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Welcome. I look forward to working with you. This form requests information about you and/or your family that will help me plan your care. If you have any questions, please feel free to discuss them with me.

Patient Name _____ today's Date _____
Address _____ Birthdate _____
City, State, Zip _____ Age _____

Phone # (____) _____ (____) _____ (____) _____

Home OK to leave messages? Y N **Work** OK to leave messages? Y N **Cell** OK to leave messages? Y N

Occupation _____ E-mail _____

Emergency Contact _____
Name Relationship to patient phone number

Name & phone of primary care physician _____

Name & phone of psychiatrist (if any) _____

Primary Insurance Information:

Insured Name: _____

Insured SSN: _____

Insured DOB: _____

Employer: _____

Mental Health Carrier: _____

Relationship to Insured: _____

Member No: _____

Policy/Group No: _____

Benefit Information:

Insurance Company: _____

Address: _____

Telephone: _____

Authorization No: _____

Copay Amount: _____

Max. Visits: _____

Areas of Concern:

Please describe your reason(s) for seeking treatment at this time (include date the problem started): _____

Was there an event that made these issues or problems surface? ___Y ___N If yes, please describe: _____

Do you have any specific goals for treatment? What result(s) do you expect from treatment? _____

Do you have any particular concerns/fears with regard to treatment? _____

Other Information:

Please describe your spiritual/religious orientation _____

Please describe your interests/hobbies _____

Are you now or have you ever been involved in a lawsuit? ___Y ___N Please describe _____

Has anyone in your family had a serious medical illness? If so, please explain what/when: _____

Has anyone in your family had a psychiatric (nervous or mental) illness? ___Yes ___No If yes, please explain what/when: _____

Any medication? ___Y ___N What? _____ Hospitalization? ___Y ___N When? _____

Please feel free to include any other information that you believe is relevant to your mental health treatment _____

Please indicate & rate the severity (1-4) of the following issues or problems you would like to work on in treatment:

NO PROBLEM 1	MILD PROBLEM 2	MODERATE PROBLEM 3	SEVERE PROBLEM 4
___ Anger/temper	___ Diet	___ Motivation	___ Headaches
___ Depression	___ Anxiety	___ Controlling stress	___ Loss of loved one
___ Problems at school	___ Problems at work	___ Lack of friend's	___ Loneliness
___ Problems coping	___ Abuse/victimization	___ Financial problems	___ Legal matters
___ Panic	___ Concentration	___ Sleep	___ Fears
___ Body Image	___ Nightmares	___ Energy	___ Divorce/Separation
___ Marriage/Relationship issues	___ Sexuality/Sexual issues	___ Family conflict	___ Behavioral problems
___ Drug/alcohol habit	___ Relaxation	___ ADD/ADHD	___ Shyness
___ Self-control	___ My thoughts	___ Eating Disorder	___ Being a parent

Are there any compulsive/repetitive behaviors or thoughts that are of concern to you and/or the people close to you? (i.e., overeating, Hoarding, checking, counting, washing, illness-related, thoughts of harming someone, sexual behavior, etc.)? ___ Yes ___ No
 If yes, please describe: _____

MEDICAL

When were you last examined by a physician? _____ Outcome? _____

Medications

Type	Dosage	Start Date	Prescribing M.D.	Phone No.
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Side Effects _____

Alternative treatments _____

Allergies

Type _____ Severity _____ Treatment _____

Type _____ Severity _____ Treatment _____

Please list any over-the-counter medications you currently use such as vitamins, sleeping/diet pills, aspirin/pain relievers, etc.

IMMEDIATE FAMILY

LIST MEMBERS OF YOUR FAMILY OR OTHERS WITH WHOM YOU LIVE:

Name(s)	Age	Relationship	Occupation

Marital Status

- ___ single, never married
- ___ engaged ___ mos.
- ___ married ___ yrs.
- ___ divorced ___ yrs.
- ___ separated ___ yrs.
- ___ divorce in process ___ mos.
- ___ live-in for ___ yrs.
- ___ prior marriages (self)
- ___ prior marriages (partner)

Intimate Relationship

- ___ never been in serious relationship
- ___ not currently in relationship
- ___ currently in serious relationship
- Relationship satisfaction**
- ___ very satisfied w/relationship
- ___ satisfied with relationship
- ___ somewhat satisfied w/relationship
- ___ dissatisfied w/relationship
- ___ very dissatisfied w/relationship

List minor children NOT living in same household

Name	Age	Sex	Relationship

Frequency of visitation of above: _____

Describe any part or current significant issues in **intimate** relationships: _____

Present during childhood:

	Present Entire Childhood	Present part of childhood	Not present at all	Family alcohol/ Drug Abuse History:	
Mother	_____	_____	_____	___ Father	___ Stepparent/Live-In
Father	_____	_____	_____	___ Mother	___ Uncle(s)/Aunt(s)
Stepmother	_____	_____	_____	___ Grandparent	___ Spouse/Partner
Stepfather	_____	_____	_____	___ Sibling(s)	___ Children
Brother(s)	_____	_____	_____	___ Other	_____
Sister(s)	_____	_____	_____	_____	_____

Parents' current marital status:

