutilation |  |  |  |  |
| Poor concentration |  |  |  |  | delusions |  |  |  |  | Significant weight gain/loss |  |  |  |  |
| Poor grooming |  |  |  |  | Hallucinations |  |  |  |  | Concomitant medical condition |  |  |  |  |
| Mood swings |  |  |  |  | Aggressive behaviors |  |  |  |  | Emotional trauma victim |  |  |  |  |
| Agitation |  |  |  |  | Conduct problems |  |  |  |  | Physical trauma victim |  |  |  |  |
| Emotionality |  |  |  |  | Oppositional behavior |  |  |  |  | Sexual trauma victim |  |  |  |  |
| Irritability |  |  |  |  | Sexual dysfunction |  |  |  |  | Emotional trauma perpetrator |  |  |  |  |
| Generalized anxiety |  |  |  |  | grief |  |  |  |  | Physical trauma perpetrator |  |  |  |  |
| Panic attacks |  |  |  |  | Hopelessness |  |  |  |  | Sexual trauma perpetrator |  |  |  |  |
| Phobias |  |  |  |  | Social isolation |  |  |  |  | Substance abuse |  |  |  |  |
| Obsessions/compulsions |  |  |  |  | worthlessness |  |  |  |  | Other (specify) |  |  |  |  |

**COMMENTS** (please explain any checked answers):

EMOTIONAL/PHYSIATRIC HISTORY (former mental health facilities and Dr.’s)

**[ ] [ ]** **Prior outpatient psychotherapy?**

No Yes

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Prior provider name | City | State | Phone | Diagnosis | Invention/Modality | Approx. Admit Date | Approx. D/C Date | Beneficial? |
|  |  |  |  |  |  |  |  |  |
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**[ ] [ ]** **Has any family member had outpatient psychotherapy (counseling)?** If yes, who/why (list all) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

No Yes

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Family Member | Diagnosis/Why? | Approx. Admit Date | Approx. D/C Date | Beneficial? |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**[ ] [ ]** **Prior inpatient treatment for a psychiatric, emotional, or substance use disorder?**

No Yes

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Prior provider name | City | State | Phone | Diagnosis | Invention/Modality | Approx. Admit Date | Approx. D/C Date | Beneficial? |
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**[ ] [ ] Has any family member had inpatient treatment for a psychiatric, emotional, or substance disorder?** If yes, who/why?

No Yes

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Family Member | Diagnosis/Why? | Approx. Admit Date | Approx. D/C Date | Beneficial? |
|  |  |  |  |  |
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**[ ] [ ] Prior or current psychotropic medication usage (mental health medication)?** If yes:

No Yes

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Medication | Dosage | Frequency | Start date | End date | Physician | Side effects | Beneficial? |
|  |  |  |  |  |  |  |  |
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**[ ] [ ] Has any family member used psychotropic medications (mental health medication)?** If yes, who/what/why (list all):

No Yes

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Family Member | Medication | Dosage | Frequency | Start date | End date | Physician | Side effects | Beneficial? |
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**COMMENTS** (emotional/psychiatric in detail):

FAMILY HISTORY

**FAMILY OF ORIGIN**

**Present during childhood: Parent’s current marital status: Describe parents:**

**Father Mother**

Present Present Not [ ] married to each other full name\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Entire Part of Present [ ] separated for \_\_ years occupation\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Childhood Childhood at all [ ] divorced for \_\_ years education \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Mother [ ] [ ] [ ] [ ] mother remarried \_\_ times general health \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Father [ ] [ ] [ ] [ ] father remarried \_\_ times

Stepmother [ ] [ ] [ ] [ ] mother involved with someone **Describe childhood family experience:**

Stepfather [ ] [ ] [ ] [ ] father involved with someone [ ] outstanding home environment

Brother(s) [ ] [ ] [ ] [ ] mother deceased, age of [ ] normal home environment

Sister(s) [ ] [ ] [ ] patient at mother’s death [ ] chaotic home environment

Other (specific) [ ] [ ] [ ] [ ] father deceased, age of [ ] witnessed physical/verbal/sexual

patient at father’s death abuse toward others

[ ] experienced physical/verbal/sexual

abuse from others

**Age (if) emancipated from home: \_\_\_\_\_\_\_\_\_\_\_\_**

**Circumstances: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Special circumstance in childhood (what was your childhood like):**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**IMMEDIATE FAMILY**

**Marital status: List all family member currently living in your**

**Intimate relationship: household:**

[ ] single, never married [ ] never been in a serious relationship Name Age Sex Relationship to patient

