Suffolk Psychotherapy, Inc.

425 W. Washington St
Suite 4
Suffolk, Virginia 23434
Tel. (757) 809-5376
Fax (757) 401-6912

REGISTRATION INFORMATION

(Please Print)

Patient Name: _____ Date: _____ - _____- _____
Last First Middle Initial

Birthdate: _____-_____-_____: Age: _____ Gender: _____: Race (optional): _____

Home Address: _____ City: _____ State: ___ Zip: _____
Home Phone: ( ) _____ OK to call? ( )Yes ( )No
Cell Phone: ( ) _____ OK to call? ( )Yes ( )No
Email: _____ OK to email about appointments? ( )Yes ( )No

Patient Social Security #_____ Driver's License #: _____
Employer: _____ Occupation: _____
Work Address_____ City: _____ State: ___ Zip: _____
Work Phone ( ) _____ OK to call? ( )Yes ( )No

Number to call for appointment reminders ( )_____ ( )home ( )cell ( )work
Referred by: _____ Family Physician: _____

Responsible Party: _____ Relationship to Patient: _____
Home Address: _____ City: _____ State: ___ Zip: _____
Home Phone: ( ) _____ OK to call? ( )Yes ( )No
Cell Phone: ( ) _____ OK to call ( )Yes ( )No
Email: _____ OK to email ( )Yes ( )No
Responsible Party Social Security #_____
Employer: _____ Occupation: _____
Work Address: _____ City: _____ State: _____ Zip: _____
Work Phone: ( ) _____

Primary Insurance: _____ Phone: ( )_____
Name of Insured: _____Policy #: _____ Group #: _____

Secondary Insurance: _____ Phone ( ) _____
Name of Insured: _____Policy #:_____

Emergency Contact:_____ Relationship to Patient: _____

Address: _____ Telephone #:_____

I agree that any of the numbers listed may be called in case of emergency (insert initials): _____

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PATIENT SERVICES AGREEMENT

This agreement contains information about privacy and patient rights. As required by law, your NOTICE OF PRIVACY PRACTICES for use and disclosure of Private Health Information (PHI) is attached. The law requires that we obtain your signature acknowledging that you were provided this information. Your signature represents a revocable agreement between us. A written revocation will be binding on us unless Suffolk Psychotherapy, Inc. has taken action in reliance on it; if there are obligations on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligation you have earned.

PSYCHOTHERAPY: The nature of Psychiatry/Psychotherapy varies depending on the personalities of the provider and patient. In order for services to be successful, you will have to work on things talked about both during sessions and at home. Psychotherapy/Psychiatry can be beneficial but may also have risks. Since your sessions may often involve discussing unpleasant aspects of your life, you may experience uncomfortable feelings. The benefits of therapy include better relationships, solutions to some problems and significant reductions in feelings of distress. There are no guarantees of what you will experience. Your provider will evaluate your needs and offer treatment recommendations. You can discuss any questions you may have with your provider.

SESSIONS: Psychotherapy/Psychiatry sessions may consist of 30 to 60 minutes sessions depending on your wishes and insurance company reimbursement. **Once your appointment is scheduled, you will be expected to give 24 hours advance notice or you will pay a missed appointment fee. Please note that insurance companies do not pay for missed or late cancelled sessions**.

PROFESSIONAL FEES: The fee schedule is attached. **There is a fee for returned checks.**

GIFTS: It is the policy of Suffolk Psychotherapy, Inc. not to accept gifts.

CONTACTING YOUR PROVIDER: You may contact the office during our normal business hours to leave a message for your provider with the receptionist. Please leave a working telephone number and available times that your provider may reach you.

CONFIDENTIALITY LIMITS: The law protects communications between a patient and a mental health provider. Information concerning your treatment is only released to others if you sign a written Release of Information Form. This form provides consent for the following:

- Your provider may need to consult other professionals about a case. Every effort is made to avoid revealing the identity of patients. The other professionals are also legally bound to keep the information confidential. If you don't object, you will not be told about these consultations unless your provider feels that it is important to your work together.

- Your provider practices with other mental health professionals. Suffolk Psychotherapy, Inc. employs administrative staff. In most cases, your provider needs to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

- Disclosures required by health insurers or to collect fees.