- ___ married to each other
- ___ separated for ___ years
- ___ divorced for ___ years
- ___ mother remarried ___ times
- ___ father remarried ___ times
- ___ mother involved with someone
- ___ father involved with someone
- ___ mother deceased for ___ years
- ___ age of patient at mother's death ___
- ___ father deceased for ___ years
- ___ Age of patient at father's death ___

SUBSTANCE USE HISTORY (check all that apply for patient):

Self-Perception of substance use: Amount	Substances used:	First use age	Last use age	Current?	Frequency
___ none	___ alcohol				
___ Occasional/social	___ amphetamines/speed				
___ Problem use	___ barbiturates/downers				
___ Dependent	___ cocaine/crack				
___ don't want to stop	___ hallucinogens (LSD, etc.)				
___ Addicted/Cannot stop	___ inhalants (glue, etc.)				
___ Motivated to stop	___ marijuana or hashish				
	___ PCP/Ecstasy				
Previous treatment:	___ prescription drugs				
___ 12-Step	___ nicotine/cigarettes				
___ Out Patient	___ caffeine				
___ In Patient	___ other _____				

Physical/mental consequences of substance use (check all that apply):

- | | | | | |
|------------------------------------|---------------------------------|--------------|------------------------|--------------|
| ___ Outpatient (age(s) _____) | ___ hangovers | ___ binges | ___ blackouts | ___ job loss |
| ___ Inpatient (age(s) _____) | ___ seizures | ___ overdose | ___ arrests/DUI | ___ assaults |
| ___ 12-step program (age(s) _____) | ___ withdrawal symptoms | | ___ sleep disturbances | |
| ___ stopped on own (age(s) _____) | ___ medical conditions | | ___ tolerance changes | |
| ___ other (age(s) _____) | ___ relationship conflicts | | ___ suicidal impulse | |
| Describe: _____ | ___ loss of control of amt used | | ___ other _____ | |

The following information is provided to you so you have a better understanding of how your care will be coordinated. Please read each item carefully and sign in the appropriate spaces.

TREATMENT PHILOSOPHY

During the initial evaluation period, you and your provider will clarify together the nature of the problems for which you are seeking treatment, define some reasonable treatment goals, and develop a treatment plan that will help you achieve those goals. *If your insurance is a managed healthcare plan, the number of sessions available to you may be severely limited.* You are expected to be compliant with the agreed upon treatment plan between sessions and keep your appointments. Research has shown that, often times, brief, time limited therapy focusing on specific goals results in more rapid reduction of symptoms and improvement in patient functioning. The treatment plan may include attending support groups, reading selected materials, and/or completing specific written or verbal assignments.

CONFIDENTIALITY:

All information between provider and patient is held strictly confidential unless:

- 1. Patient authorizes release of information with his/her signature.
- 2. Patient presents a physical danger to self.
- 3. Patient presents a danger to others.
- 4. Child/elder abuse is suspected.
- 5. Patient fails to pay for services rendered and formal collection becomes necessary.

We are required by law to inform potential victims and legal authorities so protective measures can be taken.

FINANCIAL TERMS

Upon verification of health plan/insurance coverage and policy limits, your insurance carrier will be billed for your treatment and your provider will be paid directly by the carrier. You will be responsible for any applicable **deductibles** and **copayments**. Copayments must be paid at the time services are rendered. If you are not eligible for benefits at the time services are rendered, you are responsible for full payment of provider's hourly rate, which is \$ _____. Your copayment for services is \$ _____. **Patient initials** _____

CANCELED/MISSED APPOINTMENTS

A scheduled appointment means that time is reserved only for you. *If an appointment is missed or canceled with less than 24 hours notice, you will be billed directly according to the scheduled fee or according to the rules of your health plan.* Most health plans do not cover payment for missed appointment; therefore, you are responsible for payment in full. **Patient initials** _____

APPEALS AND GRIEVANCES

I acknowledge my right to request an appeal in case that outpatient care is not certified. I understand that I would request an Appeal directly through my insurance carrier. I also understand that I may submit a grievance to my provider at any time to register a complaint about my care. I also understand the California Department of Managed Care (DMC) regulates health services. Their telephone number is 800-400-0815, and I may contact them to register a complaint against my health care plan.

EMERGENCY PROCEDURES

If you need to contact your provider, leave a message according to the instructions on the office telephone message and your call will be returned. If you experience a true life threatening emergency and need immediate attention, you should leave a message for your provider and then call 911 or go to the nearest hospital emergency room.

RELEASE OF INFORMATION TO HEALTH PLAN

I authorize release of information regarding my care to my health plan for the payment of claims, certification/case management decisions and other purposes related to the administration of benefits for my Health Plan. **Patient initials** _____

RELEASE OF INFORMATION TO PRIMARY CARE PHYSICIAN

I authorize the release of information to my Primary Care Physician (name) _____ at (telephone number) _____ for purposes related to my health care. **Patient initials** _____

CONSENT FOR TREATMENT

I further authorize and request that my treating provider carry out psychological examinations, treatments, and/or diagnostic procedures that now or during the course of my care as a patient are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that, while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable.

ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits to the provider for services described on Form HCFA-1500.

SIGNED _____ Date _____

I understand and agree to all of the above information.

Patient (or Parent/Guardian) Name – *Printed* Date

Patient (or Parent/Guardian) Name – *Signature* Date