**Professional Purpose**

As an LCSW, I have worked in nonprofit, hospital, crisis and community mental health settings with populations including clients with a serious mental illness, survivors of or those currently experiencing domestic/sexual violence and those with developmental disabilities. My current areas of interest include working with clients with disabilities and/or their families to overcome any current obstacles or hardships. My hope is to work with each client in determining their objective for treatment and to help them take steps in making that goal a reality.

**Education and Training**

 After completing my undergraduate studies at the University of Mary Washington, I continued my education at Virginia Commonwealth University, where I earned a Master’s in Clinical Social Work. Following graduation, I began my two years of supervised practice towards licensure. I am currently licensed by the Virginia Board of Social Work.

        With regards to my training and theoretical orientation, I base my approach in Carl Roger’s Person-Centered Therapy.  By setting certain conditions such as empathy and unconditional positive regard, the therapeutic relationship can develop in such a way that may allow for a person to experience positive change. In addition, I utilize several evidence-based practices, including Cognitive Behavioral Therapy (CBT), Internal Family Systems Therapy and Rational Emotive Behavior Therapy (REBT).

**Payment**

During your initial session, we will discuss your preferred method of payment as well as the timing of payment. For individuals, the charge for the initial session is $120.00, with each subsequent session being $100.00. The charge for couples and family therapy is $150.00. Please note that all sessions are sixty (60) minutes unless otherwise agreed upon. Accepted methods of payment are cash, check, debit and credit cards (see “Credit & Debit Card Payments” section on page 4 for more details). Please make checks payable to “Infinite Abilities Counseling, LLC”. A receipt will be offered to you upon completion of each transaction.

Initials \_\_\_\_\_\_\_\_\_\_

**Cancellation Policy and Other Contact**

 A $50.00 fee will be charged for missed appointments. If you know that you are unable to make the appointment, please call and cancel by no later than the one hour prior to your session.

You are welcome to contact me other than times when we are in session. If there is something you would like to discuss before your next session, please contact me at (804)404-2291. If I am unable to take your call, please leave a voicemail and I will get back to you as soon as possible. If I will be out of the office or unavailable for an extended period of time, I will make every effort to let you know.

Initials \_\_\_\_\_\_\_\_\_\_

**Risk**

 If you feel that you are a risk to yourself or to others, please know that you can always call 911 right away or go to your nearest hospital emergency room. You may also call your local crisis hotline 24 hours a day, 7 days a week.

* + Richmond City Residents: (804)819-4100.
	+ Chesterfield County Residents: (804)748-6356
	+ Henrico County Residents: (804)727-8484
	+ Goochland County Residents: (804)556-3716
	+ Powhatan County Residents: (804)598-2697

 Initials \_\_\_\_\_\_\_\_\_

**Other Services**

Please note that for services other than those described in the “Payment” section above, there will be an additional charge at a flat rate of $100.00 per hour (e.g. court appearances, school meetings, consultations with attorney). This charge will be discussed prior to billing. In addition, if a case requires in-depth case management services, a fee of $50.00 per hour will apply. Again, this will be discussed in detail prior to billing.

 Initials \_\_\_\_\_\_\_\_\_\_

**Technology**

Appointment Reminders: Each week that you have an appointment scheduled, you may receive an email or text reminding you of the date and time of the appointment. In order to help maintain your confidentiality, know that the email service being utilized is encrypted. Please select your preferred method of appointment reminder below. By signing your initials below, you are acknowledging that you are aware of and agree to the transmission of weekly reminders via email or text or you are opting out of reminders.

 Initials \_\_\_\_\_\_\_\_\_\_ ◯Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ◯Text: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ◯Opt Out:

***Tele-Health/Video Conferencing/Video Chat: Phone consultations and video conferencing/video chat are available options for services.***

Phone (Landlines and Cell Phones): Forms of contact such as phone consultations and phone voicemails may be part of our work together. By signing your initials below you acknowledge that you are aware of this and that you consent to voicemails being left on the number which you provide. If you would prefer not to receive voicemails, you may discuss other options at any point during services. Please note that any messages left on your voicemail will intentionally be vague.

 Initials \_\_\_\_\_\_\_\_\_\_

Video Conferencing/Video Chat: Should you choose to use this platform, please know that it will be through the HIPAA compliant site [**doxy.me**](http://doxy.me). You do not need to register in order to use this. You will receive a link via email, which will allow you to join the session via video. In addition, should we engage in services through video conferencing/video chat, you will be asked to provide the physical address of your location as well as contact information of a friend or family member in the area (in case of an emergency). By signing your initials below, you are acknowledging that you are aware of and agree to the transmission of video services through services offered by [**doxy.me**](http://doxy.me).

