Woodlands Family Institute, P.C.
Robyn J. Fairchild, LMSW, LCSW, LPC

Information, Policies, and Consent

We are very honored that you have selected Woodlands Family Institute to provide counseling or psychological services. All of us wish to do our best to assist you in making this experience meaningful and fruitful. This document is designed to inform you about my background and to ensure that you understand our professional relationship.

This process is a partnership between you and me to work on areas of dissatisfaction in your life or assist you with life goals. For this to be most effective, it is important that you take an active role in the process. This involves keeping scheduled appointments, being forthright about your issues and goals, and openly discussing the process with me. Psychotherapy has been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience. While counseling or psychotherapy can benefit most people, the process is not always helpful. Sessions can evoke strong emotions and sometimes influence unanticipated changes in one's behavior. It is important that you discuss with me any questions or discomfort you may have during the process. I may be able to help you understand the experience or use a different approach that may be more satisfying.

Although our sessions may be very intimate psychologically, it is important for you to realize that we have a professional relationship rather than a social one. Our contact will be limited to sessions you arrange with me. It may be confusing and counter-productive for me to accept gifts or be invited to social gatherings. So please do not ask me to relate to you in any way other than in the professional context of our sessions. I want your sessions to be as safe and secure as possible so that we concentrate exclusively on your concerns. You are best served by experiencing me in my professional role. If at any time you are dissatisfied with my services, please let me know.

Children can be joyful and energetic, but with respect to the concerns which brought you to us, we request that you obtain a sitter for children not receiving treatment so that our full attention can be devoted to your priorities.
I assure you that our work will be conducted in a conscientious manner consistent with accepted ethical standards. Please note that it is impossible to guarantee any specific results regarding your goals. However, together we will work to achieve the best possible results for you.

Please be aware that I do ***not*** provide consultation, evaluation, or legal testimony in child custody, child visitation, or molestation cases. If you require these services, I will be happy to refer you to professionals who work with these issues.

Office Policies

1.____ ***Initial***

Payment Policy: Payment is due in full at time of service. Please make out your check before the session begins. Visa, MasterCard and Discover are also accepted. It is not our policy to carry balances forward. We expect balances for "forgotten checkbooks" or "forgotten appointments" to be made up promptly or by the next regularly scheduled appointment at the latest.
If an outstanding balance accrues, you will be billed on the first of the month and assessed a 2% finance charge, compounded monthly. There is a $10.00 rebilling for

every statement sent out after the first billing. There is also a $15.00 fee for each check returned for insufficient funds. After 90 days with no payments or effort to arrange payment, accounts will be turned over to a collection agency and could impact your credit rating.

Session fee: for private pay clients - $160.00 (45-50 minute duration)
for insurance clients – fees determined according to benefits

Miscellaneous: Charges for other professional services are prorated on the basis of $160.00 per hour, 15 minute increments. These services include, but are not limited to, phone calls, insurance reports, third-party consultations, and correspondence. Off-site consultation is prorated at the rate of $160.00 per hour, "portal to portal", that is, for the time I am out of the office on your behalf.

Legal testimony: Please be advised that I **do not** provide consultation, evaluation or legal expert testimony in child custody, child visitation or molestation cases. Similarly, I do not consider my practice to include expert testimonials.

However, should my opinion be so ordered, fees will be charged at the rate of $800.00 per hour, portal to portal. This fee will apply as well to depositions or interrogatories. Records review; consultation with clients, litigants, attorneys (in person or via phone or by email); reports; waiting at court; or any other service provided will be charged at the rate of $1950.00 per hour or prorated accordingly. These fees are **payable in advance**.

2._____***Initial***

Office hours: Office hours are from 8 a.m. to 8 p.m. Monday through Friday; unless otherwise specified. Any other time is considered "after hours" and will be charged at 1 1/2 times the standard rate. After hours' time is generally reserved for family time and self-care.

