CONFIDENTIAL

Dr. Marcial Felan
Counseling

Client Name____ Home Phone: (____) __________

Address__________________________________ City______________ Zip Code __________

Sex________ Age________ Date of Birth______/______/______ Social Security #______________

Occupation__________________________________ Employer/school ______________

Work Phone (________________ Cell (____)______________ Marital Status ________

Spouse's Name________________________________ Social Security #______________

Age__________ Date of Birth______/______/______ Employer: ______________________

Occupation ________________ Cell (____)__________ Work Phone:______________

IN CASE OF EMERGENCY, CONTACT________________ **Phone (_____)** ______________

Children: Name ______________ DOB: __________ Living w/you Y ____ N_____

Name ______________ DOB: __________ Living w/you Y ____ N_____

Name ______________ DOB: __________ Living w/you Y ____ N_____

Parent Information (IF PATIENT IS A MINOR)

Father____ Home Phone______________

Address__________________________ City______________ Zip ______________

Date of Birth______/______/______ Social Security # ______________________

Employer____ Work Phone ______________

Mother____ Home Phone ______________

Address__________________________ City______________ Zip ______________

Date of Birth______/______/______ Social Security # ______________________

Employer____ Work Phone ______________

I was referred by________________________________ *Relationship to you:*______________

May we send a referral acknowledgment? Yes____ No____

If Fee has not been discussed: Total family annual (or monthly) gross income (include all sources): $_________ Fee:_____

If you have insurance you intend for us to bill:

We will need a copy of the front and back of the insurance card to bill insurance.
Please make the receptionist or therapist aware you have an insurance card to be copied.
Insurance is billed as a courtesy. It is important that you understand the following:

☐ I will be charged the full fee for any missed appointment and for cancellations received less than 24 hours prior to my scheduled appointment time. **Insurance will not pay for these and they are my sole responsibility.**

☐ I am responsible to obtain any preauthorization from my insurance company. If failure to do so results in non-payment from my insurance company, I understand I am financially responsible to pay for these sessions. I am responsible to pay for all deductibles, any and all co-pays, and any balance remaining after insurance has paid their portion and contractual adjustments have been made.

☐ I understand that the ultimate financial responsibility is mine.

☐ I have read and understand the above. I authorize payment of authorized benefits be made either to me or on my behalf to Dr. Marcial Felan for any services related to outpatient psychotherapy. I further authorize Dr. Marcial Felan to act on my behalf if it is necessary to file a complaint against my insurance carrier.

Signature________________________________ Date______________

Signature________________________________ Date______________

Dr. Marcial Felan Counseling

Dear Client Welcome! I am very glad to have you as a client. I will do everything possible to merit the confidence you have shown in coming here for professional help. The following information will acquaint you with our established policies and procedures.

Communication

We want to hear from you when you need us. Your call will usually be received by my 24-hour voice mail system. While the I do not answer calls during therapy sessions, I will respond to your call as soon as possible. Remember that emergency calls can also be made by dialing 911. *If the call takes more than a few minutes the therapist will assess a pro-rated charge.*

Appointments.....

When appointments are scheduled, that time is reserved only for you. If you need to change your appointment time, please allow us **twenty-four (24) hours** notification. ***A full session charge is assessed for late cancellations or missed appointments**, unless necessitated by an emergency.*

Financial Arrangements....

Our charges for psychotherapy and counseling are based on current, usual and customary fees for this area. We have agreed that your fee(s) for professional services are $________per individual session, $__________per couple/family session, and/or $________per group session. When a balance does exist a billing statement will be mailed monthly and prompt payment is expected at that time. Additionally, consultations with other professionals and reports prepared on your behalf will be charged a pro-rated fee. Assessment testing is charged on a per instrument basis. Payment may be made with cash, personal checks, Visa or MasterCard American Express for an **additonal service fee of 3.00**. **A $25 charge is made for any check returned to us as non-payable for any reason.** Accounts over 90 days past due may be sent to collections and additional fees may be applied.

Payment is ***expected*** at the time services are rendered either by Cash, Check, or Credit card. By signing below and providing my credit card information, I authorize Dr. Marcial Felan, LMFT to charge my credit card for session fees in which I do not provide payment in the form of cash or check (unless arrangements have been made with the therapist). Additionally, I authorize charges for missed appointments not cancelled within the 24 hours advanced notice, not showing up for scheduled appointments, returned check fees and amount of check paid, past due amount over 30 days. I understand my credit card will only be used under these circumstances and/or when I have failed to provide payment in another form (i.e. cash or check).

Name on Credit Card	
Billing Address for Card	
Credit Card Number	
Expiration Date	CVV (3 Digit code on back):
Credit Card Type	Visa Master Card American Express

Client Print Name______________________ Signature________________ Date__________

Client Print Name______________________ Signature________________ Date__________

Insurance....

