Couples Therapy Contract

1. The counseling being provided is couples counseling. The "patient" in this counseling is the relationship, the couple, not either person individually.

2. The patient in this counseling is the relationship, the couple, not either person individually.

3. In couples counseling, each participant has all of the rights and privileges afforded to people involved in individual psychological psychotherapy, as defined by law and ethics and stated in the written information provided to each person prior to the initial counseling appointment.

4. The specifics of what is said and discussed in counseling sessions is confidential and privileged information and cannot be shared or discussed with anyone without the express, written consent of the individuals involved. Please note that the both of you must agree to release information related to what was said and discussed in our sessions in order for the entire record to be released. I cannot and will not release information about our counseling sessions or, should the situation occur, testify in any legal proceedings, actions or venues, without both of you providing written permission for me to do so. In the event that only one of you agrees to release information, a partially redacted record will be released. Fees for time necessary to redact portions of the record must be paid in addition to any applicable records copying fees.

5. Since the success of couples counseling cannot be predicted or assured, it is possible that one or both of you may decide during the course of counseling that the best answer to your relationship issues and concerns is separation, dissolution, or divorce. If either party or parties attorney requests information, the above described procedures on release of records will apply.

6. You should be aware that once we begin couples counseling, that it is unethical for me to give any opinion about custody or visitation arrangements, even if I am compelled to be a witness in any legal proceedings, actions, or venues.

7. Should one and/or both of you decide to move to dissolution of the marriage or divorce, and a custody evaluation is ordered by the court, I want your permission to provide information to anyone appointed by the court to perform a custody evaluation or to represent the legal interests of your children. I would not in such case make any recommendation about the final decision but will provide a copy of the record through the process described above.

8. Typically we do not see couples individually other than within the assessment process. From time to time, it may be necessary or advisable to have one or more individual counseling sessions with one or both of the couples counseling participants and this is up to the clinical discretion of your clinician. Any and all such individual sessions should be understood to be part of the couples counseling process and in service to the couples counseling and, not an action that establishes an individual counseling relationship between the treating couples therapist and either of the participants involved in the couples counseling.

9. During the course of the couples counseling, the treating counselor may identify individual and/or personal issues that one and/or both of the participants may have that require individual counseling. If such situation arises, the treating therapist reserves the right to recommend and/or strongly advise individual counseling with a mental health therapist to one or both of the couples counseling participants.

10. Should one of the participants of the couples counseling process decide to discontinue participation in the previously agreed upon couples counseling, each and/or either of the couples counseling participants, should he/she desire continued counseling, will be referred to another therapist for individual counseling.

*While I have taken training in the Gottman Method Couples therapy, I want your to know that I and my agency are completely independent in providing you with clinical services and that I alone am fully responsible for those services. The Gottman Institute or its agents have no responsibility for the services you receive.

"No Secrets" Policy

This written policy is intended to inform you, the participants in therapy, that when I agree to treat a couple or a family, I consider that couple or family (the treatment unit) to be the patient. For instance, if there is a request for the treatment records of the couple or the family, I will seek the authorization of all members of the treatment unit before I release confidential information to third parties. If only one person authorizes release of records, I will release a partially redacted record with only the information disclosed by that particular person.

During the course of my work with a couple or a family, I may see a smaller part of the treatment unit (e.g., an individual or two siblings) for one or more sessions. These sessions should be seen by you as a part of the work that I am doing with the family or the couple, unless otherwise indicated. If you are involved in one or more of such sessions with me, please understand that generally these sessions are confidential in the sense that I will not release any confidential information to a third party unless I am required by law to do so or unless I have your written authorization. In fact, since those sessions can and should be considered a part of the treatment of the couple or family, I would also seek the authorization of the other individuals in the treatment unit before releasing confidential information to a third party.

