CLIENT REGISTRATION INFORMATION

First Name _____ Last Name _____

Street Address _____ City _____ State _____ Zip _____

Email Address _____

Social Security # _____ Age _____ Date of Birth _____

If minor (under age 18) please write name of legal guardian _____

Male _____ Female _____ Home Phone _____ Work Phone _____

Mobile Phone _____ Preferred method of contact: ___Home ___Work ___Mobile

Relationship to insured: ___Self ___Spouse ___Child ___Other

Marital Status: ____Single ____Married ____Widowed ____Divorced ____Other

Employment Status: ____Employed ____Full-time Student ____Part-time Student

Children _____ Ages _____

Emergency Contact Name _____ Phone _____

PARENT/GUARDIAN'S INFORMATION (if different from above)

First Name _____ Last Name _____

Street Address _____ City _____ State _____ Zip _____

Birth Date _____ Age _____ Social Security# _____

Employer/School _____

Home Phone _____ Work Phone _____

Caseworker's Name _____ Phone _____

TELEMENTAL HEALTH INFORMED CONSENT

I understand and agree to receive telemental health services from my therapist. This means that my therapist and I will, through a live interactive video connection, meet for scheduled psychotherapy sessions under the conditions outlined in this document and the Deborah A Martin, Inc. Therapy Agreement form.

I understand the potential risks of telemental health, which may include the following: 1) the video connection may not work, or it may stop working during a session;2) the video or audio transmission may not be clear; and 3)I may be asked to go to my therapist's office in person if it is determined that telemental health is not an appropriate method of treatment for me.

I recognize the benefits of telemental health, which may include the following: 1)reduced cost and time commitment for treatment due to the elimination of travel;2)ability to receive services near my home or from my home, and 3)access to services that are not available in my geographic area.

I give my consent to engage in psychotherapy via vide oconferencing. I understand that my therapist uses HIPAA-compliant technology to transmit and receive video and audio and stores all notes and information related to my treatment in a manner that is compliant with state and federal laws. I understand that it is my responsibility to ensure that my physical location during video conferencing is free of other people to ensure my confidentiality. Furthermore, I understand that recording my session is prohibited.

I understand that I have the option to request in-person treatment at any time, and my therapist will assist in scheduling this or make a referral if travel to the therapist's office is not feasible for me. I understand that closer providers may not be available depending on my location.

I understand the limitations to confidentiality with my therapist include reasonable belief that I am a danger to myself or others. I understand that, if my therapist reasonably believes that I plan to harm myself or someone else, my therapist will contact local emergency services to come to my location and ensure my safety.

My Signature indicates that I agree to participate in telemental health under the conditions described in this document

Client Name (please print): _____

Legal Guardian (if applicable): Relationship to Client: _____

Client/Guardian Signuature:_____Date:_____

Notice of Privacy Practices (3/03)

This notice describes how health information about you may be used and disclosed and how you can get access to this information. It is effective April 14, 2003, and applies to all protected health information contained in your health records maintained by us. We have the following duties regarding the maintenance use, and disclosure of your health records:

(1) We are required by law to maintain the privacy of the protected health information in your records and to provide you with this notice of our legal of our legal duties and privacy practices with respect to that information

(2) We are required to abide by the terms of this notice currently in effect

(3) We reserve the right to change the terms of this notice at any time, making the new provisions effective for all health information and records that we have and continue to maintain. All changes in this notice will be prominently displayed and available at our office.

There are a number of situations in which we may use or disclose to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received a notice of privacy practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment, or healthcare operations requires you to sign an authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your acknowledgement or authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed acknowledgement that you received this notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided consent.
TREATMENT: We will use your health information to make decisions about the provision, coordination, or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may be necessary to share your health information with another healthcare provider whom we need to consult with respect to your care. These are only examples of uses and disclosures of medical information for treatment purposes that may or may not be necessary in your case.

PAYMENT: We may need to use or disclose information in your health record to obtain reimbursement from you, from your health-insurance carrier, or from another insurer for our services rendered to you. This may include determinations of eligibility or coverage under the appropriate health care plan pre-certification and pre-authorization of services, or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes, and related healthcare data processing through our system.

