Donald M. Kaesser, Ph.D.,.P.C.

3106 Ingersoll Ave.
Des Moines, IA 50312
515-240-7997

PERSONAL DATA

Name_____ **Date**_____

Address_____ **Age**_____ **DOB** _/_/_ **Sex M F**

_____ **Years Education**_____ **Degree** _____

E-Mail Adress: _____ **Occupation**_____

Home Phone (_____)_____ **Employer**_____

Cell Phone (_____)_____ **Work Phone (_____)**_____

OK to Text/e-mail you appointment reminders? Yes No

Marital Status_____ **Partner's Name**_____ **Partner's Occupation** _____

Currently living with_____ **No. of Children**_____ **Ages** _____

Spirituality/Religious Affiliation:_____ **Military Service? Yes No; Past Current**

Emergency Contact Information: **Name:**_____ **Phone (_____)** _____

Contact Address: _____

How were you referred to me? _____

MAIN CONCERNS:

Please list the major concerns that you would like help with in therapy, and rate the severity of each one according to the scale below:

1----------2----------3----------4----------5----------6--------- 7 --------- 8 --------- 9 --------- 10

Not a Problem Mild Problem Moderate Problem Severe Problem Couldn't be worse **RATING**

1._____ _____

2._____ _____

3._____ _____

Briefly describe what motivated you to seek therapy at this time : _____

_____

Please draw a circle around any of the following problems which apply to you now:

Adoption	Drug Use	Legal Matters	Self-Esteem	Violence
Aging	Ex-Spouse	Making Decisions	Separation	Weight Loss/Gain
Alcohol Use	Fears	Marriage	Sexual Problems	Work or Job
Anxiety	Finances	Memory	Shyness	Worrying
Being a parent	Gender Identity	Menstrual Problems	Sleep	Your own Parents
Binge Eating	Grief	Nightmares	Spiritual Needs	Other:_____
Bowel Problems	Guilt	Over-Commitment	Strange Thoughts	_____
Career Choices	Headaches	Pain	Step-Parenting	
Children	Health Problems	Panic Attacks	Stress	
Co-Dependency	Home Life	Phobia	Stomach Trouble	
Concentration	Hyperactivity	Relationships	Substance Abuse	
Custody	Inferiority	Relaxation	Suicidal Thoughts	
Depression	In-Laws	School	Temper	
Divorce	Insomnia	Self-Control	Unhappiness	

Psychological History & Initial Information Information

MEDICAL HISTORY:

Name of Primary Care Physician (PCP)_____ Physician Phone # _____

How would you rate your overall health? Excellent____Good____Fair____Poor___

Do you have any serious medical conditions? (If yes, please describe)..... **No Yes**

_____

Have you had any major health conditions which significantly affected your life? (If yes, please describe)…. **No Yes**

_____

Please list all medications you are currently taking_____

_____

List any known allergies:_____ Any serious hospitalizations, illness, accidents? If yes, describe____

_____

In Past Year, how many: Visits to doctor_____Sick days_ Cigarettes-day_____Alcoholic drinks/day_____Psychotherapy sessions,**ever**_____

Number of family members with: Alcohol/drug problems____Psychiatric problems (e.g., depression, psychosis) _____

Have you ever felt you ought to cut down on your alcohol use or drug use?	**Yes**	**No**
Have people annoyed you by criticizing your drinking or drug use?	**Yes**	**No**
Have you ever felt bad or guilty about your drinking or drug use?	**Yes**	**No**
Have you ever had a drink or used drugs first thing in the morning (as an eye Opener, to steady your nerves or to get rid of a hangover?)	**Yes**	**No**

Prior outpatient psychotherapy?___Yes____No **Prior/Current Psychiatry?_____Yes____No**

Prior substance use counseling?___Yes____No

If Yes, please provide further information below:

Prior provider name(s) City State Phone Diagnosis Beneficial?

