Notice of Privacy Practices Pursuant to HIPAA

Alicia Polk, LPC, PLPC

605 Cherry Street Suite 320 Belton, MO 64012
Telephone: (816) 226-4678

Effective date: November 28, 2017

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY. If you have any questions about this notice, please contact Alicia Polk, LPC, PLPC at 816-226-4678.

Privacy is a very important concern for all those who come to this office. Federal and state laws and the codes of our profession make the issue of privacy very complicated. Some parts of this notice are quite detailed, and you may have to read the notice several times. If you have any questions, your therapist (Privacy Officer) will be happy to help you.

Contents of this Notice

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A. Introduction

This notice will tell you how this office handles information about you. It tells how information is used, shared with other professionals and organizations, and how you can see your information. This notice is required under the privacy regulations of a federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

B. What is meant by "your health information"

Each time you visit this office or any other "health care provider", information is collected about you and your physical and/or mental health. It may be information about your past, present, or future health or conditions, or about the treatment or other services you have received or about payment for health services. The information collected from you is called Protected Health
Information (PHI). This information goes into your file. In this office, your PHI is likely to include these kinds of information:

- Your history as child, in school, and at work, and marital and personal history
- Reasons you came for treatment/counseling. This includes your problems, complaints, symptoms, needs, and goals
- Diagnoses
- Treatment plan
- Progress notes. Each time you come in, your therapist will write down how you are doing, observations, and what you tell him or her
- Records received from others who have treated you or evaluated you
- Information about medications you took or are taking
- Legal matters
- Billing and insurance information

PHI is used for many purposes. For example, it may be used:

- To plan your care and treatment
- To decide how well treatment is working for you
- When speaking with other health care professionals who are also treating you, such as your family doctor or someone who referred you
- To show what services you have actually received
- For teaching and training other health care professionals
- For psychological research
- For public health officials trying to improve health care in this county
- To improve the way I am doing my job by measuring the results of my work

When you understand what is in your record and what it is used for, you can make better decisions about how, when, and why others should have this information.

Although your health record is the physical property of the practitioner or facility that collected it, the information in your health record is available for you to see, and you are entitled to copies of the file. *Psychotherapy notes are working notes and belong to the therapist and are not part of your health record.* You can inspect, read, or review the health record. If you want a copy, we can make one for you but may charge you for the costs of copying and mailing if you want it mailed. In some very unusual situations, you cannot see all of what is in your records. If you find anything in your records that you think is incorrect or something important is missing you can ask us to amend (add information to) your record, although in some rare situations the therapist does not have to agree to do that. Your therapist can explain more about this to you.

C. Privacy and the laws about privacy

The HIPPA law requires therapists to keep your PHI private and to give you this notice of legal duties *and* privacy practices, which is called the *Notice of Privacy Practices*, or NPP. Your therapist will obey the rules of this notice as long as it is in effect, but if the NPP is changed, the rules of the new NPP will apply. If the NPP is changed, the new Notice will be posted in the office
where everyone can see it. You or anyone else may obtain a copy of the NPP at any time.

D. How your PHI can be used and shared

When your therapist or others under the direction of the therapist read, share, utilize and analyze your information in the office that is called "use." If the information is shared with or transmitted to others outside the office, that is called, "disclosure." Except in some special circumstances, when your PHI is used or disclosed, only the minimum necessary PHI is shared. The law gives you rights to know about your PHI, how it is used and to have a say in how it is disclosed. Your PHI is used and disclosed for several reasons. Mainly, your PHI will be used and disclosed for routine purpose explained more fully below. For other uses, you must be told about them, and your therapist must have a written Authorization from you, unless the law allows or requires use or disclosure of PHI without your authorization. You may revoke your authorization for release of information at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that your therapist has relied on the authorization, or if the authorization was obtained on the condition of obtaining insurance coverage where the law provides the insurer the right to contest the claim under the policy. The law also says that therapists are allowed to make some uses and disclosures without your consent or authorization, and those situations are discussed below.

1. Uses and disclosures of PHI without your consent

a. For treatment, payment, or healthcare operations

In almost all cases, your PHI will be used to provide treatment to you, arrange for payment for services, or some other business functions called health care operations. These routine purposes are called TPO (Treatment, Payment, Healthcare Operations). An authorization form signed by you is not required in order for your PHI to be used for TPO. However, in order to provide therapy services, you will be asked to sign an informed consent for treatment form.