[ ] engaged \_\_ months [ ] not currently in relationship \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] married \_\_ years [ ] currently in a serious relationship \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] divorced \_\_ years \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] separated \_\_ years **Relationship satisfaction**

[ ] divorce in process \_\_ months[ ] very satisfied with relationship **List children not living in same household as patient:**

[ ] live-in for \_\_ years [ ] satisfied with relationship \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] \_\_\_prior marriages (self) [ ] somewhat satisfied with relationship \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] \_\_\_ prior marriages (partner) [ ] dissatisfied with relationship \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] very dissatisfied with relationship Frequency of visitation above \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Describe any past or current significant issues with intimate relationships:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Describe any past or current significant issues in other immediate family relationships:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

MEDICAL HISTORY (check all that apply for the patient)

**Past Medical History (medical problems that have required you to see a Dr., take medication, or be hospitalized)**

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 7. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 8. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Surgical History (procedure and date of surgery)**

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Vaccinations:**

[ ] Flu Date: \_\_\_\_\_\_\_\_\_\_\_\_

[ ] Tetanus Date: \_\_\_\_\_\_\_\_\_\_\_\_

[ ] Pneumovax Date: \_\_\_\_\_\_\_\_\_\_\_\_

**Use of Tobacco** ( ) Never ( ) Chew Current pack/day \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Quit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Caffeine** ( ) Never ( ) Rarely ( ) Daily Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Use of Drugs** ( ) Never ( ) Currently ( ) Past Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Use of Alcohol** ( ) Never ( ) Rarely ( ) Moderately ( ) Daily

**General Ear/Nose/Mouth/Throat Eyes Psychiatric**

Fatigue Y/N Decreased Hearing Y/N Eye Pain Y/N Anxiety Y/N

Fevers Y/N Earache Y/N Vision Loss Y/N Depression Y/N

Weight Loss Y/N Hoarseness Y/N DBL Vision Y/N Mental Illness Y/N

Sleep Problems Y/N Nose Bleeds Y/N

**Cardiovascular** **Respiratory Neurological Skin**

Chest Pain Y/N Cough Y/N Headache Y/N Bruising Y/N

Palpitations Y/N Coughing Blood Y/N Fainting Spell Y/N Rash Y/N

Leg Swelling Y/N Shortness of Breath Y/N Dizziness Y/N Lesions Y/N

**Gastrointestinal Musculoskeletal Allergic/Immunologic**

Abdom. Pain Y/N Back Pain Y/N Hay Fever Y/N

Constipation Y/N Neck Pain Y/N Persistent Infect. Y/N

Diarrhea Y/N Joint Pain/Swelling Y/N Hives Y/N

**Hematologic/Lymphatic Endocrine Male Only**

Bleeding Problems Y/N Cold/Heat Intolerance Y/N Difficult w/ erection Y/N

Varicose Veins Y/N Excessive Urination Y/N Increased Urination Y/N

History of Cancer Y/N Unusual Thirst Y/N

**Females Only Breasts**

Vaginal Bleeding Y/N Masses Y/N

Pelvic Pain Y/N Nipple Discharge Y/N

Vaginal Discharge Y/N Pain Y/N

**Family Medical History (Do any of the following medical problems run in your family?)**

Diabetes Y/N AIDS Y/N Asthma or Lung Condition Y/N

Heart Y/N Stroke Y/N High Blood Pressure Y/N

**COMMENTS:** (medical in detail):

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

SUBSTANCE USE HISTORY (check all that apply for patient)

**Family alcohol/drug abuse history: Substance used (self): Current Use:**

[ ] father [ ] stepparent/live-in **(Complete all that apply) First use age Last use age Y/N Frequency Amount**

[ ] mother [ ] uncle(s)/aunt(s) [ ] alcohol \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] grandparent [ ] spouse/significant other [ ] amphetimes/speed \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] sibling(s) [ ] children [ ] barbiturates/downers \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] caffeine \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] cocaine \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] crack cocaine \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Substance use status:** [ ] hallucinogens \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] no history of abuse [ ] inhalants(e.g. glue, gas) \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] active abuse [ ] marijuana or hashish \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] early full remission [ ] nicotine/cigarettes \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] early partial remission [ ] PCP \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] sustained full remission [ ] prescription \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] sustained partial remission [ ] other\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Treatment history: Consequences of substance abuse** (check all that apply):

