Behavioral Therapy & Beyond

Patient History Form

Patient Name: Date:

Patient Birthdate: Patient Gender: M F

Patient Address:

Patient Phone Numbers: Emergency Contact info:

1. What kind of problems are you having?

2. When did these problems first start?

3. What methods (if any) have you used to resolve these problems? _____

4. Have you ever had any treatment/therapy for depression, addictions or emotional problems? Yes No

5. Years of High School Graduated? Yes No
   Years of College Graduated? Yes No
   Highest degree obtained _____

6. The longest ***job*** you ever held was

7. Military Experience? Yes No Branch for years Discharge

8. Religious affiliation: Regular attendance? Yes No

9. Have you ever had any ***legal problems*** (including DUI's), trouble with the police, or juvenile authorities?
   (if yes, please explain)

10. What situations may be causing ***stress*** in your life currently? (e.g. illness, job, recent loss, family fights)

11. How well do you think you are ***coping***? (e.g. fair, poorly, well, very well)

12. Please list your ***strengths***, interests and things that make you proud:

13. Please list below everyone who is living in the home:

Name	Age	Relationship

14. Have any of your blood relatives had any ***emotional or addictive*** problems? (if yes, who and what were the problems?)

15. Have any of your blood relatives had ***heart problems*** or died suddenly from unknown causes? (if yes, who and describe the problem)

16. List any current or past ***medical problems***: (e.g. anemia, cancer, diabetes, alcoholism, liver disease, high blood pressure, headaches, stomach aches, heart problems, drug problems, sexual problems, surgery, etc.) Please note "past," if you no longer have that problem

17. List any family medical problems that you feel may be relevant:

18. Do you or have you engaged in any "high risk" activities for HIV infection (AIDS)?

19. Any current medication or treatments?

Medication	Amount	Times Per Day	Reason	Doctor

20. Do you use ***drugs and/or alcohol*** now, or have you in the past?

21. Have you ever ***fainted or blacked out*** after being hit in the head, had seizures, or seen a Neurologist?

22. How would you describe your ***diet***?

    How many ***caffeinated beverages*** do you drink per day?

    12 oz. beverages (e.g. Coke) Cups of Coffee Cups of Tea

23. ***For women only*:** Last menstrual period: Any menopausal symptoms or date of menopause:

    PMS symptoms? Method of birth control?

    # of live births: # of pregnancies:

24. Was there anything unusual about your own birth or your mother's pregnancy with you?

25. During the first six years of your life, did you have a problem with ***growth, eating, or coordination***?

26. List any serious medical problems: Birth - Age 3:

    Age 3 - 5:

    Age 5 - 18:

27. Did you have any difficulty adjusting to being ***away from home***? (when you started school, pre-school, went to camp, overnight to the house of a friend or relative, moved away to college, got married)

28. List any serious ***losses, abuse, or other painful experiences***:

29. At what age did you first decide there may a ***problem*** and why?

30. Describe your ***temperament***:

31. Did you go through a ***parental divorce or separation***? If so, what year?

32. Describe your relationship with your ***family of origin***:

33. Describe your ***support system***:

34. What would you like to accomplish in therapy?

35. Please indicate and rate severity (1-4)

1- None	**2 - Mild**	**3 - Moderate**	**4 – Severe**
Depression		Lack of Friends	Marriage/relationship issues
Anxiety		Controlling stress	Loneliness
Sexuality/sexual issues		Family conflict	Loss of a loved one
Problems coping		Abuse/victimization	Behavioral problems
Problems at school		Problems at work	Eliminating a drug/alcohol habit
Financial problems		Legal matters	Eliminating another habit (overspending, overeating, etc)

36. Past psychiatric admissions/alcohol or drug treatment

Most recent:

Date: Length of stay:

Type of admission (impatient, partial hospitalization, day treatment):

Others:

37. ***Past outpatient therapy***: Therapist(s) Start and end dates

38. Please indicate how the issue(s) for which you are seeking treatment are affecting the following areas of your life:

	No effect	**Little effect**	**Some effect**	**Much effect**	**Significant effect**	**N/A**
Marriage/Relationship	1	2	3	4	5	6
Family	1	2	3	4	5	6
Job/School Performance	1	2	3	4	5	6
Friendships	1	2	3	4	5	6
Financial Situation	1	2	3	4	5	6
Physical Health	1	2	3	4	5	6
Anxiety level/nerves	1	2	3	4	5	6
Mood	1	2	3	4	5	6
Eating Habits	1	2	3	4	5	6
Sleeping Habits	1	2	3	4	5	6
Sexual Functioning	1	2	3	4	5	6
Ability to Concentrate	1	2	3	4	5	6
Ability to Control Temper	1	2	3	4	5	6
Spirituality	1	2	3	4	5	6

Professional Services

I request that the therapist named below provide professional services to me or to _____, who is my _____, and I agree to pay this therapist's fee of $ 175 per session for these services.

I agree that this financial relationship with this therapist will continue as long as the therapist provides services or until I inform him or her, in person or by phone or mail, that I wish to end it. I agree to meet with this therapist at least once before stopping therapy. I agree to pay for services provided to me (or this client) up until the time I end the relationship.

I agree that I am responsible for the charges for services provided by this therapist to me (or this client), although other persons or insurance companies may make payments on my (or this client's) account. I understand that I will be charged for the full SESSION, NOT JUST THE CO-PAY for any sessions cancelled less than 24 hours in advance.

I have also read this therapist's "Client Information Contract" and agree to act according to everything stated there, as shown by my signature below and on the brochure.

_____ _____

Signature of client (or person acting for client) Date

_____

Printed name

I, the therapist, have discussed the issues above with the client (and/or the person acting for the client). My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Signature of therapist Date

❑ Copy accepted by client ❑ Copy kept by therapist

Consent to Treatment

I acknowledge that I have received, have read (or have had read to me), and understand the "Client Information Contract" brochure and/or other information about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I know that I must call to cancel an appointment at least 48 hours (2 days) before the time of the appointment. If I do not cancel and do not show up, I will be charged for that appointment.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

My signature below shows that I understand and agree with all of these statements.

_____ _____

Signature of client (or person acting for client) Date

_____ _____

Printed name Relationship to client (if necessary)

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Signature of therapist Date

❑ Copy accepted by client ❑ Copy kept by therapist

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.