Treatment. Your healthcare information will be used to provide you with psychological treatment or services. These might include individual, couple, family, or group therapy, psychological testing, treatment planning, or measuring the effects of services. Your PHI may be used or disclosed to others who provide treatment to you. Your information may be shared with your personal physician. If a team of providers is treating you, we can share some of your PHI with them so that the services you receive will be coordinated. Others may enter their findings, the actions taken, and treatment plans into your record. Then, a decision can be made on what treatments work best for you. A treatment plan will be developed. You may be referred to other professionals or consultants for services this office cannot offer, such as special testing or treatments. When referral occurs, the referring clinician will need to be told about you and your conditions. Information received will go into your record. If you receive treatment in the future from other professionals, your PHI from the records at this office may be requested with your authorization and shared. These are only some examples of how your PHI may be used and disclosed.

Payment. Your PHI may be used to bill you, your insurance carrier or others as you request or authorized. Your insurance company may be called in order to determine your insurance coverage. Your insurance carrier may have to be told about your diagnoses, what treatments you have received and is expected throughout treatment. The insurance carrier will need to be told when treatment began, your progress, and other similar information.

Healthcare operations. There are some other ways your PHI may be used or disclosed. Your PHI may be used to determine where improvements need to be made in the way the health care provider provides services. It is possible that the office could be required to supply information to some government health agencies studying disorders and treatment services. If so, your name and identity will be removed from what is provided.

b. Other uses in healthcare

Appointment reminders. Your PHI may be used and disclosed in order to reschedule or remind you of appointments. If you want to be called or written to only at your home or your work, or if you prefer some other way to be contacted, that can usually be arranged. You may be asked to complete a form.

Treatment alternatives. Your PHI may be used to tell you about or recommend possible treatments or alternatives that may be of interest to you.

Other benefits and services. Your PHI may be used and disclosed in order to tell you about health-related benefits or services that may be of interest to you.

Research. Your PHI may be used or disclosed in order to research treatments. In all cases your name, address, and other identifying information that reveals who you are will be removed from the information given to researchers. If there is a need for your identity to be disclosed, the research project will be discussed with you and, if you wish, you may agree to sign a special
Authorization form before identifying information is shared.

Business associates. There are some tasks that may be outsourced to other businesses. Examples would include a copy service used to make copies of your health care record, and billing services who completes and mails billing statements. These business associates may receive some of your PHI to do their jobs properly. To protect your privacy, the business associates have contracted to safeguard your information.

2. Uses and disclosures requiring your authorization

If your therapist wishes to use your information for any purpose besides the TPO described above, your permission is needed on an Authorization Form. You may revoke your authorization for release of information at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that your therapist has relied on the authorization, or if the authorization was obtained on the condition of obtaining insurance coverage where the law provides the insurer the right to contest the claim under the policy.

3. Uses and disclosures of PHI not requiring authorization or consent

Child Abuse – If your therapist has reason to suspect that a child has been injured as a result of physical, mental or emotional abuse or neglect or sexual abuse, your therapist MUST report the matter to the appropriate authorities as required by law.

Adult and Domestic Abuse – If your therapist has reasonable cause to believe that a dependent adult is being or has been abused, neglected or exploited or is in need of protective services, your therapist must report this belief to the appropriate authorities as required by law.

Health Oversight Activities – Your therapist may disclose PHI to the Kansas Behavioral Sciences Regulatory Board if necessary for a proceeding before the Board.

Judicial and Administrative Proceedings – If you are involved in a court proceeding and a request is made for information about the professional services provided you and/or the record thereof, such information is privileged under state law, and your therapist will not

release information without the written authorization of you or your legally appointed representative or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

Serious Threat to Health or Safety - If your therapist believes that there is a substantial likelihood that you have threatened an identifiable third person or the public at large and that you are likely to act on that threat in the foreseeable future, I may disclose information in order to protect that individual. If I believe that you present an imminent risk of serious physical harm or death to yourself, I may disclose information in order to initiate hospitalization or to family members or others who might be able to protect you.

For law enforcement purposes. Your PHI may be released under certain circumstances to law enforcement officials investigating a crime.

For specific government functions. Your PHI may be disclosed to military personnel and veterans, to government benefit programs relating to eligibility and enrollment, to Workers' Compensation programs, to correctional facilities if you are an inmate, and for national security reasons.

