NeuroBehavioral Concepts | llc
Tax ID 26.2350260
NPI 1851574404
www.neurobx.com
503.803.9361

PSYCHOTHERAPY SERVICES POLICIES AND PROCEDURES

Welcome to NeuroBehavioral Concepts LLC ("NeuroBehavioral Concepts" or "NBx")! We're excited to partner with you in pursuing your psychotherapy goals. We require all patients to review and agree to these policies and procedures prior to beginning (or continuing) treatment with us. There are spaces throughout this packet for you to provide your initials or signature, which demonstrates that you understand and agree to these policies. Please take a moment to read it and ask any questions before signing.

Building a therapist-patient relationship is dependent upon trust, openness, responsibility, and respect. This document contains important information about our services. To most effectively utilize our intake session, please take the time to read and complete this form prior to our first meeting. Please feel free to discuss this document with your therapist at any time.

You will be seen by:
Lonny Webb, MSW, LCSW
OR Lic # L5881

INFORMATION ABOUT YOU

"You" refers to the patient (even if someone other than the patient is completing this document).

Name:_____Date of Birth: _____

Sex:_____Pronoun Preference:_____Relationship Status: _____

Mailing Address: _____

Email: _____

INFORMATION ABOUT YOU, Continued

Cell phone:_____Home phone:_____

Email:_____With whom do you live? _____

If you experience a medical emergency (including suicidal or homicidal thoughts), immediately call 911 or visit your nearest emergency room.

Employer:_____Occupation:_____

Address: _____

EMERGENCY CONTACT

Check here if this person will be attending your sessions. ⇨☐

Name:_____Email:_____

Relationship to You:_____Phone: _____

OUR COMMUNICATION WITH YOU

By providing the above information, or by initiating communication with us by email or text message, you authorize us to call, leave voicemails, and send text messages using that information. We will use this information for non-marketing purposes, including appointment reminders, billing and invoicing updates, and treatment questions.

You further understand and agree that communicating with us by unencrypted emails and text messages may not be secure. This also means that your protected health information ("PHI") may be transmitted in this way, including information about your appointments, diagnosis, progress and other individually identifiable information. If you choose to communicate via text or email, please limit the content to general information (such as scheduling or asking for a time to talk via phone). Please be aware of privacy risks when using electronic means of communication.

I acknowledge and agree to this policy. ***(Initial here)***____

YOUR CARE TEAM

Please provide us with information about the other professionals who are involved in your healthcare. This doesn't mean we'll contact them. It just allows us to plan your care.

PRIMARY CARE PHYSICIAN

Check here if we may contact this person. ⇨☐

Name:_____Date of Last Visit:___/_____

Practice:_____Address: _____

Phone:_____Email: _____

NOTICE OF PRIVACY PRACTICES AND CONFIDENTIALITY

We maintain strict privacy policies and procedures, which are detailed in our Notice of Privacy Practices. There are exceptions, and there may be times when the law requires us to disclose your information and break confidentiality.

How we use and disclose your information is articulated in our Notice of Privacy Practices, which we will offer to you prior to our first session, and it will also be available on our website and upon your request. Your initials below and your signature at the end of this document signifies your acknowledgement that you have been offered and have accepted a copy of our Notice of Privacy Practices.

It is important for NeuroBehavioral Concepts to provide a safe and supportive environment for patients as they participate in therapy services. Information about you is generally held in confidence by law and our policy is to never release information outside of sessions without your consent. That being said, please be aware that state law and various court rulings require us to make a report to the proper authorities in certain circumstances, which are outlined in the "Notice of Mandatory Reporting Obligations" section below.

If you are engaged in couples' or family treatment, it is our policy to not hold any secrets between the parties involved. If one party tells a secret between a session or during an individual session with the couples or family therapist, then it will be assumed that you are telling this information in order to get help in disclosing it to your partner or family.

Consultation is an important component of a healthy psychotherapy practice. As such, we regularly participate in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, we will not reveal any personal identifying information regarding the Patient or you in any way.

Information regarding the Patient's treatment plan, goals and progress may be shared with NBx staff if they are directly involved in your care: members of the practice team, other clinicians or practice staff for administrative purposes, or treatment coordination.

Psychotherapist-Client Privilege

The information disclosed by the Patient, as well as any records created, is subject to the psychotherapist-client privilege. The psychotherapist-client privilege results from the special relationship between the Therapist and the Patient in the eyes of the law. It is akin to the attorney-client privilege or the doctor-client privilege. Typically, the Patient is the holder of the psychotherapist-client privilege. If the Therapist receives a subpoena for records, deposition testimony, or testimony in a court of law, the Therapist will assert the psychotherapist-client privilege on the Patient's behalf until

instructed in writing to do otherwise by the Patient or the Patient's representative. The Patient should be aware that he/she might be waiving the psychotherapist-client privilege if he/she makes his/her mental or emotional state an issue in a legal proceeding. The Patient should address any concerns he/she might have regarding the psychotherapist-client privilege with his/her attorney.

