Lynn K. Goya, M.Ed., Psy.D.
Licensed Clinical Psychologist
Mililani Tech Park
100 Kahelu Ave.
Suite 109
Mililani, HI 96797
Ph: (808) 253-9986
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Childadulttherapy-mililani.com

ADULT REGISTRATION INFORMATION

Date: _____ Appointment Time: _____

Name: _____
Last First Middle Initial

Birthdate: _____ Age: _____ Gender: Male _____ Female _____

Address: _____

Cell Phone: _____ Home Phone: _____

Ok to leave voice messages on both phones? _____

Email address: _____

Want to be sent appt. reminders on email or text? _____

Where employed: _____

Single _____ Divorced _____ Widowed _____ Married _____

Spouse's Name _____

Children:

Names	Ages
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Insurance Coverage:

Insurance: _____ Subscriber: _____

Subscriber's date of birth: _____

Address if different from above: _____

Subscriber's #: _____ Group #: _____

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ADULT CLINICAL BACKGROUND QUESTIONNAIRE

Date: _____

Name: _____
Last First

Please describe the main problems you want to deal with and when they started.

_____

_____

_____

Please estimate the severity of your problem by putting an X on the scale below:

_____

Mildly Severe	Moderately Severe	Very Severe	Extremely Severe

Have you ever seen a counselor or therapist before? _____ If so, when? _____
Name of therapist(s): _____
What problems did you deal with? _____
Have you ever been to a psychiatric hospital? _____ Which hospital? _____
When? _____ Reason: _____
Have you ever made any suicide attempts or tried to hurt yourself? _____
Please explain: _____
Are you feeling suicidal now? _____

Symptom/problem checklist. Please circle all that apply.

Headaches	Bad home conditions	Fatigue
Palpitations	Dislike weekends/vacations	Sleep problems
Dizziness	Can't keep a job	Nightmares
Use painkillers	No enjoyment	Use sleeping pills
Stomach trouble	Sexual problems	Bowel disturbances
Shy with people	Difficulty concentrating	Can't make friends
Memory problems	Conflict with others	Anger
Relationship problems	Financial problems	Trauma
Parenting problems	Feel panicky	Domestic violence
Anxiety/worry	Feel inferior	Can't stop thinking
Can't go out alone	Drink alcohol	Suicidal ideas
Use drugs	Phobias	No appetite
Stressed out	Violent thoughts	No goals
Depressed	Cry easily	Grief

Additional problems, symptoms or difficulties: _____

_____

Legal history: Have you ever been arrested or sent to jail? _____
Please explain: _____

CHILDHOOD INFORMATION

Mother's condition during her pregnancy with you (as far as you know): _____
Were you adopted? _____

Please circle all that apply to you when you were a child or adolescent:

Premature	Health problems	Accidents
Sleepwalking	Night terrors	Fears
Hyperactivity	Stuttering	Thumbsucking
Bedwetting after age 5	Nail biting	Learning disability
Death of someone close	Physical abuse	Sexual abuse
Emotional abuse	Neglect	Alcohol or drug use
Addicted parent	Unhappy childhood	Happy childhood
Honor roll	Achieved in sports	Raised by grandparents/others

Any other childhood problems or important issues? _____
_____

FAMILY INFORMATION

Mother: Biological _____ Adoptive _____ Step _____
If living, her age: _____ Her health: _____
If deceased, age at time of her death: _____ Your age at time of her death: _____
Cause of death? _____
Retired? _____ Occupation before retirement: _____
Any problems? (e.g. drugs, alchohol, emotional problems) _____
_____
Describe your mother: _____
_____
Describe your relationship with her: _____

Father: Biological _____ Adoptive _____ Step _____
If living, his age: _____ His health: _____
If deceased, age at time of his death: _____ Your age at time of his death: _____
Cause of death? _____
Retired? _____ Occupation before retirement: _____
Any problems? (e.g. drugs, alchohol, emotional problems) _____
_____
Describe your father: _____
_____
Describe your relationship with him: _____

Siblings: Please list their names, ages, and if they are half-siblings, step-siblings, or adopted.

_____
_____
_____

EDUCATIONAL AND OCCUPATIONAL INFORMATION

Which high school did you attend? _____
Did you graduate? _____ If not, did you later complete a diploma? _____
College and higher education: School attended: _____
Degree(s) earned: _____ Year: _____
Did you enjoy school? _____ Do you have any plans to go back? _____
If so, what are you goals? _____

What work are you doing now? _____
How long have you been at this job? _____ Do you enjoy your work? _____
If not, in what ways are you dissatisfied? _____
What were your past ambitions? _____

What are your interests, hobbies, or leisure activities? _____
_____
What do you see as your strengths, special abilities, or qualities? _____
_____
What do you see are your weaknesses or areas to work on? _____
_____

MEDICAL HISTORY

Childhood/adolescent serious illnesses or accidents: _____
Recent serious illnesses or accidents: _____
Any surgical operations? (list procedures, and year or age at the time). _____
_____
Any allergies? _____

List any medications, including over the counter medications, you are taking now:

Name	Dosage
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Prescribed by: _____
Name of your personal physician: _____
Permission to contact, if necessary: Yes _____ No _____ (initial here) _____
Name of any specialists you are seeing: _____

ALCOHOL AND DRUGS

How often do you drink alcohol? Daily 2x week More than 2x week
1x week Occasionally
When you drink, how many drinks do you typically have? 1 2 3 Up to 6
Up to 12 More than 12
What type(s) of drugs do you currently use? Marijuana Amphetamines Cocaine
Heroine Ecstasy Other None
How frequently do you use these drugs? Daily 2x week More than 2x week
1x week Occasionally

