Parker Psychology & Counseling Associates

Craig H. Parker, MSW, LCSW; Becky D. Parker, Ph.D.
2928 N. McKee Circle, Ste. 126, Fayetteville, AR 72703
Phone: 479.443.4222 Fax: 479.443.2114

Thank you in advance for completing this paperwork, and please know that I look forward to working with you. I have set aside 60 minutes to meet with you for this first session. If you are unable to keep your appointment, I will be happy to reschedule. However, please notify the office at least 24 hours in advance for rescheduling or cancellation. If you need to speak with me, please call 479.443.4222 to leave a confidential voicemail message, and I will return your call as soon as possible. Although I may be available after office hours, I do not offer a 24-hour emergency service and am often not immediately available.

The fee for the initial appointment (i.e., diagnostic interview) is $120.00 (this fee includes review of paperwork, as well as setting up your financial and clinical charts), and the fee for psychotherapy appointments is $90.00 for each 50-minute session. Payment in full by check, cash or Visa/MasterCard/Discover is requested at the time services are rendered unless arranged otherwise through mutual agreement. Please do not hesitate to discuss with me any questions or concerns you have.

You may wish to know my credentials. I have a Master's Degree in Social Work from the University of Arkansas at Little Rock, and am licensed as a Licensed Certified Social Worker in the state of Arkansas. In my private practice, I specialize in psychotherapy with adults, and I have a specialty focus in the area of substance abuse and addictions. My prior experiences include work at a community mental health center, inpatient and outpatient treatment with both adults and adolescents, inpatient and outpatient substance abuse treatment, and assessment and psychotherapy services with children and their families.

Our office is located in the Appleby Business Center at 2928 N. McKee Circle in Fayetteville. McKee Circle is located one block west of the intersection of College Avenue and Appleby Road, near Fiesta Square, and there is ample free parking available. Please contact me if you have any questions about locating our office. Appleby Business Center is a one-story building that has individual businesses located within it. When you arrive for your appointments, please enter the Business Center through the front door and have a seat in the lobby. I will be with you as soon as possible and will come out to the lobby to bring you to my office.

In order to assist us in setting up your clinical and financial files, please complete the enclosed forms and bring them with you at the time of your first appointment. If you have any questions, please feel free to contact me. I look forward to meeting you and working with you.

Yours truly,

Craig H. Parker, MSW, LCSW
Licensed Certified Social Worker

CONTRACT FOR PATIENT SERVICES

I, _____, understand that I have contracted for psychological services with Craig H. Parker, MSW, LCSW, for the following fees:

- $120.00 for the initial diagnostic interview.
- $ 90.00 for each 50-minute session.
- $120.00 for a 75-minute session.
- Any court-related preparation and service fees by subpoena or request are $200.00 an hour, as outlined below.

I understand that I am responsible for paying these fees. In particular,

1. I understand that I am responsible for payment of services, and this payment is independent of any insurance coverage I may have. I understand that Craig Parker may not accept all insurances and that I am responsible for full payment of services in this case.

2. I understand that Parker Psychology & Counseling Associates provides insurance filing as a courtesy and a convenience to me and/or will seek authorizations from my insurer or managed care provider. However, these activities do not guarantee that my insurer will pay. I understand that I am free to file my own insurance at any time, in which case full payment of fees will be required at the time of service. I also understand that Parker Psychology & Counseling Associates does utilize a company called Office Ally for billing and claims management services.

3. I understand that the business office will try to help me understand my insurance or managed care benefits and procedures, but denial of benefits by my insurer means that I am fully responsible for the contracted amount.

4. I understand that I am responsible for meeting the requirements of my health insurer or managed care provider. In particular, I am responsible for: a) obtaining the initial referral to Craig Parker, if necessary; b) ensuring that I have pre-certification of visits, if necessary; c) knowing limits regarding my deductible; and d) keeping track of benefit limits.

Keeping track of my benefits includes knowing any limits on my policy and ensuring that I do not exceed those limits (e.g., some insurers set a maximum of 20 mental health sessions per policy year). If I exceed my limits and my insurer refuses to pay, I will be responsible for the amount refused. Also, I understand that if I am seeing another professional for psychological services, (e.g., psychologist, psychiatrist, or other health care providing mental health services), those sessions may count against my mental health benefits. I also realize that my managed care provider may authorize visits as appropriate for me, but that does not mean that they will necessarily pay for those visits (e.g., some insurers will authorize 35 visits when they will only pay for 30 visits, based on medical necessity).

