NPI: 1538534276 FEIN: 81-0973970

ANITA MULLINS, LMFT
DBA: I Need Family Therapy

Client Name: _____ DOB:_____

Guarantor: _____ Relationship to Client: _____

FINANCIAL AGREEMENT – The undersigned individual obligates himself/herself to pay Anita Mullins, LMFT in accordance with the contract agreed rates and terms, notwithstanding the assignment of health coverage. *Members are responsible for the difference in the insurance contracted rate and what the insurance company does or does not pay.*
INSURANCE RESPONSIBILTY – I understand it is the sole responsibility of the subscriber/guarantor to know what his/her insurance benefits are, and if the policy is in effect. Every effort will be made to verify the insurance and to obtain the benefits from the insurance company. No employee or anyone affiliated with I Need Family Therapy will, or can be held responsible for knowing what a client's insurance will or will not cover. This includes benefits that may have been quoted by the insurance company. The business office will bill your insurance as a courtesy to you and make every effort to obtain payment. However, all or any portion of the bill that is not paid by the insurance carrier is the sole responsibility of the client. Benefits that are quoted by the insurance company may only reflect coverage charges and not 100% of the billed charges. Benefit quotations are subject to the member's eligibility at the time benefits were requested and any quotations are not a guarantee of benefit coverage or of member eligibility until actual insurance payment for services is received.

Guarantor _____ Date _____ Staff _____

ASSIGNMENT OF INSURANCE BENEFITS for CLIENT

Primary Insurance: _____

Is there another health insurance?_____ If so that information is required at time of first visit.

Primary Subscriber (PS):_____ DOB:_____

Address of PS:_____

Subscriber ID#: _____ Group Name/#: _____

I hereby authorize and direct the above named insurance carrier to pay directly to Anita Mullins, LMFT / I Need Family Therapy any benefits that may accrue to me under the above indicated insurance benefit plan. I agree to pay Anita Mullins, LMFT / I Need Family Therapy for all services incidental to the said program and for services not paid for by the insurance carrier named above.

Guarantor _____ Date _____ Staff _____

BUSINESS OFFICE USE ONLY Date Verified: _____

Deductible and OOP Estimate: _____ Does Deductible apply? _____
Estimated Co-Pay per visit:_____ Claims Fax #_____
Claims address/Contact:_____
_____
In Network:_____ Out of Network_____
Other: _____
_____
_____

Anita Mullins, LMFT / I Need Family Therapy
130 Riverstone Terrace, Suite 101, Canton GA 30114
770-722-9060, email: info@INeedFamilyTherapy.com

INFORMATION, AUTHORIZATION, & CONSENT TO TREATMENT

Welcome to *I Need Family Therapy*. We are very pleased that you selected our facility for your therapy, and we are sincerely looking forward to assisting you. This document is designed to inform you about what you can expect from your therapist or group leader, policies regarding confidentiality and emergencies, and several other details regarding your treatment here at *I Need Family Therapy* Although providing this document is part of an ethical obligation to our profession, more importantly, it is part of our commitment to you to keep you fully informed of every part of your therapeutic experience. Please know that your relationship with your therapist or group leader is a collaborative one, and we welcome any questions, comments, or suggestions regarding your course of therapy at any time.

Background Information, Theoretical Views, & Client Participation

Information regarding your therapist's educational background and experience may be found on our website under his or her name. Please feel free to view that information at www.ineedfamilytherapy.com.

It is our belief that as people become more aware accepting of themselves, they are more capable of finding a sense of peace and contentment in their lives. However, self-awareness and self-acceptance are goals that may take a long time to achieve. Some clients need only a few sessions to achieve these goals, whereas others may require months or even years of therapy. As a client, you are in complete control, and you may end your relationship with your therapist/group leader at any point.

In order for therapy to be most successful, it is important for you to take an active role. This means working on the things you and your therapist talk about both during and between sessions. This also means avoiding any mind-altering substances like alcohol or non-prescription drugs for at least eight hours prior to your therapy sessions. Generally, the more of yourself you are willing to invest, the greater the return.

Furthermore, it is our policy to only see clients who we believe have the capacity to resolve their own problems with our assistance. It is our intention to empower you in your growth process to the degree that you are capable of facing life's challenges in the future without your therapist. We also don't believe in creating dependency or prolonging therapy if the therapeutic intervention does not seem to be helping. If this is the case, your therapist will direct you to other resources that will be of assistance to you. Your personal development is our number one priority. We encourage you to let us know if you feel that transferring to another facility or another therapist is necessary at any time. Our goal is to facilitate healing and growth, and we are very committed to helping you in whatever way seems to produce maximum benefit. If at any point you are unable to keep your appointments or we don't hear from you for one month, we will need to close your chart. However, reopening your chart and resuming treatment is always an option.

Confidentiality & Records

Your communications with your therapist will become part of a clinical record of treatment, and it is referred to as Protected Health Information (PHI). Your PHI will be kept in a file stored in a locked cabinet in our locked office and/or your PHI will be kept on our password protected computer system in an encrypted file format.

Your therapist will always keep everything you say to him or her completely confidential, with the following exceptions:

- You direct your therapist to tell someone else and you sign a "Release of Information" form;
- Your therapist determines that you are a danger to yourself or to others;
- You or a family member in treatment with us report information about the abuse of a child, an elderly person, or a disabled individual who may require protection; or
- Your therapist is ordered by a judge to disclose information. In the latter case, your therapist's license does provide him or her with the ability to uphold what is legally termed "privileged communication." Privileged communication is your right as a client to have a confidential relationship with a counselor. This state has a very good track record in respecting this legal right. If for some unusual reason a judge were to order the disclosure of your private information, this order can be appealed. We cannot guarantee that the appeal will be sustained, but we will do everything in our power to keep what you say confidential.
- Please note that in couple's counseling, your therapist does not agree to keep secrets. Information revealed in any context may be discussed with either partner.

