13026 Lebanon Road, Suite 300

Mount Juliet, TN 37122

615-281-5267

Adult Client Questionnaire

Please provide the following information and answer the questions below. Please note:

Information you provide here is protected as confidential information.

Today’s Date: Referred by:

Name: DOB:

Marital Status:

□Never Married □Domestic Partnership □Married

□Separated □Divorced □Widowed

Annual Household Income:

Please list any children/age:

Home Address:

Home Phone: May I leave a message at this number? □Yes □No

Cell/Other Phone: May I leave a message at this number? □Yes □No

E-mail address:

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

□No

□Yes, please give name(s) of provider(s), location(s) and treatment dates:

Are you currently taking any prescription medication?

□Yes

□No

If yes, please list:

Have you ever been prescribed psychiatric medication?

□Yes

□No

Please list and provide dates:

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

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

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific health problems you are currently experiencing:

2. 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:

3. How many times per week do you generally exercise?

What types of exercise do you participate in?

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

5. Are you currently experiencing overwhelming sadness, grief, or depression?

□Yes

□No

If yes, for approximately how long?

6. Are you currently experiencing anxiety, panic attacks, or have phobias?

□Yes

□No

If yes, when did you begin experiencing this?

7. Are you currently experiencing any chronic pain?

□Yes

□No

If yes, please describe:

8. Do you drink alcohol more than once a week? □Yes □No

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

□Daily □Weekly □Monthly □Infrequently □Never

10. Are you currently in a romantic relationship? □Yes □No

If yes, for how long?

On a scale of 1-10, how would you rate your relationship?

11. Please list any significant life changes or stressful events have you experienced recently:

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:

Please Circle Family Member

Addictions (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes/No

Alcohol/Substance Abuse Yes/No

Anxiety Yes/No

Depression Yes/No

Domestic Violence Yes/No

Eating Disorders Yes/No

Obesity Yes/No

Obsessive Compulsive Behavior Yes/No

Schizophrenia Yes/No

Suicide Attempts Yes/No

ADDITIONAL INFORMATION:

1. Are you currently employed? □Yes □No

If yes, what is your current employment situation?

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

2. Do you consider yourself to be spiritual or religious? □Yes □No

If yes, please describe your faith or belief:

3. What do you consider to be some of your strengths?

4. What do you consider to be some of your weaknesses?

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

6. Please provide any other information that you think would be helpful for me to know:

I have/will read the following practice policies section and agree to abide by the terms. □Yes □No

Signature: Date:

Practice Policies

In order to answer questions that are frequently asked by clients regarding fees, confidentiality, services, etc., I have developed these policy statements for your information. I value you as a client and want you to be informed.

Fee Policy

Fees for therapy services are $150 per session and are due at the close of each session. A therapy session is traditionally 50 minutes. I request that cancellations be made 24 hours in advance; otherwise you may be billed for the full session fee. Other services, such as inpatient visits, significant telephone therapy, etc. are based on the agreed upon per session fee. The rate for court appearances, depositions, mediation and other court-related services is double the normal per-session fee. I do not accept insurance; however your health insurance may provide reimbursement for professional psychological services. I encourage you to consult your policy for specifics.

Records Requests

• A charge of up to $30.00 may be collected for administrative costs. In addition;

• A fee, not to exceed $9.70, for certifying the medical records may also be charged. In addition;

• The cost of postage may also be charged. In addition;

• Fees for copying documents may be:

• $0.97 per page for the first 20 pages

• $0.83 per page for pages 21 through 100

• $0.66 for each page copied in excess of 100 pages

• For medical records that are not in paper form, the provider shall be entitled to recover the full reasonable cost of reproduction.

Writing a Treatment Summary

• Preparation time (including submission of records): $300/hour

Attendance in Court

1. Preparation time (including submission of records): $300/hour

2. Phone calls: $300/hour

3. Depositions: $300/hour

4. Time required in giving testimony: $300/hour

5. Mileage: $0.50/mile

6. Time away from office due to depositions or testimony: $300/hour

7. All attorney fees and costs incurred by the therapist as a result of the legal action.

8. Filing a document with the court: $150

9. The minimum charge for a court appearance: $1500

A retainer of $1500 is due in advance. If a subpoena or notice to meet attorney(s) is received without a minimum of 48-hour notice there will be an additional $300 “express” charge. Also, if the case is reset with less than 72 business hours’ notice, then the client will be charged $600 (in addition to the retainer of $1500). Finally, all fees are doubled if Dr. Stride had scheduled plans to go out of town.

Confidentiality

Professional ethics and Tennessee State law indicate that the client controls confidential information. This means that, as a general rule, information shared in session with a psychologist will be held in confidence. There are three exceptions to this general rule. In the case of an emergency where the counselor believes the client is at risk of hurting himself/herself or another person, the psychologist may breach the requirement of confidentiality. Secondly, Tennessee law requires that child or elder abuse in any form be reported to the Department of Human Services or another authority, such as a juvenile judge. Thirdly, if I am subpoenaed for court I may be required to disclose some confidential information.

Professional Services

I am available for counseling appointments at selected times throughout the week. If for some reason you are unable to contact me during an emergency, you may obtain assistance by calling the Crisis Help Line at (615) 244-7444 or by going to your local hospital emergency room.

Benefits and Risks of Therapy

Persons contemplating therapy services should realize they might make significant changes in their lives. People often modify their emotions, attitudes, and behaviors. They may change employment, begin to feel differently about themselves or others, and may change other aspects of their lives. They may also make changes in their marriages or other significant relationships, such as with parents, friends, children, relatives, etc. While I will assist the client in effecting change, I cannot guarantee specific outcome. Clients are ultimately responsible for their own growth.

Credentials

I have a Doctorate of Philosophy in Clinical Psychology from the California School of Professional Psychology. Additionally, I have my Masters in Clinical Psychology with an emphasis in Marriage and Family Therapy from Azusa Pacific University. I am also a Licensed Psychologist (2999) with Health Service Provider designation in the state of Tennessee.

Informed Consent

By signing this document, I authorize and request Steve Stride, PhD, to provide treatment deemed necessary or desirable for my welfare and therapeutic growth. Additionally, I consent to participate in treatment and understand the limits of confidentiality as well as the benefits and risks of therapy. I understand that I can terminate therapy with Steve at any time.

Do you have any questions about fees, confidentiality or other matters? □Yes □No

Do you agree with the conditions and provisions of the Practice Policies? □ Yes □No

Signature: Date:

If you desire a copy of these policies check here: □Yes □No

Non-secure Communication Policy

Email Confidentiality Agreement

It is my normal practice to email my clients at times to touch base or discuss appointment times. When

communicating via email, it is important to remember that confidentiality is limited. By signing below you

are saying that you have considered and understand the limitations of confidentiality and agree that you are

responsible for keeping your email account private to the extent that you desire for it to be private.

Text Messaging Confidentiality Agreement

At times, I text message my clients to inform them of upcoming appointment, to change appointment times,

or to reschedule appointments. By signing below you are saying that you have considered and understand

the limitations of confidentiality and agree that you are responsible for keeping your text messages private

to the extent that you desire for them to be private.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, allow my therapist (Steve Stride) to email me at this address:

PLEASE PRINT CLEARLY

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

and to text message me at this telephone number:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

concerning logistical matters (i.e. appointment times, dates)

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_