[ ] outpatient age(s)\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] hangovers [ ] withdrawal symptoms [ ] sleep disturbance [ ] binge

[ ] inpatient age(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] seizures [ ] medical conditions [ ] assaults [ ] job loss

[ ] 12-step program age(s)\_\_\_\_\_\_\_\_ [ ] blackouts [ ] tolerance changes [ ] suicidal impulse [ ] arrest

[ ] stopped on own age(s)\_\_\_\_\_\_\_\_\_ [ ] overdose [ ] loss of control [ ] relationship conflicts [ ] other age(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] other Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**COMMENTS**

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

DEVELOPMENTAL HISTORY (check all that apply for a child/adolescent patient)

**Problems during Birth: Childhood health:**

**Mother’s pregnancy:** [ ] normal delivery [ ] chicken pox (age\_\_\_\_\_) [ ] lead poisoning (age\_\_\_\_\_)

[ ] high blood pressure [ ] difficult delivery [ ] German measles (age\_\_\_\_) [ ] mumps (age\_\_\_\_)

[ ] kidney infections [ ] cesarean delivery [ ] red measles (age\_\_\_\_) [ ] diphtheria (age\_\_\_\_)

[ ] emotional stress [ ] complications [ ] rheumatic fever (age\_\_\_\_) [ ] poliomyelitis (age\_\_\_\_)

[ ] alcohol use [ ] feeding problems [ ] whooping cough (age\_\_\_\_) [ ] pneumonia (age\_\_\_\_)

[ ] drug use [ ] sleep problems [ ] scarlet fever (age\_\_\_\_) [ ] tuberculosis (age\_\_\_\_)

[ ] cigarette use [ ] toilet training prob. [ ] bleeding **Infancy:** [ ] ear infections [ ] asthma

[ ] allergies to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] significant injuries\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] chronic serious health problems\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] autism

[ ] epilepsy (age\_\_\_\_)

[ ] mental retardation/intellectual disability (age\_\_\_\_)

[ ] other developmental diagnosis: (age\_\_\_\_)

**Delayed developmental milestones** (check only **Emotional/ behavior problems** (check all that apply):

those milestones that did not occur at expected age):

[ ] sitting [ ] controlling bowels [ ] drug use [ ] repeats words of others [ ] distrustful

[ ] rolling over [ ] sleeping alone [ ] alcohol abuse [ ] not trustworthy [ ] extreme worrier

[ ] standing [ ] dressing self [ ] chronic lying [ ] hostile/angry mood [ ] self-injurious acts

[ ] walking [ ] engaging peers [ ] stealing [ ] indecisive [ ] impulsive

[ ] feeding self [ ] tolerating separation [ ] violent temper [ ] immature [ ] easily distracted

[ ] speaking words [ ] playing cooperatively [ ] fire-setting [ ] bizarre behavior [ ] poor concentration

[ ] speaking sentences [ ] riding tricycle [ ] hyperactive [ ] self-injurious threats [ ] often sad

[ ] controlling bladder [ ] riding bicycle [ ] animal cruelty [ ] frequently tearful [ ] breaks things

[ ] other\_\_\_\_\_\_\_\_\_\_\_ [ ] assaults others [ ] frequently daydreams [ ]other \_\_\_\_\_\_\_\_\_\_

[ ] disobedient [ ] lack of attachment

**Social interaction** (check all that apply) **Intellectual/Academic functioning** (check all that apply)

[ ] norm social interaction [ ] inappropriate sex play [ ] normal intelligence [ ] authority conflicts [ ] mild retardation

[ ] isolates self [ ] dominates others [ ] high intelligence [ ] attention problems [ ] mod retardation

[ ] very shy [ ] associates w/acting out peers [ ] learning problems [ ] underachieving [ ]severe retardation

[ ] alienates self [ ] other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Describe any other development problems or issues:**

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

**Comments (developmental history in detail):**

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

SOCIO-ECONMIC HISTORY (check all that apply for patient)

[ ] housing adequate [ ] supportive network [ ]heterosexual orientation [ ]currently sexually dissatisfied

[ ] homeless [ ] few friends [ ]homosexual orientation [ ]age first sex experience \_\_

[ ] housing overcrowded [ ] substance-use-based friends [ ] bisexual orientation [ ] age first pregnancy/fatherhood

[ ] dependent on others housing [ ] no friends [ ] sexually active [ ] history of promiscuity age \_\_\_

[ ] housing dangerous/deteriorating [ ] distant from family of origin [ ] sexually satisfied [ ] history of unsafe sex\_\_\_to\_\_\_