I acknowledge and agree to this policy. ***(Initial here)*** _____

NOTICE OF MANDATORY REPORTING OBLIGATIONS

Oregon and Washington State Law requires us to report all child abuse to the appropriate agency. If we have reasonable cause to believe that a child who is known to us in our professional capacity may be a victim of abuse or neglect, we are legally required to make this notification. It is our Practice's policy to notify the child's parent or legal guardian prior to making a notification, so long as we believe we can do so without putting the child at risk. The law also requires us to report any abuse of elder or vulnerable adults to DHS. This may include physical, sexual, financial, or psychological abuse, neglect, or exploitation. According to Oregon laws any kind of sexual contact, or asking for sexual contact, or sexual misconduct by a psychotherapist with a Patient is illegal as well as unethical.

I acknowledge and agree to this policy. ***(Initial here)*** _____

MEDICAL RECORDS REQUEST POLICY

The Therapist may take notes during session, and will also produce other notes and records regarding the Patient's treatment. These notes constitute the Therapist's clinical and business records, which by law, the Therapist is required to maintain. Such records are the sole property of the Therapist. The Therapist will not alter his/her normal record keeping process at the request of any Patient/Representative. Should the Patient/Representative request a copy of the Therapist's records such a request must be made in writing. The Therapist reserves the right, under Oregon law, to provide the Patient/Representative with a treatment summary in lieu of actual records. The Therapist also reserves the right to refuse to produce a copy of the record under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider. The Therapist will maintain the Patient's records for ten years following termination of therapy. However, after ten years the Patient's records will be destroyed in a manner that preserves the Patient's confidentiality.

I acknowledge and agree to this policy. ***(Initial here)*** _____

SOCIAL INTERACTIONS OUTSIDE OF SESSIONS

Public encounters. It is possible that we might encounter each other outside of our treatment sessions, either in person or online. If this happens, we will never acknowledge working therapeutically with you, and depending upon the situation, we may pretend that we didn't even see you. This is intended to protect your privacy and to avoid revealing our relationship to anyone. If youinitiate a conversation, we will respond in kind, but you should not feel pressure to acknowledgeus.

Online Encounters. To protect the professional nature of our relationship, we cannot accept socialmedia requests, social media page "follow" requests, or social event invitations. We invite you to visit our professional social media pages and our website. However, we do discourage you from: leaving

messages or comments on public "walls" or "feeds," sending "direct" or "private" messages through social media sites, or "following" or "subscribing" to our social media feeds or handles. NeuroBehavioral Concepts therapists do not accept friend or contact requests from current or former patients on any social media or networking site because it can compromise your confidentiality and privacy.

I acknowledge and agree to this policy. ***(Initial here)*** ____

EMERGENCIES

If you need to reach your therapist between sessions, please text them directly. They will make efforts to respond to your text and arrange for a crisis session phone call as soon as possible. In the event of a clinical emergency that needs immediate attention, please call 911 or go to the nearest emergency room. After one of those steps has been taken, please leave your therapist a message as soon as possible.

NeuroBehavioral Concepts is not an emergency department. Do not contact us by email or phone during an emergency as we may not get the information quickly.

I I acknowledge and agree to this policy. ***(Initial here)*** _____

INACTIVE PATIENT STATUS

If you do not make contact with your therapist for 30 days or longer, your file with NeuroBehavioral Concepts will be closed and you will no longer be considered an "active patient." You are always welcome to come back to continue getting psychotherapy services, however there is no guarantee that your usual therapist will still be available to see you.

I acknowledge and agree to this policy. ***(Initial here)*** _____

POLICIES INVOLVING THE TREATMENT OF A MINOR CHILD

Consent for the Treatment of a Minor Child

We require the consent of both parents prior to providing any services to a minor child. If any question exists regarding the authority of you to give consent for psychotherapy, we ask that you submit supporting legal documentation, such as a custody order, prior to the commencement of services.

I acknowledge and agree to this policy. ***(Initial here)*** _____

Requirement for parents' involvement and participation in minor child's treatment

In mental health therapy with children, it is critical that parents are involved throughout the therapeutic process, from the evaluation to the last session. When it comes to therapy, the therapist is the expert in the process of therapy and you, *as the parent, are the expert of your child*. Your input and active participation is invaluable and at NBx, required.

No matter your child's age, parent involvement in therapy is important. What your involvement looks like will depend on your child's needs and their age. Typically, the younger the child, the more the therapist will bring you into the sessions. Your child's therapist may also provide family therapy or parenting skills to add to your family's toolkit to improve communication and relationships with the family.

