JAN WILLER, PH.D.
LICENSED CLINICAL PSYCHOLOGIST
773-859-1822

2334 W. LAWRENCE AVE
SUITE 212, CHICAGO, IL 60625
JAN@DRWILLER.COM
WWW.DRWILLER.COM

Information about Psychotherapy

Practice Policies

Insurance. If you expect insurance or Medicare to be paying for part of your session, it is your responsibility to ensure that you remain covered by that payer. You will be charged if the other payer does not pay your bill. If you have an out-of-state Blue Cross policy, I ask that you fill out the credit card payment form.

Payments

- **Fees, coinsurance or copays**: due at the time of the appointment.
- **Deductibles:** If there is an unpaid deductable, or you have an out-of-state Blue Cross policy, or possibly for other reasons, I may ask that you fill out the credit card payment form for me to have on file.
- **Means of Payment:** I accept cash, check or charge.
- **Cash or Check:** I prefer to be paid with cash or check. Please make out a check beforehand to save time during your session.
- **Credit Card Payments:** If you prefer, I can take your credit card. I accept Visa, Mastercard and Discover cards. There is a convenience fee. See the form for further information. Please fill out the credit card form before your first session.
- **Receipts:** I will e-mail you a receipt on a monthly basis, upon request.

Cancellation/No-show Policies and Fees

- **Cancellation: If you need to cancel, call at least 24 hours ahead, otherwise there is a $100 fee.**
- **Illness**: If you have a crisis or illness and can't attend your appointment, call me and we will discuss it. If this happens rarely, or for the first incidence, I will generally waive the cancellation fee.
- **No-show Fee: If you do not show up for your appointment and do not call, there is a $100 fee**.

Lateness. Please come on time. Due to the scheduling of others' appointments, I am unable to extend past the usual end time. Your full fee will be due even if you are late. However, if I am running late, I will either prorate your session fee (if possible, given your payment situation) or extend the time.

Non-payment of Fees. If you have not paid your psychotherapy fees and do not respond to my attempts to contact you and work out a payment plan, I reserve the right to forward any past due amount to collections. By coming to see me, you agree to this policy.

Phone Messages. I check my messages at least once each day. I will attempt to return any message you leave for me within 24 hours of getting it. Routine messages left on Saturday or Sunday will be returned on Monday. I am not available by phone after 7 pm or before 9 am. There is be a charge for lengthy phone consultations.

Availability. I am not available at all times. If you think this will be a problem, please ask me for a referral to someone else who may meet your needs better.

E-mail. Please feel free to communicate with me about routine matters by e-mail. My e-mail address is jan@drwiller.com. I typically check my e-mail every day, unless I am out of town. I will do the best I can to assure your confidentiality through e-mail, but due to viruses, hackers, etc, no e-mail correspondence can be guaranteed to be confidential. So do not send any information that you would consider to be sensitive information through e-mail.

Texting. Please do not communicate with me by text. If you are running late, however, and want to send me a text to let me know, that is ok. **If any of these policies do not work for you, please let me know; I will attempt to refer you to someone who may be able to meet your needs better.**

Informed Consent

What is Informed Consent? **Informed consent is the process of you learning about psychotherapy and its risks and benefits. It also includes you learning what my practice policies are and about confidentiality. Part of the informed consent process is standard written information, provided to you so that you don't miss anything important. Over time, as I get to know you better, I will talk to you about what treatment I think would be most helpful. That is part of the informed consent process as well.**

Your Involvement: Psychotherapy is not like visiting a medical doctor. It requires your very active involvement. It requires your best efforts to change thoughts, feelings, and behaviors. An important part of your therapy will be practicing new skills that you will learn in sessions. You will probably have to work on relationships in your life and make long-term efforts to get the best results. Change will sometimes be easy and quick, but more often it will be slow and frustrating, and you will need to keep trying.

Length and Frequency of Therapy: At first, you should attend on a weekly basis. Standard session lengths are either 55 or 45 minutes. Some problems can be improved in 2-3 months of therapy. Other problems need long-term treatment. Once I have evaluated you, I can answer any questions you have about the length of therapy.

Ending Therapy: It is best if we decide together when to end your therapy. However, if you wish to stop therapy at any time, please tell me ahead of time and attend at least one more session.