- If a patient seriously threatens to harm himself/herself, your provider may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide supervision.

- If your treatment involves couple, marital or family therapy, notes on each person are comingled in the record. In the case where one party requests records, it may not be possible to exclude notes involving other parties involved in treatment sessions.

There are some situations where your doctor or provider may disclose information without either your consent or authorizations:

- If you are involved in a court proceeding and a request is made for information concerning your treatment, such information is protected by law. Your provider cannot provide any information without your (or your legal representative's) written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information.

- If a government agency requests information for health oversight activities, we may be required to provide it.

- If a patient files a complaint or lawsuit against a provider of Suffolk Psychotherapy, your provider may disclose relevant information regarding that patient for the purpose of legal defense.

- If a patient files a worker's compensation claim, your provider must upon request provide records relating to treatment or hospitalization for which compensation is being sought.

There are some unusual situations in which your provider is legally obligated to take actions necessary to protect others from harm and may have to reveal some information about a patient's treatment.

- If your provider believes that a child has been or may be abused or neglected (including physical injury, substantial threat of harm, mental or emotional injury, or any kind of sexual contact or conduct), or that a child is a victim of a sexual offense, or that an elderly or disabled person is in a state of abuse, neglect or exploitation, a report must be made to the appropriate governmental agency. Your provider may then be required to provide additional information.

- If a provider believes that the patient will inflict imminent physical, mental or emotional harm upon him/herself, or others, the provider may be required to take protective action by disclosing information to medical or law enforcement personnel or by securing hospitalization of the patient.

If such a situation arises, your provider will make every effort to discuss it with you before taking any action.

RECORDINGS: Audio and video recording devices during appointments are not permitted.

PROFESSIONAL RECORDS: Protected Health Information about you is kept in two sets of records.

Your Clinical Record includes information about your reasons for seeking services, your diagnosis, treatment goals, medications, your progress, your medical and social history, your treatment history, any past treatment records received from other providers, reports of professional consultations, billing records, and reports that have been sent to anyone, including reports to insurance carriers. Typically, you may examine and/or receive a copy of your Clinical Record. If your provider refuses your request for access to your Clinical Record, you have a right of review by the Clinical Director.

Your Psychotherapy Notes assist your provider in providing treatment. They contain the sensitive information that you may reveal. While insurance companies can request and receive a copy of your Clinical Record, they cannot receive a copy of your Psychotherapy Notes without your signed, written authorization. You may examine and/or receive a copy of your Psychotherapy Notes unless your doctor or provider determines that release would be harmful to your physical, mental or emotional health.

PATIENT RIGHTS: You have some rights regarding your protected health information including requesting that your provider amend your record; requesting restrictions on what is disclosed to others; requesting an accounting of most disclosures of protected health information that you have not authorized; determining the location to which protected information disclosures are sent; having complaints about your provider policies and procedures recorded in your records; and a paper copy of this agreement, the attached notice form and our privacy and policies and procedures.

MINORS AND PARENTS: The law allows parents to examine a minor child's treatment records unless the treatment is for suicide prevention, chemical addiction, or sexual, physical or emotional abuse. Because privacy is often crucial to success, your provider will typically provide parents only with general information of the child's treatment. Before giving parents any additional information, the provider will discuss the matter with the child.

BILLING AND PAYMENTS: Payment is due at each session, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure payment. Use of a collection agency or small claims court will require us to disclose otherwise confidential information. In most collection situations, the only information released regarding a patient's treatment is his/her name, the nature of the services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

INSURANCE REIMBURSEMENT: If your health insurance provides coverage for mental health treatment, your provider will fill out forms and help you receive the benefits to which you are entitled; however, **you (not your insurance company) are responsible for full payment of our fees.** Please find out exactly what mental health services your insurance policy covers. In the event that Suffolk Psychotherapy files claims for insurance reimbursement, your signature below authorizes payment of benefits to be issued directly to Suffolk Psychotherapy. If your insurance company

mistakenly remits payment to you, you agree to send that check along with any paperwork to Suffolk Psychotherapy. If your insurance company denies these claims due to reasons beyond our billing control, you will be directly responsible for the payment of our fees.