We provide assistance in billing your insurance company as a courtesy. Please note we are not contracted with Medicare, Medi-Cal, any medical groups or HMOs. In order to bill your out-of-network insurance we must obtain a copy of your insurance card (front and back). You are responsible for obtaining any pre authorization, paying all deductibles, co pays and any balance remaining after insurance has paid their portion. We are happy to file your insurance claims for you, but due to the wide variations in coverage, payment may be requested from you as services are rendered until it is determined what portion, if any, your insurance will pay. If your insurance denies payment of any service, payment of these services are ultimately your responsibility.

Confidentiality....

Successful therapy requires that you be as honest and open with your therapist as you possibly can. As a safeguard to you and the information that you share with your therapist, the State of California provides a legal privilege which protects the confidentiality of the information that you disclose to your therapist. The fact of your presence in therapy, the verbal disclosures which you make to your therapist, any written or other documentation which you might give to your therapist, and all of your therapist's clinical notes are protected as confidential information. It is important that you understand the legal exceptions to confidentiality and that you know that it is our policy to work only with those clients who irrevocably agree that the right to confidentiality is waived when the client is: imminently a danger to self; imminently a danger to others; and disclosing information regarding suspected child or elder abuse. The client's confidentiality is also waived when the client signs an authorization to release information or when a minor client's legal guardian signs such release. Confidentiality can also be waived when the therapist is served with a Court- ordered subpoena and is advised by professional legal counsel to release the subpoenaed information.

To ensure the highest quality of excellent professional care you deserve, I may consult on your case with other therapist on a confidential basis to make sure I am providing the best care possible.

Appropriate Professional Conduct...

As with any professional relationship, the psychotherapeutic relationship requires high standards of moral, ethical, and appropriate conduct on the part of the psychotherapist. Specifically, any form of sexual intimacy between a therapist and a client is never appropriate. The booklet ***"Therapy Never Includes Sex"*** is available to you upon your request if sexual intimacy has ever occurred between you and a therapist during any previous courses of psychotherapy.

If you have any questions please let us know. Your therapist is happy to discuss any of the above with you in greater detail. As a client, I have read and understand (or have asked for clarification about) the information If presented in this two page form, and consent to treatment within the aforementioned guidelines.

____________________ Client Signature	____________________ Therapist Signature
____________________ Print Name	____________________ Print Name
____________________ Client Signature	
____________________ Print Name	____________________ Date

CLIENT CONTACT FORM

You may request to receive confidential communications of your protected health information (PHI) from Dr. Marcial Felan by alternative means or at alternative addresses. For example, you may not want your bills to go to your home where a family member might see them. Dr. Felan cannot ask you the reason for your request, and will accommodate all reasonable requests that you make. If you make a special request, you must give an alternative address or other method of contacting you. **Dr. Felan uses an online scheduler that will send text and email reminders of appointments your signing this also approves the receiving of these reminders to the cellphone number and email address below.**

I wish to be contacted in the following manner (check all that apply):

☐Home telephone (_____) ______________

- ☐Okay to leave message
- ☐Leave call-back number only

☐Work telephone (_____) ______________

- ☐Okay to leave message
- ☐Leave call-back number only

☐Written communication

- ☐ okay to mail to my home
- ☐ okay to mail to my work/office

☐Cell____________________________

- ☐Okay to leave message
- ☐Leave call-back number only
- ___Text messages okay

☐ E-mail ____________________________

____________________ ____________________ ____________________

Patient/guardian signature | Print Name | Relationship

____________________ ____________________ ____________________

Patient/guardian signature | Print Name | Relationship

All disclosures will be made pursuant to the guidelines and requirements as detailed in the "Notice of Privacy Practices". Healthcare entities must keep a record of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

Date:____________________ Date of Birth: ____________________

Date	Disclosed to	(1)	Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized
(2) Type key: T=Treatment Records; P = Payment information; S = dictated summary O= healthcare operations
(3) Enter how disclosure was made: F=Fax; P=Phone; M=mail; O=other

Dr. Marcial Felan Counseling

Acknowledgment of Receipt of Notice of Privacy Practices

By signing this form, you acknowledge receipt of the Notice of Privacy Practices that was given to you. Notice of Privacy Practices provides information about how Dr. Marcial Felan may use and disclose your protected health information. I encourage you to read it in full.

Notice of Privacy Practices is subject to change. If Dr. Felan changes this notice, you may obtain a copy of the revised notice from Dr. Felan by calling 619-212-5222.

If you have any questions about the Notice of Privacy Practices, please ask me and I will be glad to explain them to you in more detail.

