CLIENT DEMOGRAPHIC FORM **Date _____**

Laura Vail Sage, LISW, LICDC

Last Name _____First Name_____ Age_____

Marital: M S W D Gender M F Client Date of Birth _____

Mailing Address _____City:_____

State _____Zip_____Email:_____

Home Phone_____Work Phone_____Other / Cell _____

IN ORDER TO FOLLOW UP WITH YOU DURING AND AFTER SERVICES, CHECK EACH APPLICABLE BOX

HOME:	**WORK:**	**OTHER/ CELL:**
Permission to call you Y N	Permission to call you Y N	Permission to call you Y N
Permission to leave message Y N	Permission to leave message Y N	Permission to leave message Y N

Permission to use Mailing Address: Y N Special Instructions_____

EAP BENEFITS? Yes No EAP COMPANY NAME_____

EAP AUTHORIZATION #_____ SESSION #_____

Primary Insurance Information: Insurance Company_____

Insurance ID #:_____ Insurance Group #:_____Co-pay Amount: $_____

Have you called Insurance for benefit information? Yes No Authorization # if required:_____

Name of Benefit Holder_____Benefit Holder Birth Date:_____

Benefit Holder's Relationship to Client _____

Secondary Insurance Information: Insurance Company_____

Insurance ID #:_____ Insurance Group #:_____Co-pay Amount: $_____

Have you called Insurance for benefit information? Yes No Authorization # if required:_____

Name of Benefit Holder_____Benefit Holder Birth Date:_____

Benefit Holder's Relationship to Client _____

Who referred you to me?_____

PERMISSION TO TREAT and FINANCIAL POLICY

Laura Vail Sage, LISW, LICDC

THIS FEE AGREEMENT dated below BETWEEN: _____ *(Print Name)* **AND Grandi Inc, DBA: Mason Family Counseling, 5134 Cedar Village Dr, Mason, OH 45040.**

BACKGROUND:

The Responsible Party (RP) is of the opinion that the Service Provider has the necessary qualifications, experience and abilities to provide services in connection with the Client and hereby gives permission to treat same Client

The Service Provider is agreeable to providing such services to the Client, on the terms and conditions as set out in this Agreement.

Engagement: The Client hereby agrees to engage the Service Provider to provide the Client with services consisting of Individual, Group or Family Counseling/Therapy, and such other services as the Client and the Service Provider may agree upon from time to time.

Insurance Benefits and Authorization:

It is the responsibility of the client to provide current Insurance card(s) and/or authorization information at the time of you visit: If client does not have card at that time, they will be given ten (10) business days to provide the office with current card. Insurance cannot be billed without this information and the full session amount will become client responsibility.

It is the responsibility of the client to contact Insurance to verify all benefits and coverage prior to appointments. Our office holds no liability or responsibility for verification and/or authorization requirements.

Performance: Both parties agree to do everything necessary to ensure that the terms of this Agreement take effect.

Compensation:

1) **Co-payments** are due at the beginning of each session. A five dollar service charge is added to the account for each session where the co-pay is not paid at time of service.
2) **Deductibles:** If you have a deductible to meet – the contract rate for your session is to be paid at the time of service. We will file your claim with the Insurance Company
3) **Denied Insurance Claims:** will be billed to the client at full session cost and are due 10 days after the date on client bill
4) **Self-Pay Sessions**: Initial Session $135.00, Individual Sessions $95.00, Family and Marital/Couples Sessions $100.00
5) **Late Payment Penalties:** The following penalties will be imposed on the RP for failing to pay the Service Provider in a timely fashion.
    a. A service fee of 2% of the balance per month will be charged for unpaid amounts over 60 days old.
    b. A $5.00 Service Fee will be charged if Co-pay is not paid at time of Service
    c. Unpaid amounts over 90 days old are subject to be forwarded to Collections. In the event your account is sent to collections your account will be terminated with our office

No Show and Late Cancellation:

1) **First No Show / Late Cancel: $30.00, Second No Show / Late Cancel: $65.00, Third No Show / Late Cancel: $80.00**

Special situations such as inclement weather or emergencies can be discussed with the provider.

