

New Client Information Sheet

Please complete ALL questions

PSY Family Services

301 W. Rosedale, Fort Worth, TX 76104

1. Client Demographics							
Patient Name: Last:			First:			Middle:	
Sex: ()M ()F	DOB:	Age:	School Grade:	Marital Status: ()Single ()Separated ()Married ()Divorced	Ethnic Origin: ()Caucasian ()African-Amer. ()Amer. Indian ()Hispanic ()Asian		
Address:			Apt. #:	City:		State/Zip:	
Phone Number: ()-		Social Security #:		Drivers License #:		State of License:	
Employer Name:		Occupation:		Length of Employment:		Employer Phone Number: ()-	
Employer Address:		Suite #:		City:		State/Zip:	
2. Emergency Contact							
Emergency Contact: Name:							
Address:			Apt. #:	City:		State/Zip:	
Phone Number: ()-			Alternate Phone Number: ()-			Relationship:	
3. Referral Source							
How were you referred to this office? ()Insurance ()Hospital ()Mental Health Professional ()Other:_____							
4. Previous Counseling							
Last 12 months: ()Yes ()No		When:			How Long:		
Where:		Why:			If ended, why:		
5. Health Insurance Information							
Insurance Company:		Policy #:		Group Name:		Group #:	
Insured's Full Name:			Sex: ()M ()F		Relationship:		DOB:
Employer Name:				Employer Phone Number: ()-			
Employer Address:			Suite #:	City:		State/Zip:	

CLIENT INFORMATION AND CONSENT

Client's Name: _____ *Date of Birth:* _____

Consent to Treatment

I, voluntarily, agree to receive Mental Health assessment, care, treatment, or services, and authorize the undersigned therapist to provide such care, treatment, or services as are considered necessary and advisable. I understand and agree that I will participate in the planning of my care, treatment, or services, and that I may stop such care, treatment, or services that I receive through the undersigned therapist at any time. I understand that the session may be audio or video taped for educational purposes.

Appointments

Appointments are made by calling (817)338-4471. Please call to cancel or reschedule at least 24 hours in advance, or you may be charged for the missed appointment. Third-party payments will not usually cover or reimburse for missed appointments.

Number of Visits

The number of sessions needed depends on many factors and will be discussed by the therapist.

Length of Visits

Therapy sessions are approximately 45-50 minutes in length. The charge for individual and family sessions is \$75.00 per visit, unless there is an agreed-upon rate with your insurance. Different co-payments are required by various group coverage plans.

Assignment of Benefits

We will communicate with and work with your health/medical insurance for you. **PSY** will be assigned all medical and psychological benefits from insurance. **PSY** will release information necessary for payment to the paying agency. Your insurance carrier(s), including Medicaid, Medicare, private insurance, and any other health/medical plan, will issue payment directly to **PSY** for services rendered.

Confidentiality

Discussions between a therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; situations where the therapist has a duty to disclose, or where, in the therapist's judgment, it is necessary to warn or disclose; fee disputes between the therapist and client; a negligence suit brought by the client against the therapist; or the filing of a complaint with the licensing board. If you have any questions regarding confidentiality, you should bring them to the attention of the therapist when you and the therapist discuss this matter further. By signing this information and consent form, you are giving your consent to the undersigned therapist to share confidential information with all persons mandated by law and with the agency that referred you and the managed care company and/or insurance carrier responsible or providing your mental health care services and payment for those services, and you are also releasing and holding harmless the undersigned therapist from any departure from your right of confidentiality that may result.

Duty to Warn

In the event that the undersigned therapist reasonably believes that I am a danger, physically or emotionally, to myself or another person, I specifically consent for the therapist to warn the person in danger and to contact the following persons, in addition to medical and law enforcement personnel.

NAME	RELATIONSHIP	TELEPHONE NUMBER
-------------	---------------------	-------------------------

_____	_____	_____
_____	_____	_____
_____	_____	_____

Risks of Therapy

Therapy is the Greek word for change. You may learn things about yourself that you don't like. Often, growth cannot occur until you experience and confront issues that induce you to feel sadness, sorrow, anxiety, or pain. The success of our work together depends on the quality of the efforts on both our parts, and the realization that you are responsible for lifestyle choices/changes that may result from therapy.

By signing this Client Information and Consent form, I, the undersigned client, acknowledge that I have read, understood, and agree to all the terms and information contained herein.