Nonattendance at Therapy: If you miss 3 appointments in a row for any reason, we will need to think about whether your life is conducive to therapy at this time. We may need to put your therapy on hold.

Risks of Therapy: You may have negative feelings during therapy. You may recall and discuss unpleasant memories. You may decide to change some relationships and this may not always go well. Also, there is a risk that therapy may not work for you.

Benefits of Therapy: The benefits of therapy have been shown by scientists in hundreds of well-designed research studies. People who are depressed usually find their mood lifting. Others may no longer feel as afraid, angry, or anxious. In therapy, people have a chance to talk things out fully until their feelings are relieved or the problems are solved. Clients' relationships and coping skills may improve greatly. They may get more satisfaction out of social and family relationships. Their personal goals and values may become clearer. They may enjoy their lives more.

Additional and Alternative Treatments: If you could benefit from a treatment I do not provide, I can help you to get it. You have a right to ask me about such other treatments, their risks, and their benefits. I may recommend a medical exam, medications and other treatments. If you wish for another professional's opinion at any time, or wish to talk with another therapist, I can help you and can provide them with the information needed. Most mental health problems can be treated with medication instead of, or in addition to psychotherapy. Once I understand your personal issues, I will talk to you further about your options regarding medication.

The Therapeutic Relationship: As a professional, I follow the standards of my professional organization, which puts ethical limits on our relationship. I will do my utmost to maintain your privacy.

- If I see you in a **public place**, if you are with someone else I may not say hello to you, and if you are by yourself I might just say hi but not talk to you much. This is not a negative personal reaction to you, instead, I am trying to maintain your confidentiality.
- I cannot attend your **personal events**, such as parties or weddings.
- Also, **I cannot have any other role** in your life. I cannot, now or ever, be a close friend or socialize with you. I can never have a sexual or romantic relationship with any client during, or after, the course of therapy. I cannot have a business relationship with any clients, other than the therapy relationship.
- **I cannot "friend" you** on any social media sites.
- On rare occasions and for reasons I cannot fully predict, but which may include safety issues or perhaps something that you request me to look at, I may do an **online search** of a client before the beginning of psychotherapy or during psychotherapy. If you have concerns or questions regarding this practice, please discuss it with me.

No Court Testimony: If you ever become involved in a divorce or custody dispute, or any other legal matter, I will not provide evaluations or expert testimony in court. Your signature indicates your agreement with this provision.

Subpoena: If I am, for any reason, subpoenaed or otherwise required to participate in a legal proceeding as a result of providing professional services to you, you will be responsible for paying me at a forensic rate of $250 an hour for all time expended on your case. This includes phone calls, preparation, record copying and mailing, travel time, time testifying and time waiting at court.

Complaint Procedures: If you are not satisfied with my work, please raise your concerns with me at once. Our work together will be slower and harder if your concerns with me are not worked out. I will make every effort to hear any complaints you have and to seek solutions to them. If you feel that I, or any other therapist, has treated you unfairly or has even broken a professional rule, please tell me. You can also contact the state or local psychological association and speak to the chairperson of the ethics committee. He or she can help clarify your concerns or tell you how to file a complaint. You may also contact the state board of psychologist examiners, the organization that licenses those of us in the independent practice of psychology.

Emergencies

If you are feeling suicidal, do not call me, since I may not be available 24/7. Instead, it is your responsibility to seek out help immediately. Go to your nearest emergency room or call 911.

Questions: Please feel free to ask any questions you have about therapy at any time.

Confidentiality

I will treat what you tell me with great care. My professional ethics and the laws of this state prevent me from telling anyone else what you tell me unless you give me written permission except in certain specific situations that I list below. These rules and laws are the ways our society recognizes and supports the privacy of what we talk about—in other words, the **confidentiality** of therapy. But I cannot promise that everything you tell me will *never* be revealed to someone else. The **HIPAA Notice of Privacy Practices** (next page) provides details about these limits to confidentiality. Please review it carefully.

Releasing Your Health Information. If you want me to send information out of my office, or I need information about you from someone else, or I need to coordinate your health care with another professional, I will ask you to sign a **release-of-information form**. You can see this form on my website. This form states exactly what information is to be shared, with whom, and why, and it also sets time limits. If you have questions, please ask me.