However, I may need to share information learned in an individual session (or a session with only a portion of the treatment unit being present) with the entire treatment unit – that is, the family or the couple, if I am to effectively serve the unit being treated. I will use my best judgment as to whether, when, and to what extent I will make disclosures to the treatment unit, and will also, if appropriate, first give the individual or the smaller part of the treatment unit being seen the opportunity to make the disclosure. Thus, if you feel it necessary to talk about matters that you absolutely want to be shared with no one, you might want to consult with an individual therapist who can treat you individually.

This "no secrets" policy is intended to allow me to continue to treat the couple or family by preventing, to the extent possible, a conflict of interest to arise where an individual's interests may not be consistent with the interests of the unit being treated. For instance, information learned in the course of an individual session may be relevant or even essential to the proper treatment of the couple or the family. If I am not free to exercise my clinical judgment regarding the need to bring this information to the family or the couple during their therapy, I might be placed in a situation where I will have to terminate treatment of the couple or the family. This policy is intended to prevent the need for such a termination.

The Gottman Relationship CHECKUP

Created by Drs. John and Julie Gottman in collaboration with The Gottman Institute

A new online assessment that automatically scores a couple's strengths and challenges.

This clinical tool consists of 480 questions about friendship, intimacy, how well you know your partner, how you manage emotions and conflict, how you share your values and goals, and what gives meaning to your lives. There are additional questions about parenting, housework, finances, trust, and individual areas of concern. The questionnaire is completely confidential, fully HIPAA compliant, and your therapist will be the only person to see your responses.

The Gottman Relationship Checkup is a breakthrough in couple's therapy as it allows for a confidential, efficient way for your clinician to complete the evaluation process. By using this new technology, your assessment can be done at any time and in the setting of your choice! Upon completion, it automatically provides valuable clinical information by pinpointing specific strengths and challenges in your relationship, while also suggesting actionable, research-based recommendations for therapy.

You can feel confident in your results. Drs. John and Julie Gottman created this research-based assessment in collaboration with The Gottman Institute to help couples build a personalized treatment plan with their therapist. Dr. John Gottman is a clinical psychologist who has completed more than 40 years of research on couple relationships, and is recognized as one of the top 10 most influential therapists of the last quarter century. Dr. Julie Gottman is a highly respected clinical psychologist who is sought internationally by the media and clinical organizations as an expert advisor on relationships. Together, they have dedicated their lives to helping couples, and The Gottman Relationship Checkup is the result of this life work.

How it works:

1. Accept your invitation

Your therapist will send each of you a separate email inviting you to The Gottman Relationship Checkup.

2. Create a private profile

Once you have accepted the email invitation to join The Gottman Relationship Checkup, you and your partner will each create individual, separate profiles.

3. Complete the questionnaire

You and your partner will each complete your own questionnaire at your convenience. Stop and start at anytime. Neither partner will be able to access the other's information at any point in the process. In order to pre-serve the integrity and accuracy of the tool, you are encouraged not to share your responses with each other or log in to your partner's account. The actual time it takes to complete each assessment varies, but it will take, on average, about two hours.

4. Get your results

When you have both completed your individual questionnaires, your therapist will be notified and will be able to securely log in to review your scores and the analysis of your relationship. Your therapist will be able to discuss the results with you and suggest a treatment plan for improving and strengthening your relationship.

KENT PSYCHOLOGICAL ASSOCIATES

Payment Policy for Couples Counseling

1. **Fees for Couples Counseling**
   - Initial appointment: $225 (90 minutes, includes Couples Relationship Check-Up)
   - All follow-up appointments: $175 (90 minutes)
   - Speak with your clinician about available extended appointment times as needed

2. **Additional services.** Please be aware that some services we provide may be at an additional cost beyond the standard per session fees. Payment is required for these services in full at the time the service is rendered or in some cases prior to release of any requested documents. Other fees that may not be covered by your per session fee are fees for services that are beyond standard coordination of care. Please ask your clinician if you have a question about non-covered services.
   - Single page letter or form fee: $20
   - Multi page letter or form fee: $40
   - Phone calls: $20 for each up-to-15-minute block (no charge first 15 minutes)
   - Fees associated with testifying in court or participating in a deposition: billed for preparation, travel time, wait time, and testifying or deposition. $175 per hour. Three-hour minimum. Minimum must be paid prior to court/deposition date.