5. To help me obtain reimbursement, I agree to inform Craig Parker immediately if my health benefits change or if I switch insurance companies. If Craig Parker's office does not have the proper information and cannot collect payment from the insurer, I remain responsible for the amount that the insurance company will not pay.

6. I will be charged and agree to pay $50.00 for missed appointments without 24 hours prior notice for non-emergency reasons. Insurance cannot be billed for this fee, as they will not pay for missed appointments.

7. I understand that, in the case of my account getting turned over to collections, that I am responsible for the entire bill plus 100% of collection fees.

8. I understand that any court-related service fees by subpoena or request are $200.00 an hour (with minimum of $800.00 paid one business day in advance) for preparation and attendance at any legal proceeding. Court appearances/testimony and/or on-call availability for appearances are charged in four-hour increments (e.g., 8:00am to 12:00pm or 1:00pm to 5:00pm) at $800.00 per morning and/or afternoon sessions. These charges apply regardless of whether testimony is given. I understand that my insurance company cannot be billed for any changes related to litigation, and I agree to be responsible for the full balance even in the case that a responsible third party (e.g., attorney) does not pay the required amount.
Please talk with Craig Parker if you have any questions about these policies.

_____	_____	_____
Printed name of patient/patient representative	Signature	Date

PRIMARY INSURANCE INFORMATION

☐ No Insurance/self-pay

Policy Holder Name: _____ Date of Birth: _____
Patient's Relationship to Policy Holder: _____ Employer: _____
Insurance Company Name: _____
ID/Policy #: _____ Group/Plan/Division #: _____
Insurance Company Phone Number for Providers: _____
Insurance Company Address for Claims: _____
_____

SECONDARY INSURANCE INFORMATION

Policy Holder Name: _____ Date of Birth: _____
Patient's Relationship to Policy Holder: _____ Employer: _____
Insurance Company Name: _____
ID/Policy #: _____ Group/Plan/Division #: _____
Insurance Company Phone Number for Providers: _____
Insurance Company Address for Claims: _____
_____

PERSON RESPONSIBLE FOR PAYMENT

Name of Person Responsible for Patient: _____ Date of Birth: _____
Patient's Relationship to Person (if not self): _____ Phone: _____
Address: _____

AUTHORIZATION FOR INSURANCE PAYMENT

My signature below indicates that I agree to authorize payment of insurance benefits to the service provider, authorize the release of any information necessary to process insurance claims, and accept payment responsibility of the portion of the bill which insurance does not cover.

_____	_____	_____
Name	Signature	Date

CONFIDENTIALITY POLICY AND CONSENT TO TREATMENT

Although we are bound by ethical principles to keep information about you confidential, there are certain exceptions to these principles that you should understand prior to entering into the therapeutic relationship. Please also read our *Notice of Privacy Practices* for more information about federal HIPAA regulations concerning privacy of your medical information.

1. In a case of suspected child abuse, we are required to report this to the appropriate county authorities even when this requires breaking confidentiality.

2. If, at some point, we believe that your life or someone else's life is endangered by actions you are about to take, we may break confidentiality to warn or prevent harm to you or another person.

3. If you are using a third party payer (e.g., private insurance or managed health care), we may be required to submit reports or information (e.g., diagnosis) to obtain reimbursement from your insurer. We do utilize a company called Practice Management Solutions for our billing and claims management services. If there are irresolvable difficulties in payment of fees, it may be necessary to turn account names and relevant information over to an attorney, collection agency, or court of law.

4. Under some circumstances, such as custody and divorce litigation, case records may be subpoenaed. It is our policy to appeal these requests and protect this information to the extent the law allows. However, records may be required to be turned over in the case of a judge's order.

5. If you sign a release of information so that we may speak or correspond with other professionals (e.g., previous providers, psychiatrist), information about you will be divulged with your consent.

If you engage in behaviors that are seriously threatening your health and well-being, this information may be given to your parents if: (a) you are a legal minor (i.e., under age 18); or (b) you are under the age of 21 and still under the supervision of your parents who have contracted with us for your treatment. We will try to inform you of the decision to divulge this information before the disclosure.