 Initials \_\_\_\_\_\_\_\_\_\_

**Technology (continued)**

Credit & Debit Card Payments: For credit and/or debit cards used for payments, Ivy Pay is the technology used to process payments. Upon completion of each payment, you will be provided the choice to receive your receipt via email. If you elect this option, please know that your information will be kept confidential in compliance with HIPAA standards. If you are not comfortable with this option, you may elect to not enter you email address and we can decide upon another option that is preferable to you. By signing your initials below, you are acknowledging that you are aware of and agree to the transmission of receipt via Ivy Pay’s email services.

 Initials \_\_\_\_\_\_\_\_\_\_

Social Media: No friend or contact requests will be made or accepted from current or former clients on any social networking site (Facebook, Instagram, Twitter, LinkedIn, etc).

 Initials \_\_\_\_\_\_\_\_\_\_

**Confidentiality**

Confidentiality is perhaps the most important part of the counseling process as it is the foundation for building trust. For the purposes of this agreement, confidentiality can be defined as a form of privileged communication passed from one individual to another, intended to be heard only by the individual addressed.  Your rights are defined under Federal laws (substance abuse is 42 CFR and HIPAA Privacy Standards45 CFR Parts 160 and 164) as well as under the Commonwealth of Virginia’s Administrative Code, Title 12, sections 35-155-80 and 35-115-90 (Human Rights).  Please understand that your participation in services cannot be reported to anyone outside of session unless there is written permission to speak with that person.

 Notwithstanding; please understand that there are three major exceptions to maintaining your confidentiality. As a mandated reporter, I am required by law to report the following information:

* There is reason to believe that you may harm yourself or someone else. This information will be shared with a local crisis unit such as the police or a medical emergency team or with a parent (in the case of a minor).
* Evidence of neglect to a vulnerable population is reported. This includes children, disabled persons, or elderly individuals. This information will be reported to the local Department of Social Services.
* If a judge has court ordered your treatment records, they must be provided.

 In addition to the information listed above, it is important to note that if Aryn LR Gentry sees you in a public or private setting, she will not initiate contact with you. Please understand this is out of respect for your privacy and to uphold confidentiality.

By printing, signing, and dating below, you acknowledge that you fully understand the above information on confidentiality, have asked any questions, and have received answers satisfactory to your understanding.

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

Print Name Date Signed

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

Sign Name Relationship

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

Print Name Date Signed

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

Sign Name Relationship

**Emergency Contact Information**

 In the event of a medical or psychiatric emergency, I give Aryn LR Gentry or any nearby or associated party, permission to take action perceived to be in my best interest. This may include, but is not limited to, administering CPR, calling 911 for an ambulance, medical assistance, if Aryn LR Gentry deems I am a threat to myself or other person (specified or in general), or the delivery of previously identified emergency medications (e.g. Epipen, nitroglycerin).

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

Print Name Date Signed

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

Sign Name Relationship

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

Print Name Date Signed

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

Sign Name Relationship

Please list the primary person you would like contacted in a medical or psychiatric emergency.

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

Name

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

Relationship

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

Phone Number

Please list any current medications.

|  |  |  |
| --- | --- | --- |
| **Medication Name** | **Dose** | **Frequency** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Please list any allergies.

|  |  |  |
| --- | --- | --- |
| **Allergy** | **Reaction** | **Mild/Moderate/Severe** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Please feel free to use the back of this sheet if more room is needed.

Client Admission Summary

**(1) Identifying Information:**

Client Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (H):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(W):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(C):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is it okay to leave a message? (H):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(W):\_\_\_\_\_\_\_\_\_\_\_\_\_\_(C):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age:\_\_\_\_\_ Marital Status:\_\_\_\_\_\_\_\_\_\_\_\_Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you find out about services here?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**(2) Socio-Medical-Family Background:**

Names, ages and relationship of family members or people living in the house with you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(3) Suspected or Known Special Circumstances:**

Not Applicable \_\_\_\_\_ Domestic Violence\_\_\_\_ Child Abuse Survivor\_\_\_\_ Child Abuse Offender \_\_\_\_\_ Parental Incarceration \_\_\_\_\_ Loss of Parent(s) or Parental Figure: \_\_\_\_\_