2) **Late Cancel / No Show Fees are to be paid at your next appointment or upon receipt of the charge**
3) **Your provider reserves the right to terminate services if continued appointments are missed and/or canceled late**

Other Expenses: The Service Provider will be reimbursed for following expenses incurred by the Service Provider in connection with providing the services:

1) **Paperwork and Letters** completed outside of session: $25.00 per 15 minutes**.**
2) **Written Report** for any purpose: $85.00 including postage. This fee is not reimbursable by your insurance company
3) **Returned Checks:** $25.00 per occurrence.
4) **Phone calls** over 2 minutes: $25.00 per quarter hour (15 minutes). *(Note: phone session may or may not be covered by your insurance).*
5) **Court Appearance or Conferences with 3rd parties:** To be determined individually by provider; maximum charge not to exceed $2000 per 8 hour day. Mileage will be charged if over 50 miles and it will be charged at the Federal reimbursement rate**. An upfront amount of half the estimated cost will be required before scheduled date of appearance and/or conference.**

Term of Agreement: The term of this Agreement will begin on the date of this Agreement and will remain in full force and effect until completion of the Services. By executing this agreement, you are agreeing to pay for all services that are received.

I fully understand the above agreement and I freely agree to the above conditions:

BY THE CLIENT SIGNATURE BELOW, the client has duly executed this Fee Agreement with Grandi, Inc.

_____ _____

Client Signature Date

OFFICE POLICIES

1). Your appointment time is reserved for you; I do not double book appointments. Therefore, I have to charge if you fail to show for that appointment or do not cancel twenty-four hours in advance. Policies for Missed Appointments are:

- **First No Show / Late Cancel: $30.00, Second No Show / Late Cancel: $65.00, Third No Show / Late Cancel: $80.00**

Special situations such as inclement weather or emergencies can be discussed with the provider.

- **Late Cancel / No Show Fees are to be paid at your next appointment or upon receipt of the charge**
- **Your provider reserves the right to terminate services if continued appointments are missed and/or canceled late**

2) Please pay your co-pays and/or deductible by cash, check or credit card at the time of your session. A five dollar service charge is added to the account for each session where the co-pay is not paid at time of service. You may contact our office within 24 hours of your appointment to pay your co-pay and avoid the $5.00 fee. There is a $25.00 charge for any returned checks.

3). Your insurance company may require that you have your sessions authorized prior to being seen for the first time.
You will need to contact insurance initially for the following information:

a) **Requirements for Prior Authorization of services**
b) **Number of Session allowed per year by Insurance**
c) **Co-pay amount and/or percentage per session**
d) **Annual Deductible amount**
e) **Total Deductible amount met to date**

4). Sessions are 45 minutes long except for the first session, which may be a bit longer. Please help me monitor the time so that I do not keep you or another client waiting.

5) **Please bring all paperwork including insurance authorizations to my attention at the beginning of your session. I may not be able to complete this work if given to me at the end of a session and there is a charge for paperwork outside of sessions** ***(see Fee Agreement & Schedule)***

6). **Emergency Care**: I have a twenty-four hour message service. If you leave a message for me, I am notified shortly of your call. If you do not hear from me immediately: you must call the 24 hour crisis hotline at 281-2273, your primary care physician, insurance company, or go to the emergency room so that you are safe and receive the care you need.

7) Termination of Treatment: Your account will be terminated with me under the following circumstances:

a. If you are not seen for more than three (3) months, then you will no longer be considered an "active" client. *For legal purposes this policy must be defined.* (If you wish to return for treatment, simply call me and you case will become active again at the time of your first appointment).
b. If you miss three or more scheduled appointments in a row
c. If you are delinquent in payment and therefore forwarded to Collections process

8) **Confidentiality**: The Service Provider acknowledges that a material term of the Agreement with the Client is to keep confidential information belonging to the Client confidential and protect its release to the public. The Service Provider agrees not to divulge, reveal, report or use, for any purpose, any confidential information which the Service Provider has obtained or which was disclosed to the Service Provider by the Client or RP, except as outlined in a., b., or c., below. The obligation to protect the confidentiality of the Client's confidential information will survive the termination of this Agreement and will continue indefinitely.