Legal Limits to Confidentiality. (1) If my assessment is that you are at high and immediate risk of committing *suicide*, and you refuse to go to a hospital, I may need to ask the police to take you to a hospital and/or contact someone close to you—perhaps a relative, spouse, or close friend. I will also need to alert the State of Illinois. *However, please realize that most people who think about suicide or who think that they might be better off dead are **not** at high or immediate risk of committing suicide and I will not hospital them or make any reports.* (2) Also, I need to contact the State of Illinois authorities if you are at serious risk of *harming someone else* or if you have exhibited threatening behavior towards that person. (3) If you have harmed or abused a *child or elderly person* or exploited or neglected them in any way, I must contact the appropriate State of Illinois authorities. (4) The fourth legal limit is highly unlikely to apply to you, even if you have ADHD, but involves reporting individuals who are developmentally or intellectually disabled to the degree that it is a substantial handicap or impairs adaptive behavior.

Professional Consultation. I sometimes consult other psychotherapists. This helps me give high-quality treatment. These persons are also required to keep your information private. Your name will never be given to them, and they will be told only as much as they need to know to understand your situation.

Back-Up Therapeutic Coverage. When I am away from the office for a few days, I have a trusted fellow psychotherapist cover for me. This therapist will be available to you in emergencies. He or she may need to

know about you. Of course, this therapist is bound by the same laws and rules as I am to protect your confidentiality.

Professional Educational Use of Case Materials. As a therapist, I naturally want to know more about how therapy helps people. I would be grateful for your consent to use your case material in my other professional activities. Your material may help in the development of the mental health field or in the training of health care workers. It is possible that I may use some information about your treatment in teaching, supervision, consultation with other therapists, publishing, or scientific research. You would not get any financial benefit from this. When I use information from my therapy work, I do not want anyone who hears, reads, or sees it to be able to identify the clients involved. Therefore, I conceal your identity by changing your identifying information and I will also typically merge your information with that of a client who has similar difficulties. If you do not agree to the uses of case materials as indicated, you will not be penalized in any way, and it will not affect the care you receive in any way. You may draw an X through this section on the signature page if you do not want your case materials used in this way.

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HIPAA Notice of Privacy Practices

Effective Date: *July 1, 2013*

THIS NOTICE DESCRIBES HOW PERSONAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact me.

MY OBLIGATIONS. I am required by law to (1) maintain the privacy of protected health information, (2) give you this notice of our legal duties and privacy practices regarding health information about you, and (3) follow the terms of my notice that is currently in effect

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION

The following describes the ways I may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, I will use and disclose Health Information only with your written permission. You may revoke such permission at any time in writing.

For Payment. I may use and disclose Health Information so that I may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, I may send your health plan information about you, including a diagnosis, so that they will pay for your treatment. Insurers such as Blue Cross/Blue Shield or managed care organizations on rare occasions may ask for additional information about you and your symptoms. I have no control over how these records are handled at the insurance company. My policy is to provide the minimum amount of information that the insurance company needs to pay your benefits.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, I may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. Unless it is an emergency, I will first ask you to fill out a release of information form and we will discuss what information will be shared with your family member or close friend.

SPECIAL SITUATIONS

As Required by Law. I will disclose Health Information when required to do so by international, federal, state or local law.

Abuse and Neglect Reporting. I may disclose Health Information to report child abuse or neglect, and elder abuse or neglect.

To Avert a Suicide or Violence/Homicide. I may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. If such a situation does come up, I will fully discuss the situation with you before I do anything, unless there is a very strong reason not to. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Health Oversight Activities. I may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws. That said, to date, I have never had to make any disclosures of this type.

Data Breach Notification Purposes. I may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, I may be required to disclose Health Information in response to a court or administrative order. I also may be required to disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. I may be required to release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, I are unable to obtain the person's agreement; (4) about a death I believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

National Security and Intelligence Activities. If mandated to do so, I will release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law. Or to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT OUT. In all instances, unless mandated by law or noted above, I will obtain your written permission before releasing your Protected Health Information, so opting out and objecting to uses and disclosures would not be needed.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation and I will no longer disclose Protected Health Information under the authorization. But disclosure that I made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS. You have the following rights regarding Health Information I have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing. I have up to 30 days to make your Protected Health Information available to you and I may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. I may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. I may deny your request in certain limited circumstances. If I do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and I will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another

individual or entity. I will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. I may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information I have is incorrect or incomplete, you may ask me to amend the information. You have the right to request an amendment for as long as the information is kept by or for my office. To request an amendment, you must make your request, in writing.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures I made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information I use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information I disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that I not share information about a particular diagnosis or treatment with your spouse. To request a restriction, please specify this restriction in writing on your release of information form.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that I not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and I will honor that request.

