GENERAL INFORMATION:

Date: _____ Referred by: _____

Full Name: _____ Sex: **O** Male **O** Female

Name you prefer: _____ Age: _____ date of birth: _____

Employer: _____ Length of Employment: _____

Occupation: _____ Average hours worked per week: _____

Last year of school completed: **O**9 **O**10 **O**11 **O**12 **O**GED College: **O** 1 **O** 2 **O** 3 **O** 4 **O** other _____

CONTACT INFORMATION:

Mailing Address:

_____

City: _____ State: _____ Zip Code: _____ May we send mail here: **O** yes **O** no

Home Address (if different):

_____

City: _____ State: _____ Zip Code: _____ May we send mail here: **O** yes **O** no

Home Phone: (_____) _____ May we leave a message here: **O** yes **O** no

Cell Phone: (_____)_____ May we leave a message here: **O** yes **O** no

Work Phone: (_____) _____ May we leave a message here: **O** yes **O** no

Email Address: _____ May we leave a message here: **O** yes **O** no

EMERGENCY CONTACT:

Name: _____ Relationship: _____

Home Phone: (_____)_____ Mobile Phone: (_____)_____

I declare, under penalty of perjury, that all information printed above are correct.

Signature: **X** _____ Date: _____

INFORMED CONSENT AND RELEASE OF LIABILITY

Welcome to our private practice. This document contains important information about our professional services and business policies. Please read it carefully and make note of any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between YOU and Julia Davis LLC, 14502 North Dale Mabry Hwy, Suite# 200, Tampa, FL 33618.

PSYCHOTHERAPY SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and patient, and the particular problems you bring forward. There are many different methods I may use 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, you will have to actively work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, we 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. Therapy involves a large commitment of time, money, and energy, so you should carefully select a therapist that is a good fit . If you have questions about our procedures, we should discuss them whenever they arise. Julia Davis LLC offers Standard-Appointments (8:00am - 5:00pm).

_____, I understand and agree to the Psychotherapy Services policy as stated above.

MEETINGS

We normally conduct an informal evaluation of your needs that may last from 1 to 3 sessions. During this time, we can both decide what your needs and goals are and what services will best support you in order to meet your treatment goals. Depending upon the needs and goals we can schedule regular appointments (twice each, weekly, bi-weekly, or monthly). Once an appointment is scheduled, you will be expected to pay for it unless you provide **advance notice of cancellation (read Cancellation & Rescheduling Section)** unless we both agree that you were unable to attend due to circumstances beyond your control, this includes "no-show" attendance. If it is possible, we will try to find another time to reschedule the appointment.

_____, I understand and agree to the Meetings policy as stated above.

PROFESSIONAL FEES

Our hourly fee for Face to Face Counseling Service is ……

Individual.. . . . .$90.00 Couples …….$100.00 Family $110.00

In addition to weekly appointments, we charge this amount for other professional counseling based upon services you may need, though we will break down the hourly cost if we work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request. If you become involved in legal proceedings that require our participation, you will be expected to pay for our professional time even if your clinician is called to testify by another party. Because of the difficulty of legal involvement, we charge $250 per hour for preparation and attendance at any legal proceeding. An additional mileage fee will be charged.

Other Fees (that will not be covered by your insurance):

Email Counseling (anything other than brief updates and documents exchange that requires writing or reading more than 3-4 sentences): $20/ exchange or $50 for 4 eexchanges in one string of emails within 48 hours

Phone Sessions (anything over 10 minutes on the phone initiieated by the client): $45/25 minutes or $80/50 minutes.

Text theapy (therapy via texting app) 2 text responses from theapist, 5 days a week. $35 per week.

Video theapy sessions (video session over Doxyme) $80/50 minutes.

Preparation of Summaries of Treatment or Letters at request of client: $75 per item requested.

Administrative Fee for Record Copy Requests: $25

_____, I understand and agree to the Professional Fees policy as stated above.

BILLING AND PAYMENTS

You will be expected to pay for each standard session at the time it is held, unless we agree otherwise. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, we may be willing to negotiate a fee adjustment or payment installment plan.

I understand and agree that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Julia Davis, LLC and/or its affiliated entities for any charges not covered by my healthcare benefits. It is my responsibility to notify Julia Davis, LLC of any changes in my healthcare coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by Julia Davis, LLC and/or my healthcare insurer if the submitted claims or any part of them are denied for payment.

I understand and agree that If my account has not been paid for more than 30 business days and arrangements for payment have not been agreed upon, Julia Davis LLC has the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information we release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. It is our legal right to disclose this information in the event that I need to collect overdue payment. I understand that Invoices not paid within terms are subject to a 2.0% monthly finance charge plus an administration fee of $25.00.