The Service Provider may disclose the minimum necessary confidential information:

A. To a ***third party insurance provider*** where the Client or RP presents an insurance card/company as a reimbursement source.
B. To the extent ***required by law*** or by the request or requirement of any judicial, legislative, administrative or other governmental body. However, the Service Provider will first give notice to the Client or RP of any possible or prospective order (or proceeding pursuant to which any order may result), and the Client or RP will have been afforded a reasonable opportunity to prevent or limit any disclosure.
C. ***In the event*** Client or RP ***accounts have gone unpaid for 90 days***, the Service Provider may release a copy of this agreement, Client or RP contact information and a copy(s) of any billing sent to the client to a third party collection service. No other confidential information will be released.

CLIENT RIGHTS

- Clients have the right to be treated with dignity and respect.
- Clients have the right to impartial services and access to treatment, regardless of race, religion, gender, ethnicity, age, disability, or source of payment.
- Clients will be assured that all information is kept confidential.
- Information will not be released without their prior consent, except in an emergency, or as required by law.
- Clients have the right to be treated by staff/providers who communicate, or arrange for communication in a language and format they understand.
- Clients have the right to be provided with a complete, easily understood explanation of their condition and

treatment.

- Clients have the right to be informed of all treatment options regardless of the cost of benefit coverage.
- Clients have the right to receive information about services and their role in the treatment process.
- Clients have the right to receive information on availability of providers and the clinical guidelines used in providing and/or managing their care.
- Clients have the right to provide input on policies, services and their rights and responsibilities offered by their insurance company(s).
- Clients will be informed of the complaint, grievance and appeal processes should a dispute arise over treatment and/or claims.
- Clients will be afforded all of his/her rights and privileges guaranteed by state and federal laws.
- Clients have the right to be informed of their rights and responsibilities in the treatment process.
- Clients have the right to participate with providers in decision-making regarding their treatment planning.

Limitation in rights:

The main limitation is in the area of confidentiality. In the following situations, confidentiality does not apply:

(1) An order by the Court, (2) in the case of suspected child, elder or domestic abuse, and (3) for you own welfare (suicide) or that of others (homicide) in serious and imminent life-threatening situations.

For those clients using their insurance to pay for therapy, a consultation with your attending/primary care physician and your insurance company may be needed. Disclosure of your diagnosis, review of your treatment sessions and a review of your treatment plan may be required to access your insurance benefits. You may chose not to authorize the release of this information, however this may prevent you from using your insurance benefits. ***Your signature below indicates your willingness to disclose the needed information to your insurance company so that you may use these benefits.***

THE PROCESS OF COUNSELING/THERAPY:

1. Possible benefits derived from therapy include:
   a. Better ways to deal with social, familial and occupational relationships.
   b. Better personal adjustment and contentment.
   c. Better ability to cope with problems and stress.
   d. Better productivity.
2. It is important to note that professional ethic do not permit a guarantee that you will receive these benefits. It is believed that a better life is possible for most people and that an individual's investment and commitment in therapy can determine the outcome.
3. Therapy may also involve some feelings of discomfort. These feelings can occur when you begin to work on changing your beliefs and/or behaviors. This discomfort is viewed as a stepping-stone to a more effective and satisfying life.

COORDINATION OF CARE

It is important for your health care providers to speak to each other so we may work together to help you. Please complete the information below and indicate your approval for us to coordinate care.

I Do Not Have Primary Care_____

Primary care physician: _____ Phone: _____

Address:_____ City:_____

State: _____ ZIP: _____ May we contact your physician: YES NO

I fully understand the above agreement and I freely agree to the above conditions:

_____ _____

Client Signature Date

Laura Vail Sage, LISW, LICDC

The above conforms to the Counselor and Social Worker Board that regulates the practice of professional counseling and therapy and requires this information be given to clients.