_____

_____

_____

Please place an X by any of the following conditions experienced by you or any member of your immediate family (parents, siblings, children) in the past or present. Also, please write who experienced the condition (e.g., you, mom, dad, sibling) in the column marked "Person?" for any condition you put an X next to.

Psychological Condition	X	Person?
Attention deficit hyperactivity disorder		
Anxiety (frequent)		
Obsessive-compulsive disorder		
Panic disorder		
Bipolar disorder		
Depression		
Anorexia		
Bulimia		
Binge eating		
Reading disorder		
Math disorder		
Written language disorder		
Schizophrenia		
Suicidal thoughts, plans, or behavior		

Psychological History & Initial Information Information

FAMILY OF ORIGIN HISTORY:

Describe Parents: **Father** **Mother**

Full Name _____ _____

Occupation _____ _____

Education _____ _____

General Health _____ _____

Age _____ or Age at time of death _____ Age _____ or Age at time of death _____

Marital status _____ To Whom _____ Marital Status _____ To Whom _____

Present during childhood:

	Present entire childhood	Present part of childhood	Not present at all
mother	[ ]	[ ]	[ ]
father	[ ]	[ ]	[ ]
stepmother	[ ]	[ ]	[ ]
stepfather	[ ]	[ ]	[ ]
other (specify) _____	[ ]	[ ]	[ ]

Brothers & Sisters

Name	Age	Sex	Occupation	Education	Health	Marital Status	Comments

Describe childhood family experience:

[ ] outstanding home environment
[ ] normal home environment
[ ] chaotic home environment
[ ] experienced physical/verbal/sexual abuse

Special or unusual circumstances in childhood: _____

_____

_____

IMMEDIATE FAMILY HISTORY:

Currently Living in Your Home

Name	Age	Sex	Occupation or Grade in School	Living With Whom	Other Special Information

Marital status: _____

[ ] _____ prior marriages (self)
[ ] _____ prior marriages (partner)

Intimate relationship:

[ ] not currently in relationship
[ ] currently in a serious relationship

Relationship satisfaction:

[ ] very satisfied with relationship
[ ] satisfied with relationship
[ ] somewhat satisfied with relationship
[ ] dissatisfied with relationship

Describe any past or current significant issues in intimate relationships: _____

_____

_____

_____

Describe any past or current significant issues in other immediate family relationships: _____

_____

_____

_____

Psychological History & Initial Information

Self -Report on Assessment of Functioning

CURRENT STRESSFUL EVENTS: Legal___ Financial___ Family problems___ Family Illness ___

Other_____**Are you in an abusive relationship?** No__ Somewhat__ Yes

Recent losses (jobs, relationships, or difficult changes)_

Changes in friendships?___Yes___No **Academic/School Stress?_Yes_No**

SELF-ASSESSMENT OF FUNCTIONING:

Please rate (from 1-10) how well you feel you are currently functioning in each of the three areas listed below, according the following scale:

10 ------- 9 -------- 8---------7 -------- 6 -------- 5 --------4---------3 -------- 2 -------- 1

Excellent Functioning Mild difficulty Moderate difficulty Severe Difficulty Barely able to function

1. General Mood (Depression, Anxiety, etc.)_____2. Social Relationships?_____ 3. Daily work or school?____

WORST TIME IN LIFE:

(Please briefly describe). (You may use the back of this page for answers in the following sections, if needed:)

_____

_____

Who helped you through it?_____

Are there things that cause you to feel ashamed or that would be difficult to talk about? (No need to specify) ..... No Yes

BEST TIME IN LIFE:

(Please briefly describe)_____

_____

_____ Was there someone to share it with? Yes No

Do you have a close friend who is supportive and someone you can confide in during difficult times?. ..... Yes No

What have you done that you are **MOST PROUD OF?** _____

_____

What are your **STRENGTHS** (How do you cope) when times are hard? _____

_____

Do you feel you are a person of worth at least on an equal basis with others? VeryMuch Much Somewhat A little No

How much enjoyment or pleasure are you currently getting out of living? VeryMuch Much Moderate A little None

Adapted from: PSYCHOTHERAPY ASSESSMENT CHECKLIST (1/01) Psychotherapy Research Program at HMS, Leigh McCullough Ph.D.