I acknowledge receipt of the Notice of Privacy Practices of Dr. Marcial Felan Counseling

Signature: ______________________________________ Date: ________________
Client/parent/conservator/guardian

Signature: ______________________________________ Date: ________________
Client/parent/conservator/guardian

Therapist: ______________________________________ Date: ________________

INABILITY TO OBTAIN ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I made good faith attempts to obtain my clients acknowledgment of his or her receipt including _

____

.

However, because of ____ I was unable to obtain my client's acknowledgment.

Signature of Provider: ________________________________ Date: ________________

Dr. Marcial Felan Counseling
NOTICE OF PRIVACY PRACTICES

I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. **For purposes of clarification and understandability, this document is written in the first person as it pertains to your therapist, Dr. Marcial Felan.**

II. I HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)

I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you that I've created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of this health care. I must provide you with this Notice about my privacy practices', and such Notice must explain how, when, and why I will "use" and "disclose" your PHI. A "use" of PHI occurs when I share, examine, utilize, apply, or analyze such information within my practice; PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. And, I am legally required to follow the privacy practices described in this Notice.

However, I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI on file with me already. Before I make any important changes to my policies, I will promptly change this Notice and post a new copy of it in my office and on my website (if applicable). You can also request a copy of this Notice from me, or you can view a copy of it in my office or at my website, which is located at FCSchristiancounseling.com.

III. HOW I MAY USE AND DISCLOSE YOUR PHI.

I will use and disclose your PHI for many different reasons. For some of these uses or disclosures, I will need your prior authorization; for others, however, I do not. Listed below are the different categories of my uses and disclosures along with some examples of each category.

A. Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. I can use and disclose your PHI without your consent for the following reasons:

1. For treatment. I can disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are involved in your care. For example, if you're being treated by a psychiatrist, I can disclose your PHI to your psychiatrist in order to coordinate your care.
2. To obtain payment for treatment. I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company or health plan to get paid for the health care services that I have provided to you. I may also provide your PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims.
3. For health care operations. I can disclose your PHI to operate my practice. For example, I might use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided such services to you. I may also provide your PHI to our accountants, attorneys, consultants, and others to make sure I'm complying with applicable laws.
4. Other disclosures. I may also disclose your PHI to others without your consent in certain situations. For example, your consent isn't required if you need emergency treatment, as long as I try to get your consent after treatment is rendered, or if I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) and I think that you would consent to such treatment if you were able to do so.

B. Certain Uses and Disclosures Do Not Require Your Consent. I can use and disclose your PHI without your consent or authorization for the following reasons:

1. When disclosure is required by federal, state or local law; judicial or administrative proceedings; or, law enforcement. For example, I may make a disclosure to applicable officials when a law requires me to report information to government agencies and law enforcement personnel about victims of abuse or neglect; or when ordered in a judicial or administrative proceeding.
2. For public health activities. For example, I may have to report information about you to the county coroner.
3. For health oversight activities. For example, I may have to provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.
4. For research purposes. In certain circumstances, I may provide PHI in order to conduct medical research.
5. To avoid harm. In order to avoid a serious threat to the health or safety of a person or the public, I may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.
6. For specific government functions. I may disclose PHI of military personnel and veterans in certain situations. And I may disclose PHI for national security purposes, such as protecting the President of the United States or conducting intelligence operations.
7. For workers' compensation purposes. I may provide PHI in order to comply with workers' compensation laws.
8. Appointment reminders and health related benefits or services. I may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits I offer.

C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other

person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in sections III A, B, and C above, I will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I haven't taken any action in reliance on such authorization) of your PHI by me.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

You have the following rights with respect to your PHI:

A. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that I limit how I use and disclose your PHI. I will consider your request, but I am not legally required to accept it. If I accept your request, I will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that I am legally required or allowed to make.

B. The Right to Choose How I Send PHI to You. You have the right to ask that I send information to you to at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail) I must agree to your request so long as I can easily provide the PHI to you in the format you requested.

C. The Right to See and Get Copies of Your PHI. In most cases, you have the right to look at or get copies of your PHI that I have, but you must make the request in writing. If I don't have your PHI but I know who does, I will tell you how to get it. I will respond to you within 30 days of receiving your written request. In certain situations, I may deny your request. If do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed.

If you request copies of your PHI, I will charge you not more than $.25 for each page. Instead of providing the PHI you requested, I may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

D. The Right to Get a List of the Disclosures I Have Made. You have the right to get a list of instances in which I have disclosed your PHI. The list will not include uses or disclosures that you have already consented to, such as those made for treatment, payment, or health care operations, directly to you, or to your family. The list also won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003.

I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost-based fee for each additional request.

E. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. I will respond within 60 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by me, (iii) not allowed to be disclosed, or (iv) not part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and my denial be attached to all future disclosures of your PHI. If I approve your request, I will make the change to your PHI, tell you that I have done it, and tell others that need to know about the change to your PHI.

F. The Right to Get This Notice by E-Mail. You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of it.

V. HOW TO complain ABOUT MY PRIVACY PRACTICES

If you think that I may have violated your privacy rights, or you disagree with a decision I made about access to your PHI, you may file a complaint with the person listed in Section VI below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue SW., Washington, D.C. 20201. I will take no retaliatory action against you if you file a complaint about my privacy practices.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me at: 7777 Alvarado Rd., #255, La Mesa, CA., 91942, 619-212-5222

VII. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on April 14, 2003.

Dr. Marcial Felan Counseling
7777 Alvarado Rd., #255
La Mesa, CA., 91942

A Message to My Clients About Arbitration Please Read Before Continuing

The attached contract is an arbitration agreement. By signing this agreement, we are both agreeing that any dispute arising out of the services you receive is to be resolved in binding arbitration rather than a suit in court. Lawsuits are something that no one anticipates and everyone hopes to avoid. I believe that the method of resolving disputes by arbitration is one of the fairest systems for both clients and providers. Arbitration agreements between health care providers and their patients have long been recognized and approved by the California courts. By signing this agreement, you are changing the place where your claim will be presented. You are not forfeiting your right to file a claim should you feel the need arises. You may still call witnesses and present evidence. Each party selects and arbitrator (party arbitrators) who then select a third, neutral arbitrator. These three arbitrators hear the case. This agreement generally helps to limit the legal costs for both patients and providers. Further, both parties are spared some of the rigors of a trial and the publicity that may accompany judicial proceedings. My goal is always to provide mental health services in such a way as to avoid any such disputes. Still, I know that most problems begin with miscommunication. If you have any questions at any time about your care, please ask me immediately. Please sign/initial the highlighted areas on the next page. A copy of this agreement will be provided to you upon your request.

THERAPIST-PATIENT ARBITRATION AGREEMENT Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical/mental health services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided on in a court of law before a jury, and instead are accepting the use of arbitration. Article 2: All Claims Must be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or related to treatment or service provided by the therapist including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean the mother and the mother's expected child or children. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the therapist, and the therapist's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any court by the therapist to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the

arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law. Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrations a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator. Article 4: General Provisions: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration. Article 5: Revocation: This agreement may be revoked by written notice delivered to the therapist within 30 days, or signature. It is the intent of this agreement to apply to all medical/mental health services rendered any time for any condition. Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is Effective as of the date of first medical/mental health services.
______________________________ Patient's or Patient Representative's Initials If any provision if this arbitration agreement is held invalid of unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT. IF YOU WISH TO HAVE A COPY OF THIS CONTRACT, YOU MUST REQUEST ONE. PLEASE NOTIFY YOUR PROVIDER AND A SIGNED COPY WILL BE PROVIDED.

Signature ______________________________ Date________________

Primary Patient's or Representative's

Signature________________ ________________ Date________________

DETAILED INTAKEFORMTION FORM

Please provide the following information and answer the questions below. Please note : information you provide here is protected **as confidential information.**

Please fill out this form and bring it to your first session.

Name : (Last) (First)

Name of parent/guardian (if under 18 years) :

(Last) (First) (Middle Initial)

Marital Status: (please circle one)

Never Married | Domestic Partnership | Married
Divorced | Widow
Separated

If married how many years?________ If divorced how long?__________

If separated how long?____

Please list any children/age(s):

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

_No

_Yes, previous therapist/practitioner name:
How long did you see this person?

ADDITIONAL INFORMATION:

1. Are you currently employed? No Yes

If yes, what is your current employment situation?

Do you enjoy your work? Is there anything stressful about your current work?

2. Do you consider yourself to be spiritual or religious? o No o Yes

If yes describe your faith or belief:

3. What do you consider to be some of your strengths?

4. What do you consider to be some of your weaknesses?

5. What would you like to accomplish from your therapy?

6. Are you currently experiencing anxiety, panic attacks, or have any phobias?
o No
o Yes

If yes, when did you begin experiencing this?____________________

7. Are you currently experiencing any chronic pain?
o No
a Yes

If yes, please describe: ____________________

8. Do you drink alcohol more than once a week? o No o Yes

9. How often do you engage recreational drug use?
o Daily o Weekly o Monthly o Infrequently o Never

10. Are you currently in a romantic relationship? o No o Yes

If yes, for how long?______________

On a scale of 1-10, how would you rate your relationship__________

11. What significant life changes or stressful events have you experienced recently:
____
____

PERSONAL AND FAMILY MENTAL HEALTH HISTORY:

In the section below, identify if YOU OR A family member has a history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Self/Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depressed	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	