The Being Place—where humans can learn healthier ways of being

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PERSONAL DATA:

NAME _____
ADDRESS _____
_____
_____
EMAIL: _____
NO. YEARS EDUCATION _____ DEGREE _____
MARITAL STATUS _____
SPOUSE/PARTNER'S OCCUPATION _____
SPIRITUALITY/RELIGIOUS AFFILIATION _____
EMERGENCY CONTACT: _____
CONTACT ADDRESS: _____

DATE _____
AGE ____ DOB ____/____/____ SEX MALE FEMALE
HOME PHONE (____)_____ LEAVE MESSAGES? Y/N
CELL PHONE (____) _____ LEAVE MESSAGES? Y/N
WORK PHONE (____) _____ LEAVE MESSAGES? Y/N
OCCUPATION _____
CURRENTLY LIVING WITH _____
NO. OF CHILDREN _____ AGE _____
MILITARY SERVICE ? ___ NO ___ YES __ PAST __ CURRENT
PHONE (_____) _____

MAIN CONCERNS:

PLEASE LIST THE 3 MAJOR CONCERNS YOU WANT HELP WITH IN THERAPY AND RATE THE SEVERITY OF EACH ONE ACCORDING TO THIS SCALE:

1 ----------2 ----------3 ---------- 4 ---------- 5 ---------- 6 ---------- 7 ------ 8 ---------- 9 ---------- 10
NOT A PROBLEM MILD PROBLEM MODERATE PROBLEM SEVERE PROBLEM COULDN'T BE WORSE

		RATING
1.	_____	_____
2.	_____	_____
3.	_____	_____

BRIEFLY DESCRIBE WHAT MOTIVATED YOU TO SEEK THERAPY **AT THIS TIME** (RATHER THAN SOME TIME EARLIER OR LATER): _____

_____

MEDICAL HISTORY: DO YOU HAVE ANY SERIOUS MEDICAL CONDITIONS ____ YES ____ NO IF YES, DESCRIBE: _____

_____

HOW WOULD YOU RATE YOUR OVERALL HEALTH? EXCELLENT ____ GOOD ____ FAIR ____ POOR ____

NAME OF PRIMARY CARE PHYSICIAN (PCP) _____ PHYSICIAN PHONE # _____
PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: _____
_____
PLEASE LIST ALL OF THE MEDICATIONS YOU HAVE PREVIOUSLY TAKEN _____

_____

LIST ANY KNOWN ALLERGIES: _____ ANY SERIOUS HOSPITALIZATIONS, ILLNESS, ACCIDENTS? ___ YES ___ NO
IF YES, DESCRIBE: _____

IN PAST YEAR, HOW MANY: VISITS TO DOCTOR? __ SICK DAYS __ CIGARETTES/DAY __

ALCOHOLIC DRINKS/DAY __ PSYCHOTHERAPY SESSIONS ___

NUMBER OF FAMILY MEMBERS WITH: ALCOHOL/DRUG ISSUES: ___ PSYCHIATRIC PROBLEMS (E.G., DEPRESSION, PSYCHOSIS ETC.) _____

• HAVE YOU EVER FELT YOU OUGHT TO CUT DOWN YOUR ALCOHOL OR DRUG USE?	___ YES	____ NO
• HAVE PEOPLE ANNOYED YOU BY CRITICIZING YOUR DRINKING OR DRUG USE?	___ YES	___ NO
• HAVE YOU EVER FELT BAD OR GUILTY ABOUT YOUR DRINKING OR DRUG USE?	___ YES	___ NO
• HAVE YOU EVER HAD A DRINK OR USED DRUGS FIRST THING IN THE MORNING? AS AN EYE OPENER, TO STEADY YOUR NERVES OR TO GET RID OF A HANGOVER?)	___ YES	___ NO

PRIOR MENTAL HEALTH OR SUBSTANCE ABUSE TREATMENT

PRIOR SUBSTANCE USE/ABUSE COUNSELING	___ YES	___ NO
PRIOR OUTPATIENT PSYCHOTHERAPY?	___ YES	___ NO
PRIOR INPATIENT PSYCHOTHERAPY	___ YES	___ NO
PRIOR PSYCHIATRY?	___ YES	___ NO