Right to Request Confidential Communications. Unless you tell me otherwise, I will usually contact you through your cell phone and/or your email address. Occasionally, I may use your home or work phone numbers, if you gave them to me. You have the right to request that I communicate with you about mental health matters in a certain way or at a certain location. For example, you can ask that I only contact you by mail or at work. To request confidential communications, you must make your request, in writing. Your request must specify how or where you wish to be contacted. I will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may download a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at www.drwiller.com. To obtain a paper copy of this notice, just ask.

FOR YOUR INFORMATION

One Set of Progress Notes. Some psychotherapists maintain two sets of progress notes about your treatment. I do not do that, unless there is a compelling reason to do so. If I will keep two sets of notes, I will let you know. If there are two sets of notes, the set that contains more details about your personal situation (called "psychotherapy notes") would require separate authorizations from you to disclose.

No Marketing, Sale or Fundraising. I will never use your information for marketing purposes, nor will I sell your information, nor use it for fundraising. Any health organization that does any of these things would need your authorization.

CHANGES TO THIS NOTICE. I reserve the right to change this notice and make the new notice apply to Health Information I already have as well as any information I receive in the future. I will post a copy of my

current notice on my website. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with me or with the Secretary of the Department of Health and Human Services. All complaints must be made in writing. You will not be penalized for filing a complaint.

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Signature Page

Information about Psychotherapy Handout

I have received and read the handout entitled Information about Psychotherapy and agree to abide by Dr Willer's practice policies. If at any time I have any questions about the subjects discussed in this handout, I can talk with Dr Willer about them. I also understand that I can review this information at any time at Dr Willer's website, www.drwiller.com. My signature does not indicate that I am waiving any rights. I understand that I have the right not to sign this form.

HIPAA Notice of Privacy Practices Handout

I have received and read the handout entitled HIPAA Notice of Privacy Practices. My signature below shows that I understand how my personal health information may and may not be disclosed by Dr Willer.

Case Materials

I give Jan Willer, Ph.D. my permission to use her knowledge of my psychotherapy work for research, teaching, writing and other professional purposes that involve educating mental health professionals and students. I understand that my name will never be used, my information will always be disguised, and in almost all cases, my information will be merged with details from other individuals. *(Please X out this paragraph if you do not agree to it).*

Cancellation and No-Show Policy

My signature below shows that I understand and agree to comply with the cancellation/no-show policy. **I understand that there is a $100 fee if I do not show up for an appointment or if I cancel with less than 24 hours notice.**

I also understand and agree that I will not call Dr Willer as a witness in a court of law regarding divorce, child custody or any other legal matter.

_____ _____

Signature of client Date

_____

Printed name

CHECKLIST OF CONCERNS

Name:_____ Date: _____

Please mark any items that apply to you. Feel free to add other concerns at the bottom.

PROBLEM AREAS--CAREER, SCHOOL

___Career concerns, goals, and choices
___Unemployment
___Job stress
___School problems
___Learning problems
___Work performance issues such as procrastination,
___Work life balance issues, e.g. workaholism/overworking
___Difficulty maintaining employment

PROBLEM AREAS--RELATIONSHIPS

___Communication problems
___Dating issues
___Detachment or estrangement from others
___Divorce, separation
___Friendships
___Infidelity, affairs
___Interpersonal conflicts
___Parenting issues
___Sexual issues with partner
___Social problems
___Physical fights with relationship partner
___Physical fights with others
___Relationship conflict
___Relationship problems
___Withdrawal, isolating

PROBLEM AREAS--LIFE EVENTS

___Childhood issues (your own childhood)
___Financial or money troubles, debt, impulsive spending, low income
___Grieving, mourning, deaths, losses
___Legal matters, charges, suits
___Other (Please specify: _____)