If you have any questions regarding our privacy policy or practices, please discuss them with us as soon as possible. We ask for your signature below as consent for psychological treatment and as a sign that you have read the above statement and agree to the above terms. We appreciate your commitment to this process and thank you for your assistance in and understanding of these necessary policies.

_____	_____	_____
Printed name of patient/patient representative	Signature	Date

CONSENT TO USE PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I understand that as part of my healthcare, Parker Psychology & Counseling Associates creates, receives, and maintains health records describing my history, symptoms, evaluation and test results, diagnoses, treatment and any plans for future care or treatment. According to federal HIPAA regulations, I understand that my health information may be used and disclosed to carry out my care and treatment, to obtain payment, and for health care operations. Please also refer to the *Confidentiality Policy and Consent to Treatment* form for Parker Psychology & Counseling Associate's standards for protection of your medical information.

I have received a copy of the *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures, and I have had an opportunity to ask questions about anything I did not understand. I understand that Parker Psychology & Counseling Associates reserves the right to change the privacy practices that are described in the *Notice of Privacy Practices*. If changes are made, I understand that Parker Psychology & Counseling Associates will post/provide a copy of any revisions, or I will receive a copy of the updated *Notice* at my request.

As more fully explained in the *Notice of Privacy Practices*, I understand that I have the right to request restrictions on how this office uses and discloses my information for treatment, payment and health care operations. This request must be submitted in writing to this office. I understand that this office is not required to agree to the restrictions requested, although they are bound to adhere to my request for restrictions if they agree. I understand that I may revoke this Consent at any time, in writing, except to the extent that any action has been taken in reliance on my consent.

If you have any questions regarding the privacy policy or practices, please discuss them with your healthcare professional as soon as possible. Your signature below serves as an acknowledgment that you have received a copy of the *Notice of Privacy Practices*, as well as consent for the use and disclosure of your health information for the purposes of treatment, payment and health care operations. Your assistance in this process and understanding of these necessary policies is very much appreciated.

_____	_____	_____
Printed name of patient/patient representative	Signature	Date

❑ Copy of *Notice of Privacy Practices* given to patient or personal representative

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For office use only:

If consent form was not signed, please explain why not and efforts made to obtain the patient's signature:

_____

_____

_____

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NOTICE OF PRIVACY PRACTICES: OUR COMMITMENT TO YOUR PRIVACY

We understand the importance of keeping your personal and health information private, and we have long been committed to protecting this information. We create a record of the care and services you receive at our practice in order to provide you with quality care and comply with certain legal and ethical requirements. Keeping your information secure is one of our most important duties, and we carefully limit access to your personal information to those who need it. We maintain appropriate safeguards to protect your information, and we strictly adhere to all privacy and security policies in our office.

This Notice describes the ways in which we may protect, use, and disclose health information about you. This Notice also describes your rights and certain obligations we have regarding the use and disclosure of health information.

We are required by law to:

- Maintain the privacy of health information that identifies you, including implementing reasonable and appropriate physical, administrative, and technical safeguards to protect the information;
- Give you this Notice of our legal duties and privacy practices with respect to individually identifiable health information that we collect and maintain about you;
- Follow the terms of the Notice that is currently in effect;
- Train our personnel concerning privacy and confidentiality;
- Implement a sanction policy to discipline those who breach privacy/confidentiality or our policies with regard thereto; and
- Notify you following any breach of unsecured protected health information (PHI) and mitigate (i.e., lessen the harm of) any breach of privacy/confidentiality.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We will not disclose your health information without your authorization, except as described in this Notice or as otherwise permitted or required by law. These include most uses or disclosures of psychotherapy notes, marketing communications, and sales of PHI. Other uses and disclosures *not described in this notice* will be made only with your written authorization. In most instances, we will get your written authorization to use or disclose your health information. However, the law permits or requires us to use or disclose your health information for the following purposes without your authorization:

- **For Treatment.** Treatment includes activities performed by this office in providing care and treatment, coordinating or managing care with third parties, and consultations with and between other health care professionals. For example, we may use and disclose your health information to other, current health care providers (e.g., physicians, psychiatrists, and hospitals) for coordination and management of your care. We may also provide subsequent healthcare providers copies of your records to assist them in treating you once we are no longer treating you.

