



Couples Therapy Contract

1. The counseling being provided is couples counseling. The “patient” in this counseling is the relationship, the couple, not either person individually.
2. The patient in this counseling is the relationship, the couple, not either person individually.
3. In couples counseling, each participant has all of the rights and privileges afforded to people involved in individual psychological psychotherapy, as defined by law and ethics and stated in the written information provided to each person prior to the initial counseling appointment.
4. The specifics of what is said and discussed in counseling sessions is confidential and privileged information and cannot be shared or discussed with anyone without the express, written consent of the individuals involved. Please note that the both of you must agree to release information related to what was said and discussed in our sessions in order for the entire record to be released. I cannot and will not release information about our counseling sessions or, should the situation occur, testify in any legal proceedings, actions or venues, without both of you providing written permission for me to do so. In the event that only one of you agrees to release information, a partially redacted record will be released. Fees for time necessary to redact portions of the record must be paid in addition to any applicable records copying fees.
5. Since the success of couples counseling cannot be predicted or assured, it is possible that one or both of you may decide during the course of counseling that the best answer to your relationship issues and concerns is separation, dissolution, or divorce. If either party or parties attorney requests information, the above described procedures on release of records will apply.
6. You should be aware that once we begin couples counseling, that it is unethical for me to give any opinion about custody or visitation arrangements, even if I am compelled to be a witness in any legal proceedings, actions, or venues.

7. Should one and/or both of you decide to move to dissolution of the marriage or divorce, and a custody evaluation is ordered by the court, I want your permission to provide information to anyone appointed by the court to perform a custody evaluation or to represent the legal interests of your children. I would not in such case make any recommendation about the final decision but will provide a copy of the record through the process described above.

8. From time to time, it may be necessary or advisable to have one or more individual counseling sessions with one or both of the couples counseling participants. Any and all such individual sessions should be understood to be part of the couples counseling process and in service to the couples counseling and, not an action that establishes an individual counseling relationship between the treating couples therapist and either of the participants involved in the couples counseling.

9. During the course of the couples counseling, the treating counselor may identify individual and/or personal issues that one and/or both of the participants may have that require individual counseling. If such situation arises, the treating therapist reserves the right to recommend and/or strongly advise individual counseling with a mental health therapist to one or both of the couples counseling participants.

10. Should one of the participants of the couples counseling process decide to discontinue participation in the previously agreed upon couples counseling, each and/or either of the couples counseling participants, should he/she desire continued counseling, will be referred to another therapist for individual counseling.



“No Secrets” Policy

This written policy is intended to inform you, the participants in therapy, that when I agree to treat a couple or a family, I consider that couple or family (the treatment unit) to be the patient. For instance, if there is a request for the treatment records of the couple or the family, I will seek the authorization of all members of the treatment unit before I release confidential information to third parties. If only one person authorizes release of records, I will release a partially redacted record with only the information disclosed by that particular person.

During the course of my work with a couple or a family, I may see a smaller part of the treatment unit (e.g., an individual or two siblings) for one or more sessions. These sessions should be seen by you as a part of the work that I am doing with the family or the couple, unless otherwise indicated. If you are involved in one or more of such sessions with me, please understand that generally these sessions are confidential in the sense that I will not release any confidential information to a third party unless I am required by law to do so or unless I have your written authorization. In fact, since those sessions can and should be considered a part of the treatment of the couple or family, I would also seek the authorization of the other individuals in the treatment unit before releasing confidential information to a third party.

However, I may need to share information learned in an individual session (or a session with only a portion of the treatment unit being present) with the entire treatment unit – that is, the family or the couple, if I am to effectively serve the unit being treated. I will use my best judgment as to whether, when, and to what extent I will make disclosures to the treatment unit, and will also, if appropriate, first give the individual or the smaller part of the treatment unit being seen the opportunity to make the disclosure. Thus, if you feel it necessary to talk about matters that you absolutely want to be shared with no one, you might want to consult with an individual therapist who can treat you individually.

