

PSYCHOLOGY INFORMATION SHEET



Phone: 734-454-0866

Fax: 734-454-1744

Patient Name:
DOB:
Insured:
Insurance ID:
Referring Dr.:
DX Code:

INDIVIDUAL/ COUPLE/ FAMILY INFORMATION SHEET

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session. Date: _____

Your Full Name: _____

Address: _____

City, State: _____ Zip: _____

Home Phone: (____) _____ May I leave a message? (circle) yes / no

Cell/ Other Phone: (____) _____ May I leave a message? (circle) yes / no

Email: _____ May I email you? (circle) yes / no

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): _____

Birthdate: ____/____/____ Age: ____ Gender: _____

Education: _____

Ethnicity: _____

Are you currently employed? (circle) yes / no

If yes, what is your current employment situation? _____

Employer: _____

Position: _____ For how long? _____

Do you enjoy your work? Is there anything stressful about your current work? _____

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Do you consider yourself to be spiritual or religious? (circle) yes / no

If yes, describe your faith and/or religious or spiritual affiliation: _____

Marital/ relationship status:

- | | |
|---|---|
| <input type="checkbox"/> Never married | <input type="checkbox"/> Divorced |
| <input type="checkbox"/> Domestic Partnership | <input type="checkbox"/> Widowed |
| <input type="checkbox"/> Married | <input type="checkbox"/> Other (describe) _____ |
| <input type="checkbox"/> Separated | |

Your partner/ spouse/ primary partner's name: _____

How long have you been together? _____

Address (if different): _____

City, State: _____ Zip: _____

Home Phone: (____) _____ May I leave a message? (circle) yes / no

Cell/ Other Phone: (____) _____ May I leave a message? (circle) yes / no

Names and ages of all children in the home: _____

Names and ages of all children *not* in the home: _____

Who shall I contact in case of emergency?

Name: _____ Phone: (____) _____

Relationship: _____

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In this box, please indicate the address and telephone number you want to use when sending bills or when I need to contact you. If this box is left blank, I will use the address and any of the telephone numbers you have provided above.

If you do *not* want me to leave a message via text or voicemail, please tell me how you want me to reach you by phone:

I hereby consent for Building Bridges Therapy Center to provide me with evaluation and treatment.

Signature

Date

Signature

Date

Signature

Date

Signature

Date



Medical and Health History
Please complete a medical history for all participants.

Name: _____ Date: _____

List any allergies you have: _____ None: _____

Primary Care Physician: _____

Address: _____

City, State: _____ Zip: _____

Primary Care Physician's phone number: (____) _____

Date of your most recent physical examination: _____

1. Are you currently taking any prescription medication? (circle) yes / no

If yes, please list all current medications and dosages:

Name of Medication	Dosage	Name of Prescribing Doctor	When did you start taking it?

2. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list all current or past health problems, and any major operations:

Current	Past

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3. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing: _____

4. How many times per week do you generally exercise? _____

What types of exercise do you participate in: _____

5. Please list any difficulties you experience with your appetite or eating patterns: _____

6. Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

No

Yes, list all therapists you have seen, and dates you saw them:

7. List any substance abuse treatment or inpatient psychiatric treatment you have had, and the dates: _____

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8. How often do you engage in recreational drug use?

- Daily Weekly Monthly Infrequently Never

Please indicate which of these substances you currently use, or have used in the past:

Substance	Amount used	How often?	Former usage?
Cigarettes			
Alcohol			
Pills not prescribed for me			
Marijuana			
Cocaine or Crack			
LSD			
Heroin			
Other (please list):			

9. Are you currently experiencing any chronic pain?

- No
 Yes, please describe? _____

What significant life changes or stressful events have you experienced recently:

What kind of problem(s) brings you to seek counseling at this time?