Other \_\_\_\_\_

If you are comfortable doing so, please provide any additional information on checked items listed above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(4) Prior Therapy:** Any prior outpatient or inpatient therapy? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Any prior diagnostic or psychological evaluations?: Yes\_\_\_\_ No\_\_\_\_\_ If yes, please list evaluators and dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any history of suicidal thoughts, plans or actions?: Yes\_\_\_\_ No\_\_\_\_ If yes, please elaborate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Any history of homicidal thought, plans or actions?: Yes\_\_\_\_\_ No\_\_\_\_ If yes, please elaborate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

If there is a history of suicidal thoughts, plans or actions, are you willing to sign an Agreement for Safety? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(5) Legal:**

Past or current court involvement? Yes\_\_\_\_\_ No\_\_\_\_\_

If yes, please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**(6) Educational:**

Highest grade completed, or current grade: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current or Last School Attended:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Special Education Services? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Behavioral and Academic Concerns at School: Aggressive \_\_\_\_\_ Destructive \_\_\_\_\_

Talks Out\_\_\_\_\_ Poor Attention Span \_\_\_\_\_ Distractible \_\_\_\_\_ Trouble Focusing \_\_\_\_\_ Poor Academic Performance \_\_\_\_\_ Poor Social Skills \_\_\_\_\_ Disciplinary Problems \_\_\_\_\_ Difficulty Making Friends \_\_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(7) Medical:**

Primary Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Last Medical Evaluation\_\_\_\_\_\_\_\_\_

Do you want therapist to consult with physician? \_\_\_\_\_

For children, any complications with pregnancy, mother’s health, labor or delivery?

Yes\_\_\_ No\_\_\_\_

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Any known or suspected history of traumatic brain or head injury: Yes\_\_\_\_\_ No\_\_\_\_\_ If yes, please list date(s) and circumstances:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Medical History/Review of Systems

**Cardiac/respiratory** **Gastrointestinal**

\_\_\_ High Blood Pressure \_\_\_ Nausea/Vomiting

\_\_\_ Heart Attack \_\_\_ Blood in Stool

\_\_\_ Arrhythmia (Unusual Heart Beat) \_\_\_ Severe Abdominal Pain

\_\_\_ Asthma \_\_\_ Irritable Bowel

\_\_\_ COPD (Emphysema/Bronchitis) \_\_\_ Liver Problems/Jaundice

**Childhood/developmental Neurological**

\_\_\_ Intrauterine Toxic Exposure \_\_\_ Seizure Disorder

\_\_\_ Problematic Pregnancy/Delivery \_\_\_ Migraine

\_\_\_ Nutritional/Feeding Problems \_\_\_ Movement Disorders

\_\_\_ Sensory Organ Impairments \_\_\_ Dementia

\_\_\_ Delayed Development Milestones \_\_\_ Stroke

\_\_\_ Intellectual Disabilities

\_\_\_ Environmental Hazards (Lead, etc)

\_\_\_ Learning Disabilities

**Urogenital/Gynecological Muscular/skeletal**

\_\_\_ Prostate Disease \_\_\_ Lupus

\_\_\_ Complicated Pregnancy \_\_\_ Fibromyalgia

\_\_\_ Menstrual Irregularity \_\_\_ Joint Problems

\_\_\_ Endometriosis

\_\_\_ Currently Pregnant **Endocrine/Metabolic**

 \_\_\_ Diabetes

**Infectious Disease** \_\_\_ Thyroid Disease

\_\_\_ HIV \_\_\_ Genetic Defect

\_\_\_ Hepatitis

\_\_\_ Other **Major Surgeries?** Yes \_\_ No \_\_

**(8) Medication and Substance Use History:**

|  |  |  |
| --- | --- | --- |
| **Substance** | **Current Use** | **Heaviest Period of Use** |
| Caffeine |  |  |
| Herbal/Natural |  |  |
| Cold Medecine |  |  |
| Nicotine |  |  |
| Alcohol |  |  |
| Marijuana |  |  |
| Pain Killers |  |  |
| Prescription Meds |  |  |
| Cocaine |  |  |
| Sedatives |  |  |
| Amphetamines |  |  |
| Hallucinogens |  |  |
| Heroin/Morphine |  |  |
| Benzodiazepines |  |  |
| Other |  |  |

**(9) Questions for You:**

What are your goals or expectations of therapy? Please, be as specific as possible.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any concerns about therapy or the therapeutic process? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thank you for taking the time to complete this assessment. Your information will help me in our work together.