Northbrook Psychological Clinic, PLC

Adult Personal History

(All information obtained in this form is confidential)

Name: ____ Date: ____________________

Birth Date: ________________ Age: ______ Gender: ____________________________________

Referred by: ____

Address : ____

Phone: ______________________________ Phone: _______________________________

Spouse / Partner Name: ______________________ Your Ethnic Background: ________________

Emergency Contact Person: _______________________ Relationship: ______________________

Emergency contact phone number(s):____

Marital status: ___ Married ___ Divorced ___ Single ___ Engaged ___ Separated ___Widowed.

If married, number of years: ____ If engaged, length of engagement: ____________

Any previous marriages? ____

What is your overall impression of family life: ____

____

Please give a brief reason for coming to the clinic: ____

____

Briefly explain what you have tried in the past to deal with these issues and the results you have had: __

____

____

Below is a list of words that describe personality and behavior. Please circle that describe you.

happy, independent, prefers to be alone, follower, cheerful, quiet, even tempered, very active, friendly, disruptive, leader, affectionate, trouble sleeping, moody, sad, cries often, trouble eating, fearful, inattentive, angry, dependent, cries often.

Do you currently have thoughts of harming yourself? ________ In the past? _____ If yes, please explain:

____

Do you currently have thoughts of harming others? ________ If yes, please explain: ________________

____

Do you have any hobbies or special interest? ____

What are your strengths? ____

What are your weaknesses? ____

Health

Name of physician: ____

Address: ____

Phone: ______________________________ Have you received your immunizations? Y or N

List all illnesses, hospitalizations, medications, allergies, head trauma, significant accidents/ injuries, surgeries, periods of loss of consciousness, convulsions/seizures, and other medical conditions.

____

____

____

Describe your eating habits? ____

Please list any medications (including how long been taking, dose, frequency): ____________________

____

____

Have you had any side effects to medication?____

____

Please list any surgeries/ hospitalizations (include age / length of hospital stay): ___________________

____

____

Have you suffered from any type of head injury? Y or N, if yes please indicate what age, how the injury occurred, and if there was a loss of consciousness: ____________________________________

____

____

Where have you have lived? Who lives with you?

Date from:	Date to:	City/State:	Reason for Moving:	Any Problems?
_________	_________	_________________	______________________	_____________
_________	_________	_________________	______________________	_____________
_________	_________	_________________	______________________	_____________
_________	_________	_________________	______________________	_____________

Family History

Your Parent 1 Name: ____________________________ Education:________________________________

Your Parent 2 Name: ______________________________ Education:______________________________

Do you have any children? _________ If yes, List the name and age ______________________________

____

____

How many siblings do you have? ____

Were you adopted? _________________ Were you raised by your parents? ________ If not, please explain ____

____

Were your parents: _____ legally married _____ never legally married ____ separated ______ divorced?

When divorced ___________?

Any psychiatric problems for which your parents have received treatment? Y or N If yes please describe the problems and the treatment received:

____

____

____

Please list any unusual and/or traumatic family events in your life which you feel may have impacted your functioning (birth of a sibling, death of a family member, divorce, etc.):

____

____

____

____

____

____

Social History: Do you consider yourself religious? _______ If yes, what religion: _____________________

Do you have close friends? ______ If no, explain: ____

Are there any friends or family members that are available for support to you if needed? ____________

If so, Who ______________________ If not why? ____

Describe your financial situation: ____

____

Education

Highest level of education completed? ____

Are you currently a student? ______ If so, Where and what are you studying? ______________________

Employment

Are you presently employed? _______________ Where ____

How Long? _____ Full time/ part time What position? ____

List your responsibilities ____

How many days have you missed in the last two months, and why? ________________________________

Level of job satisfaction? Excellent / good / Average / Below average / Poor / Extremely poor

Relationship with coworkers: Excellent / good / Average / Below average / Poor / Extremely poor

Relationship with supervisors: Excellent / good / Average / Below average / Poor / Extremely poor

Have you served in the military? ____

Date entered ________ Date and type of discharge __________________________________

Briefly explain your employment / military history: ____

____

Have you had any involvement with the court system? If yes, explain: _____________________________

____

Substance use / abuse history

Do you use tobacco? What type and how often? ____

Do you use alcohol? What type and how often? ____

Do you use any illegal drugs? What type and how often? ____

Briefly describe your substance use history: ____

____

Have you ever been treated for any type of substance abuse? If so, when and what treatment center __

____

Please answer the following for which best describes you: Never, Past, or present.

1. I frequently find my conversations centers on drugs or alcohol. ____________________________
2. I drink to get high to deal with tension or physical stress. __________________________________
3. Most of my friends or acquaintances are people I drink or get high with. ___________________
4. I have lost days of work/ school because of drinking or using drugs. ________________________
5. I have had the shakes when I drink upon awakening, before eating or at work/school. _________
6. I have been arrested for driving under the influence of a substance. ________________________
7. I have periods of time that can't be remembered (blackouts/time lost). ______________________
8. Family members think drinking or drug use is a problem for me. ___________________________

9. I have tried to quit using substances but cannot. ____
10. I often double up / gulp drinks or extensively use more drugs than others I party with. _________
11. I often drink or use drugs to prepare for social events. _______________________________________
12. I often hide the use of substances, so those I know don't know how much I'm using. ___________
13. I often drink by myself. ____
14. My substance use has led to conflicts with my family and friends. ____________________________

Sexuality

If you do not feel comfortable answering these, please skip, or just discuss with your therapist.