_____, I understand and agree to the Billing and Payments policy as stated above.

CANCELLATIONS AND RESCHEDULING

I understand and agree that if for some reason I must cancel my appointment,the office is to be notified at **(813) 922-1550** as soon as you know you cannot keep the appointment. You may leave a voicemail or text.

- **Standard-Appointments (8:00am-5:00pm)** cancelled with less than two (2) business days from the scheduled session is considered late cancelled appointment and you will be billed $90.00.
- All cancellation fees are billed to the responsible party on file.
- Repeated (two or more) late cancellations (within 48 hours), and "no Shows" will mean the cancellation of future appointments. If services are requested to continue a $90 deposit will be required.
- A session is considered missed if the party has not arrived fifteen (15) minutes after the start of the session.
- Missed Appointment Fees are **not** covered by my Health Insurance and that I am personally responsible for the full cost of the Missed Appointment Fees.

_____, I understand and agree to the Cancellations and Rescheduling policy as stated above.

CREDIT CARD AUTHORIZATION AND GUARANTEE FOR PERSONAL BALANCES

Julia Davis LLC clients have the option to pay by cash, cashier's check, debit card, or credit card.

I understand and agree that after every session of service, missed appointment, late cancel or if my Insurance Claim apply to my plan deductible, Julia Davis, LLC will automatically charge my Debit Card or Credit Card we have on file for you.

Julia Davis LLC's clients are personally responsible for payment. Any balance not paid will be automatically charged to your designated debit card, or credit card. By submitting debit card or credit card information, you are requesting Julia Davis LLC to charge your credit card or debit card for your

services. You may revoke or change this election at any time by calling **(813) 922-1550** or by email to: **harborofserenity@gmail.com**.

In the event that a debit/credit card is declined, we will automatically charge the alternate credit/credit card on file. We will also ask you to choose another payment method for future plans.

I understand and agree that when I sign this contract, I agree to the above terms and authorize Julia Davis LLC to charge any payment not paid by other payment methods at the time of service to the credit card information on file with us.
I understand that declined charges will result in those charges being applied to my credit card.

_____, I understand and agree to the Credit Card Authorization policy as stated above.

PROFESSIONAL RECORDS & CONFIDENTIALITY

The laws and standards of my profession require that we keep treatment records. You are entitled to receive a copy of your records, or we can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, we recommend that you review them in the presence of your clinician so that their contents can be discussed. Patients will be charged an appropriate fee for any professional time spent in responding to information requests.

I understand and agree that my counseling records are kept confidential, expect where disclosure is required by law or the ethics of the counseling profession (i.e. abuse of a child, elderly or disabled person: potential harm or threat to self or others: child custody cases that go before court of law: and specific information subpoenaed by a court law). The clinical records are the property of Julia Davis LLC and are deemed records of confidential sessions between therapists and clients. I waive any right I may otherwise have to seek to use the clinical records of the counseling company as evidence in any judicial proceedings.
I understand and agree that if any clinician from this office is subpoenaed or court ordered to testify in court, additional service fees will be charged separate from the counselor's regular counseling rates.
I understand that I must provide Julia Davis LLC with any Court Documents, Legal Documents, Injunctions or Safety Concerns.

In general, the privacy of all communications between a patient and a therapist is protected by law, and we can only release information about our work to others with your written permission. But there are a few exceptions. In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.

There are some situations in which we are legally obligated to take action to protect others from harm, even if we have to reveal some information about a patient's treatment. For example, if we believe that a child, elderly person, or disabled person is being abused, we must file a report with the appropriate state agency.
If we believe that a patient is threatening serious bodily harm to another, we are required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, we may be

obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. These situations have rarely occurred in my practice. If a similar situation occurs, we will make every effort to fully discuss it with you before taking any action.

We usually find it helpful to consult other professionals about a case. During a consultation, we make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential. If you don't object, we will not tell you about these consultations unless we feel that it is important to our work together.

This written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, We will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and we are not an attorney.

_____, I understand and agree to the Professional Records and Confidentiality policy as stated above.

SOCIAL MEDIA AND TELECOMMUNICATION

Due to the importance of your confidentiality and the importance of minimizing dual relationships, we do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.). We believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship . If you have questions about this, please bring them up when we meet and we can talk more about it.

ELECTRONIC COMMUNICATION

I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you or your therapist choose to use information technology for some or all of your treatment, you need to understand that:

1. You retain the option to withhold or withdraw consent at any time without affecting the right to future care or treatment nor risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

2. All existing confidentiality protections and equally applicable.

3. Your access to all medical information transmitted during a Telehealth consultation is guaranteed, and copies of this information are available for a reasonable fee.