Without you, skills that your child is learning may never be practiced outside the therapist's office. Parents help immensely by noticing when their kids are using their skills and praising them for it. *Research shows that kids benefit the most from mental health therapy when both parents are actively involved.* When parents and the family are involved, your child feels more supported, that the work is not just on them, and that there is a team of people that have their back.

I acknowledge and agree to this policy. ***(Initial here)*** _____

Minors and Confidentiality

Communications between the Therapist and Patients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child's treatment are encouraged to be involved in their treatment. With the minor's permission I will discuss the treatment progress of a minor Patient with the parent or caretaker, ***but not details that would decrease trust between the minor and myself***. Minor Patients and their parents are urged to discuss any questions or concerns that they have on this topic.

I acknowledge and agree to this policy. ***(Initial here)*** ____

Minors must also acknowledge and agree to this policy. ***(Initial here)*** ____

Our Orientation

It our desire that the Patient's experience in counseling be a collaborative effort around manageable goals, that produce richer, happier and more productive living. The Patient's values and beliefs will be respected and there will be no intention to deliberately embarrass or manipulate the Patient. At times the Therapist may encourage the Patient to discuss issues that are uncomfortable, but always with the hope of improving the Patient's life and relationships.

Benefits and Risks of Therapy

Psychotherapy is a process in which the Therapist and the Patient discuss a variety of issues, events, experiences and memories for the purpose of creating positive change so the Patient can experience life more fully. It provides an opportunity to better, and more deeply understand oneself, as well as any problems or difficulties the Patient may be experiencing. Psychotherapy is a joint effort between the Patient and the Therapist. Progress and success may vary depending upon the particular problems or issues being addressed, as well as many other factors. Participating in therapy may result in a number of benefits to the Patient, including, but not limited to, reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, work, and family settings, increased capacity for intimacy, and increased self-confidence. Such benefits may also require substantial effort on the part of the Patient, including an active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts and behaviors. There is no guarantee that therapy will yield any or all of the benefits listed above and will usually take more than a few sessions of hard work to notice any sort of change. Because therapy is a process which takes time and commitment, each person involved in the counseling process is asked to regularly RATE their counseling sessions to show the intention of making a difference in his/her life through self-awareness, insight, effort and dedication.

Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. The process may evoke strong feelings of sadness, anger, fear, etc. There may be times in which the Therapist will challenge the Patient's perceptions, assumptions and offer different perspectives. The issues presented by the Patient may result in unintended outcomes, including changes in personal relationships. The Patient should be aware that any decision on the status of his/her personal relationship is the responsibility of the Patient. During the therapeutic process, many Patients find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times, but it may also be slow and frustrating. The Patient should address any concerns he/she has regarding his/her progress in therapy with the Therapist

Patient Litigation

The undersigned will neither individually nor jointly involve Lonny Webb, MSW, LCSW, or other NBx staff, in any litigation. The undersigned will neither request nor require Lonny Webb, MSW, LCSW to provide testimony in court. The reason for this is so that treatment is not compromised, the therapeutic relationship with the family is maintained, and the child experiences their therapist in a clear, consistent,

therapeutic role and not as an assessor or detective. If the services of a mental health professional are desired for court purposes, the services of a separate professional must be enlisted.

I acknowledge and agree to this policy. ***(Initial here)*** ____

PAYMENT POLICIES – RATES

The fee you are quoted is comparable to most of the therapists in this area. The Representative is expected to pay for services at the time services are rendered. It is asked that the Representative pay the Patient's fee at the end of each session. Make checks to payable to NBx.

Intake Diagnostic…….……$450.00 - 1:50- minute session
Psychotherapy…….……$175.00 - 50-minute session
Psychotherapy, extended session…….……...…$350.00 - 1:50- minute session
Psychotherapy with Interactive Complexity[1].....$250.00 - 50 minute session
Crisis Session……$225.00 - 30-minute call
Forensic Consultation[2]…….$375.00 - 60 minutes

Sessions longer than 50 minutes (Extended sessions are 110 minutes @ $350.00 per session) are charged for the additional time pro rata, $60.00 per 15-minute in person or over the phone. Assessments, Emergency Sessions or Sessions scheduled outside of customary business hours are subject to "Crisis Session" as referenced above.

The Therapist reserves the right to periodically adjust fees. The Patient's fee will be re-evaluated regularly and also at those times when the Representative's financial circumstances change. The Representative will be notified of any fee adjustment in advance. From time-to-time, the Therapist may engage in telephone contact with the Patient for purposes other than scheduling sessions. The Representative is responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than 10 minutes. In addition, from time-to- time, the Therapist may engage in telephone contact with third parties at the Patient/Representative's request and with the Patient/Representative's advance written authorization. The Representative is responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than 10 minutes.