3. ____***Initial***

Cancellations: The scheduling of an appointment involves the reservation of time specifically for you. Therefore, 24 hours cancellation notice is required so that there will be no charge to your account. **PLEASE CALL THE OFFICE TO CANCEL AN APPOINTMENT. EMAIL IS NOT MONITORED FOR CANCELLATIONS.**

If you are unable to meet this time schedule, but we are able to assign your appointment time to another client, you will not be charged. Due to the fact that your appointment is contracted time specifically set-aside for you, cancellations in advance will be appreciated. *Please note that insurance companies do not reimburse for missed appointments.*

4.____ ***Initial***

Insurance: If I am a Participating Provider with your insurance carrier, we will file claims on your behalf. Please be vigilant about providing the office with your most current policy information. Your insurance carrier

determines the portion of my fees for which you are personally responsible. Any applicable costs, not collected at the time of service, are due and payable immediately upon request. If I am not a Participating Provider with your carrier, we advise that you contact a company representative to determine how your insurance company will reimburse you. If you elect to seek reimbursement by an insurance carrier, we will provide you with a receipt to assist you in completing your insurance claim. Some insurance companies reimburse clients for services, and some do not. The client remains responsible for payment in full, including any portion not reimbursed by insurance. **Please be aware that: Third-party payers require the provision of a diagnosis and supporting clinical data. We have no control over the confidentiality procedure of third parties once clinical information leaves this office. In all likelihood, a computer record will be generated.** The office staff is happy to provide you with insurance ready receipts for filing your claim. WFI does not file out-of-network insurance claims.

5.____*Initial*

Confidentiality: The law protects the privacy of all communications between a client and psychotherapist. In most situations, we can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by federal and state law. There are other situations that require only that you provide advanced written consent. Your signature on our *Acknowledgment* form provides consent for those activities, as follows:

You should be aware that we practice with other mental health professionals and utilize administrative staff. In most cases, some protected information must be shared with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. Occasionally, it is helpful to consult other health and mental health professionals about a client. During a consultation, every effort is made to avoid revealing a client's identity. Any other professionals consulted are also legally bound to keep the information confidential. These consultations are very commonplace and routine and may not ordinarily be mentioned in our sessions, unless it seems important to our work together. If you would prefer this to be handled differently, please let us know. All administrative 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.

We also have contracts with some business services, such as an answering service, electronic claims processing service, and managed care organizations. As required by federal law, we have formal business associate contracts with these businesses, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. Details of these contracts are available upon request.

I will keep confidential anything you say to me, with the following exceptions: a) you direct me to tell someone else; b) I determine that you are a danger to yourself or others; c) I am ordered by a court or regulatory body to disclose information; d) you disclose abuse or neglect of children, the elderly, or disabled persons; e) you disclose sexual mistreatment by another therapist; f) the need to release information to other professionals involved in your treatment; g) in proceedings in which a claim

is make about one's physical, emotional, or mental condition; h) when disclosure is relevant in any suit affecting the parent-child relationship; i) where otherwise legally required. If you are under 18, your parents or legal guardian(s) may have access to your records and may authorize their release to other parties.

6._____***Initial***

Emergency services: It is assumed that outpatient clients are self-responsible, autonomous, and not in need of day-to-day supervision. Outpatient clinicians cannot assume responsibilities for clients' day-to-day functioning, as can agencies or inpatient hospital settings. Nevertheless, in the event that an emergency occurs, leave a message with the answering service, making sure to state that your call is an emergency. We will respond to your call as promptly as possible. Routine calls will be returned during normal office hours. We can be reached at 281-363-4220 or 713-866-4494. If we are unable to respond quickly enough, please call 911 or your local emergency room.

Having read the policies described above, I agree to all professional policies, agree to meet all financial obligations, and agree that this contract replaces any earlier contracts. Additionally, I understand that there can be no absolute guarantee of cure in the practice of psychotherapy.

