Psychological Services New Client Referral Summary

Please indicate who referred your child for psychological services:

- ❑ School staff
- ❑ Primary care doctor
- ❑ Psychiatrist
- ❑ Self-referred
- ❑ Other: ______________________________

Please indicate services requested (check all that apply)

- ❑ Psychological Testing
- ❑ Individual/Family Therapy
- ❑ Group Therapy
- ❑ Unsure

Does your child already have a formal diagnosis?

- ❑ Yes
- ❑ No

Please select everything below that you are looking for (check all that apply):

- ❑ Diagnosis
- ❑ IQ Testing
- ❑ School Observation
- ❑ Testing for ADHD, Autism, Learning Disability
- ❑ Ongoing treatment for anxiety, depression, or ADHD
- ❑ Assistance coping with family change
- ❑ Assistance with challenging behaviors
- ❑ Other: ______________________________

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:

- ☐ Never married
- ☐ Domestic Partnership
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed
- ☐ Other (describe) ____________________

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

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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?

____

____

____

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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:

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

____

Signature Date

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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: ______________________________

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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

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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
bhcshelp@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

Greetings;

Building Bridges Therapy Center provides comprehensive outpatient therapeutic services. As a part of the integrated healthcare initiatives, we want to coordinate services to provide our mutual client ______________________________ with the best care. The information will assist in developing a comprehensive treatment plan that incorporates their physical health along with mental health.

We are requesting a copy of the most current physical even if it is not within the past year. Please fax to 734-454-1744. We are also requesting that any pertinent medical change is relayed our team. We look forward to working with you. A release/request has been enclosed.

Sincerely,
Building Bridges Therapy Center
46200 Port St
Plymouth, MI 48170
Ph: 734-454-0866
Fax: 734-454-1744