I acknowledge and agree to this policy. ***(Initial here)*** ____

[1] This code may be used when at least one of the following factors are present during the visit:
1. The need to manage maladaptive communication
2. Caregiver emotions or behaviors that interfere with treatment
3. Mandated reporting of a sentinel event to a third party (like abuse or neglect to state agency) with initiated discussion of the event and/or a report with the patient and other visit participants
4. Use of play equipment, physical devices, interpreters or translators to communicate with a patient who has a language barrier

[2] Such as a custody evaluation or testifying in court, both of which must be pre-arranged.

CREDIT CARD AUTHORIZATION AND PAYMENTS

We request that you complete the attached Credit Card Payment authorization. NBx will retain your credit card information to secure payment. If you do not keep a credit card on file with our Practice, you must pay for your sessions at the time of service by either cash or check. NBx will email invoices by the 5th of each month and payment is expected on or before the 15th of each month. If you have not received your invoice by the 5th of the month, please check your junk email folder or contact us.

Please initial one of the following:

_____You authorize payment[3] to be collected using the credit card on file on a monthly basis.

OR

____You will mail in your check, money order, or electronic check by the 15th of each month.

If we do not receive payment in full within thirty (30) days of the invoice date on any invoice you receive from us, and you do not make contact with us to make payment arrangements or provide notice of your intention to contest our fees pursuant to this Consent for Services agreement you authorize us to bill your credit card for the full amount plus a 5% fee for any invoice with a balance over thirty days overdue.

If a balance is owed and remains unpaid after the due date of the invoice, you will be asked to postpone further sessions until your account is brought to a "zero" balance.

Any failure or delay in exercising our rights under this paragraph does not constitute waiver or preclude any later exercise of such rights or any exercise of any other right. Such reserved rights include but are not limited to the right to release a Patient's name and address to a collection agency, to charge a monthly interest fee of 10% for unpaid balances.

You consent to billing pursuant to these terms and to our storage of your credit card information. No additional authorization is required, and you agree that you will not contest or reverse ("charge-back") the charges, if we are unable to process your payment by credit card, we will notify you immediately.

You will then be responsible for arranging an alternate form of payment in full within five (5) business days.

By executing the Credit Card Payment Authorization attached, you agree to such automatic charges, and you agree to promptly inform us of any changes to your credit card or billing information.

I acknowledge and agree to this policy. ***(Initial here)*** ____

I acknowledge and agree to this policy. ***(Initial here)*** ____

[3] Balance plus a 5% processing fee.

CREDIT CARD PAYMENT AUTHORIZATION

Patient Name:		
Card Type:	☐ Visa ☐ MasterCard ☐ HSA ☐ Other	
Credit Card #:		
Exp. Date on Credit Card (mm/yr.):		
Card Verification Code: (the 3 or 4 digit code on the back of your credit card):		
Name as it appears on card:		
Company name on Card (if applicable):		
Credit Card Billing Address:		
City:	State:	Zip:
This authorization is given subject to the terms of the attached Engagement Letter and Consent For Services, Policies, And Fee Agreement, the terms of which are incorporated by reference herein. By signing this authorization, I acknowledge that I have read and agree to all of the terms contained in the Engagement Letter and Standard Terms of Representation and warrant all information given is true.		
Signature of Card Holder:		Date:

INSURANCE

If you have insurance, please realize that you are responsible for submitting a billing statement directly to your insurance company for reimbursement and that full payment of the fee for services provided will be paid at each session. The Therapist is not a contracted provider with your insurance company or managed care organization, and the Therapist will provide the Representative with a statement (known as a superbill) which the Patient may submit to the third-party of his/her choice to seek reimbursement of fees already paid. The Representative is responsible for any and all fees not reimbursed by his/her insurance company, managed care organization, or any other third-party payor. The Representative is responsible for verifying and understanding the limits of the Patient's coverage, as well as any copayments and/or deductibles.

CANCELLATIONS

Scheduling appointments is your responsibility and is done online at www.NeuroBx.com/calendar. The Representative is responsible for payment of the session for any missed session(s) not cancelled at least 24 hours in advance. Please call your therapist to cancel or leave other messages. Your Therapist will wait 15 minutes for you if you are late for an appointment. Please be advised if you are late the session may not be extended to make up for late starts.