Court / Legal Appearance / Reporting Requirements

Clinician maintains the right to refuse to participate in any request for attendance to court/legal proceedings. Any attendance/participation in legal/court proceedings will be required to comply with all legal and ethical guidelines of the clinician. Frequently there are situation where having the clinician participate, in any capacity including providing notes, may be detrimental to your cause. Clinician will need a signed release of information to speak to anyone regarding your treatment. In instances of couples or family therapy everyone involved in the treatment of the client must give permission for any information to be released. Otherwise no information can be released! Court/legal participation requires excessive

Please initial that you have read this page _____

disruption to the clinician and other client's scheduled appointments. For the clinician to participate in any legal procedures there will be a cost of $1500 per 4-hour blocks of time. Time includes travel to and from the event location, time there and preparation time including the need to consult with any outside sources. Charges are not waived if court is cancelled with less than 10 days' notice. If additional costs are incurred by the clinician, such as consultation fees, coping, etc. the client is responsible for those costs. Any time over 4 hours will result in another $1500. Time is not prorated. Clinicians are not ethically nor legally required to respond to subpoenas from attorneys. Clinicians are only required to respond to court orders signed by a judge. Even in those cases the clinician is frequently required to contact the judge and explained that providing the information requested may be harmful to the client or others involved and may request the ability to provide a summary letter of pertinent information instead or to be excused from responding to the order

Structure and Cost of Sessions

Your therapist agrees to provide psychotherapy for the fee of $100 per individual 45-50-minute session, $150 per 75-minute session, and/or $50 per 90-minute group therapy session, unless otherwise negotiated by you or your insurance carrier. Additional individuals in a session will be charged at $10 per person per session over 2 people. Doing psychotherapy by telephone is not ideal and needing to talk to your therapist between sessions may indicate that you need extra support. If this is the case, you and your therapist will need to explore adding sessions or developing other resources you have available to help you. Telephone calls that exceed 10 minutes in duration will be billed at $20 per 10-minute session. The fee for each session will be due at the beginning of the session. Cash, personal checks, Visa, MasterCard, Discover, or American Express are acceptable for payment, and we will provide you with a receipt of payment. The receipt of payment may also be used as a statement for insurance if applicable to you. Please note that there is a $50 fee for any returned checks.

There are a limited number of reduced rates available. If you believe you need a reduced rate, please ask your therapist. Reduced rates may be cancelled if there is an issue with therapeutic compliance, and for excessive missed appointments.

Insurance companies have many rules and requirements specific to certain plans. Unless otherwise negotiated, it is your responsibility to find out your insurance company's policies and to file for insurance reimbursement. We will be glad to provide you with a statement for your insurance company and to assist you with any questions you may have in this area.

Cancellation Policy

If you are unable to keep an appointment, you must notify your therapist at least 2 hours in advance. If such advance notice is not received, you will be financially responsible for the session you missed. Please note that insurance companies do not reimburse for missed sessions. First no call no show there will be no charge. Second and subsequent no call no show will result in a $50 fee. If you are receiving a sliding/discount rate for services on the 3rd no call no show you will either lose the discount and be required to pay full rate or be discharged from therapy services.

In Case of an Emergency

I Need Family Therapy/Anita Mullins, MFT, LMFT is an outpatient facility, and we are set up to accommodate individuals who are reasonably safe and resourceful. We do not carry beepers nor are we available at all times. If at any time this does not feel like enough support, please inform your therapist, and he or she can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. Generally, your therapist will return phone calls within 24-48 hours. If you have a mental health emergency, we encourage you not to wait for a call back, but to do one or more of the following:

- Call 911.
- Go to the emergency room of your choice
- Call Behavioral Health Link/GCAL: 800-715-4225
- Call Lifeline at (800) 273-8255 (National Crisis Line)
- Call Ridgeview Institute at 770.434.4567
- Call Peachford Hospital at 770.454.5589

Professional Relationship

Psychotherapy is a professional service we will provide to you. Because of the nature of therapy, your relationship with your therapist must be different from most relationships. It may differ in how long it lasts, the objectives, or the topics discussed. It must also be limited to only the relationship of therapist and client. If you and your therapist were to interact in any other ways, you would then have a "dual relationship," which could prove to be harmful to you in the long run and is, therefore, unethical in the mental health profession. Dual relationships can set up conflicts between the therapist's interests and the client's interests, and then the client's (your) interests might not be put first. In order to offer all our clients, the best care, your therapist's judgment needs to be unselfish and purely focused on your needs. This is why your relationship with your therapist must remain professional in nature.

Additionally, there are important differences between therapy and friendship. Friends may see your position only from their personal viewpoints and experiences. Friends may want to find quick and easy solutions to your problems so that they can feel helpful. These short-term solutions may not be in your long-term best interest. Friends do not usually follow up on their advice to see whether it was useful. They may *need* to have you do

what they advise. A therapist offers you choices and helps you choose what is best for you. A therapist helps you learn how to solve problems better and make better decisions. A therapist's responses to your situation are based on tested theories and methods of change.

You should also know that therapists are required to keep the identity of their clients confidential. As much as your therapist would like to, for your confidentiality he or she will not address you in public unless you speak to him or her first. Your therapist also must decline any invitation to attend gatherings with your family or friends. Lastly, when your therapy is completed, your therapist will not be able to be a friend to you like your other friends. In sum, it is the duty of your therapist to always maintain a professional role. Please note that these guidelines are not meant to be discourteous in any way, they are strictly for your long-term protection.

Statement Regarding Ethics, Client Welfare & Safety

I Need Family Therapy assures you that our services will be rendered in a professional manner consistent with the ethical standards of the American Association for Marriage and Family Therapy. If at any time you feel that your therapist is not performing in an ethical or professional manner, we ask that you please let him or her know immediately. If the two of you are unable to resolve your concern, please contact Anita Mullins (e.g., Practice Director) at 770-722-9060.

Due to the very nature of psychotherapy, as much as we would like to guarantee specific results regarding your therapeutic goals, we are unable to do so. However, your therapist, with your participation, will work to achieve the best possible results for you. Please also be aware that changes made in therapy may affect other people in your life. For example, an increase in your assertiveness may not always be welcomed by others. It is our intention to help you manage changes in your interpersonal relationships as they arise, but it is important for you to be aware of this possibility, nonetheless.