PROBLEM AREAS--PHYSICAL WELL-BEING

___Headaches, neck or back pain (Please specify: _____)
___Health, illness, medical concerns, physical problems
___Menstrual problems, PMS
___Pains, chronic (Please specify: _____)
___Sexual functioning problem (e.g. erectile dysfunction, painful intercourse)

PROBLEM AREAS--SELF

___Identity issues
___Sexual identity issues
___ Wishing you were dead or could go to sleep and not wake up
___Thoughts of actually killing yourself
___Self-esteem problems

EMOTIONAL CONCERNS

___Alert for danger, even in safe locations
___Anger, hostility
___Distressing memories of the past
___Suspiciousness
___Anxiety, nervousness
___Aggitated

___Fear of leaving my home
___Fear of specific locations, such as elevators or planes (Please specify: _____)
___Fear of specific situations, such as heights or snakes (Please specify:_____)
___Fear of social situations
___Fear of abandonment
___Obsessive thoughts
___Panic or anxiety attacks
___Feeling hyper or wound up
___Phobias (Please specify: _____)
___Shyness
___Tension—can't relax
___Attention, concentration, are poor
___Confusion
___Distractibility
___Memory problems
___Loneliness
___Depression, low mood, sadness, crying
___More depressed in the morning, with mood better later in the day
___More depressed in the winter, mood better in the summer
___Emptiness feelings
___Failure feelings
___Fatigue, tiredness, low energy
___Guilt
___Inferiority feelings
___Motivation problems
___Oversensitivity to rejection
___Oversensitivity to criticism
___Lack of interest in my usual activities
___Hopelessness
___Mood swings
___Overly high energy level for my age
___Perfectionism
___Sexual drive—lack of
___Feeling that others are out to get me
___Feeling that others are watching me
___Hearing voices

BEHAVIORAL ISSUES

___I drink alcohol more than 2 nights per week
___At least one day a week, I have 4 drinks or more (if female) or 5 drinks or more (if male)
___I have used an illegal drug in the last month
___I smoke at least one cigarette per week
___At least once a week, I drink more than 2 cups of coffee, OR more than 4 colas or cups of tea
___I have had a DUI (When? _____)
___I have been charged with a crime in the past (other than parking, speeding or DUI)
___Aggressive or violent thoughts or behaviors
___Arguing
___Compulsive behaviors (Please specify: _____)
___Repetitive behaviors (e.g handwashing, checking doors, checking stove)
___Cutting or otherwise injuring self
___Other self-harm in past (Describe: _____)
___Decision making problems, indecision, mixed feelings, putting off decisions
___Disorganization
___Gambling
___Irritability

___Impulsiveness
___Irresponsibility
___Judgment problems, risk taking
___Self-neglect, poor self-care
___Suicide attempt in past (When? _____)
___Temper problems, self-control, low frustration tolerance
___Ever done anything, started to do anything or prepared to do anything to end your life

EATING/WEIGHT ISSUES

___Lack of appetite
___Weight loss (How much? _____ Over what time? _____)
___Overeating
___Weight gain (How much? _____ Over what time? _____)
___Vomiting
___Taking laxatives, enemas or diuretics to lose weight
___Binging on food
___Diet issues
___Fear of becoming fat

SLEEP ISSUES

___Sleeping too much
___Insomnia
___Difficulty going back to sleep upon awakening during night
___Too much worrying or thinking keeps me from getting to sleep
___Waking at least 2 hours too early in the morning
___Feeling extremely restless or squirmy prior to bedtime
___I have taken a sleeping pill or drank alcohol to sleep at least once in the past month
___Nightmares or upsetting dreams
___Suddenly falling asleep in inappropriate locations
___Snoring
___Grinding teeth during sleep
___Stopping breathing briefly during sleep (noticed by you OR partner)
___Sleepwalking

ANY OTHER CONCERNS OR ISSUES:

_____

WHICH CONCERN DO YOU MOST WANT HELP WITH? _____

INFORMATION CHECKLIST

Please review the following list of treatments you may have had in the past. Please put a check next to any that apply to you and indicate the dates, to the best of your recollection.