TERMINATION OF THERAPY

The Therapist reserves the right to terminate therapy at his/her discretion. Reasons for termination include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, the Patient's needs are outside of the Therapist's scope of competence or practice, or the Patient is not making adequate progress in therapy. The Patient has the right to terminate therapy at his/her discretion. Upon either party's decision to terminate therapy, the Therapist will generally recommend that the Patient participate in at least one, or possibly more, termination sessions. These sessions are intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the work that has been conducted. The Therapist will also attempt to ensure a smooth transition to another Therapist by offering referrals to the Patient. Acknowledgement: By signing below, the Representative acknowledges that he/she has reviewed and fully understands the terms and conditions of this agreement. The Representative has discussed such terms and conditions with the Therapist and has had any questions with regard to its terms and conditions answered to the Representative's satisfaction. The Representative agrees to abide by the terms and conditions of this Agreement and consents to the Patient's participation in psychotherapy with the Therapist. Moreover, the Representative agrees to hold the Therapist free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment. I understand that I am financially responsible to the Therapist for all charges, including unpaid charges by my insurance company or any other third-party payor.

AGREEMENT FOR SERVICE/INFORMED CONSENT

SIGNATURE PAGE:

_____

Client Name (Please Print)

_____ _____

Signature of Patient (or authorized Representative) Date

_____

Name of Responsible Party (if other than client) please print.

_____ _____

Signature of Responsible Party (if other than client) Date

INTAKE FORM

Today's date: _____

Patient Information:

Individual Name: _____ Date of Birth: _____ Age: _____
(first) (last)

Gender M/F Ethnicity (optional): _____

Name of Person completing this form (if different from "Patient"): _____

Relationship to individual: _____ Years known: _____

Residence of child: (circle) Biological parents Adoptive parents Foster parents PCS Home

Other: _____

Patient Contacts (if Minor):

Mother's name: _____ Age: _____
(first) (last)

Father's name: _____ Age: _____
(first) (last)

Marital Status of Parents: (circle) Married Divorced Separated Widowed

Mother's Address: _____
(street) (city) (state) (zip code)

Father's Address: _____
(street) (city) (state) (zip code)

Contact phone numbers:
Name/Relationship: _____ Number: _____

Who has legal/physical custody? _____ Type: _____
(please provide legal documentation)

Patient's School: _____ Grade: _____

Patient's Siblings Names and Ages: _____

Support Services:

Does this individual receive services from Health and Welfare? Yes No
Case Worker (name): _____ Phone: _____
Services Received: _____ Region: _____

Referral Information:

Who referred you to this clinic?

_____
(Name) (phone) (Address)

Presenting Problem:

What concerns you most about this individual (or yourself if you are the patient) ?

When did you first notice this problem?

How has this problem affected his/her/your function?

At home:

At school/work:

Community:

Do you have other concerns you want addressed?

What are your goals/expectations for treatment?

Have you recently worried that the individual has (please circle items relevant to the patient):

Yes No DEPRESSION (sad, irritable, hopeless, poor sleep, crying, social withdrawal/isolative behaviors, lack of interest in things, etc.)

Yes No MOOD SWINGS (energetic, little sleep, pleasure seeking, racing thoughts, too talkative, inappropriate sexual behaviors, grandiose, etc.)

Yes No ANXIETY (worries, restless, scared, poor sleep, obsessive thoughts and/or compulsive behaviors, frequent complaining of headaches and/or stomach aches, frequent school absences, etc)

Yes No BEHAVIORAL PROBLEM (fights, anger, arguing, truancy, destruction of property, fire setting, etc.)

Yes No ATTENTION/HYPERACTIVITY PROBLEM (difficulty sustaining attention, hyperactive, impulsive, distractibility, not completing tasks)

Yes No ABNORMAL EATING BEHAVIORS (too much, too little, fear of weight gain, distorted body image, over exercising, etc.)

Yes	No	SOCIAL ANXIETY (shy and/or afraid to be around others)
Yes	No	REMEMBERING PAST TRAUMAS (frequent nightmares, intrusive and/or recurrent memories, etc.)
Yes	No	AUTISM (social and language impairments, rigidity)
Yes	No	PSYCHOSIS (hearing voices, seeing things, paranoia, delusions)
Yes	No	DISSOCIATION (feeling outside your body or things are not real, etc.)
Yes	No	Has the Patient ever harmed themselves intentionally? Attempted suicide? Harmed others?

Sleep Patterns:

Total hours of sleep per night: __Usual Schedule: __to _____
Does the individual take naps during the day? Yes No
If Yes, how many hours in a typical day? ___

	Current Problem	Change within last 6 months
Difficulty falling asleep:	Yes No	Yes No
Snoring:	Yes No	Yes No
Frequent awakening:	Yes No	Yes No
Restlessness/Movements:	Yes No	Yes No
Early morning awakening:	Yes No	Yes No
Nightmares:	Yes No	Yes No
Not rested:	Yes No	Yes No

If yes to any of the concerns listed above, please describe:

Past Psychiatric History:

Please list any previous psychiatric hospitalizations, residential or day treatment programs (including any alcohol and drug treatment programs)

Diagnosis	Length of Stay	Treatment	Response

Please list any **current or prior outpatient psychiatrists and therapists** the individual has seen.