3. **Nonpayment.** All payments are due at the time of service. An exception may be made in an urgent situation if you contact us in advance and make an arrangement with terms agreed upon by our office. However, if your account is over thirty (30) days past due we will be unable to schedule additional appointments. If your account lapses to ninety (90) days past due, you will receive a letter stating that you have twenty (20) days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from this practice. If this occurs, you will be notified by regular and certified mail that you have thirty (30) days to find alternative care. During that 30-day period, our staff will assist you with a referral to another agency.

4. **Missed appointments.** **The full session fee is charged for missed ("no-show") appointments and appointments cancelled without sufficient prior notice. Sufficient notice is 24 hours prior to the appointment time.** This fee must be paid in full prior to your next scheduled appointment or your appointment may be rescheduled. Please help us to serve you better by keeping your regularly scheduled appointment. Clients who develop a pattern of frequent missed or cancelled appointments may be discharged from the practice. A credit card must be kept on file and will be charged for missed appointments.

5. **Financial Hardship:** If you experience financial difficulties that affect timely payment of your account, please discuss this issue with your therapist or our billing staff at your earliest possible convenience, before any misunderstandings can develop. We will assist you in finding lower cost alternatives.

6. **Non-sufficient Funds:** There is a $25 fee for returned checks.

If you have difficulty understanding your account or billing statements please contact our office and ask to speak with a member of our billing staff.

Thank you for understanding. Please let us know if you have any questions or concerns.

Revised 11/01/2018

KENT PSYCHOLOGICAL ASSOCIATES

Notice of Patient Rights and Responsibilities for Kent Psychological Associates, LLC

Kent Psychological Associates, LLC recognizes that all patients have basic individual rights and responsibilities. To protect these rights, we have adopted specific guidelines to ensure the support and respect each patient's basic human dignity, as well as each patient's civil, constitutional, and statutory rights. We respect each patient's right to participate in decisions about his or her care, treatment, and services, and to give or withhold informed consent.

As a patient, you have the following rights and responsibilities. If you have any questions about these rights and responsibilities, please contact us at (330) 673-5812.

Patient Rights.
As a patient, you have the right to:

- **Access to care.** You have the right to not be discriminated against in the provision of service on the basis of religion, race, color, creed, sex, national origin, age, sexual orientation, gender identity, physical or mental handicap, or developmental disability. This includes the right to a current written, individualized service plan that addresses one's own mental and physical health, and that specifies the provision of appropriate and adequate services, as available, either directly or by referral.
- **Be treated with dignity and respect.** You have the right to be treated with respect for personal dignity, autonomy, and privacy. This includes:
  - the right to be fully informed of all rights;
  - the right to exercise any and all rights without reprisal, including continued uncompromised access to service;
  - the right to be free from all forms of harassment, neglect, exploitation, and verbal, mental, physical, and sexual abuse;
  - the right to service in a humane setting which is the least restrictive feasible, as defined by the treatment;
  - the right to freedom from unnecessary or excessive medication; and
  - the right to freedom from unnecessary restraint or seclusion.
- **Participate in decisions about your care.** You have the right to be reasonably informed about and to participate in decisions made involving your healthcare, including the right of competent adults to refuse treatment. This includes:
  - the right to be informed of your condition, of proposed or current services, or therapies, and of the alternatives;
  - the right to consent or refuse any service, treatment, or therapy upon full explanation of the expected consequences of such consent or refusal;
  - the right to active, informed participation in the establishment, periodic review, and reassessment of the service plan;
  - the right to participate in any appropriate and available organizational service, regardless of refusal of one or more other services, treatment or therapies, or regardless of relapse from earlier treatment in that or another service, unless there is a valid and specific necessity which precludes and/or requires the client's participation in other services. This necessity shall be explained to the client's current service plan;
  - the right to be informed of and refuse any unusual or hazardous treatment procedure;
  - the right to be advised of and to refuse observation by methods such as one-way mirrors, tape recorders, televisions, movies, or photographs;
  - the right to consult with independent treatment specialists or legal counsel at one's own expense;
  - the right to be informed in advance of the reason(s) for discontinuation of service provision, and to be involved in planning for the consequences of that event;
  - the right to receive an explanation of the reason for denial of service; and
  - the right to know the cost of services.