PRIOR PROVIDER NAME(S) **CITY** **STATE** **PHONE** **DIAGNOSIS** **BENEFICIAL?**

_____

_____

_____

CURRENT STRESSFUL EVENTS: _____ LEGAL _____ FINANCIAL _____ FAMILY PROBLEMS _____ FAMILY ILLNESS

OTHER: _____ ARE YOU IN ABUSIVE RELATIONSHIP? _____ YES _____ SOMEWHAT _____ NO
CHANGES IN FRIENDSHIPS? _____ YES _____ NO ACADEMIC/SCHOOL STRESS _____ YES _____ NO

FAMILY OF ORIGIN HISTORY:

PRESENT DURING CHILDHOOD

	PRESENT ENTIRE CHILDHOOD	PRESENT PART OF CHILDHOOD	NOT PRESENT AT ALL
MOTHER/PARENT	[ ]	[ ]	[ ]
FATHER/PARENT	[ ]	[ ]	[ ]
STEPMOTHER	[ ]	[ ]	[ ]
STEPFATHER	[ ]	[ ]	[ ]
BROTHER(S)	[ ]	[ ]	[ ]
SISTER(S)	[ ]	[ ]	[ ]
OTHER (SPECIFY)	[ ]	[ ]	[ ]

PARENTS' CURRENT MARITAL STATUS
[ ] MARRIED TO EACH OTHER
[ ] SEPARATED FOR ___ YEARS
[ ] DIVORCED FOR ___ YEARS
[ ] MOTHER REMARRIED ___ TIMES
[ ] FATHER REMARRIED ___ TIMES
[ ] MOTHER INVOLVED WITH SOMEONE
[ ] FATHER INVOLVED WITH SOMEONE
[ ] MOTHER DECEASED FOR ___ YEARS AGE OF PATIENT AT MOTHER'S DEATH: _____
[ ] FATHER DECEASED FOR ___ YEARS AGE OF PATIENT AT FATHER'S DEATH: ___

DESCRIBE CHILDHOOD FAMILY EXPERIENCE
[ ] OUTSTANDING HOME ENVIRONMENT
[ ] NORMAL HOME ENVIRONMENT
[ ] CHAOTIC HOME ENVIRONMENT
[ ] WITNESSED PHYSICAL/VERBAL/SEXUAL ABUSE
[ ] EXPERIENCED PHYSICAL/VERBAL/SEXUAL ABUSE

DESCRIBE PARENTS **FATHER/PARENT** **MOTHER/PARENT**
FULL NAME: _____ _____
OCCUPATION: _____ _____
EDUCATION: _____ _____
GENERAL HEALTH: _____ _____
SPECIAL OR UNUSUAL CIRCUMSTANCES IN CHILDHOOD: _____
_____

IMMEDIATE FAMILY HISTORY:

MARITAL STATUS:
[ ] SINGLE, NEVER MARRIED
[ ] ENGAGED _____ MONTHS
[ ] MARRIED FOR ___ YEARS
[ ] DIVORCED FOR ___ YEARS
[ ] SEPARATED FOR ___ YEARS
[ ] DIVORCE IN PROCESS _____ MONTHS
[ ] LIVE-IN FOR ___ YEARS
[ ] ___ PRIOR MARRIAGES (SELF)
[ ] ___ PRIOR MARRIAGES (PARTNER)

INTIMATE RELATIONSHIP
[ ] NEVER BEEN IN A SERIOUS RELATIONSHIP
[ ] NOT CURRENTLY IN A RELATIONSHIP
[ ] CURRENTLY IN A SERIOUS RELATIONSHIP

RELATIONSHIP SATISFACTION
[ ] VERY SATISFIED WITH RELATIONSHIP
[ ] SATISFIED WITH RELATIONSHIP
[ ] SOMEWHAT SATISFIED WITH RELATIONSHIP
[ ] DISSATISFIED WITH RELATIONSHIP