Name	Title	Location	How Long?

Please list this individual's current **psychiatric medications**. (You may refer to the list of medications on the next page)

Name	Dosage	Duration	Response

Please list this individual's current **non-psychiatric medications**.

Name	Dosage	Duration	Response

Substance	Date of Last Use	Problems Related to Use	Treatment Required
Benzodiazepines(Valium, Xanax, Ativan)		Yes No	Yes No
Caffeine		Yes No	Yes No
Marijuana		Yes No	Yes No
Cocaine		Yes No	Yes No
Designer Drugs(Club Drugs: G, X)		Yes No	Yes No
Hallucinogens(LSD, Mushrooms)		Yes No	Yes No
Inhalants(Gasoline, Glue, Aerosol)		Yes No	Yes No
Methamphetamines (Speed, Ice, Ritalin)		Yes No	Yes No
Opiates/Methadone (Vicodin, OxyContin, Heroin)		Yes No	Yes No
OTC – Over the counter (Benadryl, Nyquil, Dramamine)		Yes No	Yes No
Tobacco Yes No Amount per day:			
Is there anything else we should know about any drug history?			

Adderall® (dextroamphetamine + amphetamine) Abilify® (aripiprazole) Adipex-P® (phentermine) Ambien® (zolpidem) amitriptyline (Elavil®) Amoxapine Antabuse® (disulfiram) Anafranil® (clomipramine) Aricept® (donepezil) Ativan® (lorazepam) Aventyl® (nortriptyline) Benadryl® (diphenhydramine) Buspar® (buspirone) Carbatrol® (carbamazepine) Catapres® (clonidine) Celexa® (citalopram) Chloral hydrate Clozaril® (clozapine) Cogentin® (benztropine) Concerta® (methylphenidate) Cymbalta® (duloxetine) Cylert® (pemoline) Dalmane® (flurazepam) Depakote®/Depakene® (valproic acid/valproate Dexedrine® (dextroamphetamine) Didrex® (benzphetamine) Dilantin® (phenytoin) Dolophine®/Methadose® (methadone) Effexor XR® (venlafaxine) Elavil® (amitriptyline) Ephedra® Eskalith® (lithium) Evening primrose oil Focalin® (dexmethylphenidate)	Gabitril® (tiagabine) Geodon® (ziprasidone) Ginkgo biloba Ginseng Halcion® (triazolam) Haldol® (haloperidol) imipramine (Tofranil®) Inderal® (propranolol) Keppra® (levetiracetam) Klonopin® (clonazepam) Lamictal® (lamotrigine) Lexapro® (escitalopram) L ibrium® (chlordiazepoxide) Lithobid® (lithium) Loxitane® (loxapine) Luminal® (phenobarbital) Luvox® (fluvoxamine) Melatonin Mellaril® (thioridazine) Marplan® (isocarboxazid) Meridia® (sibutramine) Metadate® (methylphenidate) Methylin® (methylphenidate) Moban® (molindone) Mysoline® (primidone) Nardil® (phenelzine) Navane® (thiothixene) Neurontin® (gabapentin) Norprami (desipramine) nortriptyline (Pamelor) Omega fatty acids Orap (pimozide) Pamelor (nortriptyline) Parnate® (tranylcypromine) Paxil®(paroxetine) Periactin(cyproheptadine) Prolixin®(fluphenazine) propranolol ® (Inderal) ProSom® (estazolam) protriptyline® (Vivactil)	Provigil®(modafinil) Prozac®(fluoxetine) Restoril® (temazepam) ReVia® (naltrexone) Risperdal® (risperidone) Ritalin® (methylphenidate) SAM-e Saint john's wort Sarafem® (fluoxetine) Serax® (oxazepam) Seroquel® (quetiapine) Serzone® (nefazodone) Sinequan® (doxepin) Sonata® (zaleplon) Stelazine® (trifluoperazine) Strattera® (atomoxetine) Subutex® (buprenorphine) Suboxone® (buprenorphine +naloxone) Symbiax ® (olanzapine + fluoxetine) Tegretol® (carbamazepine) Tenex® (guanfacine) Tenuate® (diethylpropion) Thorazine® (chlorpromazine) Tofranil® (imipramine) Topamax® (topiramate) Tranxene® (clorazepate) trazodone (Desyrel®) Trilafon® (perphenazine) Trileptal® (oxcarbazepine) Valerian Valium® (diazepam) Vistaril® (hydroxyzine) Paxil® (paroxetine) Xanax® (alprazolam) Zarontin® (ethosuximide) Zoloft® (sertraline) Zonegran® (zonisamide) Zyprexa®(olanzapine) Zydis®(olanzapine)

Family History:

Consider this individual's immediate family and all of their relatives on both sides (parents, brothers, sisters, aunts, uncles, grandparents, and 1st cousins)

Review the list below – if any relative has one of these disorders, check the disorder and describe their relation to the Patient (such as "Maternal Uncle") and their treatment history (if applicable). Maternal is mother's side of the family and Paternal is father's side of the family.

