Jim Williams, MA, LMHC

Revised 7/9/10

Background Information

Today's Date _____

I. Primary Client Name (If couple, family, or group, the one person who will be the identified client):

First Name _____MI_____ Last Name_____M___F___

Home Phone # ( ) _____ Cellular Phone # ( ) _____ Work Phone # ( ) _____

Address _____City_____State_____Zip_____

Mailing address if different from above: _____

Drivers license #_____Date of Birth (DOB) _____ SS# _____

Employer _____ Client E-mail _____

II, Spouses's/Other Client's Information (or if primary client is a minor, give parent/guardian information below):

Relationship to primary client: Spouse_____ Parent _____ Legal Guardian _____ Child _____ Other_____

First Name _____MI_____Last Name_____M___F___

Home Phone # ( )_____ Work Phone# ( )_____ Cellular Phone # ( ) _____

Address _____City_____State_____Zip_____

Mailing address if different from above: _____

Driver's license # _____ Date of Birth (DOB) _____ SS # _____

Employer _____ Client E-mail _____

If we are billing your insurance please fill out the following information completely:

Are you using an Employee Assistance Program (EAP)? _____ yes _____ no If yes, who do we bill? _____

EAP Phone# ( )_____ How many sessions? _____ Authorization # _____

Primary Ins. Co _____ *Grp #* _____ *ID#* _____

Ins. Billing Address _____Ins. Phone # _____

City_____State_____Zip_____

Name of Subscriber _____ Relationship to client _____

Subscriber's Address (if not above)_____ DOB _____

City_____State_____Zip_____

Subscriber's Employer _____ Phone # _____

*Any secondary insurance?(please give complete information)*_____

_____

_____

Signature of person financially responsible for bill: (Include address and Phone # if not above) _____

_____

Have you (or any member of your family) previously been a client of Pearl Counseling Associates, LLC? □ Yes □ No
If yes, is your (or family members) portion of the account with that counselor clear and/or current? □ Yes □ No

PERSON TO NOTIFY IF EMERGENCY:
Relative: _____ Phone: ( ) _____
Name and address of person, organization, or ad that referred you:
_____Phone: ( ) _____

PEARL
Counseling Associates

JIM WILLIAMS, MA, LMHC
Marriage, Family & Adolescent Counseling

INFORMATION FOR CLIENTS

GENERAL

Since counseling is based upon a particular theoretical orientation as well as the personal style and experience of the counselor, I believe it is in the best interest of my clients to briefly explain my particular background as well as my view of the counseling process. In addition, I wish to clarify administrative policies to avoid misunderstandings.

PROFESSIONAL PROFILE

I am a Licensed Mental Health Counselor with the state of Washington (License # LH00007686). I received my Masters of Counseling from Western Seminary, Seattle and my Bachelors in Psychology from Seattle Pacific University. I have counseling experience in a variety of settings including residential treatment centers, schools, and mental health counseling centers. My professional training and experience encompasses clinical problems including: relational issues, emotional and behavior problems, depression, anxiety, anger, child and adolescent issues, and family relationships.

I am not a physician and cannot prescribe or provide medication. If a client is under current medical treatment, I will work in cooperation with the doctor. If medical treatment is needed, I will recommend competent medical personnel and work in cooperation toward the client's best interests.

I am an independent private practitioner. My work as a therapist is solely my responsibility and does not necessarily reflect the views of the other independent therapists at Pearl Counseling Associates. You are a client of Jim Williams, MA, LMHC and **not** a client of Pearl Counseling Associates.

COUNSELING PROCESS

I view the counseling process as forming an alliance with you to explore the nature of your problem. Although we will spend time exploring the specific problem that brought you into counseling, we will also explore in depth, the nature of your relationships with other significant people in your life. In my theoretical orientation, dynamics that have influenced the complexity and intensity of your problem are rooted in relational issues. In using a Biblical foundation in my counseling, I believe you are made to deeply relate—this is the source of your greatest joy, but also your deepest pain. This is not to simplify your problem, but rather to highlight the complexity of the problem and how it interferes with the enjoyment for which you are most deeply made. This is also meant to give you hope—by dealing not only with the problem itself, but also the source of the problem. I believe that certain problems may also have (or develop into) a physical component. In such cases, medical consultation will be sought.