State of Ohio Counselor & Social Work Board
LeVeque Tower, 50 W. Broad Suite 1425
Columbus, OH 43215-5919
Phone: (614) 466-0912

Ohio Credentialing Board
280 North High Street
Columbus, OH 43215-5919
(614) 387-1110

Notice of Privacy Practices

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

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy and security of PHI and to provide you with notice of our legal duties and privacy and security practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website or in our office, by sending a copy to you in the mail upon request, or by providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization, such as your primary care physician.

For Payment. We may use and disclosed PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility of coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services or our lawyer) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI or we have otherwise obtained your authorization to release the information. For training and teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy and/or Security Rule.

Without Authorization. Applicable law and ethical standards permit me to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required or allowed by law, such as (including but are not necessarily limited to): the reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the social work licensing board or the health department), or abuse involving the elderly or the developmentally disabled/mentally retarded.
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat, or to other persons as permitted by law, including you.

Verbal Permission. We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked, unless we have already relied on it.

Your Rights Regarding Your PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to Brandi Barrowcliff – 5134 Cedar Village Drive, Mason, OH 45040.

- **Right of Access to Inspect and Copy**. You have the right to inspect and copy PHI that are part of treatment records that we have created. .
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period. We are not required to report disclosures made for treatment, payment, or health care operations.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Right to a Copy of this Notice.** You have a right to a copy of this notice.

Complaints

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with Brandi Barrowcliff, at 5134 Cedar Village Drive, Mason, OH 45040, Voice Ph. - 513-229-7900, or with Region V, Office for Civil Rights, U.S. Department of Health and Human Services, 233 N. Michigan Avenue, Suite 240, Chicago, IL 60601. Voice Ph. (312)886-2359; Fax (312) 886-1807; TDD (312) 353-5693.

We will not retaliate against you for filing a complaint.

The effective date of this notice is January 1, 2017. If you need additional information regarding this Notice of Privacy Practices, please contact:

Laura Vail Sage, LISW, LICDC
Mason Family Counseling
5134 Cedar Village Drive
Mason, OH 45040
Phone (513)229-7900
Fax (513)229-0202

I, _____ (Print your name) hereby acknowledge that I have received the Notice of Privacy Practices from Laura Vail Sage, LISW, LICDC

_____ _____

Signature of Client Date

**Informed Consent For Distance Therapy

I hereby consent to engaging in telemedicine with Grandi, Inc as part of my psychotherapy. Ms. Sage is licensed as a LISW, LICDC in Ohio and holds a DCC. I understand that "telemedicine" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telemedicine also involves the communication of my medical/mental information, both orally and visually, to a health care practitioner located in Ohio or outside of Ohio.

I understand that I have the following rights with respect to telemedicine:

- I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
- The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.

I also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.

(2) I understand that there are risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

In addition, I understand that telemedicine based services have certain benefits and limitations. Care may not be as complete as face-to-face service if using chat or email. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be referred to a psychotherapist who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not be improve, and in some cases may even get worse.

- I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured.
- I understand that I have a right to access my medical information and copies of medical records in accordance with Ohio law. However, Laura Vail Sage, Inc is the legal owner of all written or recorded information.

If I have a life threatening clinical emergency I will dial 911 immediately or go to my nearest emergency room. If my crisis is not life threatening and my psychotherapist is unavailable I will contact: http://www.befrienders.org/ or the National Suicide Hotline at 800-784-2433 for assistance.

If for some reason there is a technology problem and our session does not start on-time or is interrupted I will use an alternative contact given to me by my psychotherapist.

I understand that the time I have scheduled with my psychotherapist is reserved only for me and in compensation for the exclusive reservation of the psychotherapist's professional time; I will pay in advance for our session and will not obtain a refund if I fail to be available at the appointed time without 24 hours prior notice.

If I would like more information on my psychotherapists license, ethics or of the rules and regulations governing the above licenses, I can find information at:

4) http://www.cswmft.ohio.gov/

5) http://ocdp.ohio.gov/licensing.stm

6) http://www.naswdc.org/pubs/code/default.asp

My signature below indicates that I have read and understood the information provided above.