4. Uses and disclosures requiring you to have an opportunity to object

Information can be shared with your family or close others, but only those involved with your care and those you choose, such as close friends or clergy. You will be asked what information can be shared about your condition and treatment. Your therapist will honor your wishes as long as it is not against the law. If there is an emergency – and in that case you may not be asked if you agree – personal information may be shared if your therapist believes that it is in your best interests.

5. An accounting of disclosures

You are entitled to an accounting (a list) of disclosures of your PHI. The accounting includes what was disclosed, when it was disseminated, and the person/agency that received the information.

E. If you have questions or problems

If you need more information or have questions about the privacy practices described above, please speak to your therapist (Privacy Officer), whose name and telephone number are listed on the top page of this Notice. If you have a problem with how your PHI has been handled or if you believe your privacy rights have been violated, contact your therapist. You have the right to file a complaint with your therapist, with the Kansas Behavioral Sciences Regulatory Board at 785-296-3240, and with the Secretary of the Federal Department of Health and Human Services. Filing a complaint will not result in a limitation of care.

The effective date of this notice is November 28, 2017.

Alicia Polk, LPC, PLPC
Vitalis Counseling
605 Cherry St., Suite 320
Belton, MO 64012

Practice Policies

Appointments & Cancellations
The standard session is 45-minutes in length; longer appointments can be made in advance. The session will end on time even if you arrive late; this may mean your session is shorter than usual. The full session fee will be charged for appointments which are canceled or rescheduled within 24 hours of the appointment. This is because the appointment time is held exclusively for you. Emergencies do sometimes happen and, when appropriate, the fee may be waived at the therapist's discretion. The first late cancellation, reschedule, or missed appointment will be waived.

The therapist has legal and ethical responsibilities for the client and because of this, the therapist must end the counseling relationship, unless arrangements have been made with the therapist, if the client has not had an appointment in three weeks. If this happens, the client is welcome to return to counseling in the future and re-establish the counseling relationship.

If the client has three late cancellations or missed appointments in a quarter, the therapist will end the counseling relationship and provide referrals to other clinicians. Without prior discussion as to the reason (such as having a job where one is on-call), excessive rescheduling will prompt the therapist to talk with the client about whether this is the right time in the client's life to be doing counseling.

Financial Policies
The regular session fee is $90 per 45-minute session. The therapist participates in the Open Path program and offers reduced rates for qualifying individuals of $30-$60 based on income. The fee is collected at the beginning of each session.

The only insurance plans currently accepted are Optum and Sunflower from Kansas Medicaid. Upon request, the therapist will provide you with a superbill to submit to your insurance for possible out-of-network reimbursement. Please note that the therapist cannot assist in filing the claim or in answering insurance questions and cannot guarantee any amount of reimbursement.

Returned check fees are $25.00. Any time the therapist has to be at court, even if it is just an hour, is $1.600. Time spent traveling or for preparation (such as phone calls or meetings with your attorney) outside of court is billed at $200 per hour.

Communication Between Sessions
Email and text are not considered to be secure modes of communication because they pass through third party equipment as they go between the sender and receiver. Best practice is to not write anything you wouldn't mind seeing on the front page of a newspaper. However, if you have signed the email/text policy, the therapist will use these methods of communication with you. The therapist offers secure, HIPAA-compliant messaging (that looks like email) through the client portal. You are invited to use this, as well.

If you have an emergency, please call 911 or go to the nearest emergency room. The therapist is not on call 24/7. The therapist will do her best to return your call within 24 business hours. Phone calls that last more than 10 minutes will be charged at the prorated amount.

If the therapist encounters you in a public setting, the therapist will not acknowledge you unless you make the first contact. This is to protect your confidentiality. The therapist does not "like" or "friend" clients on social media as this also guards your confidentiality.

Kansas Medical Waiver
Because the therapist practices under both Missouri and Kansas law, even if she sees you at her Missouri office she must also follow Kansas law. Kansas law requires therapists to consult with your primary care physician or psychiatrist to determine if there may be a medical issue that is contributing to your symptoms. If you do not wish for the therapist to consult with your doctor, you will need to sign the waiver included in your paperwork.

