SPENCER H. GELERNTER, PH.D.& ASSOCIATES

CHILD . ADULT . FAMILY . COUPLES

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CLIENT INFORMATION QUESTIONAIRE

Your assistance in supplying the following information is appreciated and will be used in strict confidence

Full Name_____ Date ____/____/_____

Address_____City_____ Zip_____

Telephone (H)_____ (W)_____(Pager/Cellular)_____

Age _____Birthdate_____/_____/_____Social Security #_____-____-_____Religion_____

Highest level of education completed: _____ Email: _____

Occupation_____ Employed by_____

Spouse's name _____Social Security #_____/___/_____

Age_____ Religion _____Highest level of education_____

Occupation _____Employed by_____

E-mail Address_____ E-mail Address_____
(Mother) (Father)

Nearest relative not living with you _____Phone #_____

Referred by _____

List the members of your family and all others in your home:

Name	Age	Birthdate	Occupation or Highest Grade	Lives In/Out of Home

Name of person completing form if not the Patient:_____(relationship):_____

Briefly describe your reasons for seeking help:_____

_____

_____

_____

_____

Check any issues you are having difficulty with:

ADHD	**Depression**	**Anxiety**	**Relationship**
☐ hyperactive	☐ sad	☐ excessive worry	☐ marital/significant other
☐ impulsive	☐ sleep problems	☐ panic attacks	☐ sexual problems
☐ under achievement	☐ negative thinking	☐ irrational fear	☐ parenting
☐ non-compliant	☐ poor concentration	☐ obsessions	☐ difficulty with friends
☐ inattentive	☐ hopeless/worthless	☐ social isolation	☐ work/school problems
☐ poor concentration	☐ mood swings	☐ phobias	☐ personal growth
☐ disorganized	☐ guilt	☐ compulsive	☐ grief/loss
☐ self-control	☐ fatigue/lethargy	☐ shyness	☐ bullying/teasing

Anger	**Addictions**	**Abuse**	**Other**
☐ short-fused	☐ alcohol	☐ physical	☐ agitated
☐ temper tantrums	☐ drugs	☐ emotional	☐ mania
☐ impulse control	☐ gambling	☐ domestic violence	☐ paranoia
☐ violent/assaultive	☐ relationships/sex	☐ rape	☐ delusions
☐ runaway risk	☐ eating disorders	☐ sexual	☐ tics/Tourettes
☐ fighting	☐ cyber/internet	☐ dissociative	☐ cutting behavior
☐ irritable	☐ spending		☐ appetite changes
☐ oppositional	☐ tobacco		☐ nightmares/flashbacks
			☐ eating disorders

On a 1-10 scale (poor-great) please answer the following questions:

How would you rate your marriage? _____
How would you rate your job? _____
How would you rate school? _____
How would you rate your support network? _____

Are you now, or have you even, had thoughts of hurting yourself or someone else? yes no
Please explain:_____

Have you ever been treated for psychiatric, substance abuse, emotional, or behavioral problems in the past? yes no

If yes, when, where, and with whom? _____
Inpatient _____ Outpatient _____

Are you currently under the care of a psychiatrist or therapist for your current problem? yes no
If yes, whom? _____

Are you or any one in your family currently taking any medications for psychiatric problems? yes no
If yes, please list:_____
_____

Psychological Testing: Please name the person or agency performing test, location and dates:
_____
_____

EMPLOYMENT/EDUCATION

Circle current employment status:
Full-time Part-time Unemployed Homemaker Student Disabled Retired

Are you currently on leave from work or seeking medical leave/disability? yes no
If yes, do you have paperwork that needs to be completed? yes no
(If yes, please give clinician paperwork at beginning of session!)