- **Keep your medical records and identity private.** You can expect that any information, images, or recordings with information that could identify you will be kept private. This includes:
  - the right to confidentiality of communications and of all personal identifying information within the limitations and requirement for disclosure of various funding and/or certifying sources, state laws, or federal statutes, unless release of information is specifically authorized by the client or court appointed guardian of the person of an adult child; and
  - The right to have access to one's own psychiatric, medical, or other treatment records, unless access to particular identified items of information is specifically restricted to that individual client for clear treatment reasons in the client's treatment plan. "Clear treatment reasons" shall be understood to mean only severe emotional damage to the client, such that the danger of self-injurious behavior is an imminent risk. The person restricting the information shall explain to the client that factual information about the individual client that necessitates the restriction. The restriction must be renewed annually to retain validity. Any person authorized by the client has unrestricted access to all information. Clients shall be informed in writing agency policies and procedure to viewing or obtaining copies of personal records.
- **File a grievance.** You have the right to report concerns or complaints about your care and safety and receive help to resolve your concerns. This includes the right to have oral and written instructions for filing a grievance.

In order to protect each client's rights, we have adopted the following procedures:

- Each client shall receive this written Notice of Client Rights during the intake procedure;
- Clients will sign the Permission to Treat sheet indicating receipt of the Notice of Client Rights;
- Copies of the Notice of Client Rights are posted within the agency to ensure that the clients as well as staff are well aware of the basic rights.

If you feel that any of these rights have not been respected, then please follow our grievance procedure. We would like to help you get any complaint or concern resolved quickly and to your satisfaction. The grievance procedure will be posted in a highly visible place in each agency location.

Additionally, all Kent Psychological Associates clients and/or guardians shall have the option to register a complaint with any or all, but not exclusively, the following:

- Ohio Department of Mental Health
- Ohio Legal Rights Service
- United States Department of Health & Human Services
- Appropriate professional licensing, regulatory associates, and/or other State Departments. The names, addresses, and phone numbers of the aforementioned will be given to the griever. The relevant addresses and phone numbers about the grievance shall be included along with all relevant information about the grievance as requested.

<u>Patient Responsibilities</u>

As a patient you are expected to:

- respect the dignity and rights of others, clients and staff alike, and to exercise care for the physical surroundings (agency property);
- comply with all reasonable requests for information in the intake/admissions process;
- participate fully in the formulation of your treatment plan and to carry out the agreement to the fullest extent of your ability;
- respect the confidentiality of others, especially in the family, group, and educational sessions;
- give written permission for the release of necessary information to other institutions or professionals in the treatment program; and
- contribute, according to the fee structure, to the cost of services.

Kent Psychological Associates, LLC

DATE ____________________

ADULT BACKGROUND INFORMATION

NAME ________________________________ DOB ____________ AGE______ SSN_____-____-______
GENDER____________ PRONOUNS: ☐ he/him/his ☐ she/her/her ☐ they/them/theirs ☐ ze/hir/hirs
ADDRESS ____________________________________ CITY ____________________ ZIP____________
PHONE (H) (___) __________________ (W) (___) ____________________
EMERGENCY CONTACT: __________________________ PHONE_______________ RELATION_______
FAMILY PHYSICIAN: ______________________________ PHONE_________________
REFERRED BY: ____