SEXUAL AND REPRODUCTIVE HISTORY

Are you sexually active?____ With: Men Women Both
Is your sex life satisfying? _____ Any concerns? _____
Are you practicing safe sex? _____ Type of contraception: _____
Have you ever had a sexually transmitted disease? _____ Type? _____
Have you tested positive for HIV? _____

RELATIONSHIP INFORMATION

Are you currently in a relationship? _____
When and how did your meet your partner? _____
_____
How long have you been together/did you live together before you got married? _____
If married, or in a 'domestic partnership', how long? _____
Describe the personality of your partner: _____
_____
In what areas are you compatible? _____
_____
In what areas are you not compatible? _____
_____
Do you have major concerns about your relationship? Please explain. _____
_____
_____
Is there any violence, or emotional, mental or sexual abuse in your relationship? _____
Describe any previous significant relationships: _____
_____

CHILDREN

Please list the names and ages of your children:

Biological children: _____
_____
Step-children: _____
_____
Adopted children: _____
_____
Do they live with you? _____
If you are divorced, what are your custody/visitation arrangements? _____

Do any of your children have special problems? Please explain. _____

FAMILY RELATIONSHIPS

Describe any problems in relationships between you and your parents, or you and your siblings: _____

Describe any problems between your parents, between your parents and other family members, or between siblings, which do not specifically involve you: _____

TRAUMA HISTORY

Have you suffered a physically or emotionally traumatic event? Please explain.

OTHER INFORMATION

Is there anything else that you feel is important for me to know about you? Please explain. _____

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FREQUENTLY ASKED QUESTIONS

Does my health insurance cover treatment?

It is your responsibility to insure that your health insurance plan will cover your treatment. Many plans cover at least part of the cost of mental health services. However, please note that some carriers require pre-authorization for psychological treatment, some have an annual deductible, and some plans have limitations such as a "maximum number of visits per year" clause. This differs with each insurance plan. Please check with your insurance representative regarding the need for pre-authorization and the number of visits you are allowed.

Please be aware that in the unusual instance that your insurance company chooses not to cover part or all of the psychological services rendered, you are financially responsible for payment in full.

Worker's Compensation and No-fault insurance cover the complete cost for preapproved psychological treatment related to conditions caused by an accident or work-related injury.

Professional Fees

My hourly fee is $250 plus tax for the initial evaluation meeting and $200 plus tax for subsequent sessions of the same episode. I also charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 5 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $350 plus tax per hour for preparation and attendance at any legal proceeding.

What is the payment procedure?

If you are covered by health insurance, our office will file claim forms with your insurance company. Co-payments and/or allowable portions of treatment fees not

covered by your insurance company will be your responsibility to pay. Co-payments for each session are due at the time of service. A handling charge of $25.00 will be assessed to your account for any returned checks.

What if I miss a session?

Please call us if you cannot make an appointment so we can give your slot to another patient. If you call at least 48 hours in advance of your scheduled appointment, there will be no charge for the missed session. If you cancel an appointment less than 48 hours in advance, you will be charged a fee ranging from $25 to $75 depending on the frequency of your late cancellations. You will be charged $100 for not showing up for an appointment and not calling us to let us know you won't be coming. After the second no-show (not calling and not coming to your appointment), you will be referred to another therapist.

Will any records be kept?

Brief notes are kept to assist in the organization and direction of your treatment. You are entitled to receive a copy of your records, or I can prepare a summary for you. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you view them in my presence so that we can discuss the contents. Patients will be charged an appropriate fee for any professional time spent in responding to information requests.

What are my responsibilities in treatment?

Other than discussing with me the various things that are currently happening in your life, the major responsibility you have is to keep me informed of changes that occur with your emotions or behaviors during treatment. While in most instances, treatment will result in a decrease in uncomfortable emotions and undesired behaviors, it is possible that strong feelings of anger, sadness and/or depression may surface for a period of time during the course of treatment. If this occurs for you, it is extremely important that I know about it as soon as possible.

In general, if a situation arises that you believe to be a psychological emergency, you should call me at my office during working hours at 253-9986. If I am not immediately available, call the Suicide and Crisis Hotline at 832-3100, 911, or go to the nearest hospital emergency room.

If a specific situation comes up in which you feel like you want to harm yourself (suicide) or hurt someone else, you must promise to talk to me about the thoughts or plans before acting upon them. Again, if you feel that you cannot wait until the next regular appointment to discuss such thoughts, you must call me, or if I am not available, call 911, the Suicide and Crisis Hotline at 832-3100, or go to the nearest emergency room.

I have read the above and will abide by the stipulations contained herein.

_____ _____

Signature Date

Lynn K. Goya, M.Ed., Psy.D.
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CONFIDENTIALITY

I understand that the information gathered in the course of Dr. Goya's work with me will remain confidential. However, there are some exceptions to this confidentiality as mandated by law:

1. If information is shared which leads the therapist to believe that I/my minor child would cause injury to another person, Dr. Goya is obligated to contact either that person and/or the police in order to warn of a potential threat.

2. In cases where child abuse is communicated to the therapist. Dr. Goya is mandated to contact Child Protective Services.

3. If it is felt that I am/my minor child is actively suicidal, Dr. Goya would attempt to take all reasonable precautions to protect me/my minor child from harm, and this may include divulging information to others.

In all cases where there is a need to reveal information to others, the situation will be discussed with me in order to help me understand the need to report and in the hope of securing my consent.

In addition to the legally required limits on confidentiality, insurance companies and managed care company employees may request the following information to assist in processing claims for therapy services received: medical records and information necessary for the filing of claims and the authorization process which may include information relating to drug and alcohol use. I understand that I am/my minor child is protected by Federal law from secondary release of information by the insurance carrier.

I understand the statement of confidentiality and limits on confidentiality given above.

_____	_____
Signed	Date
_____	_____
Witnessed	Date