Additionally, at times people find that they feel somewhat worse when they first start therapy before they begin to feel better. This may occur as you begin discussing certain sensitive areas of your life. However, a topic usually isn't sensitive unless it needs attention. Therefore, discovering the discomfort is actually a success. Once you and your therapist can target your specific treatment needs and the modalities that work the best for you, help is generally on the way.

Technology Statement

In our ever-changing technological society, there are several ways we could potentially communicate and/or follow each other electronically. It is of utmost importance to us that we maintain your confidentiality, respect your boundaries, and ascertain that your relationship with your therapist remains therapeutic and professional. Therefore, we've developed the following policies:

Cell phones: It is important for you to know that cell phones may not be completely secure or confidential. However, we realize that most people have and utilize a cell phone. Your therapist may also use a cell phone to contact you. If this is a problem, please feel free to discuss this with your therapist.

Text Messaging and Email: Both text messaging and emailing are not secure means of communication and may compromise your confidentiality. We realize that many people prefer to text and/or email because it is a quick way to convey information. However, please know that it is our policy to utilize these means of communication strictly for appointment confirmations or to communicate when safety may be in question (nothing that could be inferred as therapy). Please do not bring up any therapeutic content via text or email to prevent compromising your confidentiality. If you do, please know that your therapist will not respond. You also need to know that we are required to keep a summary or a copy of all emails and texts as part of your clinical record that address anything related to therapy.

Facebook, LinkedIn, Instagram, Pinterest, Twitter, Etc: It is our policy not to accept requests from any current or former clients on social networking sites such as Facebook, LinkedIn, Instagram, Pinterest, etc. because it may compromise your confidentiality. *I Need Family Therapy* has a business Facebook page, and is on LinkedIn You are welcome to follow us on any of these pages. However, please do so only if you are comfortable with the general public knowing your name is attached to *I Need Family Therapy.* Please refrain from contacting us using social media messaging systems such as Facebook Messenger or Twitter Direct Message. These methods have insufficient security, and we do not watch them closely. We would not want to miss an important message from you.

Google, Bing, etc.: It is our policy not to search for our clients on Google or any other search engine. We respect your privacy and make it a policy to allow you to share information about yourself to your therapist as you feel appropriate. If there is content on the Internet that you would like to share with your therapist for therapeutic reasons, please print this material and bring it to your session.

Blog: We may post psychology information/counseling information/therapeutic content on our blog. If you have an interest in following our blog, you are welcome to. However, please do so only if you are comfortable with the general public knowing your name is attached to *I Need Family Therapy.*

Faxing Medical Records: If you authorize us (in writing) via a "Release of Information" form to send your medical records or any form of protected health information to another entity for any reason, we may need to fax that information to the authorized entity. It is our responsibility to let you know that fax machines may not be a secure form of transmitting information. Additionally, information that has been faxed may also remain in the hard drive of our fax machine. However, our fax machine is kept behind two locks in our office. And, when our fax machine needs to be replaced, we will destroy the hard drive in a manner that makes future access to information on that device inaccessible.

Audio / Video Recordings or electronic note taking of sessions by clients is not permitted. If there is a therapeutic need for any recordings to occur written permission will be obtained by the clinician from the client. Written permission will include specific reasons for the recording and will only be used for the reason stated/granted.

Recommendations to Websites or Applications (Apps):

Please initial that you have read this page _____

During the course of treatment, your therapist may recommend that you visit certain websites for pertinent information or self-help. She or he may also recommend certain apps that could be of assistance to you and enhance your treatment. Please be aware that websites and apps may have tracking devices that allow automated software or other entities to know that you've visited these sites or applications. They may even utilize your information to attempt to sell you other products. Additionally, anyone who has access to the device you used to visit these sites and/or apps, may be able to see that you have been to these sites by viewing the history on your device. Therefore, it is your responsibility to decide and communicate to your therapist if you would like this information as adjunct to your treatment or if you prefer that your therapist does not make these recommendations.

In summary, technology is constantly changing, and there are implications to all the above that we may not realize at this time. Please feel free to ask questions and know that we are open to any feelings or thoughts you have about these and other modalities of communication.

Inclement Weather:

If Cherokee County schools are dismissed early or closed due to inclement weather therapy appointments are cancelled and need to be rescheduled. You are not responsible for cancelling your appointment at these times. Every effort will be made to notify you of the cancellation and to reschedule. If the weather changes to be potentially hazardous when school is out of session, I will attempt to contact you that the office is closing, and therapy sessions are cancelled. I ask that you let me know if you are unable to keep your appointment due to weather conditions in your area. The time required to cancel your appointment will not apply when inclement weather is at play. It is more important that you be safe.

Drug Testing: Mutual clients of Craig Wellness and Recovery and Anita Mullins, LMFT may be drug tested at any or all therapy appointments. If you are drug tested, either by request or requirement, you are responsible for the cost of testing. Your insurance will not cover drug testing. Currently the cost is $30 per test read in the office. Additional costs apply to testing that must be sent off to a lab for qualitative results. Clients who receive a reduced fee and are non-compliant with substance use abstinence will forfeit their reduced fee until such a time as therapeutic compliance with abstinence has occurred for three (3) consecutive months.

Our Agreement to Enter into a Therapeutic Relationship

We are sincerely looking forward to facilitating you on your journey toward healing and growth. If you have any questions about any part of this document, please ask your therapist.

Please print, date, and sign your name below indicating that you have read and understand the contents of this form, you agree to the policies of your relationship with your therapist/group leader, and you are authorizing your therapist/group leader to begin treatment with you.

_____ _____
Client Name (Please Print) Date

_____
Client Signature

If Applicable:

_____ _____
Parent's or Legal Guardian's Name (Please Print) Date

_____
Parent's or Legal Guardian's Signature

The signature of the Therapist below indicates that she or he has discussed this form with you and has answered any questions you have regarding this information.