PAYMENT FOR TIME AND SERVICES

PLEASE NOTE: WHILE INSURANCE OR ANOTHER PERSON MAY BE PAYING FOR ALL OR PART OF OUR CHARGES, OUR AGREEMENT IS WITH YOU RATHER THAN THE INSURANCE COMP ANY. **YOUR SIGNATURE BELOW INDICATES YOUR UNDERSTANDING AND WILLI NGNESS TO ABIDE BY OUR OFFICE POLICIES REGARDING:**

- PAYMENT OF ALL REASONABLE CHARGES INVOLVED IN THE RENDERING OF SERVICES.
- PAYMENT IS DUE AT THE TIME OF EACH VISIT UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE. **NOTE:** WE ACCEPT MASTERCARD, VISA, DISCOVER AND AMERICAN EXPRESS.
- OUR FULL SERVICE FEE IS CHARGED FOR TIME RESERVED WHEN APPOINTMENTS ARE FAILED OR CANCELLED WITHOUT **24 HOUR NOTICE**.

IF YOU BELIEVE YOUR MEDICAL INSURANCE MAY COVER THE COSTS OF ALL OR PART OF YOUR VISITS HERE, PLEASE GIVE US A COPY OF YOUR INSURANCE CARD **AND** COMPLETE THE FOLLOWING INFORMATION:

POLICY HOLDER (you, partner or other?)	INSURANCE COMPANY/ PLAN	GROUP OR POLICY NUMBER
EMPLOYER OF POLICY HOLDER	**POLICY HOLDERS DATE OF BIRTH**	RELATIONSHIP TO YOU?
POLICY HOLDERS SSN	POLICY HOLDERS ADDRESS (If different)	

While we will file your insurance claimfor you, WE SUGGEST YOU CALLYOUR INSURANCE COMPANY to get informationconcerning your co-payand deductible. We suggest you do this before your 1st or 2nd visit and ask them about your coverage for "outpatient mental health services". This will help you to determinethe appropriate payment for your counseling sessions. In lieu of this information we suggest a payment of at least 50% of the initial fee for the session. We will reimburse any excess amount once your insurance company pays us. All co-payments must be paid at the time of each session unless you make other arrangements with your therapist. MasterCard, Visa, Discover and American Express are accepted. If your plan requires a physician's referral, please contact your family doctor or primary care physician (PCP) before treatment begins.

DISCLOSURE OF MENTAL HEALTH INFORMATION AND ASSIGMENT/AGREEMENT TO PAY

1,_____,on my own behalf, authorize Donald M. Kaesser, Ph.D.,P.C. (DMK) and/or his representatives to release mental
(PRINT YOUR NAME)
health information to my Insurance Company to the full extent specified under any or all Federal laws and Iowa Code Chapter 228, or as subsequently amended, to provide utilization review or quality assurance service for the administration of claims for benefits. I further authorize DMK to directly receive all payment of benefits due.

This authorization allows (DMK) and/or it's representatives to release information to my Insurance Company, to administrator claims submitted, or to be submitted for payment, to conduct a utilization and quality control review of mental health care services provided or proposed to be provided, or to conduct an audit of claims paid.

I acknowledge that I am aware that I may inspect the information disclosed at any time, and may revoke this authorization at any time it I furnish written revocation to (DMK) and/or hiss representatives and thus, I agree to accept financial liability, for mental health care services provided if insurance should deny claims for benefits because of the inability to examine my mental health records or the mental health records of the person named in this authorization.

I certify that all the information is true, accurate, and complete and I agree to be personally responsible for all reasonable charges not paid by my insurance company.

CLIENT SIGNATURE_____DATE_____

INSURANCE I.D. # _____