Client

Date

Any inquiries/complaints about licensees from this office may be addressed by contacting the following:
Complaints Management and Investigative Section, P.O. Box 141369, Austin, Texas 78714-1369

ASSIGNMENT OF BENEFITS AND INSURANCE RELEASE FORM

Client's Name: _____

Date of Birth: _____

Financial Responsibility

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to **PSY** for any charges not covered by my healthcare benefits, as well as any applicable co-payments and deductibles. It is my responsibility to notify **PSY** of any changes in my healthcare coverage. In some cases, exact insurance benefits can not be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by **PSY** and/or my healthcare insurer if the submitted claims or any part of the claims, are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for services rendered.

Assignment of Benefits

I hereby assign all medical, mental health, behavioral health and substance abuse treatment benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including private insurance and any other health/medical plan, to issue payment check(s) directly to **PSY** for substance abuse/behavioral health treatment services rendered to myself and/or my dependent(s). I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize **PSY** to: 1) Release any information necessary to insurance carriers regarding my illness and treatments; 2) To process insurance claims generated in the course of counseling and treatment; and 3) To allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

Copy of Insurance Card/Verification

I understand that it is my responsibility to provide **PSY** with a copy of my current insurance card. It is also my responsibility to notify **PSY** of any changes to my insurance plan or insurance carrier.

Patient/Responsible Party Signature

Date

PSY Family Services

Assessment and Counseling Services
301 W. Rosedale, Fort Worth, TX 76104
(817) 338-4471

RELEASE OF INFORMATION

CLIENT NAME: _____

DATE OF BIRTH: _____

SOCIAL SECURITY #: _____

By signing below, I hereby authorize **PSY** to Release and to obtain information with respect to any physical, psychiatric or drug/alcohol related condition obtained during the course of diagnosis and/or treatment to/from the individual(s) or healthcare providers below. The type of information authorized for disclosures includes, but may not be limited to notification of admission/discharge, Psychiatric Evaluation, reports of Testing, discharge planning and summary, progress and treatment reports, physical exam, assessments, treatment content, treatment progress, payment records, social history, and any statements made by me to **PSY**. The purpose of this disclosure is to identify persons supporting and using services, to aid in diagnosis, continuing care, and treatment.

Mental Health Professional (name, address, phone)

Primary Care Physician (name, address, phone)

Psychiatrist (name, address, phone)

Family / Parent / Guardian (name, address, phone)

Insurance (name, address, phone)

Other (name, address, phone)

I have been advised that I may revoke this release of information at any time, except to the extent that information has already been released.

Client Signature

Date

Intake Questionnaire For New Patients (Adult)

This questionnaire is for the purpose of getting to know you better in order to provide the best possible mental health services. Please complete this form as honestly and completely as possible. All information that you provide us will be confidential as required by state and federal law.

Date: _____

Social Security Number: _____

Name: _____

Date of Birth: _____

Age: _____

Home Address: _____

City/State/Zip code: _____

Home Phone: _____

Cellular/Alternate Phone: _____

Marital Status: single married separated divorced
 remarried engaged widowed cohabiting

If applicable, please complete the following:

Partner's Name: _____

Partner's Age: _____

Partner's Occupation: _____

IF YOU HAVE CHILDREN PLEASE LIST THEIR NAMES AND AGES:

#	Name	Sex	Age	#	Name	Sex	Age
1				4			
2				5			
3				6			

WHO CURRENTLY LIVES IN YOUR RESIDENCE (adults and children):

#	Name	Relation	Sex	Age	#	Name	Relation	Sex	Age
1					4				
2					5				
3					6				

In your own words, describe the current problems as you see them:

How long has this been going on? _____

What made you come in at this time? _____

What do you hope to gain from this evaluation and/or counseling?

If you had difficulties in the past, what have you done to cope? Was it helpful?

Symptoms

Please **check** any symptoms or experiences that you have had **in the last month**

- | | |
|--|--|
| <input type="checkbox"/> Difficulty falling asleep | <input type="checkbox"/> Difficulty staying asleep |
| <input type="checkbox"/> Difficulty getting out of bed | <input type="checkbox"/> Not feeling rested in the morning |

Average hours of sleep per night: _____

- | | |
|--|---|
| <input type="checkbox"/> Persistent loss of interest in previously enjoyed activities | |
| <input type="checkbox"/> Withdrawing from other people | <input type="checkbox"/> Spending increased time alone |
| <input type="checkbox"/> Depressed Mood | <input type="checkbox"/> Feeling Numb |
| <input type="checkbox"/> Rapid mood changes | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Panic attacks |
| <input type="checkbox"/> Frequent feelings of guilt | <input type="checkbox"/> Avoiding people, places, activities or specific things |
| <input type="checkbox"/> Difficulty leaving your home | |
| <input type="checkbox"/> Fear of certain objects or situations (i.e., flying, heights, bugs) Describe: _____ | |
| <input type="checkbox"/> Repetitive behaviors or mental acts (i.e., counting, checking doors, washing hands) | |
| <input type="checkbox"/> Outbursts of anger | |