_____ _____
Therapist's Signature Date

Please initial that you have read this page _____

www.INeedFamilyTherapy.com

INITIAL HISTORY AND ASSESSMENT QUESTIONNAIRE

CLIENT INFORMATION:

NAME:_____ DATE OF BIRTH:_____ AGE: _____

ADDRESS: _____

PREFERRED PHONE NUMBER: _____ ☐CELL ☐HOME ☐ WORK ☐ TEXT PREFERRED

EMAIL: _____, GENDER: _____

LAST 4 OF SOCIAL SECURITY #_____ PLACE OF EMPLOYMENT/SCHOOL:_____

EMERGENCY CONTACT NAME & PHONE NUMBER: _____

PRESENTING POBLEM:

	Mild	Mod.	Severe
Learning / school difficulties			
Communication difficulties			
Racing thoughts			
Distractibility			
Excessive goal directed behaviors			
Difficulty paying attention			
Hyperactivity			
Impulsivity			
Aggressive behavior			
Animal cruelty			
Property destruction			
Chronic lying			
Stealing			
Conduct / Oppositional behavior problems			
Easily loses temper			
Eating non-food items			
Hypervigilance / frequently on alert			
Indiscriminate sociability / harmful socializing			
Immaturity			
Inappropriate sexual behaviors			
Not trustworthy / distrustful			
Self-injurious ideas/threats/actions			
Disorientation			
Cognitive impairment (thinking issues)			
Drug abuse / dependence			
Alcohol overuse/ abuse / dependence			
Delusions			
Hallucinations			
Paranoia			
Poor hygiene / grooming			
Depressed mood / sadness			
Diminished interest in activities			

	Mild	Mod.	Severe
Mood changes			
Repetitive behaviors			
Poor relationships			
Lack of motivation			
Panic attacks			
Excessive anxiety / worry			
Avoidance of situations / social events			
Phobia(s)_____			
Obsessive thoughts			
Compulsive behaviors			
Exposure to a trauma			
Intrusive memories			
Sleep issues ☐lack of ☐ a lot ☐interrupted			
Nightmares			
Flashbacks			
Loss of time / memory deficits			
Anger Outbursts			
Exaggerated startle response			
Restlessness			
Chronic pain			
Clinginess			
Lack of attachment to others			
Significant weight ☐gain ☐loss			
Fatigue / low energy			
Appetite disturbance ☐over ☐undereating			
Agitation			
Feelings of worthlessness			
Feelings of Guilt			
Poor concentration			
Suicidal thoughts			
Irritability			
☐Physical complaints ☐Chronic pain			

PRESENTING POBLEM:

	Mild	Mod.	Severe
Low self esteem			
Unresolved grief			
Hopelessness			
Dissociation (checking out, out of body exp.)			
Gender concerns			
Excessive ☐eating ☐ purging ☐ restricting			
Sleepwalking			
Fire-setting/ fascination with fire			
Social discomfort / isolation			
Self ☐cutting ☐burning ☐ picking, etc.			
Sexual promiscuity / unsafe sex practices			
Gambling excessively			
☐Witness ☐victim of domestic violence			
☐Witness ☐victim of physical/emotional abuse			
Perpetrator of ☐physical ☐emotional abuse			

	Mild	Mod.	Severe
Impaired ☐sensory or ☐motor function			
Preoccupation with appearance			
☐Depersonalization ☐difficulty w/reality			
Sexual dysfunction ☐concerns ☐addiction			
☐Laxative ☐ diuretic ☐food abuse			
Excessive ☐exercise ☐liquid intake			
Night / sleep terrors			
☐Suspicious of others ☐paranoia			
Unstable personal relationships			
Feelings of being overly emotional			
Attention-seeking behaviors			
Excessive dependency on others			
☐Witness ☐victim of sexual abuse			
Perpetrator of sexual abuse			
Arrested for Abuse of a ☐person ☐ animal			

Please mark your primary concerns or symptoms. Use this space for any brief explanation you feel is necessary:

_____

_____

_____

_____

ARE YOU CURRENTLY INVOLVED WITH THE LEGAL SYSTEM IN **ANY** MANNER, INCLUDING CIVIL LAW SUITS/DIVORCE, CRIMAL, CHILD CUSTODY, ETC? ☐YES ☐NO, IF YES BRIEFLY EXPLAIN:_____

_____

WHAT IS YOUR SEXUAL ORIENTATION: ☐HETERO ☐ GAY/LESBIAN ☐ PAN ☐BI ☐UNDECIDED/CONFLICTED

IF YOU HAVE EVER BEEN SEXUALLY ABUSED/MOLESTED/RAPED WHAT WAS THE RELATIONSHIP OF THE PERPETRATOR:
☐ACQUAINTANCE ☐ FRIEND ☐ SPOUSE ☐BOY/GIRLFRIEND ☐ PARENT ☐ STRANGER ☐COWORKER ☐SIBLING
☐PROFESSIONAL ☐ EXTENDED RELATIVE ☐TEACHER/PASTOR/PRIEST ☐OTHER_____

MILITARY HISTORY: ☐YES ☐NO. BRANCH:_____ RANK_____ ☐REGULAR ☐RESERVE
☐CURRENT ☐RETIRED ☐OPTED OUT ☐HONORABLE ☐DISHONORABLE ☐ SERVED IN ACTIVE WAR ZONE

FAMILY HISTORY:

MOTHER'S NAME: _____ ☐ BIOLOGICAL PARENT ☐ADOPTIVE PARENT ☐ LIVING ☐DECEASED
AGE_____ IF DECEASED YOUR AGE AT THAT TIME _____ MARITAL STATUS: ☐ SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED
☐SEPARATED ☐ REMARRIED ____ # OF TIMES. IF DIVORCED WHO HAD PRIMARY CUSTODY OF YOU?_____
PRESENSE DURING YOUR CHILDHOOD ☐ENTIRE ☐PART ☐NONE, HISTORY OF ABUSE: ☐ NO ☐Yes ☐EMOTIONAL ☐ PHYSICAL ☐ SEXUAL
CURRENT RELATIONSHIP WITH PARENT: ☐POSITIVE ☐NEUTRAL ☐NEGATIVE ☐ABUSIVE ☐ ABSENT ☐ENABLING ☐MANIPULATIVE
CHILDHOOD RELATIONSHIP WITH PARENT: ☐POSITIVE ☐NEUTRAL ☐NEGATIVE ☐ABUSIVE ☐ ABSENT ☐ENABLING ☐MANIPULATIVE