LIST ALL PERSONS CURRENTLY LIVING IN YOUR HOUSEHOLD

NAME	AGE	SEX	RELATIONSHIP TO YOU

LIST CHILDREN NOT LIVING IN SAME HOUSEHOLD AS YOU

NAME	AGE	SEX	RELATIONSHIP TO YOU

FREQUENCY OF VISITATION OF ABOVE: _____

DESCRIBE ANY PAST OR CURRENT SIGNIFICANT ISSUES IN INTIMATE AND/OR IMMEDIATE FAMILY RELATIONSHIPS: _____

_____

_____

SELF-REPORT ASSESSMENT OF FUNCTIONING

DAILY FUNCTIONING: PLEASE GIVE A ROUGH ESTIMATE OF HOW MANY HOURS PER WEEK YOU SPEND DOING THE FOLLOWING IN A TYPICAL WEEK:

WORKING IN YOUR PRIMARY JOB	_____
PARENTING/CARETAKING OF OTHERS	_____
DOING HOUSEHOLD CHORES, BILLS ETC.	_____
TV, MOVIES, PHONE, ELECTRONICS, ETC.	_____
PHYSICAL RECREATION OR EXERCISE	_____
HOBBIES (CRAFTS, GAMES, MUSIC, ETC.)	_____
SOCIAL ACTIVITY WITH FRIENDS, FAMILY	_____
CHURCH, CHARITY, INSPIRATIONAL	_____
	_____
QUIET, NON-PRODUCTIVE, OR RELAXING TIME…	_____
AVG. NO. OF HOURS OF SLEEP PER NIGHT	_____

LIFELONG FUNCTIONING: PLEASE CHECK THE BEST AND WORST TIMES OF YOUR LIFE

AGES	BEST TIMES	AVERAGE TIMES	WORST TIMES
0-5	_____	_____	_____
6-12	_____	_____	_____
13-19	_____	_____	_____
20-29	_____	_____	_____
30-39	_____	_____	_____
40-49	_____	_____	_____
50-59	_____	_____	_____
60-69	_____	_____	_____
70-79+	_____	_____	_____

WORST TIME IN LIFE:

PLEASE BRIEFLY DESCRIBE: YOU MAY USE THE BACK OF THIS PAGE FOR ANSWERS IN THE FOLLOWING SECTIONS IF NEEDED: _____

_____

_____

WHO HELPED YOU THROUGH IT? _____

ARE THERE THINGS THAT CAUSE YOU TO FEEL ASHAMED OR THAT WOULD BE DIFFICULT TO TALK ABOUT? (NO NEED TO SPECIFY) ____ YES ____ NO

BEST TIME IN LIFE:

PLEASE BRIEFLY DESCRIBE: YOU MAY USE THE BACK OF THIS PAGE FOR ANSWERS IN THE FOLLOWING SECTIONS, IF NEEDED: _____

_____

_____ WAS THERE SOMEONE TO SHARE IT WITH? ____ YES ____ NO

DO YOU HAVE SOMEONE YOU CAN CONFIDE IN DURING DIFFICULT TIMES? ____ YES ____ NO

WHAT HAVE YOU DONE THAT YOU ARE **MOST PROUD OF?** _____

_____

WHAT ARE YOUR **STRENGTHS** (HOW DO YOU COPE) WHEN TIMES ARE HARD? _____

_____

DO YOU FEEL YOU ARE A PERSON OF WORTH AT LEAST ON AN EQUAL BASIS WITH OTHERS? VERY MUCH | MUCH | SOMEWHAT | A LITTLE | NO

HOW MUCH ENJOYMENT OR PLEASURE ARE YOU CURRENTLY GETTING OUT OF LIVING? VERY MUCH | MUCH | SOMEWHAT | A LITTLE | NONE

SELF-ASSESSMENT OF FUNCTIONING:

PLEASE RATE (FROM 1-10) HOW WELL YOU FEEL YOU ARE CURRENTLY FUNCTIONING IN EACH OF THE THREE AREAS LISTED BELOW, ACCORDING TO THE FOLLOWING SCALE:

1 ----------2 ----------3 ---------- 4 ---------- 5 ---------- 6 ---------- 7 ------ 8 ---------- 9 ---------- 10
NOT A PROBLEM MILD PROBLEM MODERATE PROBLEM SEVERE PROBLEM COULDN'T BE WORSE

GENERAL MOOD/MENTAL HEALTH (DEPRESSION, ANXIETY, ETC.) ___ SOCIAL RELATIONSHIPS ___ DAILY WORK/SCHOOL ____

PERSONAL AND FAMILY MEDICAL HISTORY

PLEASE PLACE AN X BY ANY OF THE FOLLOWING MEDICAL PROBLEMS EXPERIENCED BY YOU OR ANY MEMBER OF YOUR IMMEDIATE FAMILY (PARENTS, SIBLINGS, CHILDREN) IN THE PAST OR PRESENT. ALSO, PLEASE WRITE WHO EXPERIENCED THE MEDICAL CONDITIONS (E.G., YOU, MOM, DAD, SIBLING) IN THE COLUMN MARKED "PERSON?" FOR ANY CONDITION YOU PUT AN X NEXT TO.