_____ _____

Name Date

*****This notice must be signed and received by Laura Vail Sage, prior to the commencement of treatment.***

Client Copy

FEE SCHEDULE

Effective January 2017 Fee Schedule is as follows
For Grandi Inc. dba Mason Family Counseling

Initial Consultation *(Self-Pay)*	$135.00
Individual Sessions *(Self-Pay)*	$95.00/session
Couples and Family Sessions *(Self-Pay)*	$100.00/session
No Show or Late Cancel ***(Less then 24 hour notice)***	1st - $30.00 2nd - $65.00 3rd - $80.00
Summary / Treatment Reports ***(Not billable to Insurance)***	$85.00
Paperwork and Letter Fees ***(Not billable to Insurance)***	$25.00 per 15 Minutes
Phone Calls (over 2 minutes) ***(Not billable to Insurance)***	$25.00 per 15 Minutes

If you have a deductible through your Insurance - you will be expected to pay the following amounts at the time of service:

Initial consultation $ 70.00 Follow up sessions $ 50.00
(This is merely an estimate and we cannot guarantee this is the final amount due.)

- Please be advised that any previous balances are due at the next scheduled appointment or within 30days of date on billing invoice.
- All Deductible Payments and Co-pays are Due At Time of Service – or Session Will Be Rescheduled
- Any client who incurs a balance of $200.00 or more – will not be able to reschedule appointments until their balance is paid in full.

CLIENT INFORMATION FORM

Completed by Client

Please Print Legibly – Information Remains Strictly Confidential

Client Name:_____

Emergency Contact_____ Relationship_____

Home / Work Phone: _____ Cell Phone:_____

WHAT CONCERNS BROUGHT YOU TO COUNSELING?_____

_____

_____

Symptoms (please mark all that apply):

Emotional:

- Feeling of extreme happiness
- Feeling of extreme sadness
- Feeling stressed
- Feeling nervous or anxious
- Feeling fearful
- Excessive worry
- Indecisiveness
- Depression
- Easily irritated
- Paranoid thoughts
- Self-esteem problem
- Feeling guilty
- Sudden feelings of panic
- Perfectionism
- Change in sleeping habits
- Procrastination
- Crying spells
- Problems with anger
- Exaggerated startle response

- Lack of enjoyment of usual activities
- Increased use of alcohol / drugs
- Avoiding things
- Trouble performing your job
- Poor interpersonal skills
- Reckless behavior
- Trouble concentrating
- Not getting along with friends / family
- Hearing voices
- Fear of situations where escape is difficult
- Obsessions or compulsions
- Thoughts about hurting yourself
- Thoughts about hurting others
- Thoughts about killing yourself
- Thoughts about killing others
- Suicide attempts
- Acting violently
- Intrusive thoughts

Physical:

- Lack of energy
- Dry mouth
- Memory problems
- Chronic weakness
- Chronic pain
- Muscle tension / aches
- Numbness
- Sweating / clammy hands
- Nerve problems
- Trembling / twitching
- Hot flashes
- Dizziness
- Frequent urination
- Stomach or bowel problem
- Weight changes
- Change in eating habits
- Self-starvation
- Chest pain
- Shortness of breath
- Heart symptoms
- Trouble swallowing
- Change in sexual interest

HOW LONG HAVE YOU HAD THE SYMPTOMS CHECKED ABOVE? ***(APPROXIMATE DATE SYMPTOMS BEGAN)***

_____

WHAT DO YOU WANT TO SEE HAPPEN AS A RESULT OF COMING HERE?

_____

_____

ANY DETERIORATION IN JOB / SCHOOL PERFORMANCE DUE TO THE PROBLEM?

___Attendance ___Tardiness ___Decrease in productivity ___Conflicts with Fellow Employees

___Erratic Behavior ___Conflict with Supervisors ___Discipline ___None

On a Scale of 1-5, how would your rate your distress? (l is low, 5 is severe distress)_____

MEDICAL HISTORY:

Date of last primary care doctor exam/visit:_____

Medical Condition You Have: (If yes check)

___Diabetes ___ High Blood Pressure ___Heart Disease
___Blood Problems ___Bone/Joint Problems ___Brain Problems
___Skin/Hair/Nail Problems ___Liver Disease ___Respiratory Problems (Breathing)
___Genital ___Kidney/Bladder ___Cancer
___Allergies ___Eyes ___Autoimmune
___Chronic Pain ___Gastrointestinal ___Head Injury