- | | |
|--|--|
| <input type="checkbox"/> Worthlessness | <input type="checkbox"/> Hopelessness |
| <input type="checkbox"/> Sadness | <input type="checkbox"/> Helplessness |
| <input type="checkbox"/> Fear | <input type="checkbox"/> Feeling or acting like a different person |

- | | |
|--|---|
| <input type="checkbox"/> Changes in eating/appetite | |
| <input type="checkbox"/> Eating more | <input type="checkbox"/> Eating less |
| <input type="checkbox"/> Voluntary vomiting | <input type="checkbox"/> Use of laxatives |
| <input type="checkbox"/> Excessive exercise to avoid weight gain | <input type="checkbox"/> Binge eating |

- | | |
|---|--|
| <input type="checkbox"/> Are you trying to lose weight? _____ | |
| <input type="checkbox"/> Weight gain: _____ lbs | <input type="checkbox"/> Weight loss: _____ lbs. |

- | | |
|--|--|
| <input type="checkbox"/> Difficulty catching your breath | <input type="checkbox"/> Increase muscle tension |
| <input type="checkbox"/> Unusual sweating | <input type="checkbox"/> Easily started, feeling “jumpy” |
| <input type="checkbox"/> Increased energy | <input type="checkbox"/> Decreased energy |
| <input type="checkbox"/> Tremor | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Frequent worry | <input type="checkbox"/> Physical sensations others don’t have |
| <input type="checkbox"/> Racing thoughts | <input type="checkbox"/> Intrusive memories |

- | | |
|---|---|
| <input type="checkbox"/> Difficulty concentrating or thinking | <input type="checkbox"/> Large gaps in memory |
| <input type="checkbox"/> Flashbacks | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Thoughts about harming or killing yourself | <input type="checkbox"/> Thoughts about harming or killing someone else |

- | | |
|--|--|
| <input type="checkbox"/> Feeling as if you were outside yourself, detached, observing what you are doing | |
| <input type="checkbox"/> Feeling puzzled as to what is real and unreal | |
| <input type="checkbox"/> Persistent, repetitive, intrusive thoughts, impulses, or images | |
| <input type="checkbox"/> Unusual visual experiences such as flashes of light, shadows | |

- Hear voices when no one else is present
- Feeling that your thoughts are controlled or placed in your mind
- Feeling that the television or the radio is communicating with you
- Difficulty problem solving
- Dependency on others
- Inappropriate expression of anger
- Difficulty or inability to say "no" to others
- Sense of lack of control
- Abusive relationship
- Concerns about your sexuality
- Difficulty meeting role expectations
- Manipulation of others to fulfill your own desires
- Self-mutilation/cutting
- Ineffective communication
- Decreased ability to handle stress
- Difficulty expression emotions

Sexual Orientation: Heterosexual Homosexual Bisexual I choose not to answer

Please describe any other symptoms or experiences you have had problems with:

Have you seen a counselor, psychologist, psychiatrist or other mental health professional before?

No Yes If so:

Name of therapist: _____
Reason for seeking help: _____

Dates of Treatment _____

Name of therapist: _____
Reason for seeking help: _____

Dates of Treatment _____

Are you **CURRENTLY** taking **PSYCHIATRIC** medication? No Yes If YES, please list:

Medication	Dosage	How long have you been taking it?	Has it been helpful?

Are you **CURRENTLY** taking **NON-PSYCHIATRIC** medication? No Yes If YES, please list:

Medication	Dosage	How long have you been taking it?

Have you been on **PSYCHIATRIC** medication in the past? No Yes If YES, please list:

Medication	Dosage	First/Last time you took it	Effect of Medication

Have you been hospitalized for psychiatric reasons? No Yes If YES, describe:

Hospital	Dates	Reason

Have you ever attempted suicide? No Yes If YES, describe:

MEDICAL HISTORY

Are you **CURRENTLY** under treatment for any medical condition? No Yes If YES, describe:

List any **PRIOR** illnesses, operations and accidents

FAMILY HISTORY

Father: Age: Living
 If deceased, HIS age at time of his death____
 Occupation: _____
 Frequency of contact with him: _____

Deceased Cause of death:
 YOUR age at time of his death____
 Health: _____
 Are you/Have you been close to him? _____

Mother: Age: Living
 If deceased, HER age at time of his death____
 Occupation: _____
 Frequency of contact with her: _____

Deceased Cause of death:
 YOUR age at time of his death____
 Health: _____
 Are you/Have you been close to her? _____

Brothers and Sisters

Name	Sex	Age	Whereabouts	Are you close to him/her?	
				No	Yes
				No	Yes
				No	Yes
				No	Yes
				No	Yes

During your childhood, did you live any significant period of time with anyone other than your natural parents?