Medical condition	X	Person?	Medical Condition	X	Person?	Medical Condition	X	Person?
Cardiovascular/circulatory			**Urinary**			**Psychological**		
Heart Disease			Bladder or kidney infections			Attention deficit hyperactivity disorder		Person?
High blood cholesterol			Kidney disease/stones			Anxiety (frequent)		
High Blood pressure			Urinary stress Incontinence			Obsessive-compulsive disorder		
Rheumatic fever			Nighttime Wetting			Panic disorder		
Swelling of feet			Daytime wetting			Bipolar disorder		
			Painful Urination			Depression		
Endocrine			Frequent Urination			Anorexia		
Diabetes			Respiratory			Bulimia		
If yes, at what age?			Asthma or emphysema			Binge Eating		
Gallstones/gallbladder disease			Lung Disease/ pneumonia			Reading disorder		
Thyroid disease/goiter			Chronic Obstructive pulmonary disease			Math disorder		
Gastrointestinal digestive			Tuberculosis			Writing disorder		
Acid reflux/heartburn			Shortness of breath			Schizophrenia		
Diverticulosis			Sleep apnea/on c-pap			Suicidal thoughts, plans, or behavior		
Ulcers(stomach/intestine)			**Musculoskeletal**			**Neurological**		
Pancreatitis			Arthritis			Epilepsy or seizure		
Liver disease/hepatitis			Joint Pain			Stroke		
Frequent diarrhea			Back Pain			Dizziness		
Frequent Constipation			Hip Pain			Headaches		
Blood in stools			Knee Pain			Migraines		
Irritable colon/bowel			Ankle & Foot Pain			Numbness or tingling		
			Broken Bones			Pins and needles Feelings		
Hematological			**Sleep Related**			Muscle weakness		
Anemia			Snoring			Weakness of grip		
Blood Clots			Observed apnea			Shakiness		
Bleeding disorders			Restless sleep			Convulsions		
			Trouble falling asleep			Loss of consciousness		
			Trouble Waking up			**Other medical issues list below**		
			Morning headache					
			Daytime drowsiness					

PAYMENT FOR TIME AND SERVICES

PLEASE NOTE: WHILE INSURANCE OR ANOTHER PERSON MAY BE PAYING FOR ALL OR PART OF OUR CHARGES, OUR AGREEMENT IS WITH YOU RATHER THAN THE INSURANCE COMPANY. **YOUR SIGNATURE BELOW INDICATES YOUR UNDERSTANDING AND WILLINGNESS TO ABIDE BY OUR OFFICE POLICIES REGARDING:**

- PAYMENT OF ALL REASONABLE CHARGES INVOLVED IN THE RENDERING OF SERVICES
- PAYMENT IS DUE AT THE TIME OF EACH VISIT UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE. PLEASE NOTE WE ACCEPT CASH OR CHECKS AT THIS TIME.
- OUR FULL-SERVICE FEE IS CHARGED FOR TIME RESERVED WHEN APPOINTMENTS ARE FAILED OR CANCELLED WITHOUT SUFFICIENT NOTICE (ONE DAY)

IF YOU BELIEVE YOUR MEDICAL INSURANCE MAY COVER THE COSTS OF ALL OR PART OF YOUR VISITS HERE, PLEASE GIVE US A COPY OF YOUR INSURANCE CARD AND COMPLETE THE FOLLOWING INFORMATION:

POLICY HOLDER	INSURANCE COMPANY OR PLAN	GROUP OR POLICY NUMBER
EMPLOYER OF POLICY HOLDER	RELATIONSHIP TO CLIENT	POLICY HOLDER'S DATE OF BIRTH
POLICY HOLDER'S SS#	POLICY HOLDER'S ADDRESS IF DIFFERENT	