FATHER'S NAME: _____ ☐ BIOLOGICAL PARENT ☐ADOPTIVE PARENT ☐ LIVING ☐DECEASED
AGE_____ IF DECEASED YOUR AGE AT THAT TIME _____ MARITAL STATUS: ☐ SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED
☐SEPARATED ☐ REMARRIED ____ # OF TIMES. IF DIVORCED WHO HAD PRIMARY CUSTODY OF YOU?_____
PRESENSE DURING YOUR CHILDHOOD ☐ENTIRE ☐PART ☐NONE, HISTORY OF ABUSE: ☐ NO ☐Yes ☐EMOTIONAL ☐ PHYSICAL ☐ SEXUAL
CURRENT RELATIONSHIP WITH PARENT: ☐POSITIVE ☐NEUTRAL ☐NEGATIVE ☐ABUSIVE ☐ ABSENT ☐ENABLING ☐MANIPULATIVE
CHILDHOOD RELATIONSHIP WITH PARENT: ☐POSITIVE ☐NEUTRAL ☐NEGATIVE ☐ABUSIVE ☐ ABSENT ☐ENABLING ☐MANIPULATIVE

STEP MOTHER'S NAME: _____ ARE THEY STILL IN YOUR LIFE? ☐ YES ☐ NO
PRESENSE DURING YOUR CHILDHOOD ☐ENTIRE ☐PART ☐NONE, HISTORY OF ABUSE: ☐ NO ☐Yes ☐EMOTIONAL ☐ PHYSICAL ☐ SEXUAL
CURRENT RELATIONSHIP WITH STEP PARENT: ☐POSITIVE ☐NEUTRAL ☐NEGATIVE ☐ABUSIVE ☐ ABSENT ☐ENABLING ☐MANIPULATIVE
CHILDHOOD RELATIONSHIP WITH STEP PARENT: ☐POSITIVE ☐NEUTRAL ☐NEGATIVE ☐ABUSIVE ☐ ABSENT ☐ENABLING ☐MANIPULATIVE

STEP FATHER'S NAME: _____ ARE THEY STILL IN YOUR LIFE ☐YES ☐ NO
PRESENSE DURING YOUR CHILDHOOD ☐ENTIRE ☐PART ☐NONE, HISTORY OF ABUSE: ☐ NO ☐Yes ☐EMOTIONAL ☐ PHYSICAL ☐ SEXUAL
CURRENT RELATIONSHIP WITH STEP PARENT: ☐POSITIVE ☐NEUTRAL ☐NEGATIVE ☐ABUSIVE ☐ ABSENT ☐ENABLING ☐MANIPULATIVE
CHILDHOOD RELATIONSHIP WITH STEP PARENT: ☐POSITIVE ☐NEUTRAL ☐NEGATIVE ☐ABUSIVE ☐ ABSENT ☐ENABLING ☐MANIPULATIVE

SIBLINGS: ☐NO SIBLINGS
NUMBER OF SIBLINGS_____ AGES_____ ***YOUR*** BIRTH ORDER _____ # OF BROTHERS _____ # OF SISTERS_____
OF STEP/HALF SIBLINGS YOU LIVED WITH _____ # OF STEP/HALF BROTHERS _____ # OF STEP/HALF SISTERS _____ AGES: _____
ANY HISTORY OF ABUSE BETWEEN SIBLINGS: ☐ NO ☐Yes ☐EMOTIONAL ☐ PHYSICAL ☐ SEXUAL ☐ FINANCIAL

RELATIONSHIP STATUS:
☐SINGLE ☐ENGAGED ☐MARRIED ☐DIVORCED ☐WIDOWED ☐SEPERATED ☐COMMITED REL. ☐ OTHER_____
OF MARRIAGES_____ # OF ENGAGEMENTS _____ # OF DIVORCES_____ LENGTH OF TIME AT CURRENT STATUS:_____
CURRENT RELATIONSHIP: ☐POSITIVE ☐NEUTRAL ☐NEGATIVE ☐ABUSIVE_____ ☐ ABSENT ☐ENABLING ☐MANIPULATIVE
OF CHILDREN & AGES INVOLVED IN THIS RELATIONSHIP: #_____ AGES: _____
PREVIOUS RELATIONSHIP(S): ☐POSITIVE ☐NEUTRAL ☐NEGATIVE ☐ABUSIVE ☐ ABSENT ☐ENABLING ☐MANIPULATIVE.
LENGTH OF TIME SINCE RELATIONSHIP ENDED:_____

CHILDREN: ☐N/A – NO CHILDREN
OF LIVING BIOLOGICAL CHILDREN _____ / AGES:_____ # OF LIVING STEP CHILDREN _____ / AGES:_____
OF DECEASED CHILDREN _____ / THEIR AGES AT DEATH _____ YOUR AGE AT THEIR DEATH _____
CAUSE OF CHILD(RENS) DEATH _____
DO THE CHILDREN CURRENTLY LIVE WITH YOU? _____ HOW FAR AWAY DO THEY LIVE?_____
RELATIONSHIP WITH CHILDREN: ☐POSITIVE ☐NEUTRAL ☐NEGATIVE ☐ABUSIVE_____
☐ENABLING ☐MANIPULATIVE ☐ OTHER_____
FIRST NAMES OF CHILDREN: _____
DO ANY CHILDREN HAVE BEHAVIORAL HEALTH ISSUES? ☐YES ☐NO, IF YES WHO/WHAT_____
_____
DO ANY CHILDREN HAVE CHRONIC ILLNESS OR DISABILTIES? ☐YES ☐NO, IF YES WHO/WHAT _____
_____
DO ANY CHILDREN HAVE SUBSTANCE USE OR ADDICTION PROBLEMS? ☐YES ☐NO, IF YES WHO/WHAT_____
_____