Family Mental Health History:

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
ADHD	Yes / No	
Alcohol/ Substance Abuse	Yes / No	
Anxiety	Yes / No	
Bipolar Disorder	Yes / No	
Depression	Yes / No	
Domestic Violence	Yes / No	
Eating Disorders	Yes / No	
Obesity	Yes / No	
Obsessive Compulsive Behavior	Yes / No	
Phobias/ Panic	Yes / No	
Schizophrenia	Yes / No	
Suicide Attempts	Yes / No	

What do you consider to be some of your strengths?

What do you consider to be some of your weakness?

What would you like to accomplish out of your time in therapy?

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Please indicate with a check mark if your childhood/ adolescent/ young adult history includes any of the following:

- | | |
|---|---|
| <input type="checkbox"/> Birth complications | <input type="checkbox"/> Attention difficulties |
| <input type="checkbox"/> Major childhood illnesses | <input type="checkbox"/> Victim of sexual abuse |
| <input type="checkbox"/> Major childhood injuries | <input type="checkbox"/> Victim of physical abuse |
| <input type="checkbox"/> Major childhood stresses | <input type="checkbox"/> Difficult family situation |
| <input type="checkbox"/> Head injury (major or minor) | <input type="checkbox"/> Problematic childhood/ adolescence |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Childhood behavior problems |
| <input type="checkbox"/> Substance or alcohol abuse | <input type="checkbox"/> Learning disabilities |
| <input type="checkbox"/> Childhood anxiety | <input type="checkbox"/> Parental separation/ divorce |
| <input type="checkbox"/> Childhood depression | <input type="checkbox"/> Adoption |
| <input type="checkbox"/> Allergies | |

Signature

Date



Present Areas of Concern

All people encounter difficulties from time to time. Please indicate with a check mark those areas of concern which you believe pose particular challenges for you at this time.

TENSIONS/ WORRIES

- Fearful
- Panicky
- Feeling keyed-up or on-edge
- Easily fatigued
- Difficulty concentrating
- Repetitive worries
- Repetitive actions to prevent stress
- Fear of dying
- Irritable
- Frequent stomachaches
- Frequent headaches
- Specific fears
(indicate _____)

EMOTIONS

- Sadness or tearfulness
- Low self-esteem
- Lack of enjoyment/ interest
- Low energy
- Feelings of worthlessness
- Feelings of guilt
- Grieving
- Feeling hopeless
- Over-excited
- Under-excited
- Angry
- Slow-moving/ under-active
- Moody
- Difficulty controlling temper
- Thoughts of hurting self
- Thoughts of doing something uncontrolled

OTHER

- Career indecision
- Identity issues
- Eating problems
- Weight loss or gain
- Substance abuse
- Excessive use of alcohol
- Unusual thoughts or feelings
- Legal problems

ATTENTION / LEARNING

- Memory difficulties
- Disorganization
- Difficulty with attention
- Lose things frequently
- Easily distracted
- Forgetful
- Fidgety
- Feelings of restlessness
- Act without thinking
- Learning disability
- Difficulty reading
- Difficulty writing
- Difficulty understanding what others say

INTERPERSONAL STRESSES

- Lonely or isolated
- Difficulty with coworkers
- Difficulty with boss
- Difficulty with family
- Difficulty with friends

REACTIONS/ LIFESTYLE

- Too emotional
- Under emotional
- Like to be the center of attention
- Hard to trust others
- Feel people talk about me
- Avoid people when possible
- Fear of criticism
- Difficulty with decisions
- Fears others will abandon me
- Difficulty doing things on own
- Perfectionist
- Overly focused on work
- Rigid/ stubborn
- Fluctuating, unstable relationships
- Reckless
- Feelings of emptiness
- Difficulty following rules
- Physically aggressive
- Preoccupied with fantasies of success
- Special talents
- Eccentric

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Please elaborate on any items from the previous page and specify any other concerns: _____

Self-Description

Please give a word-picture of yourself as you would be described by:

- a) Spouse or significant other: _____
- b) Your best friend: _____
- c) Someone who dislikes you: _____
- d) Self-description: _____



Consent to Treatment

Psychotherapy is a technique for treating emotional/ mental distress and some psychiatric disorders. All clinical care will be provided by a qualified and trained professional. Please note that:

- You have the right to refuse any treatments.
- Your agreement to treatment may be cancelled in writing at any time, except to the extent that previous action(s) have been taken that involve a previously provided consent.