_____ _____

Signature(s) **Date**

Client Information Statement

The Texas Boards of Examiners of Licensed Psychologists, Marriage and Family Therapists, Licensed Social Workers and Licensed Professional Counselors were established by the legislature to protect the public. In fulfilling its mission, the Boards enacted rules governing the practice of psychology, family therapy, and counseling. These rules require that a therapist provide prospective clients with sufficient information about the therapeutic process so that the client can make an informed decision whether or not to enter therapy.

Attached to this Information Statement is a general information statement, Agreement for Services and the information regarding the procedures or psychotherapy in general and our office policies.

After reading the agreements, please ask about any part of the agreement that you do not understand.

Woodlands Family Institute, P.C.
Robyn J. Fairchild, LMSW, LCSW, LPC

PERSONAL DATA RECORD

Client Name _____ Date of Birth _____

Address _____

City/State/Zip _____

SSN _____ TXDL _____

Employer/School/Address _____

May we leave a message at any of the following?

Cell phone (circle one) _____ Yes No

Work phone (circle one) _____ Yes No

Unencrypted email address _____ Yes No

*** Please do not cancel appointments via email. You must contact the office directly.**

If you would like to use an address other than your home address for billing and other correspondence, please provide an alternative address below.

Other _____

CONSENT FOR TREATMENT

Client Name _____Date of Birth _____

I give full consent for ***myself, my child/adolescent or dependent*** due to legal guardianship to receive outpatient mental health services until I notify WFI of any changes or until it is determined the treatment is no longer necessary. I certify that I have the legal right to seek and authorize treatment for the individual stated above.

_____ _____

Authorized Signature Date

REQUIRED: We require that a credit card be provided for after-hours appointments, missed sessions, and late cancellations. You may also designate the use of this card for regularly scheduled sessions.

Cardholder's Name_____Relationship_____

MC/VISA/DISC No._____ Exp. Date _____

Signature of Authorized User _____

☐ **Use for <u>regular</u> sessions, after hours, missed or late cancel sessions**

It is preferred that policy information be given to us for verification at the time your initial appointment is made. If unable to do so, please complete the following information.

Insured's Name:_____

Insured's DOB: _____ Relationship to Client: _____

Policy ID No.: _____Group No. :_____

Insured's Employer: _____

Financial Responsibility

Name of person(s) financially responsible for this account _____

Address/phone if different from client _____

_____

_____

Signature(s) _____

Relationship to client _____

Emergency Contact

Name _____ Phone _____

Alternate phone _____ Address_____

_____

Relationship to client _____

Referred to our office by _____

May we send a **thank you** to the person who referred you? (circle one) Yes No

May we mention your **name** in that thank you? (circle one) Yes No

Appointment Reminders

As a courtesy, you will receive an appointment reminder to your email address or your cell phone (via text message or computer generated voice mail message), the day before your scheduled appointments.

Your name: (Please print): _____

Your email address: _____

Your cell number: _____

Where would you like to receive appointment reminders? (Check one)

_____ Via text message on my cell phone (normal text message rates will apply)

_____ Via email message to the address listed above

_____Via automated voice mail message on my cell phone

****Missed appointment fees will still apply. 24 hour cancellation policy still applies. Please call the office if you need to cancel an appointment.****

Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above.

_____ _____

Signature Date

{Please refer to pages 8 – 9 of this document}

I acknowledge that I have been provided a copy of the **Notice of Policies and Practices to Protect the Privacy of Your Health Information and the Office Information and Office Policies.** I understand and accept those policies and practices. WFI is hereby granted consent to contact me as specified above and for the use and disclosure of my health information as described in those policies for Treatment, Payment and Health Care Operations.