There are certain circumstances under which we may use or disclose your health information without first obtaining your acknowledgement or authorization. Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases, or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect, or domestic violence. We are required to report to appropriate agencies and law-enforcement

officials information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

OTHERS INVOLVED IN YOUR HEALTHCARE: Unless you object we may disclose to a member of your family, a close friend, or any other person you identify, your protected health information that directly relates to that persons involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or disclose protected health information to notify or assist in notifying a family member, person representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

COMMUNICATION BARRIERS AND EMERGENCIES: We may use or disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as responsibly practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to contain your consent, we may still use or disclose your protected health information to treat you.

Except as indicated above, your health information will not be used or disclosed to any other person or entity without your specific authorization which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without your written authorization.

You have certain rights regarding your health record information, as follows:

(1) You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to your care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.

(2) You have the right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.

(3) You have the right to inspect, copy, and request amendments to your health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for those in a civil, criminal, or administrative action or proceeding to which your access is restricted by law. We will charge a responsible fee for providing a copy of your health records, or a summary of your records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of information.

(4) All requests for inspection, copying and/or amending information in your health records, and all requests related to your rights under this notice, must be made in writing and addressed to the privacy officer at our address. We will respond to your request in a timely fashion.

(5) You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your health information except for disclosures required for treatment, payment and healthcare operations, disclosures that require authorization, disclosure incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any twelve month period; however, we will charge you a responsible fee for each subsequent request for an accounting within the same twelve month period.

(6) If this notice was initially provided to you electronically, you have the right to obtain a paper copy of this notice and to take one home with you if you wish.

You may file a written complaint to us or to the secretary of health and human services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the privacy officer (in the case of complaints to us) your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints at the government's website, http://www.hhs.gov/ocr/hipaa.

Printed name	Signature	Date

Witness	Signature	Date

Client Name _____ Date_____

Age____Race____Wt____Ht___Hair Color_____ Eye Color_____

Medication Allergies_____

Food Allergies_____

Current Medications (includes over the counter medications):

NAME OF MEDICATION	REASON FOR MEDICATION	TIME ON MEDICATION

History of Hospitalizations:

DATE	REASON	DISCHARGE RESULT

History of Baker Acts/Residential Treatment Facilities:

DATE	REASON	DISCHARGE RESULT

Primary Physician_____Phone_____

Are your currently/or have ever seen a Psychiatrist___No___Yes Date_____ Reason for visit_____.

LEVEL OF DISTRESS Tell us how distressed you are by using a scale of 1 (low) to 10 (extreme): _____
Are You Currently Experiencing Any Suicidal Thoughts___ Yes ___ No
Have You Experienced Them in the Past___ Yes___ No

PRESENTING ISSUES AND GOALS
Please Describe Why You Are Coming to Counseling Now (i.e., What Are Your Issues, concerns Problems,?_____
_____
_____

Client Name_____Date_____

What Do You Hope to Gain or Change by Coming for Counseling?

_____

_____

PREVIOUS COUNSELING: List any Previous Counseling, Psychiatric Treatment, or Residential/In-Patient Care You Have Received (Use Back If Necessary)

Therapist: _____ Location: _____

Directions: Please check any symptoms present within the last six months. If parent/caregiver, please check any symptoms present within the last six months for your child/adolescent.

MOOD:

__feeling sad __Mood swings __negative attitude __feels worthless
__useless __lack of interest __fatigue __withdrawn
__Hypersensitive __irritable __feels alone with others around __lethargic
__says no good __decrease in activity level __talks about wishing to be dead __ frequently cries
__lonely __easily annoyed __complains no one loves him/her __feels helpless and or hopeless
__talks about self-harm __ has attempted self-harm __how many times? __number of Baker Acts__

TRAUMA WITNESSED/EXPERIENCED:

__ loss of family member __substance abuse/alcohol abuse __kidnapping
__loss of animal __domestic violence __custody dispute
__an accident __neglect __ murder
__natural disaster __sexual abuse __divorce
__physical abuse __sexual assault __removal from caretakers
__violent acts __Medical trauma (amputation) __human trafficking

FEARS:

__being alone __ghosts __crowded places
__someone will harm him/her __nightmares __new conditions
__taking medicine __being trapped __ caregivers will leave
__dirt/germs __thunder and lightning __animals
__flashbacks of trauma __trouble sleeping __the dark
__fire __wont sleep alone __people

Client Name_____Date_____

ANXIETY:

__feeling foolish
__getting harmed
__becoming sick
__family getting sick/harmed
__the future
__whines
__Upsets easily
__own ability to do things
__being teased
__making mistakes
__making right choices
__needs reassurance
__nervous
__difficult to calm down
__something happening at bedtime
__caregivers will leave
__what others think about him/her
__easily embarrassed
__clingy
__refuses to leave caregivers
__excessive worry most of the time

ANGER:

__tantrums
__throws things
__argumentative
__quickly becomes angry
__takes things that are not his/hers
__uses things without permission
__gets into physical altercations
__verbally aggressive
__directs anger at self
__hurts others feelings
__wants revenge
__regrets actions later

SOMATIC SYMPTOMS (No medical diagnoses have been found):

__Headaches
__Constipation
__ complains to not feel good
__bowel issues (soils self) __ other:_____
__stomachaches
__diarrhea
__bed wetting
__vomiting
__aches/pains
__urination issues (wets self)

SOCIAL SKILLS/SCHOOL:

__Bullied by others
__Bullies others
__Issues with making/keeping friends
__Follower
__Shy
__Not listening/following directions
__makes poor social choices
__aggressive to peers
__refuses to go to school
__makes excuses to not go to school
__skips classes
__failing grades
__procrastinates doing homework
__negative towards authority figures
__in-school suspensions
__indifferent attitude
__suspension/expelled
__other:_____

Client Name_____Date_____

ATTENTION SPAN/HYPERACTIVITY:

__distracted
__easily frustrated
__inattentive
__impulsive actions
__unorganized
__cannot complete projects/homework/chores
__overexcited
__robotically driven (two switches on/off)
__not respect others privacy/personal space
__cannot focus
__cannot concentrate
__interrupts frequently
__ignores consequence
__careless
__demanding
__restless
__loses control of physical self
__problems listening/following directions
__excessive noises
__cannot complete work
__forgetful
__requires frequent repetition
__fidgety
__fast speech
__instantly regrets choices/actions

BEHAVIORAL ISSUES:

__poor hygiene
__hoarding
__stealing
__uses baby talk
__regression
__sucks finger
__displays rituals
__bites nails
__extremely interested in
__obsessive behaviors
__compulsive behaviors
__physically picks at body parts
__pulls/plays with hair setting
__blames others for own mistakes
__denies any wrong doing
__chews on clothing
__runs away
__law enforcement issues
__displays promiscuous behaviors
__poor boundaries with others
__touching own private parts
__touching others private parts
__everything must be perfect
__issues with lying
__must be the best
__sets fires
__ sexuality issues

NUTRITIONAL CONCERNS:

__hoarding food
__binging
__throwing up
__body image issues
__diarrhea
__skipping meals
__loss appetite
__excessive exercise
__wears oversized clothes
__weight loss
__chronic constipation
__weight gain

OTHER EMOTIONAL/BEHAVIORAL PROBLEMS: (please explain)_____

_____

_____

X_____ Date _____
Signature (if minor, legal guardian)
X_____ Date_____
Signature of Provider

Deborah A Martin, Inc. 708 NE 6th St, Crystal River, Fl. 34428, Phone: (352) 228-4969 Fax: (352) 228-8901

GENERAL AUTHORIZATION FOR TREATMENT EXCEPT PSYCOTROPIC MEDICATIONS

CLIENT'S NAME:_____ **Date**_____

The undersigned a client, a parent, a legal guardian, a guardian advocate, or a health care surrogate/proxy herby authorize the professional staff of this agency to administer assessments and treatment specified below.

- Routine medical care_____
- Assessments_____
- Psychiatric assessment_____
- Therapeutic placement_____
- School based therapy_____
- Family therapy_____
- Individual therapy _____
- Group therapy _____
- Video feedback _____
- Other (specify & initial) _____
- Psychiatric evaluation and consultation_____
- Random drug screening (if deemed necessary) _____

Initial of patient or authorized decision maker confirms authorization and consent for each treatment.
I understand that my consent can be revoked orally or in writing prior to, or during the treatment period.
I have read and had this information fully explained to me and I have had the opportunity to ask questions and receive answers about the treatment. Finally, I understand that by signing this document, I am giving my therapist permission to evaluate and treat my presenting concerns, and to follow the applicable laws governing confidentiality. I also agree to consume the responsibility for payment of professional services incurred on my behalf.