This “no secrets” policy is intended to allow me to continue to treat the couple or family by preventing, to the extent possible, a conflict of interest to arise where an individual’s interests may not be consistent with the interests of the unit being treated. For instance, information learned in the course of an individual session may be relevant or even essential to the proper treatment of the couple or the family. If I am not free to exercise my clinical judgment regarding the need to bring this information to the family or the couple during their therapy, I might be placed in a situation where I will have to terminate treatment of the couple or the family. This policy is intended to prevent the need for such a termination.

Kent Psychological Associates, LLC

DATE _____

ADULT BACKGROUND INFORMATION

NAME _____ DOB _____ AGE _____ SSN _____ - _____ - _____
 ADDRESS _____ CITY _____ ZIP _____
 PHONE (H) (____) _____ (W) (____) _____ MARITAL S M W D
 REFERRED BY: _____
 EMERGENCY CONTACT: _____ PHONE _____ RELATION _____
 FAMILY PHYSICIAN: _____ PHONE _____

FAMILY INFORMATION:

<u>NAME</u>	<u>RELATIONSHIP</u>	<u>AGE</u>	<u>SEX</u>	<u>OCCUPATION</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

DEVELOPMENTAL HISTORY:

Please check the following which were problems in the family of origin:

<input type="checkbox"/> Frequent moves	<input type="checkbox"/> Alcohol/Drugs	<input type="checkbox"/> Death of family member
<input type="checkbox"/> Parents divorce	<input type="checkbox"/> Legal problems	<input type="checkbox"/> Physical abuse/Neglect
<input type="checkbox"/> Parents remarriage	<input type="checkbox"/> Parent conflict	<input type="checkbox"/> Sexual abuse
<input type="checkbox"/> Parents separated	<input type="checkbox"/> Parent job loss	<input type="checkbox"/> Domestic violence
<input type="checkbox"/> Family illness	<input type="checkbox"/> Financial stress	<input type="checkbox"/> Emotional problems
<input type="checkbox"/> Other _____		
<input type="checkbox"/> Other issue (You wish to discuss with counselor in person)		

Clarify information about your development up to age 18. Check those that apply.

<input type="checkbox"/> Premature birth	<input type="checkbox"/> Avoiding others	<input type="checkbox"/> Bedwetting	<input type="checkbox"/> Birth Defect
<input type="checkbox"/> Nervous	<input type="checkbox"/> Fidgety/restless	<input type="checkbox"/> Head injury	<input type="checkbox"/> Abuse/neglect
<input type="checkbox"/> Eating problems	<input type="checkbox"/> Talking/refusing	<input type="checkbox"/> Picked on	<input type="checkbox"/> Bad dreams
<input type="checkbox"/> Learning problems	<input type="checkbox"/> Speech problems	<input type="checkbox"/> Sleepwalking	<input type="checkbox"/> School behavior
<input type="checkbox"/> Poor coordination	<input type="checkbox"/> Trouble w/ police	<input type="checkbox"/> Feeling rejected	<input type="checkbox"/> Strong willed
<input type="checkbox"/> Visual difficulties	<input type="checkbox"/> Fear leaving home	<input type="checkbox"/> Repeated grade	<input type="checkbox"/> Few friends
<input type="checkbox"/> Leaving loved one	<input type="checkbox"/> Behavioral prob.	<input type="checkbox"/> "Worry wart"	<input type="checkbox"/> Overweight
<input type="checkbox"/> Small for age	<input type="checkbox"/> Ran away	<input type="checkbox"/> Fighting	<input type="checkbox"/> Shy

How would you rate your present relationship with the following? If it does not apply put N/A.