Patient Confidentiality
The information you share with the therapist will be kept confidential aside from the following exceptions:
1. Mandated reporting of suspicious physical or sexual abuse or a child or someone who is in need of protection (i.e. dependent adult).
2. Threats of suicide or homicide
3. Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.
4. If you, the client sign a release of information
5. Information necessary for supervision (see supervision form)
6. To defend myself or my practice in court of law
7. As required by law (i.e. when asked to provide information in legal cases when under court order)
8. As a Provisional Licensed Professional Counselor in Missouri and a Licensed Professional Counselor in Kansas, the therapist is under supervision and may share information with her supervisor, Jennifer Agee. The supervisor is bound by the same rules of confidentiality.

**Information that can be requested includes, but is not limited to: types of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, case notes and summaries.

Telemental Health
The therapist is Board-Certified in telemental health (video counseling) and will make this option available to clients when appropriate. The same confidentiality applies to the therapist, with the exception that the therapist cannot guarantee confidentiality on the client's end which is out of the therapist's control.

There are potential risks, consequences, and benefits of telemedicine. Potential benefits include, but are not limited to improved communication capabilities, providing convenient access to up-to-date information, consultations, support, reduced costs, improved quality, change in the conditions of practice, improved access to therapy, better continuity of care, and reduction of lost work time and travel costs. Effective therapy is often facilitated when the therapist gathers within a session or a series of sessions, a multitude of observations, information, and experiences about the client. Therapists may make clinical assessments, diagnosis, and interventions based not only on direct verbal or auditory

communications, written reports, and third person consultations, but also from direct visual and olfactory observations, information, and experiences. When using information technology in therapy services, potential risks include, but are not limited to the therapist's inability to make visual and olfactory observations of clinically or therapeutically potentially relevant issues such as: your physical condition including deformities, apparent height and weight, body type, attractiveness relative to social and cultural norms or standards, gait and motor coordination, posture, work speed, any noteworthy mannerism or gestures, physical or medical conditions including bruises or injuries, basic grooming and hygiene including appropriateness of dress, eye contact (including any changes in the previously listed issues), sex, chronological and apparent age, ethnicity, facial and body language, and congruence of language and facial or bodily expression. Potential consequences thus include the therapist not being aware of what he or she would consider important information, that you may not recognize as significant to present verbally to the therapist.

Potential Risks and Benefits of Therapy
It is important to understand that therapy has potential benefits as well as emotional risks. Sessions may bring about intense emotions and new or long avoided thoughts may arise and be painful, at least initially. Making changes, even beneficial ones, can evoke feelings of fear or worry and can be disruptive to some relationships. It is important for you to consider carefully whether these or other risks are worth the benefits to you of changing. Most people who take these risks find that counseling is helpful and the change is positive.

Ending the Counseling Relationship
The counseling relationship is meant to end at some point. The client may make the decision to end at any time. It is most beneficial if the conclusion of services be discussed in regular session rather than over the phone. Our sessions will be limited by either: rules of insurance, your choice, mutual decision that goals are met, or my assessment that I am not the best clinician to work with you at this time. If the later is the case, the therapist will provide the names of other clinicians.

Client Rights and Responsibilities
The client has the right to:

- be informed about your therapist's education, experience, and professional licensure.
- have all that you say treated confidentially and to be informed of any state laws which limit confidentiality within the counseling relationship.
- considerate, safe, and respectful care without discrimination as to race, ethnicity, gender, sexual orientation, age, or religion.
- have an interpreter provided for you, if needed, at no cost to you.
- ask questions about the counseling techniques and strategies and you have the right to participate in goal setting.
- see the contents of your file (progress notes, assessments, etc), with advance notice.
- say "no" and decline any aspect of therapy, such as a counseling technique, without negative repercussions. If your therapist believes that the approach she recommends is the best approach

and is not comfortable with the approach you wish to take, your therapist will give you referrals to other qualified professionals she believes can help you.

- terminate therapy at any time and without repercussions (aside from court-ordered therapy). Should you choose to terminate therapy, you have the right to get referrals from your therapist to other professionals who are qualified to help you.

The client is responsible for:

- scheduling appointments, either with the therapist or through the client portal.
- giving at least 24 hours of notice when you need to cancel or reschedule an appointment.
- helping to set therapeutic goals, for doing any homework you agree to do, and for keeping your therapist updated on your progress.

Supervision and Concerns

As a Provisional Licensed Professional Counselor in Missouri and a Licensed Professional Counselor in Kansas, the therapist is under the supervision of Jennifer Agee. If you ever have an issue or concern about the therapist, you may talk to Jennifer Agee at (913) 237-3011. Additionally, you may call the regulating body of the appropriate state. In Kansas, this is the Behavioral Science Regulatory Board at (785) 296-3240. In Missouri, this is the Committee for Professional Counselors at (573) 751-0018.