_____ _____
Signature of Competent Client* Date

_____ _____
Signature of Witness Date

ENROLLEE RIGHTS AND RESPONSIBILITIES STATEMENT

YOU HAVE THE RIGHT TO:

- Be treated with courtesy, respect, and dignity. You have the right to privacy.
- Prompt and fair answers to questions.
- Know who is providing services and who is in charge of your care.
- Know what support services are available and if there are interpreters if you do not speak English.
- Know what rules and regulations apply to how you act.
- Be told what problem you may have, what care is planned, what other kind of care is available, risks and outcomes.
- Refuse care, unless the law says care must be given.
- Tell us if you are not satisfied with anything we have done or said we will not do. These complaints are called grievances.
- Information and counseling on how to pay for your care, if asked.
- Know before any care is given if the provider or facility takes Medicaid.
- Get an estimate of how much it will cost before care is given, if asked.
- Get a clear and easy to understand bill and have the bill explained to you, if you ask.
- Get help regardless of your race, ethnicity, religion, disability, or how you can pay.
- Help with any emergency problem that will get worse if help is not given.
- Be informed when treatment is for experimental research.
- Opt in or out of the experimental research. • Take part in decisions about your care. You have the Right to decline care.
- Get easy to follow information on the care options and what other kinds of care there are for you.
- Understand that methods such as seclusion and restraint are not used to make you do something you do not want to do.

YOU ARE RESPONSIBLE FOR:

- Telling your provider, to the best of your ability, everything you know about your problem to include what sicknesses you had in the past, if you have you been in the hospital before, what medication you have taken and/or are taking, and other things about your health.
- Telling your provider about any changes in how you feel.
- Letting your provider know you understand what care you are going to get and what you are supposed to do to help yourself.
- Making sure you follow your care plan.
- **Not missing appointments and calling 24 hours in advance if you need to reschedule the appointment. If you cancel or reschedule more than (3) appointments, it is as the discretion of your therapist to discharge you for lack of commitment to treatment. After one no show/no call, you will lose your standing appointment. After three no shows/no calls, you will be discharged from this facility. You are responsible for a $25 fee for each missed appointment.**
- What happens if you refuse help or do not follow the care plan.
- Following all rules on patient/client care and conduct.

My signature below shows that I have been informed and understand my rights and responsibilities.

_____ _____

Client Signature ***Date***

The signature below shows that I have explained this statement to the client and have provided the enrollee a copy of this statement.

_____ _____

Provider Signature ***Date***

INFORMED CONSENT CONTRACT

Confidentiality: Please understand that all records, written information, or any electronic data are marked CONFIDENTIAL. I understand that discussions between a therapist and a client are confidential. No such information will be released without the client's written consent EXCEPT in the specific circumstances mandated by law including (1) disclosure of harm or intent to harm another; (2) disclosure of intent to harm oneself; (3) situations in which a judge issues a court order for the release of records. I also understand that I am releasing and holding harmless my therapist to share that specific information mandated by law or as require by an insurance company if I should seek reimbursement.

I am required by law to report:
--threats of harm to another or oneself
--domestic violence
--child or elder abuse, neglect or exploitation

Permission to Treat: I acknowledge that it is my choice to participate in psychotherapy services
Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychotherapist and patient and the particular problems you are experiencing. There are many different methods that may be used to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part, in order for the therapy to be most successful. Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant parts of your life, you may temporarily experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. There are no guarantees of what you will experience.
Our first few sessions will involve an evaluation of your needs and requests. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. You have the right to participate in your treatment plan and review or revise it at any time.
Therapy sometimes involves a large commitment of time, money and energy so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. You may withdraw consent at any time simply by informing me.
Before you sign below, please ask any questions you may have of this document. **Your signature acknowledges agreement and understanding:**

_____ _____
Signature of Client **Date**

_____ _____
Signature of Therapist/Provider **Date**

Deborah A Martin, Inc.