CONFIDENTIALITY

As a professional counselor, there is a legal privilege in this state protecting the confidentiality of the information that you share with me, and I assure you that I strive to maintain the strictest ethical standards of confidentiality. It is important for you to know that the following are legal exceptions to confidentiality:

- State law **requires** suspected child abuse (physical or sexual) to be reported to Child Protective Services or law enforcement officials.
- Threat of harm to self or others (suicidal or homicidal statements) may be reported to family and/or appropriate mental health or law enforcement professionals.
- Case records and testimony may be subpoenaed by court order.

CONSULTATIONS

In order to facilitate professional development and quality counseling, I submit myself to ongoing supervision with other licensed mental health counselors. This allows me to see other perspectives and gain insight from others experienced in counseling. No identifying information about any of my clients is provided my colleagues during consultation without the specified consent of the client. Your signature below grants me permission to disclose supervision (ongoing training) only.

ETHICS AND PROFESSIONAL STANDARDS

I subscribe to the ethical and professional standards of the Washington State Licensing Law. If you have questions about our work together, please talk with me about this so that we can come to an understanding about you specific needs and the direction of our work together. In the event that you feel I have acted in an unethical manner, please discuss the situation with me so we can come to a resolution. If you find that our negotiation has not been satisfactory, you may contact directly the US Secretary of Health and Human Services.

APPOINTMENTS, FEES, AND PAYMENT OF FEES

As a private practitioner I must operate as a small business. This means that unless clients pay their bills, I cannot afford to continue offering services. Patients and their legal guardians are responsible for their accounts and are expected to pay their bill when due, whether medical insurance pays for a portion or not. The fee for counseling is $150.00 for the first session and then $130.00 per 50-minute session thereafter. If payment is made at the time of the session the fee will be reduced to $135.00 for the first session and $115.00 for each session thereafter (**fee reduction applies to non-insurance clients only**). Charges for evaluations, printed materials, reports, letters, consultations, and telephone calls will be at the $115.00 per hour rate. Additional fees may result from psychological testing, court appearances, and collection procedures. All fees are pro-rated based on the $115.00 per hour rate.

There will be a charge on checks returned for insufficient funds. If a client's account accrues a balance of more than $250.00 in personal debt (excludes amount owed by insurance), the counseling may be suspended until the client has reduce their balance below $250.00. Bills for which no payment has been made for 60 days will be considered delinquent and may be instituted for collection. The fact of our counselor-client relationship may be released to appropriate persons for collection of overdue accounts.

Appointments are generally made on a regular, weekly basis. Appointment times are not automatically held open for clients from week to week. It is the client's responsibility to reschedule at the end of the session. In the event you are unable to keep your appointment, a 24-hour notice is required for cancellation. Except for unseen circumstances, you will be charged full fee for a "no show" and a late cancel fee ($45.00) for a cancellation without 24-hour notice.

For those participating in group therapy, fees will be $30.00 per session to be paid at the first of the month unless other arrangements have been made prior to sessions beginning. You have the freedom to exit group at any time, however, except for unforeseen circumstances that make it impossible for you to continue in group, dropping from group will not release you from the financial obligation for the duration of the group.