- **For Payment.** Payment means activities undertaken by this office to obtain reimbursement for the provision of health care. For example, we may use and disclose your health information to bill and collect payment from you, your insurance company or a third party payer. The information on or accompanying the bill may include information that identifies you, your diagnosis, treatment received, and services provided.

- **For Health Care Operations.** Health care operations include the administrative and business functions of this office that are necessary to carry out operations, including quality assurance and peer review. For example, we may use and disclose your health information to review our treatment and evaluate the performance of our staff in caring for you.

OTHER USES AND DISCLOSURES NOT REQUIRING AUTHORIZATION

- **Appointment and billing contacts.** Unless you provide us with alternative instructions, we may contact you about appointments and send billing materials to your home.

- **Business Associates.** We provide some services through contracts with Business Associates. Examples include a billing company. When we use these services, we may disclose your health information to the Business Associates so that they can perform the function(s) that we have contracted with them to do and bill you or your third-party payer for services provided. To protect your health information, however, we require the Business Associates to appropriately safeguard your information, and Business Associates must comply with the same federal security and privacy rules as we do.

- **Communication with relatives, close friends and other caregivers.** Based on professional judgment, we will not disclose health information to a relative or close friend unless it is in your best interest (e.g., helping you to get to an appropriate care facility). We will ask you if you agree to such a disclosure, unless you are unable to function or there is an emergency.

- **Minors.** We follow current state law as it relates to "personal representatives" or non-emancipated minors.

- **To avoid harm.** Law and ethics require, based on professional judgment, that we must use and disclose your health information when necessary to prevent a serious threat to your health/safety or the health/safety of the public or another person.

- **Abuse or neglect.** Arkansas law requires, based on professional judgment, that we must disclose your health information to the appropriate authorities to report suspected abuse or neglect.

- **Public health activities.** We may be required to disclose your health information to public health agencies who are charged with preventing or controlling disease, injury, or disability or as required by law.

- **Law enforcement officials.** We may be required to disclose your health information for law enforcement purposes as required by law.

- **Correctional Institution.** If you are an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

- **Legal proceedings.** Under certain limited circumstances, such as custody and divorce litigation, case records may be subpoenaed by a judge. It is our policy to appeal these requests and protect this information to the extent the law allows.

- **Workers' compensation.** We may disclose your health information to the extent necessary to comply with workers' compensation law or other similar programs established by law.

- **As required by law.** We will disclose health information about you when required to do so by federal, state, or local law. We may also share your health information with the Secretary of the Department of Health and Human Services to investigate or determine our compliance with federal privacy laws.

- **Specific government functions.** We may be required to disclose health information of military personnel and veterans in certain situations, to correctional facilities in certain situations, or for national security reasons.

YOUR RIGHTS

The following is a statement of your rights with respect to your health information and a brief description of how you may exercise these rights.

- **Right to request restrictions on certain uses and disclosures of your health information.** You have the right to ask that we limit how we use or disclose your health information. We will consider your written request, but are not legally bound to agree to the restriction. To the extent that we do agree to any restrictions, we will put the agreement in writing and abide by it except in emergency situations. We cannot agree to limit uses and disclosures that are required by law. The right to request restriction does not extend to uses or disclosures permitted or required under the following sections of the federal privacy regulations: § 164.502(a)(2)(i) (disclosures to you) or § 164.512 (uses and disclosures not requiring a consent or an authorization). Examples of other uses and disclosures not requiring Authorization are included in this pamphlet. In those cases, you do not have a right to request restriction. If you request restriction on a disclosure to a health plan for purposes of payment or health care operations (not for treatment), we must grant the request if the health information pertains solely to an item or a service for which we have been paid in full.

- **Right to inspect and copy.** You have the right to request, in writing, access to your health information in order to review

or request copies of such information. In certain situations, such as if access would cause harm, we may deny you access to a portion of your health information as allowed by law. We reserve the right to charge a reasonable fee for copies of your health information (for supplies, labor, and preparing an explanation of your health information). If we deny you access, we will explain why and what your rights are, including how to seek review. If we grant access, we will tell you what, if anything, you have to do to get access.