Spouse	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> Problem for you	<input type="checkbox"/> N/A
Father	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> Problem for you	<input type="checkbox"/> N/A
Mother	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> Problem for you	<input type="checkbox"/> N/A
Brother	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> Problem for you	<input type="checkbox"/> N/A
Sister	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> Problem for you	<input type="checkbox"/> N/A
Son	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> Problem for you	<input type="checkbox"/> N/A
Daughter	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> Problem for you	<input type="checkbox"/> N/A
In-Laws	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> Problem for you	<input type="checkbox"/> N/A
Employer	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> Problem for you	<input type="checkbox"/> N/A

EDUCATIONAL HISTORY

High school attended _____ Highest grade completed _____
College/vocational/technical training yes ___ no ___ #year's ___ Degree _____

OCCUPATIONAL HISTORY

Are you presently employed? ___ yes ___ no Type of work _____ How long? _____
Have you had problems gaining employment? ___ yes ___ no
How many jobs have you held in the last 5 years? _____
Are you a veteran? ___ yes ___ no If yes, what branch of service? _____
Date entered _____ Date discharged _____ Type of discharge _____

MARITAL HISTORY

___ Single ___ Married ___ Separated ___ Divorced ___ Remarried ___ Widowed

___ Marriage Date _____ Date _____ Date _____
___ Separation Date _____ Date _____ Date _____
___ Divorce Date _____ Date _____ Date _____
___ Widowed Date _____ Date _____ Date _____

Are you considering separation or divorce? ___ yes ___ no
Are you a divorced custodial parent? ___ yes ___ no
Are you married raising minor children? ___ yes ___ no

Do you and your spouse:

Agree on the methods of discipline of the children ___ yes ___ no
Share common values in the rearing o the children ___ yes ___ no
Feel the parent/child interaction is positive ___ yes ___ no
Spend quality time as a family ___ yes ___ no

In your present relationship do you:

Enjoy good communication with each other ___ yes ___ no
Feel satisfied with your sexual relations ___ yes ___ no
Spend private couple time with each other ___ yes ___ no
Share similar interests and values ___ yes ___ no

PRIOR MENTAL HEALTH HISTORY

Have you ever had prior mental health treatment? ___ yes ___ no (If no, skip)
Date _____
Was this person a: ___ Psychiatrist ___ Psychologist ___ Clinical social worker ___ Clinical Counselor
___ Minister ___ Other
Have you ever been hospitalized for emotional problems? ___ yes ___ no (If no, skip)
Name of hospital _____ Location _____ Date _____ How long _____
Doctor who treated you _____ Medications given _____
Do you still take any psychotropic medications? ___ yes ___ no Which ones? _____

ALCOHOL/DRUG HISTORY

Do you have a history of alcohol/drug abuse? ___ yes ___ no (If no, skip)

If you are using alcohol or drugs has this resulted in:

___ Marital problems ___ Memory Blackouts ___ Legal problems
___ Problems w/family, friend's ___ Periods of abstinence ___ Physical problems
___ Preoccupation w/alcohol, drugs ___ Financial problems ___ Loss of control
___ DUI or DWI charges ___ Withdrawal symptoms

LEGAL HISTORY ___yes ___no

Check those that apply to you:

- ___ Trouble with law as a juvenile
- ___ Trouble with the law as an adult

- ___ Have legal matter pending
- ___ Have you ever been in jail?

MEDICAL HISTORY

Date of last physical exam _____ Family physician _____

Describe your chief medical/physical complaint(s) _____

Do you have any special problems with hearing, speech, vision? ___yes ___no

If yes, please explain _____

Are you on any medications? ___yes ___no

If so, please list: _____

Describe any side effects _____

Do you have any allergies? ___yes ___no

If yes, please describe _____

List any serious illnesses, injuries, or surgeries _____

Place an X in the left column if this condition exists. In the right column write self, father, mother, brother, sister, aunt, uncle, etc.