MASTER TREATMENT PLAN AND CONSENT: You understand that you are an active participant in your treatment process. This includes identifying problems and concerns, developing a plan of treatment goals and working towards resolution of identified problems on an ongoing basis. This includes seeing a psychologist, social worker, professional counselor and may include license-eligible and training personnel under supervision of licensed mental health professionals at Suffolk Psychotherapy. Your treatment may require psychological testing and other assessments, referral and consultation by other health professionals including a psychiatrist and ancillary medication therapy as part of the best-practice for treatment of your care.

You understand that mental health therapies offer no guarantee of complete resolution and do not hold Suffolk Psychotherapy, Inc. and affiliated staff liable for failed achievement of treatment goals.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT IN ITS ENTIRETY AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOLEDGEMENT THAT YOU HAVE HAD THE OPPORTUNITY TO READ AND RECEIVE A COPY OF THE HIPPAA PRIVACY NOTICE DESCRIBED ABOVE.

A copy of this document is available upon your request.

SIGNATURE: Patient:_____ Date:_____

OR

CONSENT FOR MENTAL HEALTH TREATMENT OF A MINOR: You understand that you and your child are active participants in your child's treatment process. This includes identifying problems and concerns, developing a plan of treatment goals and working towards resolution of identified problems on an ongoing basis. Your child's treatment may include seeing a psychologist, social worker, professional counselor and may include license-eligible and training personnel under supervision of licensed mental health professionals at Suffolk Psychotherapy. Your child's treatment may require psychological testing and other assessments, referral and consultation by other health professionals including a psychiatrist and ancillary medication therapy as part of the best practices for treatment of your child's care. You understand that mental health therapies offer no guarantee of complete resolution and do not hold Suffolk Psychotherapy, Inc. and affiliated staff liable for failed achievement of treatment goals.

In the event of my absence or inability to attend my child's treatment appointments, I give **permission for the following persons to accompany my child for any/all treatment-related session. I am aware that I may revoke this permission at any time.**

_____ _____
Name **Relationship to child**

_____ _____
Name **Relationship to child**

Parent or Guardian or Personal Representative : _____

SIGNATURE: :_____ Date:_____

Please note that if the patient is underage or has a guardian appointed by the court, this agreement must be signed by the patient's legal guardian if the agreement is signed by a personal representative, the authority to act for the patient must be provided.

Consent to Email or Text

Usage for appointment reminders and other healthcare communications.

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from Suffolk Psychotherapy.

_____ **(Patient Initials**) I consent to receive text messages from Suffolk Psychotherapy staff and providers at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing. I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information to the following:

Date: _____ Cell Phone Number: _____

Informed Consent for Telemedicine Services

PATIENT NAME: _____
LOCATION OF PATIENT: _____
DATE OF BIRTH: _____
DATE CONSENT DISCUSSED: _____

Introduction:

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists.
The information may be used for diagnosis, therapy follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video

Output data from medical devices and sound and video files Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

- Improved access to medical care by enabling a patient to remain in his/her home (or at a remote site) while the physician obtains test results and consults from healthcare practitioners at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

Possible Risks:

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rate cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s).

- Delay in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.

- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.

- In rare cases, a lack of access to complete medical records may result in adverse drug interaction or allergic reactions or other judgement errors.

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.

2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine during the course of my care at any time, without affecting my right to future care or treatment.

3. I understand that I have the right to inspect all information obtained and recorded during the course of a telemedicine interaction and may receive copies of this information for a reasonable fee.

4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My medical provider has explained the alternatives to my satisfaction.

5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.

6. I understand that it is my duty to inform my medical provider of electronic interactions regarding my care that I may have with other care providers.

7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

Patient Consent to The Use of Telemedicine

I have read and understand the information provided above regarding telemedicine. I have discussed it with my provider or such assistants as may be designated and all my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical and therapeutic care.

I hereby authorize Suffolk Psychotherapy and their providers to use telemedicine during the course of my diagnosis and treatment.