_____ _____

Client or Authorized Representative Signature Date

_____Refuse to Sign _____Unable to Sign (specify reason) _____

_____ _____

Signature of Person Documenting Refusal or Inability to Sign Date

Notice of Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

Woodlands Family Institute (WFI) may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *general consent*. To help clarify these terms, here are some definitions:

- "*PHI"* refers to information in your health record that could identify you.
- *"Treatment, Payment and Health Care Operations"*
  Treatment is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or a colleague.
  Payment is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within WFI such as utilizing information that identifies you.
- "*Disclosure*" applies to activities outside of WFI, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes we have made about our conversation regarding a private, group, joint, or family counseling session. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If we have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, we must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.
- **Abuse of the Elderly and Disabled:** If we have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, we must immediately report such to the Department of Protective and Regulatory Services.
- **Sexual Misconduct by a therapist:** If you report to us any situation that constitutes sexual misconduct by a current or former therapist, then we are required to inform the licensing authority of the offending therapist.
- **Regulatory Oversight:** If a complaint is filed against a therapist with a regulatory authority, they have the authority to subpoena confidential mental health information relevant to that complaint.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and we will not release information, without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case**.**

- **Serious Threat to Health or Safety:** If we determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, we may disclose relevant confidential mental health information to medical or law enforcement personnel.
- **Worker's Compensation:** If you file a worker's compensation claim, we may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

IV. Client's Rights and Our Professional Duties

Client's Rights:

- *Right to Request Restrictions* –You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeking our services. Upon your request, we will send bills or other correspondence to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, we will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Our Professional Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, we will post a current copy in our offices. A current copy will always be available on our web site and you may request a personal copy.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision we make about access to your records, or have other concerns about your privacy rights, you may contact Mary Piehl, Office Manager, or your therapist at (281) 363-4220.

If you believe that your privacy rights have been violated and wish to file a complaint with our office, you may send your written complaint to Mary Piehl or your therapist at: 1610 Woodstead Ct., Suite 420, The Woodlands, TX 77380.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. We will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on 3/28/2005. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide you with a revised notice in our lobby and on our web site. You may request a personal copy at any time.

Woodlands Family Institute, P.C.
Robyn J. Fairchild, LMSW, LCSW, LPC

Client's name: _____ Date: _____

Gender: ____ F ____ M Date of birth: _____ Age: _____

If you need any more space for any of the questions, please use the back of the sheet.

Primary reason(s) for seeking services

___ Anger management ___ Anxiety ___ Coping ___ Depression

___ Eating disorder ___ Fear/phobias ___ Mental confusion ___ Sexual concerns

___ Sleeping problems ___ Addictive behaviors ___ Alcohol/drugs

___ Other mental health concerns (specify): _____

COUNSELING/PRIOR TREATMENT HISTORY

Information about client (past and present):

	Yes	No	When	Where	Your reaction to overall experience
Counseling/psychiatric treatment	____	____	_____	_____	_____
Suicidal thoughts/attempts	____	____	_____	_____	_____
Drug/alcohol treatment	____	____	_____	_____	_____
Hospitalizations	____	____	_____	_____	_____
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	____	____	_____	_____	_____

Information about family/significant others (past and present): _____

_____

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

____ Aggression
____ Alcohol dependence
____ Anger
____ Antisocial behavior
____ Anxiety
____ Avoiding people
____ Chest pain
____ Cyber addiction
____ Depression
____ Disorientation
____ Distractibility
____ Dizziness
____ Drug dependence
____ Eating disorder
____ Elevated mood
____ Fatigue
____ Gambling
____ Hallucinations
____ Heart palpitations
____ High blood pressure
____ Hopelessness
____ Impulsivity
____ Irritability
____ Judgment errors
____ Loneliness
____ Memory impairment
____ Mood shifts
____ Panic attacks
____ Phobias/fears
____ Recurring thoughts
____ Sexual addiction
____ Sexual difficulties
____ Sick often
____ Sleeping problems
____ Speech problems
____ Suicidal thoughts
____ Thoughts disorganized
____ Trembling
____ Withdrawing
____ Worrying
____ Other (specify): _____

Briefly discuss how the above symptoms impair your ability to function effectively: _____

_____

_____

What are your goals for therapy? _____

_____

_____

Do you feel suicidal at this time? ____ Yes ____ No

If Yes, explain: _____

FAMILY INFORMATION

Relationship	Name	Age	Living		Living with you	
			Yes	No	Yes	No
Mother	_____	_____	____	____	____	____
Father	_____	_____	____	____	____	____
Spouse	_____	_____	____	____	____	____
Children	_____	_____	____	____	____	____
	_____	_____	____	____	____	____
	_____	_____	____	____	____	____

Significant others (e.g., brother, sisters, grandparents, step relatives, half relatives. Please specify relationship.)