CLIENT'S RIGHTS AND RESPONSIBILITIES

The course of therapy is determined mutually by myself, the counselor, and you, the client. You are encouraged to feel free to ask me any questions you have regarding my education and professional background, therapeutic approach, and the specific therapy plan and progress. Counselors practicing counseling for a fee must be

registered or certified with the Department of Health for the protection of the public health and safety. State certification requirements do not include recognition of any practice standards, nor necessarily imply the effectiveness of any treatment. It is your responsibility to determine whether the services offered are appropriate and ultimately helpful. The length of therapy varies depending on the needs and issues of the individual client, so the progress and treatment plan will be reviewed and modified, if necessary, on an ongoing basis. You may seek a second opinion from another therapist at any time. You have the right to end therapy at any time without any moral, legal, or financial obligations other than those already accrued.
Many of the results of counseling will depend upon your determination to deal honestly with the issues that powerfully affect your life. In that light, having a willingness to **face what is true is an important requisite.**

DISCLAIMER REGARDING CHILDREN
Unless children are a part of the therapy session it is recommended that they not be brought to the office. I am unable to guarantee their safety if left unattended in the waiting room or group room. Our receptionist, if present, cannot be responsible for keeping an eye on them, as well.

By signing this disclosure and consent statement, the client acknowledges having been informed of his/her rights and responsibilities under regulatory laws for counselors in Washington State. In addition, the client acknowledges he/she has read and understands the administrative policies for this counseling office.

_____ _____
Signature of Client Date

_____ _____
Signature of Client Date

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Counselor Date

Financial Policy
Pearl Counseling Associates, LLC

Private Pay (not using Insurance)

Payment is due at time of service unless you make other arrangements with your counselor. If you do have an alternate agreement with your counselor, please make sure the Office Manager is aware of it.

We accept as payment, Visa/MasterCard, Debit Cards, Checks, Money Orders, Cash, or online banking service. Make checks or money orders payable to your counselor (not to Pearl Counseling). Checks returned for non-sufficient funds (NSF) will be charged back to your account with an additional $18.00 service charge. If you prefer, you can use EASY PAY for billing. In that case, we will maintain your credit or debit card number on file to satisfy all fees charged, including late cancels, no shows, co pays, deductibles, coinsurances or other balances.

Insurance & Insurance Collection

Insurances doing business in the state of Washington have 30 to 90 days to pay or deny a claim. They normally respond in 2-3 weeks' time. If you have paid your account in full and insurance pays at a later date, or you pay more than is owed, you may choose either to receive a refund from your counselor or apply the credit toward future sessions.

It is your responsibility to know what your mental health benefits and financial obligations are with your insurance company. As a courtesy, we will also check on your benefits. Be aware that most insurance plans require you to authorize us to provide a clinical diagnosis, and sometimes additional clinical information. This information becomes part of the insurance company files.

We will bill your insurance for you. Co-pays, if applicable, are due at time of service. If you have a coinsurance (vs a co-pay) you will be billed after we receive the explanation of benefits from your insurer. If your counselor is out of network for your insurance, you may need to pay for the session in full, and then receive reimbursement directly from your insurance company. Note: Having more than one insurer does not necessarily mean that your services are covered 100%. Secondary insurers will pay as a function of what your primary carrier pays.

Late/Missed Sessions: Insurance does not pay for missed sessions, nor for missed time during a session. If you are late or miss a session, insurance will not pay for the lost minutes, and we will need to bill you for the missed time.

Minor Clients: The adult accompanying a minor and the parents (or guardians of the minor) are responsible for payment. (If the minor is covered by insurance the policies applicable to their type of insurance apply.) For unaccompanied minors, non-emergency treatment requires that charges be authorized to a Visa/MasterCard/Bank Card, or payment by cash or check at time of service has been verified, or we have the signature on file of the person(s) financially responsible for the bill and they have read and signed this policy.

Divorce Decrees: This office is NOT a party to your divorce decree. Adult clients are responsible for their portion of the bill at the time of service. The responsibility for minors rests with the accompanying adult. An exception may be made if we have a written authorization from a third party, prior to the start of counseling, indicating that they will be responsible for fees billed to them.

Collections / Rebilling Fees: We may charge a rebilling fee of $10.00 per bill on past due accounts (over 30 days). If it becomes necessary to send your account to collections., you will be responsible for all collection fees. An initial fee of $30.00 will be added to your account to start the collections process. Non-emergency counseling sessions will be suspended until your account is paid in full.