- ___ Alcoholism _____
- ___ Allergies _____
- ___ Developmental _____
- Disabilities _____
- ___ Obesity _____
- ___ Degenerative dis. _____
- ___ Mental health probs. _____
- ___ Suicide _____

- ___ Cancer _____
- ___ Diabetes _____
- ___ Epilepsy _____
- High blood press. _____
- ___ Heart trouble _____
- ___ Other _____

MEDICAL CONDITIONS AND SYMPTOMS

Past/Now	Past/Now	Past/Now
_____ Arthritis	_____ Can't work under pressure	_____ Distractibility
_____ Anxiety	_____ Color Blind	_____ Laxatives used
_____ Anger Outbursts	_____ Exhaustion	_____ Leg Cramps
_____ Asthma	_____ Fainting spells	_____ Loose bowel/gas often
_____ Backaches	_____ Fast pulse	_____ Loses temper easily
_____ Binging	_____ Heart medicine	_____ Moody often
_____ Barbiturates	_____ Hormones	_____ Memory problems
_____ Epilepsy	_____ Poor digestion	_____ Muscle twitching
_____ Cancer	_____ Poor appetite	_____ Much sweating
_____ Chronic Pain	_____ Treated for a mental cond.	_____ Moist palms
_____ Chest Pain	_____ Other drugs, alcohol	_____ Nervous breakdown
_____ Constipation	_____ Shaking	_____ Nervousness
_____ Depression	_____ Smoking packs/day ____	_____ Nerve Medication
_____ Diabetes	_____ Craving for sweets	_____ Overeating
_____ Diarrhea	_____ Fatigue	_____ Overworked
_____ Depersonalization	_____ Headaches	_____ Pain medication
_____ "Going Crazy" sensations	_____ Heart trouble	_____ Palpitation
_____ Difficulty going to sleep	_____ Hallucinations	_____ Perfectionist
_____ Difficulty staying asleep	_____ Hearing voices	_____ Stomach medicine
_____ Dizziness	_____ Hypertension	_____ Worries, feels insecure
_____ Drug reactions	_____ Hand tremors	_____ Reduced sex drive/lack of
_____ Early morning wakening	_____ Hay fever	_____ Upset stomach
_____ Emotional upsets	_____ Insulin medication	_____ Itchy skin

CURRENT SOURCES OF STRESS

Please list your most significant sources of stress or worry.

1. _____
2. _____

What is the main goal you wish to attain in seeking services? _____

Envision how your life would be different if you could manage some of these problems better.

ADDITIONAL INFORMATION: Please add any special information you feel which might be helpful in assisting in your treatment. _____

Your signature below indicates that you understand the questions and could ask for assistance if needed.

Client signature

Date



Payment Policy for Couples Counseling

1. Fees for Couples Counseling

- Initial appointment: \$225 (90 minutes, includes Couples Relationship Check-Up)
- All follow-up appointments: \$175 (90 minutes)
- Speak with your clinician about available extended appointment times as needed

2. Additional services. Please be aware that some services we provide may be at an additional cost beyond the standard per session fees. Payment is required for these services in full at the time the service is rendered or in some cases prior to release of any requested documents. Other fees that may not be covered by your per session fee are fees for services that are beyond standard coordination of care. Please ask your clinician if you have a question about non-covered services.

- Single page letter or form fee: \$20
- Multi page letter or form fee: \$40
- Phone calls: \$20 for each up-to-15-minute block (no charge first 15 minutes)
- Fees associated with testifying in court or participating in a deposition: billed for preparation, travel time, wait time, and testifying or deposition. \$175 per hour. Three-hour minimum. Minimum must be paid prior to court/deposition date.

3. Nonpayment. All payments are due at the time of service. An exception may be made in an urgent situation if you contact us in advance and make an arrangement with terms agreed upon by our office. However, if your account is over thirty (30) days past due we will be unable to schedule additional appointments. If your account lapses to ninety (90) days past due, you will receive a letter stating that you have twenty (20) days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from this practice. If this occurs, you will be notified by regular and certified mail that you have thirty (30) days to find alternative care. During that 30-day period, our staff will assist you with a referral to another agency.

4. Missed appointments. The full session fee is charged for missed (“no-show”) appointments and appointments cancelled without sufficient prior notice. Sufficient notice is 24 hours prior to the appointment time. This fee must be paid in full prior to your next scheduled appointment or your appointment may be rescheduled. Please help us to serve you better by keeping your regularly scheduled appointment. Clients who develop a pattern of frequent missed or cancelled appointments may be discharged from the practice. A credit card must be kept on file and will be charged for missed appointments.