[ ] living companions dysfunctional

**Employment: Military history: Cultural/Spiritual/recreational history:**

[ ] employed and satisfied [ ] served in the military-no incidentcultural identity(e.g., ethnicity, religion):\_\_\_\_\_\_\_\_\_\_

[ ] employed but dissatisfied [ ] served in the military-w/incident describe any cultural issues that contribute to current

[ ] unemployed problem:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] coworker conflicts **Legal History:** Active in community/recreation activities? Y / N

[ ] supervisor conflicts [ ] no legal problems Formerly active in community/recreational? Y / N

[ ] unstable work history [ ] now on parole/probation Currently engage in hobbies? Y / N

[ ] disabled: \_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] arrest(s) not substance-related Currently participating in spiritual activities? Y / N

[ ] arrest(s) substance-related if answered yes to any above please describe:\_\_\_\_\_\_\_

**Financial situation:** [ ] court ordered this treatment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] no current financial problems [ ] jail/prison \_\_\_\_\_ time(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] large indebtedness Total time served: \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] poverty or below income Describe last legal difficulty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] impulsive spending \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] relationship conflicts over finances \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GOAL STATEMENT**

Tami M. Morgan LPC., believes that every individual who enters our doors is of value and worth. My goal is to encourage hopes and dreams in such a way that all people whose lives I touch maximize their unique energies, skills, and talents. I believe in you!

**CLIENT INFORMATION**

Welcome to Tami M. Morgan LPC.,. I will be continually working to provide you with appropriate, high-quality services. I believe that a client who understands and participates in his/her care can achieve better results. I have the responsibility to give you the best care possible, to respect your rights, and to recognize your responsibilities as a client. I have prepared this informational handout to help you identify these rights and responsibilities.

**YOUR RIGHTS AS A CLIENT**

***Your Right to Privacy and Confidentiality:*** We follow the privacy provisions of state and federal laws and rules. You have the right to know the policies, practices, and limitations of the privacy of the information that you share with me.

Your treatment record will be stored in a locked cabinet or computer, which is protected from unauthorized access. It is accessible only to personnel whom I have authorized to help provide treatment to you. Your treatment record includes your diagnosis, treatment plan, progress notes, psychological test report, psychiatric and other medical reports, and closing summary. Your billing record will be stored separately in a locked cabinet or computer protected form unauthorized access. If you request that your insurance company pay for these services, I will only share the minimum information necessary for your insurance company; a) name and address of your insurance company; b) your subscriber and group plan numbers; c) your name, birth date, social security number, diagnosis, dates of service, type of service. If your insurance company requires further information in order to process your claim (such as date of onset of your problems, history of your problems, symptoms that meet criteria for your diagnosis, your progress in treatment to date, and your goals and objectives for treatment), I will first consult you about your insurance company’s request and give you the option to decide what, if anything, may be released. it Is your choice whether or not to use your insurance coverage for payment of my services.

All personnel (clinical, support, or billing) authorized to have access to your information in this office will limit their access and use of your healthcare information to only what is necessary.

If you are receiving clinical services from other health care professionals, I will need to routinely confer with them about your diagnosis, treatment plan, and progress for the purpose of coordinating your treatment.

AT TIMES, I MAY ALSO SEEK OUT PROFESSOINAL CONSULTAITON ABOUT SOME ASPECT OF MY WORK WITH YOU. USUALLY IT WILLL NOT BE NECESSARY TO SHRE YOU INDENTIFYING INFROAMTION WITH THE CONSULTANT (S). THE CONSULTING PROFESSIONAL (S) ALSO MUST ABIDE BY APPLICABLE ALWS AND ETHICS TO PROTECT YOUR CONFIDENTIALITY IN ALL CASES.

Other than the routine disclosure noted above which are necessary to perform treatment and billing services on your behalf, no information will be released to any other persons or agencies outside of this office without your written authorization except by court order. If anyone outside this office requests information from us or from your records, your permission in writing on a special “authorization for lease of information” for is necessary. Before giving permission, satisfy yourself that the information is really needed, that you understand the information being sent out, and that giving the information will help you. You have the right to approve or refuse the release of information to anyone, except as provided by law.