708 NE 6th Street
Crystal River, Fl. 34428
Phone: (352) 228-4969 / Fax: (352) 228-8901

AUTHORIZATION TO DISCLOSE/REQUEST CLIENT INFORMATION

Client Name: _____ **SS#:** _____ **DOB:** _____

Address: _____ **City:** _____

State: _____ **Zipcode:** _____ **Telephone #:** _____

I hereby request and authorize: Deborah A. Martin, LCSW

Fax #: _____

To obtain from or release to: _____

_____ (Name, Address, phone #).

The following information from my records: _____

_____

For the purpose of: _____

Form in which information may be released:

___Written ___Verbal ___Audio ___Video ___Electronic ___Photographic

Valid Authorization Dates or Expiration Event/Condition: 1 YEAR FROM SIGNATURE DATE BELOW.

All information I authorize to be obtained from this agency will be strictly confidential and cannot be released by the recipient without my express written consent.

_____ _____

Signature of Client Date

_____ _____

Signature of Therapist/Evaluator Date

FINANCIAL / INSURANCE AGREEMENT

AGENCY / INSURANCE INFORMATION (If Applicable)

Primary insurance carrier:_____ Insured's policy #:_____

Subscriber name:_____Subscriber date of birth_____

Co pay amount:_____Authorization#:_____Number of visits:_____ Date:_____

Secondary insurance: _____Yes _____No

Secondary insurance:(if any) _____Insured's policy #:_____

Subscriber name:_____Subscriber date of birth_____

**A copy of your insurance card(s) are needed at the time of service. Please read the following carefully and sign below.

Assignment of Benefits and Release of Information

I give permission to Deborah A. Martin, Inc. and billing staff to send required information to my insurance company or my Employee Assistance Program (EAP). I am aware that I am placing my signature on file and that this authorization shall remain valid until written notice is given by me revoking said authorization. I also understand that I will be responsible for any unpaid balances including co-payments, deductibles and non-covered services. **I understand that appointments missed or cancelled less than 24 hours before the appointment will be billed $25.00. I understand that my insurance or EAP does not cover the cost of missed visits.**

Information given was retrieved from your insurance company and that information is NOT a guarantee of payment. Provider of services accepts assignment. The client will responsible for any amount not covered by insurance. Initial _____

Client understands his/her responsibility: _____Yes _____No

Financially able to make co-payment(if any) ____Yes _____No Co-pay amount:_____

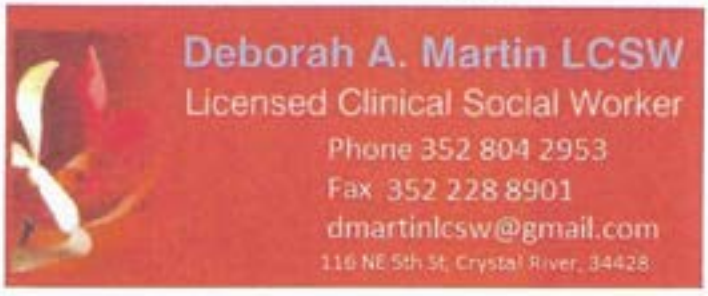
_____ _____

Signature of Responsible Party **Date**

_____ _____

Witness **Date**

Patient name: _____ **Date:** _____



Biopsychosocial: Demographic Information:

Date: _____

Name: _____

Address: _____
Phone (Home/Cell): _____ Phone (Work): _____
Date of Birth: _____ SSN #: _____
Guardianship (for children and adults when applicable): _____
Marital Status: _____

Family Members

Name	Age	Gender	Relationship

Employer: _____ Occupation: _____
School (for children, and adults when applicable): _____

Emergency Contact Information

Name of Emergency Contact

Name: _____ Phone: 1._____ 2: _____

Relationship to Patient: _____

Current Providers

Primary Medical Practitioner: _____ Phone: _____
Patient does_____/does not_____ give permission to contact provider. (If patient does give permission, please ensure a copy of the release form is in the medical record.)

Other Behavior Health Specialist of Consultants

Specialist: _____ Phone: _____
Patient does_____/does not_____ give permission to contact provider. (If patient does give permission, please ensure a copy of the release form is in the medical record.)