			Dates:
Inpatient psychiatric hospitalization	___ No	___Yes	_____
Intensive outpatient treatment (e.g. at least 2-3 days per week)	___ No	___Yes	_____
Psychotherapy	___ No	___Yes	_____
Outpatient Substance Abuse counseling	___ No	___Yes	_____
Attending AA/NA/CA meetings	___ No	___Yes	_____
Attending other substance recovery groups (Please specify:_____)	___ No	___Yes	_____
Taking medication for emotional difficulty	___ No	___Yes	_____
Taking medication for sleep	___ No	___Yes	_____

NOTE: PLEASE FILL OUT A RELEASE OF INFORMATION FORM FOR ANY MENTAL HEALTH TREATMENT, INCLUDING MEDICATION, YOU HAVE HAD DURING THE LAST 2 YEARS.

CLIENT INFORMATION FORM
TODAY'S DATE _____

GENERAL INFORMATION
Your full name (Last, First, Middle Initial) _____
Date of birth _____ Age _____
Preferred pronoun (mark as many as you prefer: ___ She/her ___He/him ___They/them
If you use another pronoun, please specify: _____
Gender Identity: ___ Woman ___Man ___Nonbinary
If you have another gender identity, please specify: _____

Address _____ Apt # ____
City _____State _____ Zip Code _____
Cell phone _____
On rare occasions, I may text or call clients about appointment times or other administrative matters. If you have any problems with this, please let me know.
E-mail address _____
I need to send e-mail to clients occasionally about appointment times or other administrative matters. If you have any problems with this, please let me know.

Are you an immigrant? ___No ___Yes, from what country? _____
Are/were any of your parents immigrants? ___No ___Yes, from what country? _____
Family Ethnic Background(s) _____

Does anyone live in your home with you? What is (are) the relationship(s) to you and their ages?
_____
How were you referred to me?_____

YOUR CURRENT CONCERNS
Please describe the main difficulty that has brought you to see me
_____
_____

PSYCHOTROPIC MEDICATIONS
_____ I do not take psychotropic medications
Prescriber _____ Phone _____ Fax _____
Address _____
*If you have a current prescriber, please be sure to fill out a release of information form to allow me to communicate with that person.

EDUCATION AND TRAINING*
Did you graduate from HIGH SCHOOL? ____ Yes ____ No
Year of graduation _____

COLLEGE OR VOCATIONAL SCHOOL Attendance and Degrees/Certificates:

From	To	School	Degree Program	Did you graduate?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

EMPLOYMENT AND MILITARY ENLISTMENT for the last 2 years

Dates From	To	Name of military or employers	Job title or duties	Reason for leaving
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

HISTORY OF EVENTS

Please indicate any of the following events that may have occurred to you in the past:

____ My parents/caretakers punished me physically as a child or teenager
____ My parents/caretakers were verbally harsh and critical of me as a child or teenager
____ My parents/caretakers did not provide appropriate supervision, food, shelter or other protection.
____ My parents/caretakers were unaware of my difficulties when I was a child or teenager.
____ There was violence in my home growing up.
____ I experienced inappropriate sexual contact as a child or teenager
____ I experienced sexual harassment as an adult
____ I experienced other upsetting sexual experience(s) as an adult
____ As an adult, I experienced a physical injury intentionally caused by another adult.
____ Someone has hit, kicked, punched or otherwise hurt me during the last 12 months.
____ Someone has threatened me verbally with bodily harm.
____ I experienced any other upsetting experience(s) as noted below:

_____
_____

PRESENT RELATIONSHIP

____ I do not have a partner at present

How would you characterize your relationship with your partner? _____
_____

USE OF CAFFEINE, ALCOHOL, MARIJUANA, TOBACCO AND STREET DRUGS

How much coffee, cola, tea, or other sources of caffeine do you consume each day?
_____

ALCOHOL

1. Have you ever felt the need to cut down on your drinking? ___ No ___Yes
2. Have you ever felt annoyed by criticism of your drinking? ___ No ___Yes
3. Have you ever felt guilty about your drinking? ___ No ___Yes
4. Have you ever taken a morning "eye-opener"? ___ No ___Yes
5. How much beer, wine, or hard liquor do you consume each week, on the average?

_____

MARIJUANA/THC

1. Have you ever felt the need to cut down on your marijuana/THC use? ___ No ___Yes
2. Have you ever felt annoyed by criticism of your use? ___ No ___Yes
3. Have you ever felt guilty about your use? ___ No ___Yes
4. Have you ever used in the morning? ___ No ___Yes
5. How much marijuana/THC do you consume each week, on the average?