4. Dissemination of any of your identifiable images or information from the Telehealth interaction to researchers or other entities shall not occur without your consent.

5. There are potential risks, consequences, and benefits of telemedicine. Potential benefits include, but are not limited to improved communication capabilities, providing convenient access to up-to-date information, consultations, support, reduced costs, improved quality, change in the conditions of practice, improved access to therapy, better continuity of care, and reduction of lost work time and

travel costs. Effective therapy is often facilitated when the therapist gathers within a session or a series of sessions, a multitude of observations, information, and experiences about the client. Therapists may make clinical assessments, diagnosis, and interventions based not only on direct verbal or auditory communication, written reports, and third person consultations, but also from direct visual and olfactory observations, information, and experiences. When using information technology in therapy services, potential risks include, but are not limited to the therapist's inability to make visual and olfactory observations of clinically or therapeutically relevant issues such as : your physical condition including deformities, apparent height and weight, body type, attractiveness relative to social and cultural norms or stands, gait and motor coordination, posture, work speed, any noteworthy mannerism or gestures, physical or medial conditions including bruises or injuries, basic grooming and hygiene including appropriateness of dress, eye contact (including any changes in the perviously listed issues), sex, chronological and apparent age, ethnicity, facial and body language, and congruence of language and facial or bodily expression. Potential consequences thus include the therapist not being aware of what they would consider important information, that you may not recognize as significant to present verbally to the therapist.

TREATMENT TERMINATION

If at any time during the course of your treatment your therapist determines that treatment should be terminated for any reason you will be provided with referrals accordingly. Ideally, therapy ends when we agree your treatment goals have been achieved. Additional conditions of termination include: You have the right to stop treatment at any time. If you make this choice, referrals to other therapists will be provided and you will be asked to attend a final 'termination' session. Professional ethics mandate that treatment continues only if it is reasonably clear you are receiving benefit.

Other legal or ethical circumstances may arise and compel us to terminate treatment. In these cases, appropriate referral(s) will be offered. Also, we do not diagnose, treat, or advise on problems outside the recognized boundaries of our competencies.

I understand and agree that in consideration of the benefits to be derived from the counseling, the receipt whereof is hereby acknowledged, I hereby release, remiss and forever discharge and covenant not to sue or hold legally liable Julia Davis, LLC, or employees of the aforesaid from any and all claims, demands, actions or causes of action of whatsoever kind and nature related to the counseling process.

_____, I understand and agree that conduct deemed inappropriate or dangerous by the therapist or support staff may warrant termination.

I have read the INFORMED CONSENT AND RELEASE OF LIABILITY. By signing this contract, I agree to participate in all Services by Julia Davis LLC. I understand and accept all its terms in full.

_____

Date

X_____ _____

Clients Signature Clients printed Name

_____

Signature Julia Davis

NOTICE OF PRIVATE PRACTICES (HIPPA)

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 DOCUMENT CAREFULLY!

Client Name (please print): _____

The Health Insurance Portability & Accountability Act of 1996 **(HIPPA)** requires all health care records and other individually identifiable health information

(protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information. As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment, and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include psychotherapy, medication management, etc.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your insurance company for your services.
- Health Care Operations include the business aspects of running or practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services. We will use and disclose your PROTECTED HEALTH INFORMATION when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law collect information;

_____
Initials

to a health oversight agency for activities authorized by law, including but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding; response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify the cause of death. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regard to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the address listed below:

The right to request restrictions or certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.
- The right to request an amendment to your PROTECTED HEALTH INFORMATION
- The right to receive an accounting of disclosures or PROTECTED HEALTH INFORMATION outside of treatment, payment and health care operations.
- The right to obtain a paper copy of this notice for us upon request. We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.

We are required to abide by the terms of the Notice of Privacy of Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

_____
Initials

For more Information about our Privacy Practice, please contact;

Julia Davis LLC
14502 North Dale Mabry Hwy
Suite # 200
Tampa, FL 33618
Phone: (813)922-1550

For more information about HIPPA or to file a complaint;

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W
Washington, D.C. 20201
Phone: (877) 6966775

I, _____ have received a copy of Julia Davis LLC. Notice of Privacy Practices.

Street Address: _____

City: _____ State: _____ Zip: _____

X _____ _____
(Client Signed) (Date)

_____ _____
(Parent / Guardian Signed) (Date)

_____ _____
(Witnessed Signed) (Date)

DEBIT CARD AUTHORIZATION FOR AUTOMATIC PAYMENTS

Julia Davis LLC clients have the option to pay by cash, check, debit card, or credit card on the date service is rendered. As a courtesy, we will automatically charge debit cards or credit cards at the close of each session.