FAMILY PSYCHIATRIC HISTORY: (ONLY CHECK IF APPLICABLE)

DISORDER	RELATIONSHIP	DISORDER	RELATIONSHIP
ADHD/ADD		ASPERGER'S	
AUTISM		BIPOLAR DISORDER	
DEMENTIA/DELIRIUM		DEPRESSION	
DISSOCIATIVE DISORDER		EATING DISORDER	
GENERALIZED ANXIETY DISORDER		OBSESSIVE COMPLUSIVE DISORDER	
OPPOSITIONAL DEFIANT / CONDUCT DISORDER		PANIC DISORDER	
PERSONALITY DISORDER		PTSD	
REACTIVE ATTACHMENT DISORDER		SCHIZOPHRENIA/SCHIZO AFFECTIVE	

ACE: **WHILE YOU WERE GROWING UP, DURING YOUR FIRST 18 YEARS OF LIFE:**	**YES**	**NO**	**SCORE**
DID A PARENT OR OTHER ADULT IN THE HOUSEHOLD **OFTEN…**SWEAR AT YOU, INSULT YOU, PUT YOU DOWN OR HUMILIATE YOU? Or ACT IN A WAY THAT MADE YOU AFRAID THAT YOU MIGHT BE PHYSICALLY HURT?			
DID A PARENT OR FOTHER ADULT IN THE HOUSEHOLD **OFTEN**…PUSH, GRAB, SLAP, OR THROW SOMETHING AT YOU? Or **EVER** HIT YOU SO HARD THAT YOU HAD MARKS OR WERE INJURED?			

DID AN ADULT OR PERSON AT LEAST 5 YEARS OLDER THAN YOU **EVER**… TOUCH OR FONDLE YOU OR HAVE YOU TOUCH THEIR BODY IN A SEXUAL WAY? Or TRY TO ACTUALLY HAVE ORAL, ANAL OR VAGINAL SEX WITH YOU?			
DID YOU **OFTEN** FEEL THAT… NO ONE IN YOUR FAMILY LOVED YOU OR THOUGHT YOU WERE IMPORTANT OR SPECIAL? Or YOUR FAMILY DIDN'T LOOK OUT FOR EACH OTHER, FEEL CLOSE TO EACH OTHER, OR SUPPORT EACH OTHER?			
DID YOU OFTEN FEEL THAT… YOU DIDN'T HAVE ENOUGH TO EAT, HAD TO WEAR DIRTY CLOTHES, AND HAD NO ONE TO PROTECT YOU? or YOUR PARENTS WERE TO DRUNK OR HIGHT TO TAKE CAR OF YOU OR TAKE YOU TO THE DOCTOR IF YOU NEEDED IT?			
WERE YOUR PARENTS **EVER** SEPARATED OR DIVORCED?			
WAS YOUR MOTHER OR STEPMOTHER: **OFTEN** PUSHED, GRABBED, SLAPPED, OR HAD SOMETHING THROWN AT HER; or **SOMETIMES OR OFTEN** KICKED, BITTEN, HIT WITH A FIST, OR HIT WITH SOMETHING HARD; or **EVER** REPEATEDLY HIT OVER AT LEAST A FEW MINUTES or THREATENED WITH A GUN OR KNIFE?			
DID YOU LIVE WITH ANYONE WHO WAS A PROBLEM DRINKER OR ALCOHOLIC OR WHO USED STREET DRUGS or ABUSED PRESCRIPTION DRUGS?			
WAS A HOUSEHOLD MEMBER DEPRESSED OR MENTALLY ILL OR DID A HOUSEHOLD MEMBER ATTEMPT SUICIDE?			
DID A HOUSEHOLD MEMBER GO TO PRISON?			
WERE YOU EVER IN FOSTER CARE? IF YES AT WHAT AGE?_____ FOR HOW LONG?_____ HOW MANY?_____			
WERE THERE ANY SIGNIFICANT DEATHS (PEOPLE, FAVORITE PET, FRIENDS, ETC)?			
DID YOUR FAMILY RELOCATE/MOVE HOMES FREQUENTLY? IF YES HOW MANY TIMES_____ AND HOW OFTEN DID YOU HAVE TO CHANGE SCHOOLS DUE TO A MOVE?_____			
SCORE:			

HOW WOULD YOU DESCRIBE THE DISCIPLINE USED IN YOUR HOME? ☐STRICT ☐MODERATE ☐ FLEXIBLE ☐PERMISSIVE ☐INCONSISTENT ☐OTHER _____.

DEVELOPMENTAL HISTORY

DID YOUR BIRTH MOTHER EXPERIENCE ANY TRAUMATIC EVENTS, DEATHS OF SIGNIFICANT OTHERS OR HIGH STRESS SITUATIONS DURING HER PREGNANCY WITH YOU? _____ IF YES DURING WHAT TRIMESTER _____ WHAT WAS THE EVENT?_____
_____
_____.

WERE YOU A FULL TERM BABY? _____ IF NO, HOW PREMATURE WERE YOU?_____ WEEKS.

PREGNANCY COMPLICATIONS WITH YOU (CHECK ALL THAT APPLY):

☐NONE ☐DRUG USE ☐ALCOHOL USE ☐ MENTAL ILLNESS ☐ DOMESTIC VIOLENCE/SEXUAL ASSUALT/EMOTIONAL ABUSE.

HOW DO YOU DESCRIBE YOUR CHILDHOOD HEALTH?