HOUSEHOLD INFORMATION: *Who do you live with?*

NAME	RELATIONSHIP	AGE	GENDER	OCCUPATION
____________	____________	_____	____	____________
____________	____________	_____	____	____________
____________	____________	_____	____	____________
____________	____________	_____	____	____________
____________	____________	_____	____	____________

Other important people in your life ____

DEVELOPMENTAL HISTORY:

Please check the following which were problems in the family of origin:

____Frequent moves	____Alcohol/Drugs	____Death of family member
____Parents divorce	____Legal problems	____Physical abuse/Neglect
____Parents remarriage	____Parent conflict	____Sexual abuse
____Parents separated	____Parent job loss	____Domestic violence
____Family illness	____Financial stress	____Emotional problems

____Other ____
____Other issue (You wish to discuss with counselor in person)

Clarify information about your development up to age 18. *Check those that apply.*

____Premature birth	____Avoiding others	____Bedwetting	____Birth Defect
____Nervous	____Fidgety/restless	____Head injury	____Abuse/neglect
____Eating problems	____Talking/refusing	____Picked on	____Bad dreams
____Learning problems	____Speech problems	____Sleepwalking	____School behavior
____Poor coordination	____Trouble w/ police	____Feeling rejected	____Strong willed
____Visual difficulties	____Fear leaving home	____Repeated grade	____Few friends
____Leaving loved one	____Behavioral prob.	____"Worry wart"	____Overweight
____Small for age	____Ran away	____Fighting	____Shy

How would you rate your present relationship with the following? *If it does not apply put N/A.*

Spouse/Significant Other/Partner	____Good	____Fair	____Poor	____Problem for you	____N/A
Father	____Good	____Fair	____Poor	____Problem for you	____N/A
Mother	____Good	____Fair	____Poor	____Problem for you	____N/A
Brother	____Good	____Fair	____Poor	____Problem for you	____N/A
Sister	____Good	____Fair	____Poor	____Problem for you	____N/A
Son	____Good	____Fair	____Poor	____Problem for you	____N/A
Daughter	____Good	____Fair	____Poor	____Problem for you	____N/A
In-Laws	____Good	____Fair	____Poor	____Problem for you	____N/A
Employer	____Good	____Fair	____Poor	____Problem for you	____N/A

EDUCATIONAL HISTORY

High school attended________________________ Highest grade completed__________
College/vocational/technical training yes ____ no ____ #year's ____ Degree _____

OCCUPATIONAL HISTORY

Are you presently employed? ____ yes ____ no Type of work ______________ How long? ________
Have you had problems gaining employment? ____ yes ____ no
How many jobs have you held in the last 5 years? ________
Are you a veteran? ____ yes ____ no If yes, what branch of service? ______
Date entered ________ Date discharged __________ Type of discharge _________

RELATIONSHIP HISTORY

Sexual Orientation ________________________

A) In a relationship☐ *If not in a relationship please see section B*

____ Married ____Significant Other ____ Remarried ____Other ____________________

Are you considering separation or divorce? ____yes ____no
Are you a divorced custodial parent? ____yes ____no
Are you married raising minor children? ____yes ____no

Do you and your spouse/significant other/partner:
Agree on the methods of discipline of the children ____yes ____no
Share common values in the rearing o the children ____yes ____no
Feel the parent/child interaction is positive ____yes ____no
Spend quality time as a family ____yes ____no

In your present relationship do you:
Enjoy good communication with each other ____yes ____no
Feel satisfied with your sexual relations ____yes ____no
Spend private couple time with each other ____yes ____no
Share similar interests and values ____yes ____no

B) Not in a relationship☐
____ Single ____ Separated ____ Divorced ____ Widowed ____Other ________________