On Call Counseling: Pearl Counseling Associates, LLC offers "on call" counseling when crisis or emergency counseling is needed during your counselor's absence. If you meet with an "on call" counselor, payment is due at the time of service, at the counselor's rate. If the "on call" counselor is in network with your insurance and you fill out their intake form, your insurance can be billed.

I have read the Financial Policy. I understand and agree to this Financial Policy:

Client or Responsible Party: _____ **Date**_____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. State and federal law protects the confidentiality of this information. "Protected Health Information," (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Your Rights Regarding Your PHI

You have the following rights regarding your PHI that I maintain about you:

Right of Access to Inspect and Copy. You have the right, which may be restricted only in certain limited circumstances, to inspect and copy PHI that may be used to make decisions about your care. I may charge a reasonable, cost-based fee for copies.

Right to Amend. If you feel that the PHI I have about you is incorrect or incomplete, you may ask me to amend the information although I am not required to agree to the amendment.

Right to an Accounting of Disclosures. You have the right to request a copy of the required accounting of disclosures that I make of your PHI.

Right to Request Restrictions. You have the right to request a restriction or limitation on the use of your PHI for treatment, payment, or health care operations. I am not required to agree to your request.

Right to Request Confidential Communication. You have the right to request that I communicate with you about medical matters in a certain way or at a certain location. I will accommodate reasonable requests and will not ask why you are making the request.

Right to a Copy of this Notice. You have the right to a paper copy of this notice.

Right of Complaint. You have the right to file a complaint in writing with me or with the Secretary of Health and Human Services if you believe I have violated your privacy rights. I will not retaliate against you for filing a complaint.

MY USES AND DISCLOSURES OF PHI FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATION

Treatment. Your PHI may be used and disclosed by me for the purpose of providing, coordinating, or managing your health care treatment and any related services. This may include coordination or management of your health care with a third party, consultation with other health care providers or referral to another provider for health care services.

Initials _____

Payment. I will not use your PHI to obtain payment for your health care services without your written authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities.

Healthcare Operations. I may use or disclose, as needed, your PHI in order to support the business activities of my professional practice. Such disclosures could be to others for health care education, or to provide planning, quality assurance, peer review, administrative, legal, or financial services to assist in the delivery of health care, provided I have a written contract requiring the recipient(s) to safeguard the privacy of your PHI. I may also contact you to remind you of your appointments, inform you of treatment alternatives and/or health related products or services that may be of interest to you.

OTHER USES AND DISCLOSURES THAT DO NOT REQUIRE YOUR AUTHORIZATION OR OPPORTUNITY TO OBJECT

Required by Law. I may use or disclose your PHI to the extent that the use or disclosure is required by law, made in compliance with the law, and limited to the relevant requirements of the law. Examples are public health reports and law enforcement reports. I also must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining my compliance with the requirements of the Privacy Rule.

Health Oversight. I may disclose PHI to a health oversight agency for activities authorized by law such as professional licensure. Oversight agencies also include government agencies and organizations that provide financial assistance to me (such as third party payers).

Abuse or Neglect. I may disclose your PHI to a state or local agency that is authorized by law to receive reports of abuse or neglect. However, the information I disclose is limited to only that information which is necessary to make the initial mandated report. I may disclose PHI regarding deceased patients for the purpose of determining the cause of death, in connection with laws requiring the collection of death or other vital statistics, or permitting inquiry into the cause of death.

Research. I may disclose PHI to researchers if (a) an Institutional Review Board reviews and approves the research and an authorization or waiver to the authorization requirement; (b) the researchers establish protocols to ensure the privacy of your PHI; and (c) the researchers agree to maintain the security of your PHI in accordance with applicable laws and regulations.

Threat to Health or Safety. I may disclose PHI when necessary to prevent a serious threat to your health or safety or to the health or safety of the public or another person.

Criminal Activity on My Business Premises/Against My Staff or Me. I may disclose your PHI to law enforcement officials if you have committed a crime on my premises or against my staff or me.