Relationship	Name	Age	Living		Living with you	
			Yes	No	Yes	No
_____	_____	_____	____	____	____	____
_____	_____	_____	____	____	____	____
_____	_____	_____	____	____	____	____
_____	_____	_____	____	____	____	____

Marital Status (more than one answer may apply)

____ Single

____ Legally married
Length of time: _____

____ Widowed
Length of time: _____

____ Divorce in process
Length of time: _____

____ Separated
Length of time: _____

____ Annulment
Length of time: _____

____ Unmarried, living together
Length of time: _____

____ Divorced
Length of time: _____

Total number of marriages: ___

Assessment of current relationship (if applicable): ____ Good ____ Fair ____ Poor

PARENTAL INFORMATION

____ Parents legally married

____ Parents have been separated

____ Parents divorced

____ Mother remarried: Number of times: _____

____ Father remarried: Number of times: _____

Special circumstances (e.g., raised by person other than parents, information about spouse/children not living with you, etc.): _____

DEVELOPMENT

Are there special, unusual, or traumatic circumstances that affected your development? __Yes ___ No

If Yes, please describe: _____

Has there been history of child abuse? ____ Yes ____ No

If Yes, which type(s)? ____ Sexual ____ Physical ____ Verbal

If Yes, the abuse was as a: ____ Victim ____ Perpetrator

Other childhood issues: ____ Neglect ____ Inadequate nutrition ____ Other (please specify): _____

SOCIAL RELATIONSHIPS

Check how you generally get along with other people: (check all that apply)

____ Affectionate ____ Aggressive ____ Avoidant ____ Fight/argue often ____ Follower

____ Friendly ____ Leader ____ Outgoing ____ Shy/withdrawn ____ Submissive

____ Other (specify): _____

Sexual orientation: _____ Comments: _____

Sexual dysfunctions? ____ Yes ____ No

If Yes, describe: _____

CULTURAL/ETHNIC

To which cultural or ethnic group, if any, do you belong? _____

Are you experiencing any problems due to cultural or ethnic issues? ____ Yes ____ No

If Yes, describe: _____

SPIRITUAL/RELIGIOUS

How important to you are spiritual matters? ____ Not ____ Little ____ Moderate ____ Much

Are you affiliated with a spiritual or religious group? ____ Yes ____ No

If Yes, describe: _____

Would you like your spiritual/religious beliefs incorporated into the counseling? ____ Yes ____ No

If Yes, describe: _____

LEGAL

CURRENT STATUS

Are you involved in any active cases (traffic, civil, criminal)? ____ Yes ____ No

If Yes, please describe and indicate the court and hearing/trial dates and charges: _____

_____

Are you presently on probation or parole? ____ Yes ____ No

If Yes, please describe: _____

PAST HISTORY

DWI, DUI, etc.: ____ Yes ____ No
Criminal involvement: ____ Yes ____ No
Civil involvement: ____ Yes ____ No

If you responded Yes to any of the above, please fill in the following information.