Are there any areas of your sexuality with which you are not comfortable with? Including but not limited to sexual orientation, gender, or any other information you wish to share ___________________________

____

I am engaging in unsafe sex practices (past or present) ____

I have been diagnosed with a sexually transmitted Infection. ____

Sexual orientation / Identity? ____

____

____

This is strictly confidential patient medical record. Re-disclosure or transfer is expressly prohibited by law.

Signature: ____ Date: ________________________

Therapist Signature/Credentials: _________________________________ Date: _________________________

NORTHBROOK PSYCHOLOGICAL CLINIC

CONSENT TO TREATMENT AND CLINICAL SERVICES &
HEATH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Client ____ Date of Birth _______________________

I give my permission to Northbrook Psychological Clinic (NPC) to provide mental health, counseling, psychiatric and educational services and any testing/treatment related to those services to me or my dependent.

I understand that the services received at NPC are based on currently accepted practice in the fields of mental health or substance abuse. I also understand that the outcome of treatment cannot be guaranteed and that the services continue with my voluntary consent.

If my dependent or I threaten to harm either myself or someone else, I understand that the law obligates NPC to take whatever action is necessary to protect people from harm. This may include divulging confidential information to others. Such action would be taken when someone's life appears to be in danger.

I understand if my dependent or I have been ordered by the court to seek treatment or diagnostic services, the court will require one or more reports. My written consent to release information will be requested.

I understand if my dependent or I have been involved in litigation of any kind and the court is informed of mental health/substance abuse treatment, I may be waiving the right to keep records confidential. I further understand I may want to consult with my attorney before disclosing to a court that my dependent or I are receiving treatment or diagnostic services.

I understand it may be necessary to reach me by mail, email or telephone during or after my or my dependent's treatment for the purpose of scheduling or confirming appointments, billing or payment issues, completion of forms, conducting surveys or any necessary follow-up. I also understand that to communicate via email or text message I will provide consent, recognizing that email or text message is not a secure form of communication. There is some risk that any protected health information that may be contained in such email or text message may be disclosed to or intercepted by unauthorized third parties.

I understand that the State of Michigan and Federal laws and regulations do not protect any information about suspected child and/or elder abuse or neglect from being reported to the appropriate state or local authorities.

I am voluntarily authorizing diagnostic and/or treatment services for my dependent or myself. I may refuse any aspect of treatment, understanding that such a refusal could, in some instances, result in termination of treatment and/or services.

I acknowledge that NPC's Notice of Privacy Practices is available upon request at any time.

__ I authorize NPC to communicate with me via text message
__ I authorize NPC to communicate with me via email at this address _________________________________

By signing below, I agree to comply with the policies and procedures of NPC.

X_______________________________________ X____
(Client/Parent/Guardian Signature) (Date) (Witness) (Date)

NORTHBROOK PSYCHOLOGICAL CLINIC
23965 Novi Rd Suite 110 Novi, MI 48375
Phone: (248) 344-7420 Fax: (248) 344-7423

Primary Care Physician Notification Form

THIS IS **NOT** A REQUEST FOR MEDICAL RECORDS

TO THE PATIENT:

☐ I **DO NOT** wish Northbrook Psychological Clinic to notify my primary care/family doctor that I am receiving services.

☐ I **DO** wish Northbrook Psychological Clinic to notify my primary care/family doctor that I am receiving services. Please provide the complete name and address of your Primary Care Physician.

Primary Care Physician: ___________________________________ Phone: ( ) ________________

Clinic Name (if any): _____________________________________ Fax: ( ) _________________

Address: ____

City: ____ State: ___________ Zip: __________________

Please read and complete the following:

I, ______________________________________ DOB __________________ hereby authorize Northbrook Psychological Clinic to exchange information regarding my mental health and/or substance abuse treatment and medical healthcare for the purpose of continuity of care as may be necessary for the administration and provision of my health care coverage. Information exchanged may include information on mental health care or substance abuse treatment as protected under 42 CFR Part 2 (respecting substance abuse records) and/or state laws respecting confidentiality of records and patient communications with health care providers and in compliance with HIPAA regulations. I understand that this authorization shall remain in effect for one year or throughout the course of this treatment, whichever is longer. I understand that I may revoke this authorization at any time by written notice to the behavioral health care provider indicated herein. I also understand that it is my responsibility to notify my behavioral health care provider if I change my primary care physician.

X____ X____________________________________
Signature Patient/Parent/Guardian Date Witness Signature Date

ATTENTION PRIMARY CARE PHYSICIAN:
Your patient is a client at Northbrook Psychological Clinic. With patient authorization, we are providing diagnoses and the therapist's contact information. Please retain for your records.

Patient Name: ____

ICD-10 Diagnoses (Including Codes): ____

____

Therapist Name & Credentials: ____

Northbrook Psychological Clinic

FAILED APPOINTMENTS/LATE CANCEL POLICY

Failed appointments or those cancelled less than 24 hours prior to your scheduled time are subject to a fee that cannot be billed to your insurance. The fee equals the amount that we ordinarily bill your insurance – which can range from roughly $80-150, depending on your policy.

Thank you for your understanding. If you have any questions or concerns, I would be glad to discuss these with you.

______________________________ ______________
Patient/Client Date

______________________________ ______________
Witness Date