_____

Signature of Patient (or authorized agent/guardian) Date

_____

If authorized signer, print name and relationship to parent

_____

Witness Signature Print Name Date

I have been offered a copy of this consent form (patient's initials) _____

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FEE SCHEDULE

Initial Diagnostic Interview	$175.00	30 Minute Psychotherapy	$75.00
60 Minute Psychotherapy	$160.00	45 Minute Psychotherapy	$125.00
Family Therapy Session	$100.00	Group Therapy Session	$ 55.00
Telehealth Therapy Session	$55-160*		
Life Coaching Initial Interview	$100.00*	60 minute Session	$65.00*
Legal Consultations (w/attorneys)	$150.00 per hour (Provider)*		
Court Appearances (Testimony, hearings, etc.)	$400.00 per hour including travel time* Providers		
Missed Appointment w/out 24 hour notice	$35.00*	Late Cancellation (if less than 24 hours notice)	$25.00*
Completion of Third Party Forms Letters, etc.	$50.00*	Returned Check Fee	$50.00*
FMLA Paperwork	$50.00* (per request)		

By signing below, you acknowledge that you have been advised of and agree to the above standard fee policy. These are the fees you will be expected to pay unless your health insurance has a lower negotiated rate. If you are using a third party reimbursement (i.e., health insurance, flexible spending accounts, etc.) and it is later determined that you do not have coverage for the dates that services were provided, you will be charged at the above rates.

I _____, am fully aware of and agree to the above fee schedule policy.
(Print Name)

_____ _____
Patient Signature Date
(or parent/guardian if patient is a minor)

Here at Suffolk Psychotherapy, Inc. our ultimate goal is to provide our patients with the utmost care. If at any time your fee or copay becomes a burden, please ask to speak with our business manager. We have options for our patients in need of assistance. Please do not forego care due to financial reasons.

*This service not typically covered by health insurance. Please check with your individual health insurance policy.

Payment Method

Please be informed that **Suffolk Psychotherapy** collects all known co-pays, co-insurances, or deductibles at the time of your service. Please be advised that this card will also be used for any form request or missed appointments without 24-hour notice. Thank you.

Suffolk Psychotherapy requires a form of payment to be kept on file at which these services will be charged at the time of service.

Card Type: ( )Visa ( )Mastercard ( )American Express

Name on Card: _____

Credit Card #: _____

Billing Address: _____

Billing Zip Code: _____

_____/ _____ _____
Expiration Date CVV

Cardholder Signature: _____ Date: _____

Patient Full Name: _____

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Patient's Full Name	Social Security Number	Date of Birth

I hereby authorize: _____

Name of Person or Organization Phone # Fax #

_____

Street Address City State Zip

To use/disclose/exchange the following healthcare information and records:

( ) Intake/Referral **( )**Diagnosis **( )**Treatment Plan **( )**Evaluation/Assessment **( )**Psychological Evaluation
( ) Physical Health **( )**Medications **( )**Progress Notes **( )**Discharge Summary **( )**Summary of Services Received
( ) Social History **( )**Transportation **( )**Financial **( )**Employment **( )**Title IV-E Eligibility
( ) Participation & Attendance **( )**Substance Abuse **( )**Infectious Diseases: AIDS, HIV, TB

Additional Information to disclose: _____

To/With:

Suffolk Psychotherapy, Inc. 425 W. Washington St., Suffolk, VA 23434

Purpose of use/disclosure/exchange of information is: (Check all that apply) **( )**Assessment **( )**Treatment **( )**Discharge Planning
( ) Benefits/Service Eligibility ( ) Coordination of care ( ) Legal ( )Other: _____

As the person signing this authorization, I understand that I am giving my permission to the above-named health care entity for disclosure of confidential health records. I want all persons and organizations to accept a copy or faxed version of this form as a valid authorization to share information. If I do not sign this form, information will not be shared, and I will have to contact each agency individually to give them information about me that they need. I understand that:

- Suffolk Psychotherapy, Inc. cannot condition treatment or payment on my willingness to sign this authorization. I may refuse to sign this authorization.
- This authorization will become effective upon the date signed below unless noted otherwise.
- Only the information needed to satisfy the stated purpose of this disclosure will be shared. I understand this will include information added after the authorization origination date and up until the authorization expiration date.
- I have the right to revoke this authorization at any time, except to the extent that action has been taken in reliance on it, by delivering the revocation in writing to the provider who is in possession of my health care records. *(Use "Revocation of Authorization to Disclose Confidential Information" (HIPAA 008).*
- A copy of this authorization and a notation concerning the persons or agencies to which disclosure was made shall be included with my original health records.
- There is a potential for any information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and, therefore, no longer protected by the provisions of the HIPAA Privacy Rule. If this information is being disclosed from records protected by the Federal substance abuse confidentiality rules (42 CFR Part 2), the Federal rules prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by your written authorization or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
- Suffolk Psychotherapy, Inc., and/or its employees are hereby released from any legal responsibility or liability for disclosing information as I have authorized by completing this form, or for the use of information by the person or organization receiving it.