You do not have a right of access to the following:

- Psychotherapy notes. Such notes consist of those notes that are recorded in any medium by a health care provider who is a mental health professional documenting or analyzing a conversation during an individual, group, joint, or family counseling session and that are separated from the rest of your medical record.
- Information compiled in reasonable anticipation of or for use in civil, criminal, or administrative actions or proceedings.
- Protected health information ("PHI") that is subject to the Clinical Laboratory Improvement Amendments of 1988 ("CLIA"), 42 U.S.C. § 263a, to the extent that giving you access would be prohibited by law.
- Information that was obtained from someone other than a health care provider under a promise of confidentiality and the requested access would be reasonably likely to reveal the source of the information.
- Information that is copyright protected, such as certain raw data obtained from testing.

In other situations, we may deny you access, but if we do, we must provide you a review of our decision denying access. These "reviewable" grounds for denial include the following:

- A licensed health care professional has determined, in the exercise of professional judgment, that the access is reasonably likely to endanger the life or physical safety of yourself or another person.
- PHI makes reference to another person (other than a health care provider) and a licensed health care provider has determined, in the exercise of professional judgment, that the access is reasonably likely to cause substantial harm to such other person.
- The request is made by your personal representative and a licensed health care professional has determined, in the exercise of professional judgment, that giving access to such personal representative is reasonably likely to cause substantial harm to you or another person.
- For these reviewable grounds, another licensed professional must review the decision of the provider denying access within 30 days.

- **Right to request amendment.** You have the right to request, in writing, that an amendment be added to your record if you feel the information is incomplete or inaccurate. We are allowed to deny this request in certain circumstances. We do not have to grant the request if the following conditions exist:
  - We did not create the record. If, as in the case of a consultation report from another provider, we did not create the record, we cannot know whether it is accurate or not. Thus, in such cases, you must seek amendment/correction from the party creating the record. If the party amends or corrects the record, we will put the corrected record into our records.
  - The records are not available to you as discussed immediately above.
  - The record is accurate and complete.

  If we deny your request for amendment/correction, we will notify you why, how you can attach a statement of disagreement to your records (which we may rebut), and how you can complain. If we grant the request, we will make the correction and distribute the correction to those who need it and those whom you identify to us that you want to receive the corrected information.

- **Right to an accounting of disclosures.** You have the right to request, in writing, a record of certain disclosures of your health information. We must provide the accounting within 60 days. The first accounting in any 12-month period is free. Thereafter, we reserve the right to charge a reasonable, cost-based fee. We do not need to provide an accounting for the following disclosures:
  - To you for disclosures of protected health information ("PHI") to you.
  - To persons involved in your care or for other notification purposes as provided in § 164.510 of the federal privacy regulations (uses and disclosures requiring an opportunity for the individual to agree or to object, including notification to family members, personal representatives, or other persons responsible for your care of your location, general condition, or death).
  - For national security or intelligence purposes under § 164.512(k)(2) of the federal privacy regulations (disclosures not requiring consent, authorization, or an opportunity to object).
  - To correctional institutions or law enforcement officials under § 164.512(k)(5) of the federal privacy regulations (disclosures not requiring consent, authorization, or an opportunity to object).
  - That occurred before April 14, 2003.

- **Right to cancel authorization.** You have the right to revoke, in writing, any authorization to disclose your health information, except to the extent that we have take action in reliance upon it.

- **Right to confidential communications.** You have the right to make a reasonable request to have confidential communications of your health information sent to you by alternative means or alternative locations.

- **Right to a paper copy of this Notice.** You have the right to obtain a paper copy of this Notice.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice and the practices described herein. If changes are made, we will post/provide a copy of any revisions, and you will receive a copy of the updated Notice at your request.

PRIVACY COMPLAINTS

If you believe your privacy rights have been violated, you may submit a written complaint to us or the U.S. Secretary of Health and Human Services. To file a complaint with us, you may request a privacy complaint form or send a letter describing the violation to: Privacy Officer, 2928 N. McKee Circle, Ste. 126, Fayetteville, AR 72703. We will not retaliate against you for filing a complaint.

THANK YOU

Your assistance in this process and understanding of these necessary policies is appreciated. Please write the privacy officer at the above address or leave a message at 479.443.4222 if you have any questions regarding your privacy rights. Please review our *Confidentiality Policy and Consent to Treatment* form for a description of our personal standards for protection of your medical information.