***Exceptions to the Above Information Release Procedures***

1. When I have knowledge of, or reasonable cause to believe, that a child/adult is being neglected or physically or sexually abused, in which case state law requires that information be reported authorities.
2. Reporting of maltreatment of vulnerable adults as specified in state law.
3. Reporting of alleged practitioner sexual misconduct as specified in state law.
4. Reporting of instances of threatened homicide or physical violence against another. I must report such threats to the appropriate police agency as well as to the intended victim.
5. In cases of threatened suicide, at lease one concerned person and/or the appropriate police agency may be contacted to intervene and the client will be referred for evaluation/
6. In cases in which a client, with a history of sexual and/or physical abuse of others, terminates therapy against our advice, I will notify those past victims of abuse that the client has terminated therapy against our advice so that proper precautions can be taken. Days
7. It is my policy to employ the use of collection agencies or to file in small claims court on all accounts, which are overdue by 90 days. Information necessary to pursue such payment due to me will be shared with the agency or court.

***Right Not To be Discriminated Against:*** You have the right not to be discriminated against in the provision of professional services on the basis of race, age, gender ethnic origin, disability, creed, or sexual orientation.

***Right to Know Your Providers Qualifications:*** You are entitled to ask us what your providers training is, where it was received, if they are licensed or certified, their professional competencies, experience, education, biases or attitudes, and any other relevant information that may be important to you in the provision of services. You have the right expect that I have met the minimum qualifications of training and experience required by state law and to examine public records maintained by the licensure boards that regulate my practice.

***Right to Be Informed:*** You have the right to be informed of my assessment of your problem in a language you understand, to know available treatment alternatives. You also have the right to understanding the purpose of the profession services, including an estimate of the number of sessions, the length of the time involved, the cost of the services, the methods used, and the expected outcomes of the treatment. In addition, you have the right and responsibility to help develop your own treatment plan.

***Right to Read Your Own Records:*** You have the right to read you r own records created by our agency with a provider assisting you. Under HIPPA regulations if I believe that the information that is contained in the file would be detrimental to your further treatment process then I have the right to withhold information with an explanation provided to you. I will assist you in understanding your written records by being available to answer questions and to explain the meaning of test scores and technical terminology . you may inform me of any inaccuracies of information in your file and give me a written amendment, which I will place in your file. In addition, you have the right to be told why the information I am requesting is needed and be told how the information will be used. You should also be informed other consequences if any, of refusing to supply requested information. The information collected will be used by us for evaluation and treatment purposes. If you choose not supply such information, I cannot determine which services are most appropriate for you and that will make it more difficult for me to carry out an effective treatment plan for you. Refusal to provide such information could result in my inability to provide effective treatment for you and I have the have the right to refuse treatment If this occurs I will provide you with a list of available resources to assist you.

***Records retention policy is as follows:*** The complete record will be retained for five years. At the end of five years, the record will be entirely destroyed, leaving only the name of the client and date of record destruction. The time period begins from the date of the last visit. Should there be any further direct client contacts; the counting period will begin again at the date of the new service/

***Right to Refuse Treatment:*** You have the right to consent or refuse recommended treatment. You can be treated without consent only if there is an emergency, and in our opinion failure to act immediately would jeopardize your health. In such emergency cases, we will make reasonable efforts to involve a close relative or friend prior to providing emergency services. No audio or video recording of a treatment sessions can be made without your permission.

***Right to Voice Grievances:*** You have the right to voice grievances and request changes in your treatment without restraint, interference, coercion, discrimination, or reprisal. I encourage you to share you concerns direct with me. You have the right to report violations of my privacy practices to the Secretary of Health and Human Services. People with developmental and mental disabilities are entitled to protection and must have access to advocacy in securing the benefits, services and rights to which they are entitled. The following are resources, which persons with developmental disabilities may call upon:

**Advocacy**

*-Idaho Parents Unlimited, Inc.: 1-800-242-4785, V/TT 208-342-5884*

*-Idaho Federation of Families: 1-800-905-3436 or 208-734-2303,* [www.idahofedration.org](http://www.idahofedration.org)

*-Disability Rights Idaho TT: 208-336-5353, VT/TT: 1-800-632-5125*

**Protection**

*-Children and Family Services: 208-734-4000*

*-Adult Protection Services: 208-736-2122*

*-Law Enforcement Agencies*

*-Mental Health Liaison: 208-732-1510*

***Right Not to Be Subjected by Harassment:*** You have the right to not be subjected to sexual, physical, or verbal harassment.

***Minors’ Right to Privacy****:* all non-emancipated minor clients under the age of 18 must have consent of their parents or guardians following an initial intake session to receive further treatment services. State law provides that minor have the right to request that their records be withheld from their parents or guardians. If a minor client requests that records be withheld and we concur that the denial of parental access is in the best interest of the child, information in the minor’s file will not be disclosed to the parents. We may deny a parent’s or legal guardian’s request for access in his or her child’s treatment record when, in our professional judgment, parental or guardian access to the record would result in harm to the child.