5. Financial Hardship: If you experience financial difficulties that affect timely payment of your account, please discuss this issue with your therapist or our billing staff at your earliest possible convenience, before any misunderstandings can develop. We will assist you in finding lower cost alternatives.

6. Non-sufficient Funds: There is a \$25 fee for returned checks.

If you have difficulty understanding your account or billing statements please contact our office and ask to speak with a member of our billing staff.

Thank you for understanding. Please let us know if you have any questions or concerns.



Notice of Patient Rights and Responsibilities for Kent Psychological Associates, LLC

Kent Psychological Associates, LLC recognizes that all patients have basic individual rights and responsibilities. To protect these rights, we have adopted specific guidelines to ensure the support and respect each patient's basic human dignity, as well as each patient's civil, constitutional, and statutory rights. We respect each patient's right to participate in decisions about his or her care, treatment, and services, and to give or withhold informed consent.

As a patient, you have the following rights and responsibilities. If you have any questions about these rights and responsibilities, please contact us at (330) 673-5812.

Patient Rights

As a patient, you have the right to:

- **Access to care.** You have the right to not be discriminated against in the provision of service on the basis of religion, race, color, creed, sex, national origin, age, sexual orientation, gender identity, physical or mental handicap, or developmental disability. This includes the right to a current written, individualized service plan that addresses one's own mental and physical health, and that specifies the provision of appropriate and adequate services, as available, either directly or by referral.
- **Be treated with dignity and respect.** You have the right to be treated with respect for personal dignity, autonomy, and privacy. This includes:
 - the right to be fully informed of all rights;
 - the right to exercise any and all rights without reprisal, including continued uncompromised access to service;
 - the right to be free from all forms of harassment, neglect, exploitation, and verbal, mental, physical, and sexual abuse;
 - the right to service in a humane setting which is the least restrictive feasible, as defined by the treatment;
 - the right to freedom from unnecessary or excessive medication; and
 - the right to freedom from unnecessary restraint or seclusion.
- **Participate in decisions about your care.** You have the right to be reasonably informed about and to participate in decisions made involving your healthcare, including the right of competent adults to refuse treatment. This includes:
 - the right to be informed of your condition, of proposed or current services, or therapies, and of the alternatives;
 - the right to consent or refuse any service, treatment, or therapy upon full explanation of the expected consequences of such consent or refusal;
 - the right to active, informed participation in the establishment, periodic review, and reassessment of the service plan;
 - the right to participate in any appropriate and available organizational service, regardless of refusal of one or more other services, treatment or therapies, or regardless of relapse from earlier treatment in that or another service, unless there is a valid and specific necessity which precludes and/or requires the client's participation in other services. This necessity shall be explained to the client's current service plan;
 - the right to be informed of and refuse any unusual or hazardous treatment procedure;
 - the right to be advised of and to refuse observation by methods such as one-way mirrors, tape recorders, televisions, movies, or photographs;
 - the right to consult with independent treatment specialists or legal counsel at one's own expense;
 - the right to be informed in advance of the reason(s) for discontinuation of service provision, and to be involved in planning for the consequences of that event;
 - the right to receive an explanation of the reason for denial of service; and
 - the right to know the cost of services.

- **Keep your medical records and identity private.** You can expect that any information, images, or recordings with information that could identify you will be kept private. This includes:
 - the right to confidentiality of communications and of all personal identifying information within the limitations and requirement for disclosure of various funding and/or certifying sources, state laws, or federal statutes, unless release of information is specifically authorized by the client or court appointed guardian of the person of an adult child; and
 - The right to have access to one's own psychiatric, medical, or other treatment records, unless access to particular identified items of information is specifically restricted to that individual client for clear treatment reasons in the client's treatment plan. "Clear treatment reasons" shall be understood to mean only severe emotional damage to the client, such that the danger of self-injurious behavior is an imminent risk. The person restricting the information shall explain to the client that factual information about the individual client that necessitates the restriction. The restriction must be renewed annually to retain validity. Any person authorized by the client has unrestricted access to all information. Clients shall be informed in writing agency policies and procedure to viewing or obtaining copies of personal records.
- **File a grievance.** You have the right to report concerns or complaints about your care and safety and receive help to resolve your concerns. This includes the right to have oral and written instructions for filing a grievance.