Effective 07.01.15

Patient Name: _____ Office Use:
Address: _____ Pt. Account #
City, State and Zip Code: _____ _____

Phone Numbers:	Preferred Contact Number:		May We Leave a Message:	
Cellular: _____	☐ Yes	☐ No	☐ Yes	☐ No
Home: _____	☐ Yes	☐ No	☐ Yes	☐ No
Work: _____	☐ Yes	☐ No	☐ Yes	☐ No

Date of Birth: _____

Relationship Status:
☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Separated ☐ Widowed

Employment Status:
☐ Full-Time ☐ Part-Time ☐ Not Employed ☐ Retired ☐ Other: _____

Place of Employment: _____

Occupation/Job Title: _____

Student Status:
☐ Full-Time ☐ Part-Time ☐ Not a Student ☐ Other: _____

Emergency Contact Information:

Name: _____ Relationship: _____
Address: _____
_____
Daytime Phone: _____ Evening Phone: _____

How did you find out about this clinic?

_____

If you were referred, what is the name of the person who referred you?

_____

Name: _____ **Date of Birth:** _____ **Today's Date:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Phone Numbers: _____

What is bringing you into therapy? Why are you seeking treatment now?

_____
_____
_____
_____
_____
_____
_____

Below are symptoms/factors you may be experiencing or may have experienced in the past. Please check whether each is something you are currently dealing with and whether it is something you have dealt with in the past.

Symptom/Factors	Current	Prior	Comments
Depression	○	○	_____
Sadness	○	○	_____
Low energy/fatigue	○	○	_____
Hopelessness	○	○	_____
Worthlessness	○	○	_____
Crying spells	○	○	_____
Guilt	○	○	_____
Negative self-esteem	○	○	_____
Decreased motivation	○	○	_____
Lower interest in activities	○	○	_____
Irritability	○	○	_____
Hyperactivity	○	○	_____
Impulsivity	○	○	_____
Elevated/manic mood	○	○	_____
Racing thoughts	○	○	_____
Bipolar symptoms	○	○	_____
Concentration problems	○	○	_____
Memory problems	○	○	_____
Changes in appetite	○	○	_____
Changes in weight	○	○	_____
Problems with sleep	○	○	_____
Anxious thoughts	○	○	_____
Persistent worry	○	○	_____
Panic attacks	○	○	_____
Obsessive thoughts	○	○	_____
Repetitive behaviors	○	○	_____
Alcohol abuse	○	○	_____
Drug abuse	○	○	_____
Tobacco use	○	○	_____

Gambling/other addictions	○	○	_____
Suicidal thoughts	○	○	_____
Suicide attempts	○	○	_____
Homicidal thoughts	○	○	_____
Relationship problems	○	○	_____
Family problems	○	○	_____
Divorce	○	○	_____
Parenting issues	○	○	_____
Sexual/physical abuse	○	○	_____
Other trauma	○	○	_____
Anger problems	○	○	_____
Grief/loss	○	○	_____
Sexual issues	○	○	_____
Eating disorder	○	○	_____
Other: _____	○	○	
Other: _____	○	○	

PHYSICAL HEALTH			
Primary Physician Name:		**Phone:**	
Psychiatrist Name:		**Phone:**	
Current Health Problems:			
Prior Health Problems:			
Are you physically active?			
Current Medications	○ No current medications		

Medication Name:	**Dosage**	**Frequency**	**Since**	**Prescribed For:**

CURRENT FUNCTIONING			
	Current	**Past**	**Notes**
Work Problems	○	○	
School Problems	○	○	
Legal Problems	○	○	
Financial Problems	○	○	
Social Problems	○	○	

MENTAL HEALTH TREATMENT HISTORY				
Year(s)	Provider or Facility Name	Therapist or Psychiatrist	Outpatient or Inpatient	Reasons Sought Treatment/ How Did It Go

FAMILY/SOCIAL/OTHER	
With whom you do you live?	
Spiritual/religious/faith?	
Spouse/partner/significant other? Name, age, how long? Describe this relationship.	
Other marriages and other significant relationships?	
Names of children, ages, and where they live?	
Name of mother and describe relationship with her (past and current if still living).	
Name of father and describe relationship with him (past and current if still living).	
Names of siblings, ages and where they live?	
Describe your social relationships and friends.	
Family history of psychological, substance abuse and health problems (who/what)?	
Highest education level/degrees?	
Any military service (describe)?	
Current occupation, employer and work history?	
Do you currently drink alcohol or use other drugs? How often and, on average, how much?	
What do you like to do for fun?	

What are your goals for therapy?

_____

_____

_____

_____

_____