Circle educational background:
Current student Some high school GED Some college Graduated college Advanced degree

Did you experience difficulties in school? yes no

FAMILY/RELATIONSHIPS

Does anyone in your **immediate** family have psychiatric, emotional, substance abuse, or behavior problems? yes no
If yes, describe:_____
_____
_____

Do you have difficulties or concerns about how you get along with other people? yes no
Are you having difficulties with spiritual or religious matters? yes no
Do you have any sexual orientation/gender issues or concerns? yes no
Do you have any domestic violence history or current issues? yes no
Do you have any history of sexual or physical abuse? yes no
Has any relative attempted or committed suicide? yes no
What are your hobbies/interests? _____

MEDICAL PROBLEMS

Personal Physician: _____Phone_____
Date of last physical exam ___/____/_____ Results of examination _____
Current medications: _____
Do you have any current medical problems? yes no
If yes, please list:_____
_____

Would you like information from today's visit communicated with your medical doctor? yes no
Do you have any pain management issues? yes no
Do you have any allergies and/or medication allergies? yes no
If yes, please list:_____

Do you have a history of head injury, seizures or loss of consciousness? yes no
Please explain:_____
_____

(Woman only) Are you pregnant? yes no
Are you taking birth control? yes no

SUBSTANCE ABUSE

Have you been treated for drug, alcohol abuse, or other addictions (food, gambling, sex)? yes no
Do you currently attend support groups? yes no
Have you ever had a DUI? yes no

Circle the following you have used in the past 30 days: yes no
Tobacco Alcohol Marijuana Tranquilizers Sleeping pills Pain killers Heroin
Cocaine/crack Amphetamines/speed Methadone LSD PCP Ecstasy Inhalants

Have you experienced withdrawal symptoms? yes no
If yes, circle all that apply:
withdrawal Headaches Nausea Vomiting Tremors Seeing things Hearing things, Intoxicated

LEGAL ISSUES

Do you have current legal problems? yes no
If yes, describe:_____

Are you currently on probation/parole? yes no
Do you have a DFACS worker? yes no
Do you have any domestic violence history or current issues? yes no

TREATMENT ACCESS/MOBILITY

Are there any financial concerns that would affect your ability to access treatment? yes no
Do you have problems with access to transportation? yes no
Do you have any disabilities, special needs, or other restrictions that may impact your treatment or access to treatment? yes no

Based on the information you provided in this self-report, what would you like to see changed?

_____
_____
_____
_____
_____
_____

In your opinion, what could block or prevent that change?

_____
_____
_____
_____
_____

Please add any additional information, which you feel, may be useful to us:

_____
_____
_____
_____
_____

INSURANCE

Primary Insurance Company _____Effective Date:_____
Policy Holder _____ Relationship to patient _____
Policy Holder's Social Security #_____Birthdate_____
Group# _____ Policy #_____Phone #_____
Claims Address _____

APPOINTMENT POLICY:

I understand that when an appointment is scheduled for me, a specific period of time is set-aside just for me. If I am late, my session cannot be extended beyond the time reserved for me, because it would infringe on the next patient's appointment time. I understand that I will be charged the full amount.

I understand that I am responsible for providing at least a 24-hour notice to cancel an appointment. I understand that I will be responsible for paying fully for all missed appointments not canceled at least 24 hours in advance.

Signature of Consumer/Legal Representative: _____ *Date:* _____

Authorizations and Consent to Treat - *Client Rights and Responsibilities*

A Person Receiving Services is Entitled to:

1. Mental Health/Chemical Dependency services in accordance with standards of professional practice, appropriate to his/her needs and designed to give him/her a reasonable opportunity to improve his/her condition.
2. Humane care, protection from harm, and to be treated with dignity and respect.
3. The right to participate in the development and review of his/her treatment plan, including the known effects of receiving and not receiving such treatment, or alternative treatment, if any
4. The right to receive treatment in the least restrictive settings
5. The right to review his/her own record in the presence of the primary therapist, unless the primary therapist's professional judgment deems this to be potentially detrimental to the person.
6. The right to confidential maintenance of all his/her identifying treatment information; no disclosure of such information without his/her written authorization, except in cases of medical emergency, by court order, or when otherwise dictated by law.
7. The right to register complaints and to have his/her complaints heard and action taken, if required, promptly.
8. The right to waive any of his/her rights, if the waiver is given voluntarily, knowingly, and in a competent state of mind. The waiver may be withdrawn at any time.