Compulsory Process. I will disclose your PHI if a court of competent jurisdiction issues an appropriate order. I will disclose your PHI if you and I have been notified in writing at least fourteen days in advance of a subpoena or other legal demand, and no protective order has been obtained, and I have satisfactory assurances that you have received notice of an opportunity to have limited or quashed the discovery demand.

Initials _____

USES AND DISCLOSURES OF PHI WITH YOUR WRITTEN AUTHORIZATION

Other uses and disclosures of your PHI will be made only with your written authorization. You may revoke this authorization in writing at any time, unless I have taken an action in reliance on the authorization of the use or disclosure you permitted, such as providing you with health care services for which I must submit subsequent claim(s) for payment.

THIS NOTICE

This *Notice of Privacy Practices* describes how I may use and disclose your protected health information (PHI) in accordance with all applicable law. It also describes your right regarding how you may gain access to and control your PHI. I am required by law to maintain the privacy of PHI and to provide you with notice of my legal duties and privacy practices with respect to PHI. I am required to abide by the terms of this *Notice of Privacy Practices*. I reserve the right to change the terms of my *Notice of Privacy Practices* at any time. Any new *Notice of Privacy Practices* will be effective for all PHI that I maintain at that time. I will make available a revised *Notice of Privacy Practices* by sending a copy to you in the mail upon request, or providing one to you at your next appointment.

CONTACT INFORMATION

I am my own Privacy Officer. So, if you have any questions about this *Notice of Privacy Practices*, please contact me. My contact information is:

Jim Williams, MA, LMHC
1919 N Pearl St., Ste. C-1
Tacoma WA 98406
(253) 752-1860x350

COMPLAINTS

If you believe I have violated your privacy rights, you may file a complaint in writing to me, as my own Privacy Officer, specified on the first page of this *Notice*. I will not retaliate against you for filing a complaint. You may also file a complaint with the U.S. Secretary of Health and Human Services.

The effective date of this notice is April 14, 2003

ACKNOWLEDGMENT

I hereby acknowledge receiving a copy of this notice.

_____

Client's Signature *Date*

_____

Client's Signature *Date*

Jim Williams, MA, LMHC
Pearl Counseling Associates, LLC
1919 N Pearl St., Ste. C-1, Tacoma WA 98406
Office: (253) 752-1860 x **350**, FAX: (253) 752-1890

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR INSURANCE CLAIMS PROCESSING

TYPE OF INFORMATION TO BE DISCLOSED

I hereby authorize **Jim Williams and/or his billing representative** to use and/or disclose the following protected health information: **Please initial.**

- ❑ _____ Information required to process manual claims
- ❑ _____ Information required to process electronic claims

ASSIGNMENT OF BENEFITS (Please initial)

- ❑ _____ I authorize my insurance benefits to be paid directly to the provider.

INSURANCE COMPANY TO WHICH PROTECTED HEALTH INFORMATION WILL GO

Name_____

Address: _____ Business Phone: _____

City: _____ State: _____ Zip: _____

REVOCATION AND REDISCLOSURE

It is my understanding that this authorization can be revoked in writing at any time, except to the extent that substantial action may have already occurred based on prior authorization, and/or including provision of health care services requiring disclosure to effectuate payment. Unauthorized re-disclosure by recipient is a potential risk.

DURATION

If not previously revoked, this authorization will expire one (1) year from date signed below.

***Specific Limitation**:* Except as to third-party payers, this authorization does not include disclosure for future health care services received more than ninety (90) days from date of last signature.

SIGNATURE

This Authorization covers protected health information pertaining to *(client)* _____.
Signature below authorizes use and/or disclosure of protected health information in accordance with the foregoing from the Date of that signature (initial or renewal). I acknowledge that I am responsible for any balance due. I agree that I will not withhold or delay payment because of any insurance/third party involvement.