Emergencies

In emergencies, please call Common Ground at 1(800) 231-1127, Detroit-Wayne County Community Mental Health at (866) 289-2641, or go to your nearest hospital emergency room.

As a *mandated reporter*, disclosure of information is required in situations such as those that follow:

- Information needed to process insurance claims, as well as reviews conducted by external auditing bodies.
- If a client is clearly likely to seriously harm him or herself, or seriously harm another person.
- If abuse of a child or senior citizen may have taken place.
- If records are requested by court order or subpoena.

Treatment of Minors: If the client is younger than age 13, both parents have access to the minor client's complete Clinical Record, unless there is a court order prohibiting one of the parents from access.

Your signature on this agreement provides written, advance consent for the above releases of information.

Building Bridges Therapy Center may occasionally consult with other health and mental health professionals about your case. Every possible effort is made to protect client identities. All consultations are noted in the Clinical Record.

____ (Initial) *As a client of Building Bridges Therapy Center, I agree to respect the confidentiality of other clients seeking services at the treatment location*

Your signature below indicates that you have read this agreement and agree to its terms, and also serves as an acknowledgement that you have received the HIPAA Notice of Privacy Practices described above.

X _____
Signature of Client or Responsible Party

____/____/____
Date



PATIENT-PROVIDER COMMUNICATIONS

If you consent to the use of email to communicate with you about information related to your case, please complete and sign this Consent below.

(You are not required to authorize the use of email and/or text messaging. A decision not to sign this authorization will not affect your health care in any way. If you prefer not to authorize the use of email we will continue to use U.S. Mail or telephone to communicate with you.)

Print Name

Signature

Date

(Email address to which we may communicate with you)

SOCIAL MEDIA PRACTICES

This document outlines the office policies of Building Bridges Therapy Center (BBTC) related to use of Social Media. If you have any questions about anything within this document, we encourage you to bring them up when we meet. As new technology develops and the Internet changes, there may be times when we need to update this policy. If this occurs, you will be notified in writing.

Friending

BBTC and its associates do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). We believe that adding clients as friends or contacts on these sites can compromise your confidentiality and possibly blur the boundaries of the therapeutic relationship.

Interacting

Please do not use messaging on Social Networking sites such as Twitter, Facebook, or LinkedIn to contact associates of BBTC. Engaging in this way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart.

Use of Search Engines

It is NOT a regular part of our practice to search for clients on Google or Facebook or other search engines. Extremely rare exceptions *may* be made in the event that your safety is of concern.

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Business Review Sites

You may find BBTC or its clinicians listed on sites such as Yelp, Healthgrades, Yahoo Local, Bing, or other places which list businesses. Please know that any listing is NOT a request for a testimonial, rating, or endorsement from you as a client.

If you do choose to write something on a business review site, we hope you will keep in mind that you may be sharing personally revealing information in a public forum. Creating a pseudonym that is not linked to your regular email address or friend networks may protect your own privacy and protection.

If you feel that an associate of BBTC has done something harmful or unethical and you do not feel comfortable discussing it with your clinician, you can always contact the Board of Psychology, which oversees licensing, and they will review the services provided.

MI Board of Psychology
611 W. OTTAWA ST.
P.O. BOX 30670
LANSING, MICHIGAN 48909
bhcshep@michigan.gov

Location-Based Services

If you used location-based and/or check-in services on your mobile phone, you may wish to be aware of the privacy issues related to using these services.

_____ Please provide your initials to indicate that you have read and understand the social media policies used at Building Bridges Therapy Center