Consumer Consent for Use/Disclosure of Health Care Information

I understand that the consumer's health information is private and confidential. I understand that the therapist/physician works very hard to protect the consumer's privacy and preserve the confidentiality of the consumer's personal health information. I understand that therapist/physician may use and disclose the consumer's personal health information to help provide health care to the consumer, to handle billing and payment, and to take care of other health care operations. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. Examples would be if a consumer threatened to hurt someone or if child abuse is reported.

The therapist/physician has a detailed document called the "Notice of Privacy Practices", that is available for me to read. It contains more information about the policies and practices protecting the consumer's privacy. I understand that I have the right to read the "Notice" before signing this agreement.

The therapist/physician may update this "Notice of Privacy Practices". If I ask, he will provide me with the most current "Notice of Privacy Practices".

Under the terms of this consent, I can ask the therapist/physician to limit how the consumer's personal health information is used or disclosed to carry out treatment, payment or health care operations. I understand that the therapist/physician does not have to agree to my request. If the therapist/physician does agree to my request, I understand that therapist/physician would follow the agreed limits. Requests must be made in writing and therapist/physician will provide a form for this purpose by request at any office.

I may cancel this consent in writing at any time by doing one of the following:

- Signing and dating a form that the therapist/physician can give me called "Revocation of Consent for Use and Disclosure of Health Care Information"; or
- Writing, signing, and dating a letter to the therapist/physician. If I write a letter, it must say that I want to revoke my consent to authorize the use and disclosure of the consumer's personal health information for treatment, payment, and health care operations.

If I revoke this consent, the therapist/physician does not have to provide any further health care services to the consumer or may require that the consumer pay directly for any service rendered.

My signature below indicates that I have been given the chance to review a current copy of the therapist/physician's "Notice of Privacy Practices". My signatures means that I agree to allow the therapist/physician to use and disclose the consumer's personal health information to carry out treatment, payment, and health care operations.

I have read the preceding information and have been given information detailing the policies and procedures. I have been given the opportunity to ask questions and agree to abide by these policies. I authorize and request my behavior healthcare professional to carry out psychological evaluations, psychiatric evaluations, treatment and/or diagnostic procedures that now, or during the course of my treatment become, advisable. I understand the purpose of these procedures will be explained to me upon my request and that they are subject to my agreement. I also understand that while the course of my treatment is designed to be helpful, my behavioral healthcare professional can make no guarantees about the outcome of my treatment. Further, the psychotherapeutic process can bring up uncomfortable feelings and reactions such as anxiety, sadness, and anger. I understand that reactions will be worked on between my behavioral professional and me. With these understandings, I hereby authorize treatment for myself.

Signature of Consumer/Legal Representative: _____ *Date:* _____

If my insurance company contacts Spencer H. Gelernter, Ph.D. & Associates:

Please do not release any information.	*yes*	*no*
Release only dates of appointments, clinicians' names, and diagnosis code.	*yes*	*no*
Release any information requested by my Insurance Company.	*yes*	*no*

Signature of Consumer/Legal Representative: _____ *Date:* _____

Medication History for: _____ (Name)

Please tell us about **ALL** drugs/medications you take. **Include** "over-the-counter" medications (aspirin, antihistamines, cough syrup, vitamins, etc.) and homeopathic/herbal products.

Medication Name (brand or generic?)	Doctor's Name, Medical Specialty	Date Started	Condition for which medication is taken	Dose each time	Times per day	Time(s) of day taken?	Side effects?	Is the medication working?

1. Do you have any nutritional/recreational practices that could impact your medicines' effectiveness? Yes □ No □

   If so, please describe: _____

2. Have you taken medication (prescription or otherwise) that belonged to family members or friends? Yes □ No □

3. Do you drink alcohol or use any illegal/illicit drugs, including marijuana, more than once per week? Yes □ No □

   If so, please describe: _____

4. Do you use any form of nicotine? Yes □ No □

   If so, please describe: _____