WHILE WE WILL FILE YOUR INSURANCE CLAIM FOR YOU, WE SUGGEST YOU CALL YOUR INSURANCE COMPANY TO GET INFORMATION CONCERNING YOUR CO-PAY AND DEDUCTIBLE. WE SUGGEST YOU DO THIS BEFORE YOUR 1ST OR 2ND VISIT AND ASK THEM ABOUT YOUR COVERAGE FOR "OUTPATIENT MENTAL HEALTH SERVICES." THIS WILL HELP YOU TO DETERMINE THE APPROPRIATE PAYMENT FOR YOUR COUNSELING SESSIONS. IN LIEU OF THIS INFORMATION, WE SUGGEST A PAYMENT OF AT LEAST 50 PERCENT OF THE INITIAL FEE FOR THE SESSION. WE WILL REIMBURSE ANY EXCESS AMOUNT ONCE YOUR INSURANCE COMPANY PAYS US. ALL CO-PAYMENTS MUST BE PAID AT THE TIME OF EACH SESSION UNLESS YOU MAKE OTHER ARRANGEMENTS WITH YOUR THERAPIST. WE ACCEPT CASH AND CHECKS. IF YOUR PLAN REQUIRES A PHYSICIAN'S REFERRAL, PLEASE CONTACT YOUR FAMILY DOCTOR BEFORE TREATMENT BEGINS.

AUTHORIZATION FOR DISCLOSURE OF MENTAL HEALTH INFORMATION AND AGREEMENT TO PAY

I, _____ ON MY OWN BEHALF OR AS LEGAL REPRESENTATIVE OF _____
YOUR NAME (FOR ADULTS) FOR A CHILD LESS THAN 18 (OR SOME OTHERS)

AUTHORIZE BRENDA HENNING, M.S., LPC OF THE BEING PLACE (TBP) AND/OR ITS REPRESENTATIVES TO RELEASE MENTAL HEALTH INFORMATION TO MY INSURANCE COMPANY TO THE FULL EXTENT SPECIFIED UNDER ANY OR ALL FEDERAL LAWS AND TEXAS STATE CODE OR AS SUBSEQUENTLY AMENDED, TO PROVIDE UTILIZATION REVIEW OR QUALITY ASSURANCE SERVICE FOR THE ADMINISTRATION OF CLAIMS FOR BENEFITS. I FURTHER AUTHORIZE BRENDA HENNING/THE BEING PLACE TO DIRECTLY RECEIVE ALL PAYMENT OF BENEFITS DUE.

THIS AUTHORIZATION ALLOWS TBP AND/OR ITS REPRESENTATIVES TO RELEASE INFORMATION TO MY INSURANCE COMPANY, TO ADMINISTRATE CLAIMS SUBMITTED, OR TO BE SUBMITTED FOR PAYMENT, TO CONDUCT A UTILIZATION AND QUALITY CONTROL REVIEW OF MENTAL HEALTH CARE SERVICES PROVIDED OR PROPOSED TO BE PROVIDED, OR TO CONDUCT AN AUDIT OF CLAIMS PAID.

I ACKNOWLEDGE THAT I AM AWARE THAT I MAY INSPECT THE INFORMATION DISCLOSED AT ANY TIME, AND MAY REVOKE THIS AUTHORIZATION AT ANY TIME IF I FURNISH WRITTEN REVOCATION TO TBP AND/OR ITS REPRESENTATIVES AND THUS, I AGREE TO ACCEPT FINANCIAL LIABILITY, FOR MENTAL HEALTH CARE SERVICES PROVIDED IF INSURANCE SHOULD DENY CLAIMS FOR BENEFITS BECAUSE OF THE INABILITY TO EXAMINE MY MENTAL HEALTH RECORDS OR THE MENTAL HEALTH RECORDS OF THE PERSON NAMED IN THIS AUTHORIZATION.

I CERTIFY THAT ALL THE INFORMATION IS TRUE, ACCURATE, COMPLETE AND I AGREE TO BE PERSONALLY RESPONSIBLE FOR ALL REASONABLE CHARGES NOT PAID BY MY INSURANCE COMPANY.

DATE _____ PATIENT SIGNATURE (IF LEGAL ADULT OR LEGAL REPRESENTATIVE OF MINOR) _____