☐NORMAL ☐FREQUENT EAR INFECTIONS/TUBES IN EARS ☐ DEVELOPMENTAL DELAY ☐HEAD INJURY(S) ☐ SCHOOL IEP ☐ ADHD/ADD ☐ SELF INJURING BEHAVIOR/SUICIDAL THOUGHTS ☐ SEIZURES ☐SIGNIFICANT INJURIES ☐HOSPITALIZATIONS ☐FREQUENT ER VISITS ☐CHRONIC/SERIOUS HEALTH PROBLEMS ☐SIGNIFICANT/UNUSUAL ILLNESSES ☐OTHER

DEVELOPMENT:

INFANCY: ☐NONE ☐ SLEEPING PROBLEMS ☐ DIFFICULT TO SOOTHE ☐ FEEDING PROBLEMS ☐ TOILET-TRAINING PROBLEMS ☐CHOLIC ☐OTHER:_____

DELAYED MILESTONES: ☐NONE ☐SPEECH ☐ TOLERATING SEPARATION ☐ BODY CONTROL ☐ PLAYING COOPERATIVELY ☐ ROLLING OVER ☐ BLADDER CONTROL ☐ BOWEL CONTROL ☐ RIDING TRICYCLE/BICYCLE ☐SITTING ☐ STANDING ☐ WALKING ☐ DRESSING SELF ☐ PERSONAL HYGIENE ☐ FEEDING SELF ☐ ENGAGING PEERS/MAKING FRIENDS ☐ READING ☐OTHER:_____

YOUR RESPONSE TO AUTHORITY:

☐ASSAULTIVE BEHAVIOR ☐INSUBORDINATION/DEFIANCE ☐THREATENING BEHAVIOR ☐DISRUPTIVE BEHAVIOR ☐ NO PROBLEMS ☐PROCRASTINATION ☐RESENTMENT ☐OTHER:_____

CURRENT EMPLOYMENT/EDUCATION STATUS:

JOB TITLE:_____ ☐STUDENT GRADE:_____

☐ EMPLOYEE ☐SELF-EMPLOYED ☐ UNEMPLOYED ☐ STAY AT HOME PARENT/CARE GIVER ☐HOME SCHOOL ☐ON LINE SCHOOL ☐WORKS AT HOME ☐EXTENSIVE TRAVEL **STATUS:** ☐ PART TIME ☐ FULL TIME ☐INTERMITTENT/PRN

PERSONAL SUBSTANCE ABUSE HISTORY:

SUBSTANCES	AGE FIRST USE	AGE LAST USE	AVERAGE AMOUNT USED WEEKLY (LAST 6 MONTHS)	FREQUENCY OF USE	CURRENT USE / LENGTH SINCE LAST USE IF 6 MONTHS OR LESS
ALCOHOL: ☐BEER ☐WINE ☐LIQUOR				☐DAILY ☐ WEEKLY OTHER:_____	☐YES ☐ NO WHEN:_____
OPIATES: ☐PAIN PILLS ☐ KRATOM ☐ HEROIN ☐ SMOKE ☐SNORT☐IV ☐OTHER:_____				☐DAILY ☐ WEEKLY OTHER:_____	☐YES ☐ NO WHEN:_____
BENZODIAZIPINES/SEDATIVES: ☐XANAX ☐ATIVAN ☐VALIUM ☐ OTHER_____ ☐ PILLS ☐SMOKE ☐SNORT ☐IV ☐0THER_____				☐DAILY ☐ WEEKLY OTHER:_____	☐YES ☐ NO WHEN:_____
BARBITUATES/DOWNERS TYPE_____ ☐ PILLS ☐SMOKE ☐SNORT ☐IV ☐0THER_____				☐DAILY ☐ WEEKLY OTHER:_____	☐YES ☐ NO WHEN:_____
☐COCAINE ☐ CRACK COCAINE ☐SMOKE ☐SNORT ☐IV ☐0THER_____				☐DAILY ☐ WEEKLY OTHER:_____	☐YES ☐ NO WHEN:_____
MARIJUANA ☐ EDIBLES ☐SMOKE ☐SNORT ☐IV ☐0THER_____				☐DAILY ☐ WEEKLY OTHER:_____	☐YES ☐ NO WHEN:_____
INHALANTS / WHAT:_____ _____				☐DAILY ☐ WEEKLY OTHER:_____	☐YES ☐ NO WHEN:_____
HALLUCINOGENICS: ☐PCP ☐LSD ☐SHROOMS ☐OTHER_____ ☐SMOKE ☐SNORT ☐IV ☐0THER_____				☐DAILY ☐ WEEKLY OTHER:_____	☐YES ☐ NO WHEN:_____
METHAMPHETAMINE ☐SMOKE ☐SNORT ☐IV ☐0THER_____				☐DAILY ☐ WEEKLY OTHER:_____	☐YES ☐ NO WHEN:_____
OTHER: _____ _____				☐DAILY ☐ WEEKLY OTHER:_____	☐YES ☐ NO WHEN:_____

PLEASE ANSWER EACH QUESTION BELOW:	YES	NO
HAVE YOU EVER RIDDEN IN A CARE DRIVEN BY SOMEONE (INCLUDING YOURSELF) WHO WAS "HIGH or INTOXICATED" OR WHO HAD BEEN USING ALCOHOL OR DRUGS		
DO YOU EVER USE ALCOHOL OR DRUGS TO RELAX, FEEL BETTER ABOUT YOURSELF, OR FIT IN?		
DO YOU EVER USE ALCOHOL OR DRUGS WHILE YOU ARE BY YOURSELF, ALONE?		
DO YOU EVER FORGET THINGS YOU DID WHILE USING ALCOHOL OR DRUGS?		
DOES YOUR FAMILY OR FRIENDS EVER TELL YOU THAT YOU SHOULD CUT DOWN ON YOUR DRINKING OR DRUG USE?		
HAVE YOU EVER GOTTEN INTO TROUBLE WHILE YOU WERE USING DRUGS OR ALCOHOL?		
HAVE YOU EVER FELT YOU SHOULD CUT DOWN ON YOUR DRINKING OR DRUG USE?		
HAVE PEOPLE ANNOYED YOU BY CRITICIZING YOUR DRINKING OR DRUG USE?		
HAVE YOU EVER FELT BAD OR GUILTY ABOUT YOUR DRINKING OR DRUG USE?		
HAVE YOU EVER HAD A DRINK OR USED DRUGS IN THE MORNING TO STEADY YOUR NERVES OR TO GET RID OF A HANGOVER		