PRIOR MENTAL HEALTH HISTORY

Have you ever had prior mental health treatment? ____yes ____no (If no, skip)
Date ________
Was this person a: ____Psychiatrist ____Psychologist ____Clinical social worker ____Clinical Counselor
____Minister ____Other
Have you ever been hospitalized for emotional problems? ____yes ____no (If no, skip)
Name of hospital ______________ Location __________ Date __________ How long _____
Doctor who treated you ____________________ Medications given ______________
Do you still take any psychotropic medications? ____yes ____no Which ones? ______________

ALCOHOL/DRUG HISTORY

Do you have a history of alcohol/drug abuse? ____yes ____no (If no, skip)
If you are using alcohol or drugs has this resulted in:

____Marital problems
____Problems w/family, friend's
____Preoccupation w/alcohol, drugs
____DUI or DWI charges
____Memory Blackouts
____Periods of abstinence
____Financial problems
____Withdrawal symptoms
____Legal problems
____Physical problems
____Loss of control

LEGAL HISTORY ____yes ____no

Check those that apply to you:

____Trouble with law as a juvenile

____Trouble with the law as an adult

____Have legal matter pending

____Have you ever been in jail?

MEDICAL HISTORY

Date of last physical exam ______________________ Family physician ____________________________________

Describe your chief medical/physical complaint(s) ____

____

Do you have any special problems with hearing, speech, vision? ____yes ____no

If yes, please explain ____

____

Are you on any medications? ____yes ____no

If so, please list: ____

____

Describe any side effects ____

____

Do you have any allergies? ____yes ____no

If yes, please describe ____

List any serious illnesses, injuries, or surgeries____

____

Place an X in the left column if this condition exists. In the right column write self, father, mother, brother, sister, aunt, uncle, etc.

____Alcoholism __________

____Allergies __________

____Developmental Disabilities __________

____Obesity __________

____Degenerative dis. __________

____Mental health probs. __________

____Suicide __________

____Cancer __________

____Diabetes __________

____Epilepsy __________

____High blood press. __________

____Heart trouble __________

____Other __________

MEDICAL CONDITIONS AND SYMPTOMS

Past/Now
___ ___ Arthritis
___ ___ Anxiety
___ ___ Anger Outbursts
___ ___ Asthma
___ ___ Backaches
___ ___ Binging
___ ___ Barbiturates
___ ___ Epilepsy
___ ___ Cancer
___ ___ Chronic Pain
___ ___ Chest Pain
___ ___ Constipation
___ ___ Depression
___ ___ Diabetes
___ ___ Diarrhea
___ ___ Depersonalization
___ ___ "Going Crazy" sensations
___ ___ Difficulty going to sleep
___ ___ Difficulty staying asleep
___ ___ Dizziness
___ ___ Drug reactions
___ ___ Early morning wakening
___ ___ Emotional upsets

Past/Now
___ ___ Can't work under pressure
___ ___ Color Blind
___ ___ Exhaustion
___ ___ Fainting spells
___ ___ Fast pulse
___ ___ Heart medicine
___ ___ Hormones
___ ___ Poor digestion
___ ___ Poor appetite
___ ___ Treated for a mental cond.
___ ___ Other drugs, alcohol
___ ___ Shaking
___ ___ Smoking packs/day ___
___ ___ Craving for sweets
___ ___ Fatigue
___ ___ Headaches
___ ___ Heart trouble
___ ___ Hallucinations
___ ___ Hearing voices
___ ___ Hypertension
___ ___ Hand tremors
___ ___ Hay fever
___ ___ Insulin medication

Past/Now
___ ___ Distractibility
___ ___ Laxatives used
___ ___ Leg Cramps
___ ___ Loose bowel/gas often
___ ___ Loses temper easily
___ ___ Moody often
___ ___ Memory problems
___ ___ Muscle twitching
___ ___ Much sweating
___ ___ Moist palms
___ ___ Nervous breakdown
___ ___ Nervousness
___ ___ Nerve Medication
___ ___ Overeating
___ ___ Overworked
___ ___ Pain medication
___ ___ Palpitation
___ ___ Perfectionist
___ ___ Stomach medicine
___ ___ Worries, feels insecure
___ ___ Reduced sex drive/lack of
___ ___ Upset stomach
___ ___ Itchy skin

CURRENT SOURCES OF STRESS

Please list your most significant sources of stress or worry.