Other health problems not listed above:_____

_____

Sleep Problems: _____

Appetite Problems: _____

Past Health Problems (include difficulties with developmental milestones under age 18)_____

_____

Medication currently using: If NONE, write your initials here_____

Medication	Dosage	Time Taken	Prescribing Doctor	Reason Prescribing

Medication Allergies: If **NONE**, initial here_____If yes what**:**_____

PAST TREATMENT INTERVENTIONS:

Date	Medical & Surgical	Provider/Program/Hospital
Date	**Psychiatric**	**Provider/Program/Hospital**
Date	**Chemical Dependency**	**Provider/Program/Hospital**

Medical Conditions that Run in Your Family: (If yes check)

___Diabetes ___ High Blood Pressure ___Heart Disease
___Blood Problems ___Bone/Joint Problems ___Brain Problems
___Skin/Hair/Nail Problems ___Liver Disease ___Respiratory Problems (Breathing)
___Genital ___Kidney/Bladder ___Cancer
___Allergies ___Eyes ___Autoimmune
___Chronic Pain ___Gastrointestinal

HEALTH HABITS INFORMATION:

For the following questions please base your answers on **the past month** (approximately).

Y N 1. Have you participated in regular exercise/sports/recreation (about 3 times/week) to keep fit?

Y N 2. Have you been dieting to lose weight?

Y N 3. Have you smoked cigarettes on a daily basis?

Y N 4. Have you experienced any increased feelings of sadness or hopelessness?

Y N 5. Have you felt more anxious or worried than usual?

How often in the past month did you drink alcohol? (Circle your answer):

A) I do not drink at all

B) About once a month.

C) Two to three times a month.

D) One to three times a week.

E) Once a day or more.

For the **past month**, please fill in a number for each day of the week indicating the **typical number of alcohol drinks** you usually consume on that day.

Day of Week	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Number of drinks:							

Y N In the past **year** have you used any illicit or non-prescription drugs?

Y N During the past **month** have you participated in leisure/social/spiritual activities?

Have you ever had a DUI? _____No _____Yes: Details: _____

Y N "In the past year, have you ever drunk or used drugs more than you meant to?" Or "have you spent more time drinking or using than you intended to?"

Y N "Have you ever neglected some of your usual responsibilities because of using alcohol or drugs?"

Y N "Have you felt you wanted or needed to ***cut down*** on your drinking or drug use in the last year?"

Y N "Has anyone objected to your drinking or drug use?"

Y N "Have you ever found yourself preoccupied with wanting to use alcohol or drugs?"

Y N "Have you ever used alcohol or drugs to relieve emotional discomfort, such as sadness, anger, or boredom?"

FAMILY RELATIONSHIPS *(MEMBERS OF HOUSEHOLD OR SIGNIFICANT OTHERS WHO LIVE WITH OR ARE DIRECTLY INVOLVED WITH YOU)*

Name	**Relationship**	**Age (or Year of Death)**	**Current Quality of Relationship: Excellent, Good, Fair, Bad**

RELATIONSHIP HISTORY: (List all marriages & divorces and/or lived together relationships)

Partner's First Name	**Indicate:** Married (M) Live together (LT)	**Length of Realtionship**	**Reason ended**

WORK HISTORY: (Start with most recent)

Place	**Position**	**From**	**To**	**Reason ended**

PERSONAL & FAMILY HISTORY:

Were you or any family member physically abused? YES NO (circle)

If yes: Self - family (circle one or both)

Were you or any family member sexually abused? YES NO (circle)

If yes: Self - family (circle one or both)

Were you or any family member emotionally abused? YES NO (circle)

If yes: Self - family (circle one or both)

Have you or any family member had a problem with drugs or alcohol? YES NO (circle)

If yes: Self - family (circle one or both)

Have you or any family member ever tried to commit suicide? YES NO (circle)

If yes: Self - family (circle one or both)

Is there any history of anxiety, depression or mental illness in your family? YES NO (circle)

If yes: Self - family (circle one or both)