No Yes If so, please give the persona's name and relationship to you

Name: _____ Relationship to you: _____

Please place a check mark in the appropriate box if these are or have been present in your relatives

	Children	Brothers	Sisters	Father	Mother	Uncle/Aunt	Grandparents
Nervous Problems							
Depression							
Hyperactivity							
Counseling							
Psychiatric Medication							
Psychiatric Hospitalization							
Suicide Attempt							
Death by Suicide							
Drinking Problem							

SOCIAL HISTORY

Past Marital History

Have you been married previously? _____ If Yes, please describe:

When? _____ How long? _____

When? _____ How long? _____

Education

Highest grade level completed: _____

Degree obtained, if applicable: _____

Did you have any disciplinary problems in school? _____

If yes, please explain: _____

Were you considered hyperactive/ADHD in school? _____

If yes, were/are you on any medication? _____

If yes, were/are you on any medication? _____

If so, which medication? _____

What kinds of grades did you get in school? _____

Have you served in the military? _____

If yes, please describe briefly: _____

What type of discharge (separation) did you get? _____

Employment

Are you currently employed? _____

If yes, employer's name: _____

What type of work do you do? _____

Employment History (most recent first)

Type of Job	Dates	Reason for Leaving

Have you been arrested? _____

If yes, please describe: _____

Do you have a religious affiliation? _____

If yes, what is it? _____

What kind of social activities do you participate in? _____

Who do you turn to for help with your problems? _____

Have you ever been abused?

Verbally

Emotionally

Physically

Sexually

Neglected

Please describe: _____

SUBSTANCE ABUSE

Alcohol

Do you drink alcohol? _____ If yes, age of first use _____

How much do you drink? _____

How often do you drink? _____

Have you ever passed out from drinking? _____

How often? _____

Have you ever blacked out from drinking? _____

How often? _____

Have you ever had the "shakes"? _____

How often? _____

Have you ever felt you should cut down on your drinking/drug use? _____

Have people annoyed you by criticizing your drinking/drug use? _____

Have you ever felt bad or guilty about your drinking/drug use? _____

Have you ever drank/used drugs in the morning to steady your nerves or relieve a hangover? _____

Do you use tobacco? _____

If yes, how often? _____

Other Drugs:

Please indicate for each drug listed below

Drug	Ever Used?	Age at 1st use	Time Since Last Use	Approx use in last 30 days
Marijuana				
Cocaine				
Crack				
Heroin				
Methamphetamine				
Ecstasy				

Is there anything else you would like us to know about you?

The Holmes-Rahe Scale

Read each of the events listed below, and **check the box** next to any even which has occurred in your life **in the last two (2) years**. There are no right or wrong answers. The aim is to identify which of these events you have experienced lately.

Life Events	Life Crisis Units	
Death of Spouse	100	
Divorce	73	
Marital Separation	65	
Gone to jail	63	
Death of close family member	63	
Personal injury or illness	53	
Marriage	50	
Fired at work	47	
Marital reconciliation	45	
Retirement	45	
Change in health of family member	44	
Pregnancy	40	
Sexual Difficulties	39	
Gain of new family member	39	
Business readjustment	39	
Change in financial state	38	
Death of a close friend	37	
Change to different line of work	36	
Increase in arguments with spouse	35	
Mortgage over \$100,000	31	
Foreclosure of mortgage or loan	30	
Change in responsibilities at work	29	

Life Events	Life Crisis Units	
Son or daughter leaving home	29	
Trouble with in-laws	29	
Outstanding personal achievement	28	
Spouse begins or stops work	26	
Begin or end school	26	
Change in living conditions	25	
Revision in personal habits	24	
Trouble with boss	23	
Change in work hours or conditions	20	
Change in residence	20	
Change in schools	20	
Change in recreation	19	
Change in church activities	19	
Change in social activities	18	
Mortgage or loan less than \$30,000	17	
Change in sleeping habits	16	
Change in number of family get-togethers	15	
Change in eating habits	15	
Vacation	13	
Christmas alone	12	
Minor violations of the law	11	

Your Total Score: _____