_____

How much TOBACCO do you smoke or chew each week? _____

Which STREET DRUGS have you used in the last 3 years? _____

LEGAL ISSUES

1. Are you presently suing anyone or thinking of suing anyone? ___ No ___Yes
If yes, please explain: _____
2. Is your reason for coming to see me related to an accident or injury? ___ No ___Yes
If yes, please explain: _____
3. Are you required by a court, the police, or a probation/parole officer to have this appointment?
___ No ___Yes If yes, please explain
_____

4. Have you had any contacts with the police, courts, and jails/prisons
regarding a crime that you were charged with? ___ No ___Yes
5. Were you ever locked up in jail or prison--even if just overnight? ___ No ___Yes
6. Are there any other legal involvements I should know about? ___ No ___Yes
If yes, pls describe:
_____

MEDICAL HISTORY

1. Please list all CURRENT MEDICAL PROBLEMS that you have. Be sure to include chronic conditions such as asthma, seizure disorder, arthritis, diabetes and so on
_____
_____
_____

2. Please rate your current level of PHYSICAL PAIN on a scale of 0-10, with 0 being no pain and 10 being the worse pain you have ever had _____
Rate the most severe pain you have had in the past month ____
Why were you experiencing pain? _____

3. List all MEDICATIONS, HERBAL SUPPLEMENTS, VITAMINS, CBD, AND OVER-THE-COUNTER DRUGS you have taken in the last month.

Medication/drug	Dose (how much?)	Taken for	Prescribed by
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

4. Have you had any SURGERIES, including any plastic surgery? If so, please list briefly:
_____
_____

5. Have you ever been hit or injured on the HEAD? ___ No ___Yes
Have you ever been knocked UNCONSCIOUS? ___ No ___Yes
Please describe:
_____
_____

HEALTH HABITS

1. What kinds of physical exercise do you get?

_____

_____

2. How many times per week do you typically exercise for 20 minutes or more? _____

3. Do you try to restrict your eating in any way? How? Why?

_____

4. Do you have any problems getting enough sleep?

_____

5. What is your average number of hours of sleep per night? _____

COVID HISTORY

How many times have you had Covid-19 that you are aware of? _____

Since your first case of Covid-19, have you had any of these symptoms emerge or get worse?

____ Cardiovascular disease, including heart attack, stroke and high blood pressure
____ POTS (Postural orthostatic tachycardia syndrome)
____ Brain fog
____ Memory and concentration problems
____ Focus and attention problems
____ Other cognitive deficits
____ Loss or alteration of taste or smell
____ Dizziness or balance issues
____ Seizures
____ Immune dysfunction (seem to get every sickness going around or a diagnosed immune condition)
____ Autoimmune disorder
____ Chronic fatigue
____ Diabetes or other pancreas disease
____ Kidney disease
____ Anxiety
____ Depression
____ Irritability
____ Emotional instability or dyscontrol
____ Thoughts of suicide
____ Insomnia or other sleep problems
____ Gastrointestinal issues
____ Respiratory problems such as cough or breathing difficulties
____ Skin issues
____ Changes in vision or hearing
____ Hair or tooth loss

Please note that this is an incomplete list of possible long covid symptoms. If you have had any other symptoms that emerged in the few months after getting covid, please note them here:

_____

OTHER INFORMATION

Is there any other information that you would like me to know about you to get a better picture of you as a person or your personal situation? If you like, you can include here any web links you might like to share (e.g. your business website, your theater company, or your Etsy shop) that would inform me more about you.

CONTACT PERSON IN CASE OF EMERGENCY

Name: _____

Address: _____

Phone: _____ Relationship to you:_____

AS A REMINDER, I HAVE REPEATED THE **CANCELLATION AND NO-SHOW POLICY** HERE:

If you need to cancel, please call at least 24 hours ahead.
Cancellation fees are as follows:

- **24 hours or more: No fee**
- **Less than 24 hours: $100 fee**
- **If you do not show up for your appointment and do not call, there is a $100 fee as well.**
- **If you have a crisis or illness and can't attend your appointment, call me and we will talk.**

My signature below shows that I understand and agree to comply with the cancellation and no-show policy.

_____ _____
Signature of client Date

_____
Printed name