Basic Background Information:

Marital Status: o Married, how long _____ o Divorced o Single o Widowed o Separated

Children: (First Name and Age): _____

Brothers and Sisters: (First Name and Age): _____

Religious Affiliation: _____ **Military history:** _____

Have you experienced any significant losses? _____

Do you have a history of being abused emotionally, sexually, physically or by neglect? _____

_____

_____

Counseling History

The reason you are seeking counseling today: _____

_____

_____

Who referred you to counseling? _____ **Is counseling court mandated? O yes O no**

Outpatient treatment? O yes O no. If yes, Please describe when, by whom, and reason.

Reason	Dates treated	By whom

Inpatient treatment? o yes o no.

Reason	Dates Hospitalized	Where

Present and Past Psychiatric Medications: Name, dates taken, response/side effects (list of common attached)

_____

_____

_____

Has anyone in your family had psychiatric treatment? _____

_____

Have you ever had feelings or thoughts that you didn't want to live? oyes o no
Are you currently feeling this way? o yes o no If yes, how often? _____ **Do you have a plan/explain?**

_____

_____ **Do you have the means?** _____

Have you ever made a suicide attempt? O yes o no If yes, when, and how: _____

_____

Have any relatives made a suicide attempt? O yes o no If yes, please describe: _____

_____

Have you ever been incarcerated? O yes o no If yes, please describe: _____

_____

Psychiatric/ Substance Use Information

Substance Category	Common Names (circle all that apply)	Never Used	Did use But Quit	Less then 1 X Per month	1-4 Times Per month	1-4 Times Per Week	1 or More Times Per day	Age First Used
Caffeine	Coffee/Tea No Doz Soda/Pop Chocolate Energy Drinks							
Tobacco	Cigarettes Snuff Cigars Chewing Tobacco							
Alcohol	Beer Wine Hard Liquor							
Marijuana	Marijuana Pot Hashish Grass Reefer Hash oil							
Cocaine	Coke Snow Crack Rock Blow Nose Candy							
Other Stimulants	Amphetamines speed Crank Dexedrine Diet Pills							
Inhalants	Glue Gasoline Aerosols Dusters Poppers Rush Nitrous Whippets							
Opiates	Codeine Vicodin(hydrocodone) MS Contin Kadian (morphine) Oxycontin Percoset(oxycodone) oxycodone							
Hallucinogens	LSD Peyote Mescaline PCP Acid Mushrooms Ecstasy							
Depressants	Benzodiazepines Klonopin Xanax Ativan Valium Pentobarbital							
Over the counter Drugs	Cold pills Diet Pills Cough Syrup Compose Sleep Aids Mini Thins Yellow Jackets							

Have you ever been treated for alcohol or drug use or abuse? __ yes __ no

If yes, for which substances, when, and where were you treated? _____

_____

Medical History

Primary Care doctor name, address, phone number: _____

_____

Name of any other medical doctor you receive treatment from, seen for, name, address, phone number:

_____

_____

_____

_____

Medical problems or diagnoses that you have been given? _____

_____

_____

Medical/Surgical Hospitalizations:

Date _____ **Reason** _____

Date _____ **Reason** _____

Date _____ **Reason** _____

Date _____ **Reason** _____

Date _____ **Reason** _____

Please list all current medications name, dose, reason taking:

_____

_____

_____

_____

_____

Allergies: _____

_____

Is there any information you would like to add? _____

_____

_____

_____

_____

_____

_____

Emergency Contact

Name: _____

Relationship: _____

Phone Number: _____ _____ _____

THE COUNSELING HOUSE, LLC
911 EMERSON AVENUE
PARKERSBURG WV 26104
304-865-5444 PHONE
304-865-5445 FAX

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, HAVE RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.