In order to protect each client's rights, we have adopted the following procedures:

- Each client shall receive this written Notice of Client Rights during the intake procedure;
- Clients will sign the Permission to Treat sheet indicating receipt of the Notice of Client Rights;
- Copies of the Notice of Client Rights are posted within the agency to ensure that the clients as well as staff are well aware of the basic rights.

If you feel that any of these rights have not been respected, then please follow our grievance procedure. We would like to help you get any complaint or concern resolved quickly and to your satisfaction. The grievance procedure will be posted in a highly visible place in each agency location.

Additionally, all Kent Psychological Associates clients and/or guardians shall have the option to register a complaint with any or all, but not exclusively, the following:

- Ohio Department of Mental Health
- Ohio Legal Rights Service
- United States Department of Health & Human Services
- Appropriate professional licensing, regulatory associates, and/or other State Departments. The names, addresses, and phone numbers of the aforementioned will be given to the griever. The relevant addresses and phone numbers about the grievance shall be included along with all relevant information about the grievance as requested.

Patient Responsibilities

As a patient you are expected to:

- respect the dignity and rights of others, clients and staff alike, and to exercise care for the physical surroundings (agency property);
- comply with all reasonable requests for information in the intake/admissions process;
- participate fully in the formulation of your treatment plan and to carry out the agreement to the fullest extent of your ability;
- respect the confidentiality of others, especially in the family, group, and educational sessions;
- give written permission for the release of necessary information to other institutions or professionals in the treatment program; and
- contribute, according to the fee structure, to the cost of services.

Effective: 01/01/2016

Kent Psychological Associates, LLC

DATE _____

ADULT BACKGROUND INFORMATION

NAME _____ DOB _____ AGE _____ SSN _____ - _____ - _____
 ADDRESS _____ CITY _____ ZIP _____
 PHONE (H) (____) _____ (W) (____) _____ MARITAL S M W D
 REFERRED BY: _____
 EMERGENCY CONTACT: _____ PHONE _____ RELATION _____
 FAMILY PHYSICIAN: _____ PHONE _____

FAMILY INFORMATION:

<u>NAME</u>	<u>RELATIONSHIP</u>	<u>AGE</u>	<u>SEX</u>	<u>OCCUPATION</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

DEVELOPMENTAL HISTORY:

Please check the following which were problems in the family of origin:

- | | | |
|---|---|---|
| <input type="checkbox"/> Frequent moves | <input type="checkbox"/> Alcohol/Drugs | <input type="checkbox"/> Death of family member |
| <input type="checkbox"/> Parents divorce | <input type="checkbox"/> Legal problems | <input type="checkbox"/> Physical abuse/Neglect |
| <input type="checkbox"/> Parents remarriage | <input type="checkbox"/> Parent conflict | <input type="checkbox"/> Sexual abuse |
| <input type="checkbox"/> Parents separated | <input type="checkbox"/> Parent job loss | <input type="checkbox"/> Domestic violence |
| <input type="checkbox"/> Family illness | <input type="checkbox"/> Financial stress | <input type="checkbox"/> Emotional problems |
| <input type="checkbox"/> Other _____ | | |
| <input type="checkbox"/> Other issue (You wish to discuss with counselor in person) | | |

Clarify information about your development up to age 18. Check those that apply.