Presenting Problem (include onset, duration, intensity)

_____
_____
_____

Patient name: _____ **Date:** _____

Precipitating Event (why treatment now):

_____

_____

Target Symptoms:

	Frequency/Duration	Degree of Impairment
Symptom #1:		
Symptom #2:		
Symptom #3:		
Symptom #4:		

IV. Mental Status (circle appropriate items)

Orientation: Person Place Time Situation All

Affect: Appropriate Inappropriate Sad Angry Anxious Restricted Labile Flat Expansive

Mood: Normal Euthymic Depressed Irritable Angry Euphoric (describe details below)

Thought Content:

Obsessions - describe:

_____

Delusions (specify and comment):

_____

Hallucinations (specify and comment):

_____

Thought Processes: Logical Coherent Goal-directed Detailed Tangential Circumstantial Illogical Looseness of **Associations** Disorganized Flight of Ideas Perseveration Blocking

Speech:	Normal	Slurred	Slow	Rapid	Pressured	Loud
Motor:	Normal	Excessive	Slow	Other	_____	
Intellect:	Average	Above	Below			
Insight:	Present	Partially Present		Impaired		
Judgment:	Intact	Impaired				
Impulse Control:		Adequate	Impaired			
Memory:	Immediate	Recent	Remote			
Concentration:		Intact	Impaired			
Attention:	Intact	Impaired				
Behavior:	Appropriate	Inappropriate (describe)	_____			

Details/additional comments:

_____

_____

V.RiskAssessment

Suicidal Ideation - check (X) all relevant and describe all checked items in comments section								
None Noted	Thoughts only	Frequency of thoughts	Plan	Intent	Means	Attempt	Active or passive	Chronic or acute

Comments

_____

_____

_____

_____

_____

Patient name: _____ **Date:** _____

Homicidal Ideation - check (X) all relevant and describe in comments section								
None noted	Thoughts only	Frequency of thoughts	Plan	Intent	Means	Attempt	Active or passive	Chronic or acute

Comments

_____
_____
_____
_____
_____

VI.Medical/BehavioralHealthHistory

_____
_____
_____

Allergies (adverse reactions to medications/food/etc.)

_____
_____

Medications

Is the patient currently prescribed Behavioral Health medication (s)? __Yes __ No (If yes please indicate below)

A. Current Behavioral Health Medications prescribed
(Include prescribed dosages, dates of initial prescription and refills, and name of doctor prescribing medication and check to indicate if member is adherent with each medication):

_____
_____
_____
_____

Were the risks, and benefits, of BH medication adherence discussed with the patient?

_____
_____

B. Is member taking other medications (prescribed or over the counter) or supplements? Yes_ No_ (if yes please list and indicate why).

_____
_____
_____

Past Psychiatric History (Mental Health and Chemical Dependency):

_____
_____
_____

Psychiatric Hospitalizations:

_____
_____
_____

Patient name: _____ **Date:** _____

Prior Outpatient Therapy (include previous practitioners, dates of treatment, previous treatment interventions, response to treatment interventions (including responses to medications), and the source(s) of clinical data collected):

_____

_____

_____

Results of recent lab tests and consultation reports (For physicians only and only where applicable):

_____

_____

Family Mental Health or Chemical Dependency History:

_____

_____

VII. Psychosocial Information

Support Systems:

_____

School/Work life:

_____

Legal History:

_____

_____

VIII. Substance Abuse History (complete for all patients age 12 and over)

Substance	Amount	Frequency	Duration	First Use	Last Use	Comments
Caffeine						
Tobacco						
Alcohol						
Marijuana						
Opioids/ Narcotics						
Amphetamines						
Cocaine						
Hallucinogens						
Others:						

FOR CHILDREN AND ADOLESCENTS:

Developmental History (developmental milestones met early, late, normal): _____

_____

_____

Risk Factors:

_____Domestic Violence
_____Child Abuse
_____Prior behavioral health inpatient admissions
_____History of multiple behavioral diagnosis
_____Suicidal/homicidal ideation
_____Sexual Abuse
_____Eating Disorder
_____Other (describe)

Diagnostic Impression:

Patient name: _____ Date: _____

Axis I: _____