This Authorization will not expire unless it has been revoked in writing by myself.

_____

Patient's signature Date

_____

Parent/Guardian/Authorized Representative's signature, when required Date

Witness signature optional, unless consumer's signature is a "mark" _____Date_____

I do not wish to sign this authorization at this time _____*(insert initials if you do not wish to sign authorization*)

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PATIENT BILL OF RIGHTS

As a patient of Suffolk Psychotherapy, Inc., you have the following rights:

To be informed of your Bill of Rights.
To confidentiality of conversations and medical records.
To have access to your medical records.
To petition a court according to law.
To participate in the development of the treatment plan.
To the least restrictive treatment conditions necessary.
Receive information from your provider regarding alternative methods of treatment.
To terminate services at any time.
To refuse to be filmed or taped.
To file a grievance within 45 days of the incident/issue, to the agency and the Board of Licensure for the Commonwealth of Virginia.

I acknowledge that I have been informed of the Master Treatment Plan, Consent for Mental Health Treatment of a Minor and my rights as stated above.

_____ _____

Patient/Responsible Party Signature Date

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PRIVACY POLICY

How We Collect Information About You: Suffolk, Psychotherapy, Inc. and its employees, training personnel and independent contractors collect data through a variety of means including but not necessarily limited to letters, phone calls, emails, voice mails, and from the submission of applications that is either required by law, or necessary to process insurance claims, applications or other requests for assistance through our organization.

What We Do Not Do With Your Information: Information about your financial situation and medical conditions and care that you provide to us in writing, via email, on the phone (including information left on voice mails), contained in or attached to applications, or directly or indirectly given to us, is held in strictest confidence.

We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about applicants or clients who apply for or actually receive our services that is considered patient confidential, is restricted by law, or has been specifically restricted by a patient/client in a signed HIPAA consent form.

How We Do Use Your Information: Information is only used as is reasonably necessary to process your application or to provide you with health or counseling services which may require communication between Suffolk Psychotherapy, Inc. and other health care providers, service providers, pharmacies, insurance companies, and others necessary to verify your medical information is accurate for reimbursement for services or respond to your requests to forward information on your behalf or by other legal demands/requests for information about you.

If you apply or attempt to apply to receive assistance/care through us and provide information with the intent or purpose of fraud or that results in either an actual crime of fraud for any reason including willful or un-willful acts of negligence whether intended or not, or in any way demonstrates or indicates attempted fraud, your non-medical information can be given to legal authorities including police, investigators, courts, and/or attorneys or other legal professionals, as well as any other information as permitted by law.

Information We Do Not Collect: We do not use cookies on our website to collect data from our site visitors. We do not collect information about site visitors except for one hit counter on the main index page (suffolkpsychotherapyinc.com) that simply records the number of visitors and no other data. We do use some affiliate programs that may or may not capture traffic data through our site. To avoid potential data capture that you visited our website simply do not click on any of our outside affiliate links.

Limited Right to Use Non-Identifying Personal Information From Biographies, Letters, Notes, and Other Sources: Any pictures, stories, letters, biographies, correspondence, or thank you notes sent to us become the

exclusive property of Suffolk Psychotherapy, Inc. We reserve the right to use non-identifying information about our clients (those who receive services or goods from or through us) for promotional purposes that are directly related to our company's care provision.

Clients will not be compensated for use of this information and no identifying information (photos, addresses, phone numbers, contact information, last names or uniquely identifiable names) will be used without a client's express advance permission.

You may specifically request that NO information be used whatsoever for promotional purposes, but you must identify any requested restrictions in writing. We respect your right to privacy and assure you no identifying information will ever be publicly used without your direct or indirect consent.