CONSEQUENCES OF SUBSTANCE USE (CHECK ALL THAT APPLY)

☐ASSAULTIVE BEHAVIOR
☐INCREASED TOLERANCE
☐SYMPTOMS OF WITHDRAWAL
☐HX OF OVERDOSE
☐MOOD CHANGES/DISTURBANCES
☐AUTO/PERSONAL ACCIDENTS
☐EMPLOYMENT PROBLEMS
☐FAMILY /SOCIAL PROBLEMS
☐BLACKOUTS
☐EDUCATIONAL PROBLEMS
☐ RELATIONSHIP PROBLEMS
☐HANGOVERS
☐INJURIES
☐HOUSING PROBLEMS
☐SUICIDAL / SELF HARMING IDEATION
☐LEGAL PROBLEMS/ARRESTS
☐MEDICAL PROBLEMS
☐SLEEP DISTURBANCES
☐NO NEGATIVE CONSEQUENCES
☐HAZARDOUS BEHAVIORS
☐DFCS INTERVENTION

☐FINANCIAL PROBLEMS ☐STEALING OR COMMITTING OTHER CRIMINAL ACTIVITIES (W/WO CHARGES)
☐OTHER:_____

TREATMENT HISTORY (CHECK ALL THAT APPLY)
FOR MENTAL HEALTH ☐YES ☐NO, IF YES PLEASE ANSWER THE FOLLOWING:
FOR SUBSTANCE ABUSE/TREATMENT? ☐YES ☐NO, IF YES PLEASE ANSWER THE FOLLOWING:
☐INDIVIDUAL THERAPY ☐ IOP/PHP GROUP ☐ DETOX ☐ RESIDENTIAL ☐HOSPITAL INPATIENT ☐TWELVE STEP GROUP
HOW MANY TREATMENT EPISODES:_____ DO YOU FEEL TREATMENT WAS BENEFICIAL?_____
DID YOU? ☐COMPLETE TREATMENT ☐LEFT EARLY ☐ WAS DISMISSED EARLY ☐OTHER_____

IS THERE A FAMILY HISTORY OF SUBSTANCE ABUSE/DEPENDENCE? ☐ YES ☐ NO, IF YES, PLEASE ANSWER THE FOLLOWING.
WHO_____ DRUG OF CHOICE_____ DO YOU USE WITH THEM? ☐YES ☐NO
WHO_____ DRUG OF CHOICE_____ DO YOU USE WITH THEM? ☐YES ☐NO
WHO_____ DRUG OF CHOICE_____ DO YOU USE WITH THEM? ☐YES ☐NO
WHO_____ DRUG OF CHOICE_____ DO YOU USE WITH THEM? ☐YES ☐NO

IS THERE A FAMILY HISTORY OF MENTAL ILLNESS? ☐ YES ☐ NO, IF YES, PLEASE ANSWER THE FOLLOWING.
WHO_____ WHAT DX _____
WHO_____ WHAT DX _____
WHO_____ WHAT DX _____
WHO_____ WHAT DX _____

PLEASE CHECK IF YOU HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS/SYMPTOMS.

	NONE		ALLERGIES		ALZHEIMER'S / DEMENTIA
	HEAD INJURY WHEN_____		FREQUENT HEADACHES		FREQUENT MIGRAINES
	RINGING IN EARS		ANEMIA/BLOOD DISORDER		HEARING PROBLEMS
	SEIZURES/CONVULSIONS		ASTHMA / COPD		HEART DISEASE / PROBLEMS
	SINUS PROBLEMS		AUTOIMMUNE DISORDER		FREQUENT BACKACHES
	BIRTH DEFECT_____		BLEEDING PROBLEMS_____		BREATHING PROBLEMS_____
	CANCER/TUMOR		CHEST PAINS		CHRONIC PAIN
	FREQUENT CONSTIPATION		DIABETES		DIGESTIVE ISSUES_____
	DIZZINESS		FREQUENT EAR INFECTIONS		FAINTING
	FREQUENT FATIQUE		FIBROMYALGIA		INCONTINENCE ☐URINE ☐BOWEL
	☐HIGH ☐LOW BLOOD PRESSURE		HYPO GLYCEMIA		NARCOLEPSY
	FREQUENT INFECTIONS/COLDS/FLU		☐KIDNEY ☐BLADDER ISSUES		POOR COORDINATION/BALANCE
	NOSEBLEEDS		☐OVER ☐UNDER EATING		SLEEP APNEA
	REPRODUCTIVE PROBLEMS		SEIZURES / CONVULSIONS		EXCESSIVE THIRST
	FREQUENT STOMACH ACHES/UPSET		STROKE		UNCONSCIOUSNESS
	THYROID PROBLEMS		TUBERCULOSIS		RAPID WEIGHT ☐GAIN ☐LOSS
	STD/STI		HIV/AIDS		OTHER:_____
	BARIATRIC SURGERY		HEPATITUS _____		

WHEN WAS YOUR LAST PHYSICAL?_____

ADDITIONAL CONCERNS:

_____

_____

_____

_____

_____

_____

AUTHORIZATION FOR USE OR RELEASE OF PROTECTED HEALTH INFORMATION

Client's Name: _____ Date of Birth:____/____/_____

Mailing Address: _____

Information to be released:
☐ Psychotherapy notes ONLY not to be used as an authorization for any other type of protected health information.
☐ Progress/statement of need to medical provider: _____

☐ Other: _____

Person or entity authorized to receive my health care information is: _____

_____

Contact information of person or entity information is to be released to. Please provide phone number, fax number, and mailing address:
_____ (phone) _____ (fax)

Address:_____

_____

This authorization will expire on ____/____/____, or upon 1 year of client's last appointment or when designated by the client.

Authorization and Signature: I authorize the release of my confidential protected health information as described above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

Client Signature: _____

Signature of Personal Representative: _____

Relationship to client if personal representative: _____

Date of signature:_____