By submitting Debit Card information on this form, you are requesting Julia Davis LLC to charge your debit card after each session. You may revoke or change this election at any time by calling **(813) 922-1550** or by email to: **harborofserenity@gmail.com.**

In the event that a debit charge is declined, we will automatically charge the credit card on file. We will also ask you to choose another payment method for future payments.

CREDIT CARD (Please Circle): AMEX /VISA /MC /Discover

CARDHOLDER'S NAME: _____

CARD #: _____ Exp. Date: _____

SECURITY CODE: _____ (3-DIGIT # ON BACK MC, VISA, DISC; OR 4-DIGIT # ON FRONT AmEx)

BILLING ADDRESS:
_____

I agree to the above terms and authorize you to automatically charge my debit card after each session. I understand that declined charges will result in those charges being applied to my credit card. Further, I understand that future payments will need to be made by cash, check, or credit card.

_____ _____

Signature Date

OPTIONAL: CREDIT CARD AUTHORIZATION FOR AUTOMATIC PAYMENTS

Julia Davis LLC´s clients are personally responsible for payment. Any balance not paid by the end of each session will be automatically charged to your designated card below.

CREDIT CARD (Please Circle): AMEX /VISA /MC /Discover

CARDHOLDER'S NAME: _____

CARD #: _____ EXP. DATE: _____

SECURITY CODE: _____ (3-DIGIT # ON BACK MC, VISA, DISC; OR 4-DIGIT # ON FRONT AMEX)

BILLING ADDRESS:
_____

I agree to the above terms and authorize you to charge any payment not paid by other payment methods/options at the end of each session to the above credit card.

_____ _____

Signature Date

Insurance Information

Self-Pay Client: O **Insurance Client: O**

TYPE OF SERVICE:

Couples Counseling: **O** Marriage Counseling: **O**

Family Counseling: **O** Individual Counseling: **O**

Child/Teen Counseling: **O** Other: _____

If you are an Insurance Patient please provide the following Information:

Insurance Company: _____ Plan Name: _____

Primary Insured Person Name: _____

Primary Insured Subscriber ID or Insurance Number: _____

Primary Insured DOB: _____

Client First Name: _____ Client Last Name: _____

Client Subscriber ID or Insurance Number: _____

Group Number: _____ Insurance Phone#: _____

ONLY FOR EAP PROGRAM: (Please leave blank if you are not using an EAP-Plan)

Authorization Number: _____ # of Visits: _____

_____
Initials

RELATIONAL INFORMATION:

Current Marital Status: **O** Single **O** Engaged **O** Married **O** Separated **O** Divorced **O** Widowed

Are you content with your current status? **O** Yes **O** No If not, briefly explain: _____

_____

If married, how long? _____ Number of previous marriages for you: _____ For Spouse: _____

If separated or divorced, how long? _____ If widowed, how long? _____

With whom do you currently live? (Check all apply): _____

O Alone **O** Parents **O** Sibling(s) **O** Spouse **O** Boyfriend **O** Girlfriend **O** Children **O** Other: _____

Do you have a personal Support System? **O** Yes **O** No If yes, why? _____

If you live with a partner, please provide the following information;

Partners Name: _____ Sex: **O** Male **O** Female

How long have you known your partner? _____ Age: _____ Preferred Name: _____

What words would you use to describe this person? _____

What is your sexual orientation? _____ Are you sexually active? **O** Yes **O** No

Children: List your children (living or deceased) as well as children you have placed for adoption. (Use back if necessary);

Name	Sex	Current Age or Year of Death	Relationship to you (e. g. Natural, Step, Adopted)	Living with	Describe Him/her

Have you ever had a miscarriage or medical abortion? **O** Yes **O** No If yes, when? _____

RELIGIOUS BACKGROUND:

Briefly describe the religious environment of your home as you were growing up: _____

_____

PRESENTING ISSUES AND GOALS:

Please describe why you are coming to counseling (What are your issues, problem?) _____

_____

_____

What do you hope to gain or change by coming for counseling?