***Rights of Adults Judge Unable to Give Informed Consent:*** For adults judged tunable to give informed consent, the same policy as that for minors applies regarding permission for services and requests that records be withheld.

***Referral Rights:*** You have the right to be referred or terminated. You have the right to active assistance from me in referring you to other appropriate services.

**YOUR RESPONSIBLITIES AS SA CLIENT**

***To be honest:*** You are responsible for being honest and direct about everything that relates to you as a client. Please tell me exactly how you feel about things that are happening to you in your life.

***To Understand Your Treatment Plan:*** You are responsible for understanding your treatment plan to your own satisfaction. If you do not understanding, ask me. Be sure you do understand since this is important for the success of the treatment plan.

***To Follow the Treatment Plan:*** It is your responsibility to discuss with us whether or not you think and/or want to follow a certain treatment plan.

***To Keep Appointments:*** You are responsible for keeping appointments. If you cannot keep an appointment, notify me as soon as possible so that another client can be seen. In any case, you will be charged for appointments when canceled with less than 24 hours’ noticed as outlined in the Financial Policy.

***To Know Your Fee:*** I am willing to discuss my fees with you and to provide a clear understanding for you of the costs of all associated service.

***To Keep Tami M. Morgan LPC., Informed:*** So that I may contact whenever necessary, I will rely upon you to notify me of any changes in your name, address, and home or work phone numbers.

**YOUR THERAPIST’S RIGHTS AND RESPONSIBILTIES**

I have the responsibility to provide care appropriate to your situation, as determined by prevailing community standards. To accomplish this goal, I also have certain rights, including:

1. The right o information needed to provide appropriate care.
2. The right to be reimbursed, as agreed, for services provided.
3. The right to provide services in an atmosphere free of verbal, physical, or sexual harassment.
4. The right and ethical obligations to refuse to provide services that are not clinically indicated.

**NOTICE OF PRIVACY PRACTICES**

*YOUR PRIVATE HEALTH INFORMATION*

My office keeps records of the mental health care and services provided to you in order to help provide quality care and services. Because of the sensitivity of health records, I am required by state and federal law to maintain the privacy of your health information. i am also required to give you this *Notice of Privacy Practices* concerning your health information.

*USE AND DISCLOSURE INFORMATION*

I use and disclose information about you for treatment, payment, and health care operations. For example:

* ***Treatment***: I may share all or part of your health information with another health care provider providing treatment to you.
* ***Payment***: My office keeps billing records that include payment information and documentation of the services provided to you. I may use and disclose your health information to obtain payment from you, your insurance company, or other third part payment provider.
* ***Health Care***: Operations I may use and disclose your health care information to improve quality of care, train my staff, provide customer service, manage costs and conduct business duties.

Federal guidelines do not require my office to have your written consent to disclose your health care information when it is for payment, treatment or health care operation purposes. However, because your private health information is sensitive, I will keep disclosures to a minimum based on my profession judgment. I will also have you sign a consent and/or authorization document to request information from other sources and to release health information to outside parties.

**HIPPA AND YOUR PRIVACY**

The ***Health Insurance Portability Accountability Act*** was enacted to maintain the confidentiality of personal medical information. You are entitled to request information about your records or about the privacy of your information, or revoke your authorization at any time with a written request.

HIPPA permits me to disclose your health information without your written consent when it is for treatment payments or health care operations. Protecting your privacy is important to me. I follow federal and state laws, professional codes of ethics and industry best practices to provide the highest quality care.

Information may be disclosed to family members or others directly involved in your care or payment for you care without you written consent. Examples include parents of dependent children, legal guardians, and assisted living/nursing home staff, Social Security Disability Officer, Worker’s Compensation.

Third parties having access to you personal medical information must follow physical, electronic, and procedural safeguards that comply with HIPPA protections of confidentiality.

Other limited situations allowing us to use or disclose health information without your signed authorization include:

* Public health purposes such as reporting communicable diseases, work-related illnesses, or reporting adverse reactions to medication, etc.
* Protection of victims of abuse, neglect or domestic violence
* Health oversight activities such as investigations, audits and inspections
* Requests from a court order
* Worker’s compensation
* Reduction or prevention of a serious threat to public health and safety

Signature of Client/Parent/Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_