Alicia Polk, LPC, PLPC
Vitalis Counseling
605 Cherry St., Suite 320
Belton, MO 64012

Practice Policies

My signature indicates that I have been given a chance to ask questions, that I have read and understand and agree to the items contained in this document, and that I give my consent for treatment by Alicia Polk, PLPC, LPC.

_____ _____

Signature Date

_____

Printed name

Alicia Polk, LPC, PLPC
Vitalis Counseling
605 Cherry Street
Belton, MO 64012
816-226-4678

Acknowledgment of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices Pursuant to HIPAA. I further acknowledge that I can request a current copy at any time or view it at https://vitaliscounseling.com.

_____ _____
Client Signature / Parent or Guardian Signature of Minor Client Date

_____ _____
Client Signature / Parent or Guardian Signature of Minor Client Date

Complete the following only if the Client refuses or is unable to sign the Acknowledgment:

Efforts to obtain _____

_____

Reason for refusal or inability to signt
_____

_____

Authorized Signature _____

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WAIVER OF MEDICAL AND PSYCHIATRIC CONSULTATION

I understand that under the provisions of Kansas law KSA 65-6404 (b) (3), my counselor is required to consult with a primary care physician or psychiatrist to determine if there may be a medical condition or medication that may be causing or contributing to any signs of a mental disorder that she may have observed while working with me.

By signing below, I am indicating that I waive such mandated consultation and that I do not wish for my counselor to contact my physician or psychiatrist.

I understand that, although I have waived my right for consultation, as concerns arise, my counselor may approach me again to discuss symptoms of concern. If there is a need for further consultation, I will be asked to complete an Authorization for Release of Information to allow for such consultation. In the event that my counselor addresses the need for further consultation, and I do not currently have a primary care physician or psychiatrist, I acknowledge that my counselor may recommend that I seek medical consultation or provide me with appropriate referrals.

I understand that I have the right not to sign this waiver and that doing so provides my counselor the full right and requirement to make appropriate consultation. I am also aware that this waiver will become part of my client record.

Client signature: _____ Date: _____

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CONSENT TO USE UNENCRYPTED E-MAIL OR TEXT

It is very important that you are aware that computer e-mail, texts, and e-fax communication, can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. E-mails, texts, and e-faxes, in particular, are vulnerable to such unauthorized access due to the fact that servers or communication companies may have unlimited and direct access to all e-mails, texts and e-faxes that go through them. Generally, e-mails, text messages, and e-faxes are not encrypted in transit over the Internet. It is always a possibility that e-faxes, texts, and e-mail can be sent erroneously to the wrong address and computers. Unencrypted e-mail or texts provide as much privacy as a postcard. You should not communicate any information to your health care provider that you would not want to be included on a postcard that is sent through the Post Office. E-mail messages on your computer, your laptop, tablet computer, phone or other devices have inherent privacy risks – especially when your e-mail access is provided through your employer or school or when access to your e-mail messages is not well protected.

Please, note that e-mails, faxes, and texts are all part of your clinical records.

Please notify Alicia Polk if you decide to avoid or limit, in any way, the use of e-mail, texts, cell phone calls, phone messages, or e-faxes. If you communicate confidential or private information via unencrypted e-mail, texts or e-fax or via phone messages, it will be assumed that you have evaluated the risks and made an informed decision; Alicia Polk will view it as your agreement to take the risk that such communication may be intercepted, and your desire to communicate on such matters will be honored. Remember that the therapist offers secure, HIPAA-compliant messaging through the client portal. **Please do not use texts, e-mail, voice mail, or faxes for emergencies.**

If you wish to communicate via unencrypted email or text, and understand and accept the possible risks, please fill out and sign below. If you do not wish to communicate with those methods, you do not need to do anything.

Client’s Name (printed): _____

Cell Phone Number: _____

E-mail Address: _____

In case that authentication is needed, please give me a password _____

Client's Signature: _____

Vitalis Counseling
605 Cherry St. Suite 320
Belton, MO 64012
Phone: (816) 226-4678 Fax: (816) 406-0046

Authorization to Disclose Protected Health Information to a Physician

Communication between behavioral health providers and your primary care physician, psychiatrist, or sleep medicine doctor is important to ensure that you receive comprehensive and quality health care. This form will allow your behavioral health provider (counselor) to share protected health information with your doctor. This information will not be released without your signed authorization. This protected health information may include diagnosis, treatment plan, prognosis, and medication if necessary.