Signature: _____ Date: _____

Patient/Parent/Guardian/Other legal representative for health care decisions: _____

Renewal Signature: _____ Date: _____

Witness: _____ Date: _____

Client Easy Pay Consent

(Optional payment plan for those paying by credit/debit card). This form is for those who wish us to keep your debit/credit card number on file and we will automatically deduct any payments owed from your debit/credit card. (Examples of payments deducted are copays, deductibles, coinsurances, late cancels, no-shows or full payment if not using insurance).

I authorize **Jim Williams, MA, LMHC**, to charge my credit/debit card for fees charged (including late cancels and no shows) and if using insurance, copays, coinsurances, deductibles and the balance of charges not paid by insurance within 90 days.

Not to exceed $ _____ per

- ❑ Month (day of month _____)
- ❑ Semi-monthly (the 15th and the last day of the month)
- ❑ Week (day of week _____)
- ❑ Each session

Insurance clients: (Don't sign this unless you are using easy pay <u>and</u> have insurance)

I assign my insurance benefits to the provider listed above. I understand that this form is valid for one year unless I cancel the authorization through written notice to the health care provider. I understand that if my insurance should pay at a later date I may choose either to have a refund issued by my counselor or use it as a credit towards future payments owed.

_____ _____

Cardholder Signature Date

Patient Name		
Cardholder Name Exactly as it Appears on the Card		
Cardholder Address		
City	State	Zip

☐ Visa ☐ MasterCard ☐ Visa Debit Card ☐ MasterCard Debit Card

Credit Card Number _____

Date of Expiration _____/_____/_____ V-code (3 digit Security Code on back of card) _____

Cardholder's Signature _____

INSURANCE QUESTIONNAIRE

While we bill the insurance company for you as a courtesy and help facilitate your receipt of benefits, we are not responsible for whether your insurance company pays or not. To help you receive the best information regarding your mental health benefits, please contact your insurance company and ask the following questions. (These questions should be asked of each insurance policy you wish us to bill and for each family member that is seeing a counselor separately.) We ask that if you have not obtained this information before coming into our facility, that you please do so by your second session. Even though mental health benefits fall under the medical category, do not assume that you have benefits or that your benefits are the same for mental health as they are for medical expenses (they usually are quite different).

Do I have mental health benefits on my policy? If additional members of my family are seeing the counselor separately, do they have the same benefits?

If yes,

1) Is my counselor covered under my policy? (Be sure and get your counselor's credentials. My counselor's credentials are **MA, LMHC (Licensed Mental Health Counselor).** (Some insurances will take only and MD, PhD, or licensed agency. Pearl Counseling Associates, LLC is not a licensed agency.) Is my counselor a preferred/participating provider or considered out of network? If my counselor is not preferred/participating, do I have out of network benefits? Are out of network providers with my counselor's credentials covered? Does my counselor need direct supervision by a MD or PhD to be covered?

2) Is this an EAP (employee assistance program) or am I using my regular insurance policy only (or both)? [If EAP, has my counselor been sent a packet for billing (If so, check with counselor to see if received)? How many sessions has my EAP approved? After my EAP sessions are finished, and I wish to continue, can I continue with my current counselor or do I need a referral?]

3) What are my deductible and/or co pay/coinsurance? (Have I met my deductible for the year? If not, how much do I still owe? When does it start over again?)

4) Do I need preauthorization, a referral from my physician (ex: family doctor) or a gatekeeper (ex. Magellan, MHN, HMC), for any or maximum benefits? If yes, questions to ask your physician or gatekeeper.
   a) How many sessions will they allow me to begin with?
   b) If necessary, who obtains the extension on the authorization?
   c) How soon will my insurance company receive the authorization so my sessions will be covered? (Client should check with insurance company a few days after expected date of receipt to see if authorization has been received.)
   d) What are the start date and ending date of my authorization? Will it cover sessions I've already had?

5) How many sessions will my insurance cover or what is the maximum dollar amount per year my insurance company will allow?

6) What are the exclusions on the policy, if any? Will my presenting issue be covered? (ex: often marriage and family issues are not covered).

7) What is the correct insurance address to send claims to? Is it different than what's on my card? Is it different for a preferred provider vs. an out of network provider?