_Depression _____
_Anxiety _____
_ADHD _____
_Bipolar (manic depressive) _____
_Schizophrenia _____
_Alcohol/Drug Problems _____
_Learning Disabilities _____
_Autism/Asperger/Pervasive Developmental Disorder _____
_Mental Retardation _____
_"Nervous Breakdown" _____
_Psychiatric Hospitalizations _____
_Suicide (or attempts) _____
_Panic Disorder _____
_PTSD (Post Traumatic Stress Disorder) _____
_OCD (Obsessive Compulsive Disorder) _____
_Seizures _____
_Migraines _____
_Heart or lung problems _____
_Thyroid _____
_Immunological disorders (lupus, scleroderma, inflammatory bowel disease) _____
_Cancer _____
_Other _____

Developmental History:

Did the Patient achieve the following milestones early (E), average (A), or late (L) compared with others his/her age (please explain if late):

_Language (age at first using words, sentences, etc…)?_____

_____

_Fine motor skills (building towers with cubes, drawing circle)?_____

_____

_Gross motor skills (rolling over, standing, walking)?_____

_____

_Toilet training?_____

_____

Has the Patient experienced any regression of these? Yes No
If yes, explain:

Pregnancy and Birth History:

How old was the individual's biological parents when he/she was conceived? _____

Was this the biological mother's first pregnancy? Yes No

If no, how many times was she pregnant before this pregnancy? _____

Did the biological mother experience any miscarriages before or after this pregnancy? Yes No

If yes, how many?__ During what trimester? _____

When was prenatal care first received (in weeks): _____

How much weight did the biological mother gain during this pregnancy?: _____

Baby's birth weight and length: _____

Length of pregnancy (in weeks): _____

Did the mother have any ultrasounds or amniocentesis? Yes No If yes, please describe the reason for these and the results: _____

Please indicate whether any of the following events/problems occurred during this pregnancy. Please include the trimester in which the event occurred, as well as any other important details.

Event/ Problem	Yes / No	# of months into pregnancy	Additional details
Infections/Colds	Yes No		
Fevers	Yes No		
Hospitalizations	Yes No		
Vaginal Bleeding, Spotting	Yes No		
Problems with Diet	Yes No		
Pregnancy Induced Hypertension	Yes No		
High Blood Pressure, Excessive Swelling	Yes No		
Diabetes	Yes No		
Rh or Blood Incompatibilities	Yes No		
Trauma (Emotional Stress and/or Physical Injury)	Yes No		

Did the mother take any medications (prescription and over the counter) during this pregnancy? (If yes, please complete the following table.)

Medication	Month(s) taken (1-9)	Dose	Reason for taking

Did the mother consume alcohol during this pregnancy?
Yes No
If yes, how much and how often? _____

Did the mother smoke or use tobacco products during this pregnancy?
Yes No
If yes, please describe how much and how often? _____

Did the mother use any drugs during this pregnancy?
Yes No
If yes, please name drug(s), how much and frequency of use: _____

Labor Information:
Type of delivery (c-section, vaginal): _____ Were forceps used? _____
Were there any problems with the baby's health right before or immediately after delivery? Yes No
If yes, please describe: _____
Were the mother and/or baby separated after birth for more than 24 hours at a time? Yes No
If yes, please explain: _____

Past Medical History:

Primary Care Provider: _____Years Involvement: _____
Phone: _____
Address: _____
Approximate Date of Last Visit: _____
Number of Visits in Last Year: _____
Other Provider(s): _____
Specialty: _____
Name: _____Phone: _____
Address: _____

Other Provider(s): _____
Specialty: _____
Name: _____Phone: _____
Address: _____

Allergies (drug, food, seasonal, environmental etc.)? Yes No If yes, please name and describe the Patient's reaction: _____

Has the individual ever experienced head injury, loss of consciousness, or seizure? Yes No
If yes, please describe: _____

Does the Patient have any chronic medical problems? Yes No
If yes, please describe : _____

Does the Patient have a history of any serious injuries or medical hospitalizations? Yes No
If yes, please describe: _____

Does the Patient have chronic pain (frequent headaches, stomachaches, chest pain)? Yes No
If yes, please describe: _____

Have you recently worried that the Patient may have problems with:

Heart	Neurological	Endocrine (i.e., diabetes; thyroid
Constipation/Diarrhea	Age of first menses _____	dysregulation; excessive hair growth)
Lungs	Regular or Irregular cycle	Immunizations up to dateY/N
Frequent infections	Kidneys/Bladder	

Has the Patient ever had an EEG, MRI, CT SCAN, etc? Yes No _____
If yes, why was it done and were the results normal? _____
If yes, where were the tests performed and who ordered them? _____

Social History:

(In the case of completing this form for a minor)

Is the Patient your biological child? Yes No
If no, at what age was he/she adopted? _____

Is there any contact with their biological parent(s)? _____
Where was the Patient born and raised? _____

Has the Patient moved a number or times? Yes No _____
If yes, please list their age at time of move and location: _____

Parents: (Including Step-Mother and Step-Father, if applicable)

Name	Education	Occupation	Hrs/Wk	Relationship with Patient (quality)

Please list the other children in the family and other household members who may also be living in your home:

Name	Age	Lives at Home?	Relation to Child	Relationship with Patient

Abuse History:

Has the Patient ever been the victim of abuse or neglect? Yes No

If yes, what was the nature of the abuse? (Please circle all that apply.)

Physical Emotional Neglect
Accidents Disasters Sexual
Witnessing violence Other: _____

Are you struggling with your marital relationship or parenting? Yes No

If yes, please describe: _____

Has the Patient ever been involved with the following and if yes, please explain:

☐ Yes No ☐ Child Protective Services _____
☐ Yes No ☐ Children's Mental Health _____
☐ Yes No ☐ Probation/Juvenile Probation/Detention _____
☐ Yes No ☐ Boys and Girls Club _____
☐ Yes No ☐ Youth Services _____
☐ Yes No ☐ Head Start _____
☐ Yes No ☐ Early Intervention Services (ages 0-3) _____

School:

Where does the Patient attend school? _____

In what grade level is he/she? _____

What are his/her typical grades? _____

What are the Patient's academic strengths? _____

_____

Academic weaknesses? _____

_____

Has there been a change in the Patient's performance at school? Yes No If yes, please describe: _____

_____

_____

Has the Patient received IQ or Academic testing? Yes No If yes, what were the results? _____

_____

Does or has the Patient participated in any of the following?

☐ Yes ☐ No Resource (for which classes/how many hours?)_____

_____

☐ Yes ☐ No Accelerated or Honors programs, explain: _____

☐ Yes ☐ No 504 Plan, explain: _____

☐ Yes ☐ No Individual Education Plan (IEP), explain: _____

☐ Yes ☐ No Virtual Academy, explain: _____

Has the Patient had problems with any of the following?

☐ Yes ☐ No Truancy, explain: _____

☐ Yes ☐ No Fights, explain: _____

☐ Yes ☐ No Absenteeism, explain: _____

☐ Yes ☐ No Detention, explain: _____

☐ Yes ☐ No Suspension, explain: _____

☐ Yes ☐ No School refusal, explain: _____

What are the Patient's favorite activities? _____

_____

_____

_____

Peers:

Does the Patient have quality relationships with other children? Yes No If no, please explain: _____

_____

_____

Culture:

Do you have a religious preference in the household? Yes No If yes, what is that preference? _____

_____

Has the Patient experienced any problems related to race, religion, or culture? Yes No If yes,
please explain: _____

TEEN/YOUNG ADULT SECTION

Do you have any concerns regarding your adolescent's friendships? Yes No ☐ ☐

(Please circle all that apply.)

Too old	Too young	Truant	Gang	Fringe
Drug/alcohol use	Violence	Too many	Too few	Sexual Promiscuity
Too much time together	Other _____			

Has your adolescent had a recent change in friendships? Yes No

If yes, what changes, if any are concerning to you? _____

Are you concerned that your adolescent is using (or has used) drugs (including over the counter medicines) or alcohol? Yes No If yes, please describe: _____

_____

Are you concerned about the Patient's sexual activities? Yes No _____

Is your adolescent sexually active? Yes No _____

Does your adolescent have a job? Yes No _____

Has your adolescent's behavior ever resulted in police, detention, or court involvement? Yes No

If yes, please explain: _____

_____

Is there anything else you would like us to know about the Patient? _____

Mental Status Exam (for your clinician to complete at first interview):

Clinical Interview Notes:

Three wishes

Wants to be when grow up

Happiest time

Saddest time

Scariest time

INITIAL FORMULATION:

INITIAL DIAGNOSES:

AXIS I:

AXIS II:

AXIS III:

AXIS IV:

AXIS V:

INITIAL TREATMENT PLAN:

1. MEDICATIONS:

2. PSYCHOTHERAPY:

3. MEDICAL:

4. ACADEMIC:

5. FOLLOW UP:

6. CRISIS (IF APPLICABLE):

Signed_____ Date:_____