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Premature birth | <input type="checkbox"/> Avoiding others | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Birth Defect |
| <input type="checkbox"/> Nervous | <input type="checkbox"/> Fidgety/restless | <input type="checkbox"/> Head injury | <input type="checkbox"/> Abuse/neglect |
| <input type="checkbox"/> Eating problems | <input type="checkbox"/> Talking/refusing | <input type="checkbox"/> Picked on | <input type="checkbox"/> Bad dreams |
| <input type="checkbox"/> Learning problems | <input type="checkbox"/> Speech problems | <input type="checkbox"/> Sleepwalking | <input type="checkbox"/> School behavior |
| <input type="checkbox"/> Poor coordination | <input type="checkbox"/> Trouble w/ police | <input type="checkbox"/> Feeling rejected | <input type="checkbox"/> Strong willed |
| <input type="checkbox"/> Visual difficulties | <input type="checkbox"/> Fear leaving home | <input type="checkbox"/> Repeated grade | <input type="checkbox"/> Few friends |
| <input type="checkbox"/> Leaving loved one | <input type="checkbox"/> Behavioral prob. | <input type="checkbox"/> "Worry wart" | <input type="checkbox"/> Overweight |
| <input type="checkbox"/> Small for age | <input type="checkbox"/> Ran away | <input type="checkbox"/> Fighting | <input type="checkbox"/> Shy |

How would you rate your present relationship with the following? If it does not apply put N/A.

- | | | | | | |
|----------|-------------------------------|-------------------------------|-------------------------------|--|------------------------------|
| Spouse | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor | <input type="checkbox"/> Problem for you | <input type="checkbox"/> N/A |
| Father | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor | <input type="checkbox"/> Problem for you | <input type="checkbox"/> N/A |
| Mother | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor | <input type="checkbox"/> Problem for you | <input type="checkbox"/> N/A |
| Brother | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor | <input type="checkbox"/> Problem for you | <input type="checkbox"/> N/A |
| Sister | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor | <input type="checkbox"/> Problem for you | <input type="checkbox"/> N/A |
| Son | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor | <input type="checkbox"/> Problem for you | <input type="checkbox"/> N/A |
| Daughter | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor | <input type="checkbox"/> Problem for you | <input type="checkbox"/> N/A |
| In-Laws | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor | <input type="checkbox"/> Problem for you | <input type="checkbox"/> N/A |
| Employer | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor | <input type="checkbox"/> Problem for you | <input type="checkbox"/> N/A |

EDUCATIONAL HISTORY

High school attended _____ Highest grade completed _____
College/vocational/technical training yes ___ no ___ #year's ___ Degree _____

OCCUPATIONAL HISTORY

Are you presently employed? ___ yes ___ no Type of work _____ How long? _____
Have you had problems gaining employment? ___ yes ___ no
How many jobs have you held in the last 5 years? _____
Are you a veteran? ___ yes ___ no If yes, what branch of service? _____
Date entered _____ Date discharged _____ Type of discharge _____

MARITAL HISTORY

___ Single ___ Married ___ Separated ___ Divorced ___ Remarried ___ Widowed

___ Marriage	Date _____	Date _____	Date _____
___ Separation	Date _____	Date _____	Date _____
___ Divorce	Date _____	Date _____	Date _____
___ Widowed	Date _____	Date _____	Date _____

Are you considering separation or divorce? ___ yes ___ no
Are you a divorced custodial parent? ___ yes ___ no
Are you married raising minor children? ___ yes ___ no

Do you and your spouse:

Agree on the methods of discipline of the children ___ yes ___ no
Share common values in the rearing o the children ___ yes ___ no
Feel the parent/child interaction is positive ___ yes ___ no
Spend quality time as a family ___ yes ___ no

In your present relationship do you:

Enjoy good communication with each other ___ yes ___ no
Feel satisfied with your sexual relations ___ yes ___ no
Spend private couple time with each other ___ yes ___ no
Share similar interests and values ___ yes ___ no

PRIOR MENTAL HEALTH HISTORY

Have you ever had prior mental health treatment? ___ yes ___ no (If no, skip)
Date _____
Was this person a: ___ Psychiatrist ___ Psychologist ___ Clinical social worker ___ Clinical Counselor
___ Minister ___ Other
Have you ever been hospitalized for emotional problems? ___ yes ___ no (If no, skip)
Name of hospital _____ Location _____ Date _____ How long _____
Doctor who treated you _____ Medications given _____
Do you still take any psychotropic medications? ___ yes ___ no Which ones? _____