Charges	Date	Where (city)	Results
_____	_____	_____	_____
_____	_____	_____	_____

EDUCATION

Fill in all that apply: Years of education: ____ Currently enrolled in school? ____ Yes____ No

____ High school grad/GED
____ Vocational: Number of years: ____ Graduated: ____ Yes ____ No Major: _____
____ College: Number of years: ____ Graduated: ____ Yes ____ No Major: _____
____ Graduate: Number of years: ____ Graduated: ____ Yes ____ No Major: _____

Other training: _____

EMPLOYMENT

Begin with most recent job, list job history:

Employer	Dates	Title	Reason left the job	How often miss work?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Currently: ____ FT ____ PT ____ Temp ____ Laid-off ____ Disabled ____ Retired

____ Social Security ____ Student ____ Other (describe): _____

MILITARY

Military experience? ____ Yes ____ No Combat experience? ____ Yes ____ No
Where: _____
Branch: _____ Discharge date: _____
Date drafted: _____ Type of discharge: _____
Date enlisted: _____ Rank at discharge: _____

LEISURE/RECREATIONAL

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

Activity	How often now?	How often in the past?

MEDICAL/PHYSICAL HEALTH

List any significant past health concerns:_____
List any current health concerns: _____
List any recent health or physical changes: _____

Current prescribed medications	Dose	Dates	Purpose	Side effects

Current over-the-counter meds	Dose	Dates	Purpose	Side effects

Are you allergic to any medications or drugs? ____ Yes ____ No
If Yes, describe: _____

Family history of medical problems: _____

Please check if there have been any recent changes in the following:
____ Sleep patterns ____ Eating patterns ____ Behavior ____ Energy level
____ Physical activity level ____ General disposition ____ Weight ____ Nervousness/tension
Describe changes in areas in which you checked above: _____

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CHEMICAL USE HISTORY

	Method of use and amount	Frequency of use	Age of first use	Age of last use	Used in last 48 hours		Used in last 30 days	
					Yes	No	Yes	No
Alcohol	_____	_____	_____	_____	____	____	____	____
Barbiturates	_____	_____	_____	_____	____	____	____	____
Valium/Librium	_____	_____	_____	_____	____	____	____	____
Cocaine/Crack	_____	_____	_____	_____	____	____	____	____
Heroin /Opiates	_____	_____	_____	_____	____	____	____	____
Marijuana	_____	_____	_____	_____	____	____	____	____
PCP/LSD/Mescaline	_____	_____	_____	_____	____	____	____	____
Inhalants	_____	_____	_____	_____	____	____	____	____
Caffeine	_____	_____	_____	_____	____	____	____	____
Nicotine	_____	_____	_____	_____	____	____	____	____
Over the counter	_____	_____	_____	_____	____	____	____	____
Prescription drugs	_____	_____	_____	_____	____	____	____	____
Other drugs	_____	_____	_____	_____	____	____	____	____

Substance of preference

1. _____ 3. _____
2. _____ 4. _____

Describe when and where you typically use substances: _____

_____

Reason(s) for use:

____ Addicted ____ Build confidence ____ Escape ____ Self-medication

____ Socialization ____ Taste ____ Other (specify): _____

How do you believe your substance use affects your life? _____

Who or what has helped you in stopping or limiting your use? _____

Does/has someone in your family present/past have/had a problem with drugs or alcohol?

____ Yes ____ No If Yes, describe: _____

Have you had adverse reactions or overdose to drugs or alcohol? (describe): _____

_____

Have drugs or alcohol created a problem for your job? ____ Yes ____ No

If Yes, describe: _____

{Your clinician will discuss the following items with you upon your initial session, and periodically thereafter as needed.}

Treatment Plan

Diagnostic Impression:

Axis I _____
Axis II_____
Axis III_____
Axis IV_____
Axis V_____

Treatment Goals:

1. Reduce frequency and intensity of:

2. Increase frequency and intensity of:

3. Eliminate:

Treatment Methods and Duration:

____Individual sessions □weekly □bi-weekly □monthly

____Couple/family sessions □weekly □bi-weekly □monthly

Recommendations for Adjunctive Treatment/Assessment:

Plan Review/Revision:

_____ _____
Robyn J. Fairchild, LMSW, LCSW, LPC Date

_____ _____
Client Signature Date