_____
PLEASE PRINT NAME

_____
SIGNATURE

_____
DATE OF SIGNATURE

_____

FOR OFFICE USE ONLY

WE ATTEMPTED TO OBTAIN WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICE, BUT ACKNOWLEDGEMENT COULD NOT BE OBTAINED DUE TO"

___ INDIVIDUAL REFUSED TO SIGN

___ COMUNICATIONS BARRIERS PROHIBITED OBTAINING THE ACKNOWLEDGEMENT

___ AN EMERGENCY SITUATION PROHIBITED US FROM OBTAINING ACKNOWLEDGEMENT

___ OTHER _____

_____ _____
SIGNATURE OF PROFESSIONAL DATE OF SIGNATURE

SESSIONS

Therapy sessions are 50 minutes in length and usually scheduled once a week.

You can always call the office in an emergency at (304)-865-5444. If the therapist cannot talk with you they will call you back as soon as possible
**Phone calls exceeding 15 minutes will be billed as follows:
-15 to 30 minutes $40.00 (not billable to insurance.)
-30 to 60 minutes $80.00 (not billable to insurance.)
We do have an answering service available if you need to cancel any appointments after business hours. Any appointments NOT CANCELLED WITH 24 HOUR NOTICE will be charged a fee of $50.00 not billable to insurance. An exception to This policy is when driving conditions are hazardous. _____initial

PAYMENT POLICY

All payment for services is due at the time of your scheduled Appointment.

As a courtesy, we will bill any insurance that you may carry, but co pays, coinsurance and deductibles are due at the time of service.

In any custody situation, the parent that brings the child for treatment, is responsible for any payment. _____initial

-If required to testify in court, the therapist's rate is 250.00 hour.
-If a written letter/report to either the court or attorney is requested
A fee of $50.00 will be charged to the requesting parent.
-There is a $30.00 minimum fee associated for any letters, records or Reports requested.

CONFIDENTIALITY

Confidentiality is one of the most important elements of therapy and one of your most important rights. Within certain legally defined Limitations, any information revealed by you or learned about you from another source during the course of our work together, will be kept strictly confidential, and will not be revealed to another person or agency, without your written permission. However there are a few exceptions to this policy: If in your therapists, professional judgment, you threaten to harm yourself or anther person. Or, if your therapist believes that a child or elder is being abused or neglected.

As you may know, your health insurance company may help cover the cost of your therapy sessions, but in order for claims to be processed insurance companies require that we provide them with certain information, including a clinical diagnosis. All insurance companies claim to keep all information confidential, but once they receive this information, we have no control over what they do with it and who may see it. If you are concerned with this, you may want to contact your insurance company before authorizing us to bill them.

If you choose for us not to bill your insurance, and to pay for services privately, you may do so.

If you are under 16 years of age, you should be aware, that your parents in most cases, can view your records without your permission. However, we can refuse to allow that to happen without without a court order.

** If co pays are not paid at the time of service a 10% billing fee may be charged to your account

_____initial

_____ Signature of client

_____ Signature of parent/guardian

_____ Date

Please check the following words that apply to you:

__ Social/outgoing	__ Assertive	__ Impulsive	__ not liked by others	__ Intelligent
__ Not easily depressed	__ Out of control	__ Impatient/edgy	__ Can't concentrate	__ self controlled
__ Resourceful	__ Unimaginative	__ Disrespectful	__ Creative	__ mostly able to relax
__ Can forgive	__ Patient	__ Isolated/Loner	__ Full of hate	__ Financially stressed
__ Respects others	__ Bottled up	__ Worthless	__ Perfectionist	__ Can ask for help
__ Unstable	__ Unattractive	__ Stable	__ Secure	__ Can express feelings
__ Insecure	__ Secure	__ Faithful	__ Physically attractive	__ Have enough money
__ Motivated	__ Happy	__ Confident	__ Shy/Backwards	__ Can accept love from others
__ Stupid/Dumb	__ Unfaithful	__ Lazy	__ Unmotivated	__ Worthwhile/"good enough:
__ Depressed	__ easily discouraged	__ Passive/Pushover	__ Tense most of the time	

Other /descriptors: _____

Please check any of the following events you have experienced in the last year:

__ Death of a spouse or child	__ In-law troubles	__ Death of a close friend	__ Death of a close family member
__ Divorce	__ Marital Separation	__ Major injury or illness	__ Detention in jail or other institution
__ Marriage	__ Fired from work	__ marital reconciliation	__ Retirement
__ Major change in health	__ Pregnancy	__ Sexual difficulties	__ Major change in behavior of family member
__ gaining a new family member	__ Change in financial state	__ Change in job	__ Change in amount of arguments with spouse
__ Taking on a significant mortgage	__ Foreclosure on mortgage	__ Default on loan	__ Change in responsibility at work
__ Child leaving home	__ Began formal schooling	__ Trouble with boss	__ Graduated formal schooling
__ Major change in spiritual activities	__ Minor violations of the law	__ Vacation	__ Major change social activities
__ Change in eating habits	__ Stressful Holiday	__ New school	__ Change in residence

Other experiences: _____

Please check any of the following issues you are currently having:

__ Custody issues
__ Substance abuse
__ Interpersonal problems
__ Anger problems
__ Depression
__ Behavior of adult children
__ Substance dependence
__Unfaithful partner
__ Parenting problems
__ financial difficulty
__ Health problems in family
__ Excessive computer use
__ Distance from loved one
__ School problems
__ Grief
__ Personal Health problems
__ Problems with pornography
__Gambling
__ Victim of physical/ sexual abuse
__ family relationships

Please check any of the symptoms that apply to you:

Physical
__ Headaches
__ Bowel/stomach
__ No appetite
__ Dizziness
__ Tremors
__ Muscle weakness
__ Fainting spells
__ Hair, skin problems
__ Jaw problems
__ Reproductive problem
__ Sexual problems
__ Excessive sweating
__ Heart problems
__ Heart racing/pounding
__ Nausea
__ Fatigue
__ Other Symptoms
_____
_____
_____

Emotional
__ Sadness
__ Worry
__ Overexcited
__ Agitated
__ Panicky
__ Nervous
__ Empty
__ Grieving
__ Despair
__ Hopelessness
__ Fits of rage
__ Jealousy
__ Moodiness
__ Desire to cry
__ Resentment
__ Frustration
__ Inadequacy
__ Other Symptoms
_____
_____

Thoughts
__ Memory problems
__ Paranoia
__ Confusion
__ Repetitive thoughts
__ Racing thoughts
__ Attention problems
__ Thoughts of escape
__ Decision problems
__ Poor judgment
__ Hallucinations
__ Disorganized thinking
__ Other Symptoms
_____
_____
_____
_____
_____
_____
_____
_____

Behaviors
__ Using drugs or alcohol more
__ Avoiding loved ones
__ Missing work or school
__ Laugh or cry inappropriately
__ Nervous Habits
__ Losing temper
__ Becoming violent
__ Risky behaviors
__ Grind teeth
__ Less or more sexual contact
__ Less or more sleeping
__ Other Symptoms
_____
_____
_____
_____
_____
_____
_____
_____

Please explain what you have done to cope with the symptoms and issues you have checked above:

_____

_____

_____

_____

_____

Osric Malone-Prioleau, APRN

Patient Medication Reconciliation

Name: _____ **DOB:** _____ **Date:** _____

Your preferred Pharmacy: _____

Mail-in Pharmacy: _____

Psychiatric Medications you are currently on: _____

_____

Systemic (all other) Medications and Doctor that prescribes them, vitamins and supplements:

_____

Birth control, if applicable: _____

Primary Care Physician and contact information:

_____

Specialty Physician and contact information:

_____

_____

_____

Get Answers to Questions on Sleep

There are things your doctor needs to know to assess the extent and impact of your insomnia. Answer the questions below and share your answers with your doctor. The better your conversation with your doctor, the sooner your doctor can help you find a way to improve your sleep.

Do you have trouble falling asleep? ☐ YES ☐ NO

Do you have trouble staying asleep? ☐ YES ☐ NO

Do you consistently wake up much earlier than you want to? ☐ YES ☐ NO

How would you rate the amount of sleep you are getting?

☆ ☆ ☆ ☆ ☆

Poor Fair Good

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