Intake Questionnaire

Name: _____ **Date:** _____ **Email (optional):** _____

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere?
_____Yes _____ No If yes, from whom, where and for how long? _____
_____

Have you had previous psychotherapy? _____ Yes_____No If yes, when? _____
Previous therapist's name: _____
What did you find helpful/not helpful about your previous therapist? _____
_____

Are you currently taking prescribed psychiatric medication (i.e. antidepressants, etc.)? ____ Yes ___ No
If yes, please list: _____
If no, have you previously taken psychiatric medication? _____ Yes _____ No
If yes, please list – Name: _____ Dosage: _____ Duration: _____

Please list any additional supplements or over the counter medications you are taking: _____
_____

Health and Social Information:

1. How is your physical health at present?
   _____ Poor _____ Unsatisfactory _____ Satisfactory _____ Good _____ Very Good

2. Please list any previous or current persistent physical symptoms, conditions, surgeries or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.): _____
   _____

3. Are you having any problems with your sleep habits? _____Yes _____ No
   If yes, check where applicable:
   _____ Sleeping too little _____Sleeping too much _____ Poor quality sleep _____ Disturbing dreams
   For how long? _____ How often? _____

4. How many times per week do you exercise? _____ For how long each time? _____

5. Are you having any difficulty with appetite or eating habits? _____ Yes _____ No

6. Do you regularly use alcohol? _____ Yes _____ No
   In a typical month, how often do you have 4 or more drinks in a 24-hour period? _____

7. Do you engage in recreational drug use? _____ Yes _____ No If yes, how often?
   _____ Daily_____Weekly _____ Monthly_____ Rarely

8. Have you had suicidal thoughts recently? ____ Frequently ___ Sometimes ___ Rarely ___ Never
   Have you had them in the past? ____ Frequently ____Sometimes ____Rarely ___ Never

9. Are you currently in a romantic relationship? ____ Yes ____ No
If yes, how long have you been in this relationship? _____
On a scale of 1-10, how would you rate the quality of your current relationship? _____

10. Please list your greatest concerns/issues/stressors: _____
_____
_____

Are you currently or have you ever experienced any of the following:

			Approximate date of onset and duration:
Extreme depressed mood:	Y	N	_____
Wild mood swings:	Y	N	_____
Rapid speech:	Y	N	_____
Extreme anxiety:	Y	N	_____
Panic attacks:	Y	N	_____
Phobias:	Y	N	_____
Sleep disturbances:	Y	N	_____
Hallucinations:	Y	N	_____
Unexplained losses of time:	Y	N	_____
Unexplained memory lapses:	Y	N	_____
Alcohol/substance abuse:	Y	N	_____
Frequent body complaints:	Y	N	_____
Eating disorder:	Y	N	_____
Body image problems:	Y	N	_____
Repetitive thoughts (obsessions):	Y	N	_____
Repetitive behaviors (hand-washing):	Y	N	_____
Homicidal thoughts:	Y	N	_____
Suicide attempt:	Y	N	_____

Occupational Information:

Are you currently employed? _____ Yes _____ No
If yes, who is your current employer/position? _____
If yes, are you happy at your current position? _____
Please list any work-related stressors: _____
_____
_____

Religious/Spiritual Information:

Do you attend church regularly? _____ Yes _____ No
If yes, what is your faith? _____
If not do you consider yourself to be spiritual? _____ Yes _____ No

Family Mental Health History:

Has anyone in your family (either immediate family members or relatives) experienced difficulty with any of the following? Please check any that apply and who it applies to (e.g. sibling, parent, uncle, etc.):

Difficulty		**Family Member**
Depression	_____	_____
Bipolar Disorder	_____	_____
Anxiety Disorder	_____	_____
Panic Attacks	_____	_____
Schizophrenia	_____	_____
Alcohol Abuse	_____	_____
Drug Abuse	_____	_____
Eating Disorders	_____	_____
Learning Disability	_____	_____
Trauma History	_____	_____
Suicide Attempts	_____	_____