I, _____, _____, _____
(Patient Name, Please Print) (Social Security Number) (Date of Birth)

Authorize Alicia Polk at Vitalis Counseling to release protected health information related to my evaluation and treatment to:

Doctor Name: _____ Doctor Phone: _____

Doctor Address: _____
(Street) City State Zip Code

Patient Rights

- You can end this authorization (permission to use or disclose information) any time by contacting Alicia Polk in writing.
- If you make a request to end this authorization, it will not include information that has already been used or disclosed based on your previous permission.
- You cannot be required to sign this form as a condition of treatment, enrollment, or eligibility for benefits.
- Information that is disclosed as a result of the Authorization Form may be re-disclosed by the recipient and may no longer be protected by law.
- You do not have to agree to this request to disclose your information. Refusal may limit coordination of services and full benefit or effectiveness of treatment.

Patient Authorization

I, the undersigned, understand that I may revoke this consent at any time except to the extent that actions have been taken in reliance upon it and that in any event this consent shall expire 1 year from the date of signature, unless another date is specified. I have read and understand the above information and give my authorization. **PATIENT, PLEASE INITIAL ONE**
_____ To release any applicable mental health/substance abuse information to my doctor.
_____ I DO NOT give my authorization to release any information to my doctor.

_____
(Patient Signature) (Date) (Signature of Patient's Authorized Representative) (Date)

INTAKE FORM

Please fill out this form and bring it to your first or second session. Please note: information you provide here is protected as confidential information.

Name: _____
(Last) (First) (Middle Initial)

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

_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female □ Other

Preferred pronouns: _____

Marital Status:
□ Never Married
□ Separated
□ Domestic Partnership
□ Divorced
□ Married
□ Widowed

Please list any children/age: _____

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: ( ) _____ May we leave a message? □ Yes □ No
Cell/Other Phone: ( ) _____ May we leave a message? □ Yes □ No

Referred by (if any): _____
May we thank your referrer (if applicable)? □ Yes □ No

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No
□ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication?
□ Yes
□ No
Please list: _____

_____

Have you ever been prescribed psychiatric medication?
□ Yes
□ No
Please list and provide dates: _____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

3. How many times per week do you generally exercise? _____

What types of exercise to you participate in? _____

4. Please list any difficulties you experience with your appetite or eating patterns:

_____

5. Are you currently experiencing overwhelming sadness, grief, or depression?
□ No □ Yes

If yes, for approximately how long? _____

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

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain?
□ No □ Yes
If yes, please describe: _____

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

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

10. Are you currently in a romantic relationship?
□ No □ Yes
If yes, for how long? _____
On a scale of 1 (terrible) -10 (perfect), how would you rate your relationship? _____

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

_____

FAMILY MENTAL HEALTH HISTORY:
In the section below, identify if there is a family 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.).

	Circle:	Family Member
Alcohol / Substance Abuse	Yes / No	
Anxiety	Yes / No	
Depression	Yes / No	
Domestic Violence	Yes / No	
Eating Disorder	Yes / No	
Obesity	Yes / No	
Obsessive Compulsive Behavior	Yes / No	
Schizophrenia	Yes / No	
Suicide Attempts	Yes / No	

ADDITIONAL INFORMATION:

1. Would you like your spiritual or religious beliefs to be part of your counseling?
□ No □ Yes
If yes, describe your faith or belief:
_____

ADDITIONAL INFORMATION:

2. 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?

_____

_____

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

_____

_____

_____

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

_____

_____

5. If you could take a magic pill before going to bed tonight and wake up tomorrow with your issue perfectly resolved, what would that look like? How would your life be different?

_____

_____

_____

_____

_____

6. Is there anything else you would like me to know?

_____

_____

_____

_____

Please provide the name and contact information for your primary care doctor and your psychiatrist (if you have one).

Primary Care Doctor's Name: _____

Practice Name: _____

Phone Number: _____ Fax Number _____

Address: _____

Street City, State, Zip code

Psychiatrist's Name: _____

Practice Name: _____

Phone Number: _____ Fax Number _____

Address: _____

Street City, State, Zip code