_____
Patient Name

I acknowledge that I have read and understand these privacy practices for Suffolk Psychotherapy, Inc.

_____ _____
Patient/Guardian Signature Date

_____ _____
Responsible Party Signature (if other than Patient/Guardian) Date

PROBLEM LIST

1. Current Marital Status (circle one) Single Married Divorced Separated Widowed
2. Previous Marriages: _____Yes _____ No
3. Number of Children (if any) _____ Ages: _____
4. Military Affiliation: _____
5. Spiritual/Religious Background: _____
   (Catholic, Baptist, Methodist, etc.)
6. How important is your relationship with God? (circle one) 1 2 3 4 5 6 7 8 9 10
   Committed Detached
7. State the main reason you are seeking counseling at this time: _____
   _____
   _____
   _____
8. How long have you been experiencing this problem? _____
9. Is this a reoccurring problem? _____
10. How long has it been since the last occurrence? _____
11. On a scale of 1-10, please rate the overall severity of your situation with 10 being the most severe:
    _____
12. Previous Counseling Received: ___ Personal ___Family ___ Group ___ None
13. Current Counseling You Receive: ___ Personal ___Family ___ Group ___ None
14. If any counseling was received for this problem, please give reason for cancelation:

_____

_____

_____

_____

15. Please indicate which of the following are concerning you at this time (check all that apply):

___Alcohol/Substance abuse by self	___Family Problems	___ Eating Disorders
___ Alcohol/Substance Abuse by others	___ Marital/Relational Problems	___ Poor appetite
___ Sexual Difficulties	___ Hopelessness, Helplessness	___ Fatigue
___ Sexual Addiction	___ Guilt, Worthlessness	___ Muscle Twitching
___ Physical Abuse	___ Restlessness	___ Chest Pain
___ Emotional Abuse	___ Crying Spells	___ Shortness of Breath
___ Sexual Abuse	___ Sudden weight gain/loss	___ Excessive Sweating
___Anxiety	___ Insomnia	___ Muscle Aches
___ Thoughts of Suicide	___Excessive Sleeping	___Panic Attacks
___ Grief	___ Decreased Concentration	___ Dizziness/Faintness
___ Illness	___ Loss of interests	___ Digestive Problems
___ Mood Changes	___ Racing Thoughts	___ Rapid/Pounding pulse
___ Adjustments to life changes	___ Uncontrollable thoughts	___ Numbness in fingers
___ Work, Vocational Problems	___ Reckless behaviors	___ Cold Hands
___ Criminal Problems	___ Anger	___ Excessive Sweating
___ Financial Problems	___ Irritability	___ Dry Mouth
___ Abortion	___ Miscarriages	

16. Please check how often the following occur to you:

a. Life is hopeless.	___ Never	___ Rarely	___ Sometimes	___ Frequently
b. I am lonely.	___ Never	___ Rarely	___ Sometimes	___ Frequently
c. No one cares about me.	___ Never	___ Rarely	___ Sometimes	___ Frequently
d. I am a failure.	___ Never	___ Rarely	___ Sometimes	___ Frequently
e. Most people don't like me.	___ Never	___ Rarely	___ Sometimes	___ Frequently
f. I want to hurt someone.	___ Never	___ Rarely	___ Sometimes	___ Frequently
g. I am so stupid.	___ Never	___ Rarely	___ Sometimes	___ Frequently
h. I am so depressed.	___ Never	___ Rarely	___ Sometimes	___ Frequently
i. God is disappointed with me.	___ Never	___ Rarely	___ Sometimes	___ Frequently
j. I am disappointed with God.	___ Never	___Rarely	___ Sometimes	___ Frequently
k. I can't be forgiven.	___ Never	___ Rarely	___ Sometimes	___ Frequently
l. Why am I so different?	___ Never	___ Rarely	___ Sometimes	___ Frequently
m. I can't do anything right.	___ Never	___ Rarely	___ Sometimes	___ Frequently
n. I am out of control.	___ Never	___ Rarely	___ Sometimes	___ Frequently
o. I am unlovable.	___ Never	___ Rarely	___ Sometimes	___ Frequently

17. Additional Comments: _____

_____

18. SIGNATURE_____ **DATE:** _____