_____

_____

_____
Initials

LEVEL OF DISTRESS:

Indicate how distress you are by placing an "X" on the scale below: (1= very little distress; 10= Extreme Distress);

_____

1 2 3 4 5 6 7 8 9 10

Are you currently experiencing any suicidal thoughts? **O** Yes **O** No Have you experienced them in the past? **O** Yes **O** No

Have you ever attempted suicide? **O** Yes **O** No If yes, When & how? _____

Have any of your friends or family ever committed or attempted suicide? **O** Yes **O** No If yes, explain on back:

PREVIOUS COUNSELING:

List any previous counseling, psychiatric treatment, or residential/in-patient care you have received. (Use back if necessary);

Therapist: _____ Location: _____ Dates: _____ Reason: _____

Therapist: _____ Location: _____ Dates: _____ Reason: _____

Therapist: _____ Location: _____ Dates: _____ Reason: _____

CURRENT STATUS:

Please check any of the following physiological symptoms that apply to you presently or in the recent past:

Headaches .....**O** Past **O** Present	Dizziness.....**O** Past **O** Present	Stomach Trouble.....**O** Past **O** Present
Visual Trouble .....**O** Past **O** Present	Sleep Trouble.....**O** Past **O** Present	Trouble Relaxing.....**O** Past **O** Present
Weakness.....**O** Past **O** Present	Tension.....**O** Past **O** Present	Rapid Heart Rate.....**O** Past **O** Present
Difficulty Breathing...**O** Past **O** Present	Intestinal Trouble .**O** Past **O** Present	Hearing Noises.....**O** Past **O** Present
Change in Appetite...**O** Past **O** Present	Tiredness.....**O** Past **O** Present	Pain.....**O** Past **O** Present
Hearing Voices.....**O** Past **O** Present	Seeling Things.....**O** Past **O** Present	Other.....**O** Past **O** Present

How has your weight changed in the last 2-3 months? (If so, how?) _____

_____

_____

_____

_____
Initials

Please check any of the following problems that apply to you and / or your family:

Stress.....**O** You **O** Family	Nervousness.....**O** You **O** Family	Anxiety.....**O** You **O** Family
Panic.....**O** You **O** Family	Unhappiness.....**O** You **O** Family	Depression.....**O** You **O** Family
Guilt.....**O** You **O** Family	Apathy.....**O** You **O** Family	Terminal Illness.....**O** You **O** Family
Recent Death.....**O** You **O** Family	Grief.....**O** You **O** Family	Hopelessness.....**O** You **O** Family
Inferiority Feelings.....**O** You **O** Family	Defective Feelings.....**O** You **O** Family	Loneliness.....**O** You **O** Family
Shyness.....**O** You **O** Family	Fears.....**O** You **O** Family	Friends.....**O** You **O** Family
Marriage.....**O** You **O** Family	Communications.....**O** You **O** Family	Physical Abuse.....**O** You **O** Family
Emotional Abuse.....**O** You **O** Family	Verbal Abuse.....**O** You **O** Family	Sexual Abuse.....**O** You **O** Family

Temper……**O** You **O** Family	Anger……**O** You **O** Family	Aggressiveness……**O** You **O** Family
Bad Dreams……**O** You **O** Family	Concentration……**O** You **O** Family	Racing Thoughts……**O** You **O** Family
Unwanted Thoughts…**O** You **O** Family	Memory……**O** You **O** Family	Loss of Control……**O** You **O** Family
Impulse Behavior……**O** You **O** Family	Self-Control……**O** You **O** Family	Compulsivity……**O** You **O** Family
Sexual Problems……**O** You **O** Family	Pregnancy……**O** You **O** Family	Abortion……**O** You **O** Family
Legal Matters……**O** You **O** Family	Trauma……**O** You **O** Family	Eating Problems……**O** You **O** Family
Drug Use……**O** You **O** Family	Alcohol Use……**O** You **O** Family	Trouble in Job……**O** You **O** Family
Career Choices……**O** You **O** Family	Ambition……**O** You **O** Family	Making Decisions……**O** You **O** Family
Children……**O** You **O** Family	Being a Parent……**O** You **O** Family	Finances……**O** You **O** Family
Recent Loss……**O** You **O** Family	Disaster……**O** You **O** Family	Other……**O** You **O** Family

MEDICAL INFORMATION:

Primacy Physician: _____ City: _____ Zip: _____

Specialty (e.g. Family, Practice, OB/GYN, Internal Medicine): _____

Are you currently receiving medical treatment? **O** No **O** Yes If yes, please specify:_____

List significant conditions, illness, surgeries, hospitalizations, traumas, or treatments you´ve had. (Use back if necessary)

_____

_____

List all current medications you are taking, include those you seldom use or take only as needed. (Use back if necessary)

Medication	Dosage	Purpose for Medication

Are you taking these medication(s) according to your doctor´s recommendations **O** Yes **O** No

If no, briefly explain: _____

Signature: **X** _____ Date: _____