ALCOHOL/DRUG HISTORY

Do you have a history of alcohol/drug abuse? ___ yes ___ no (If no, skip)

If you are using alcohol or drugs has this resulted in:

___ Marital problems	___ Memory Blackouts	___ Legal problems
___ Problems w/family, friend's	___ Periods of abstinence	___ Physical problems
___ Preoccupation w/alcohol, drugs	___ Financial problems	___ Loss of control
___ DUI or DWI charges	___ Withdrawal symptoms	

LEGAL HISTORY ___yes ___no

Check those that apply to you:

___ Trouble with law as a juvenile
___ Trouble with the law as an adult

___ Have legal matter pending
___ Have you ever been in jail?

MEDICAL HISTORY

Date of last physical exam _____ Family physician _____

Describe your chief medical/physical complaint(s) _____

Do you have any special problems with hearing, speech, vision? ___yes ___no
If yes, please explain _____

Are you on any medications? ___yes ___no
If so, please list: _____

Describe any side effects _____

Do you have any allergies? ___yes ___no
If yes, please describe _____

List any serious illnesses, injuries, or surgeries _____

Place an X in the left column if this condition exists. In the right column write self, father, mother, brother, sister, aunt, uncle, etc.

___ Alcoholism _____
___ Allergies _____
___ Developmental _____
 Disabilities _____
___ Obesity _____
___ Degenerative dis. _____
___ Mental health probs. _____
___ Suicide _____

___ Cancer _____
___ Diabetes _____
___ Epilepsy _____
 High blood press. _____
___ Heart trouble _____
___ Other _____

MEDICAL CONDITIONS AND SYMPTOMS

Past/Now	Past/Now	Past/Now
_____ Arthritis	_____ Can't work under pressure	_____ Distractibility
_____ Anxiety	_____ Color Blind	_____ Laxatives used
_____ Anger Outbursts	_____ Exhaustion	_____ Leg Cramps
_____ Asthma	_____ Fainting spells	_____ Loose bowel/gas often
_____ Backaches	_____ Fast pulse	_____ Loses temper easily
_____ Binging	_____ Heart medicine	_____ Moody often
_____ Barbiturates	_____ Hormones	_____ Memory problems
_____ Epilepsy	_____ Poor digestion	_____ Muscle twitching
_____ Cancer	_____ Poor appetite	_____ Much sweating
_____ Chronic Pain	_____ Treated for a mental cond.	_____ Moist palms
_____ Chest Pain	_____ Other drugs, alcohol	_____ Nervous breakdown
_____ Constipation	_____ Shaking	_____ Nervousness
_____ Depression	_____ Smoking packs/day _____	_____ Nerve Medication
_____ Diabetes	_____ Craving for sweets	_____ Overeating
_____ Diarrhea	_____ Fatigue	_____ Overworked
_____ Depersonalization	_____ Headaches	_____ Pain medication
_____ "Going Crazy" sensations	_____ Heart trouble	_____ Palpitation
_____ Difficulty going to sleep	_____ Hallucinations	_____ Perfectionist
_____ Difficulty staying asleep	_____ Hearing voices	_____ Stomach medicine
_____ Dizziness	_____ Hypertension	_____ Worries, feels insecure
_____ Drug reactions	_____ Hand tremors	_____ Reduced sex drive/lack of
_____ Early morning wakening	_____ Hay fever	_____ Upset stomach
_____ Emotional upsets	_____ Insulin medication	_____ Itchy skin

CURRENT SOURCES OF STRESS

Please list your most significant sources of stress or worry.

1. _____
2. _____

What is the main goal you wish to attain in seeking services? _____

Envision how your life would be different if you could manage some of these problems better.

ADDITIONAL INFORMATION: Please add any special information you feel which might be helpful in assisting in your treatment. _____

Your signature below indicates that you understand the questions and could ask for assistance if needed.

Client signature

Date