1. ______________________________

2. ______________________________

What is the main goal you wish to attain in seeking services? ______________________________

____

Envision how your life would be different if you could manage some of these problems better.

____

ADDITONAL INFORMATION: Please add any special information you feel which might be helpful in assisting in your treatment. ______________________________

____

Your signature below indicates that you understand the questions and could ask for assistance if needed.

______________________________ ______________________________
Client signature Date

Kent Psychological Associates, LLC

DATE ____________________

ADULT BACKGROUND INFORMATION

NAME ________________________________ DOB____________ AGE______ SSN_____-____-______
GENDER____________ PRONOUNS: ☐ he/him/his ☐ she/her/her ☐ they/them/theirs ☐ ze/hir/hirs
ADDRESS ____________________________________ CITY___________________ ZIP______________
PHONE (H) (____) ___________________ (W) (____) ____________________
EMERGENCY CONTACT: __________________________ PHONE_______________ RELATION_______
FAMILY PHYSICIAN: ________________________________ PHONE_________________
REFERRED BY: ____

HOUSEHOLD INFORMATION: *Who do you live with?*

NAME	RELATIONSHIP	AGE	GENDER	OCCUPATION

Other important people in your life ____

DEVELOPMENTAL HISTORY:

Please check the following which were problems in the family of origin:

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____Parents remarriage	____Parent conflict	____Sexual abuse
____Parents separated	____Parent job loss	____Domestic violence
____Family illness	____Financial stress	____Emotional problems

____Other ____
____Other issue (You wish to discuss with counselor in person)

Clarify information about your development up to age 18. *Check those that apply.*

____Premature birth	____Avoiding others	____Bedwetting	____Birth Defect
____Nervous	____Fidgety/restless	____Head injury	____Abuse/neglect
____Eating problems	____Talking/refusing	____Picked on	____Bad dreams
____Learning problems	____Speech problems	____Sleepwalking	____School behavior
____Poor coordination	____Trouble w/ police	____Feeling rejected	____Strong willed
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Brother	____Good	____Fair	____Poor	____Problem for you	____N/A
Sister	____Good	____Fair	____Poor	____Problem for you	____N/A
Son	____Good	____Fair	____Poor	____Problem for you	____N/A
Daughter	____Good	____Fair	____Poor	____Problem for you	____N/A
In-Laws	____Good	____Fair	____Poor	____Problem for you	____N/A
Employer	____Good	____Fair	____Poor	____Problem for you	____N/A

EDUCATIONAL HISTORY

High school attended_________________________________ Highest grade completed_______________
College/vocational/technical training yes ____ no ____ #year's ____ Degree _____

OCCUPATIONAL HISTORY

Are you presently employed? ____ yes ____ no Type of work _____________________ How long? __________
Have you had problems gaining employment? ____ yes ____ no
How many jobs have you held in the last 5 years? _________
Are you a veteran? ____ yes ____ no If yes, what branch of service? ______
Date entered __________ Date discharged ______________ Type of discharge _____________

RELATIONSHIP HISTORY

Sexual Orientation_______________________________________

A) In a relationship☐ *If not in a relationship please see section B*

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Are you a divorced custodial parent? ____yes ____no
Are you married raising minor children? ____yes ____no

Do you and your spouse/significant other/partner:
Agree on the methods of discipline of the children ____yes ____no
Share common values in the rearing o the children ____yes ____no
Feel the parent/child interaction is positive ____yes ____no
Spend quality time as a family ____yes ____no

In your present relationship do you:
Enjoy good communication with each other ____yes ____no
Feel satisfied with your sexual relations ____yes ____no
Spend private couple time with each other ____yes ____no
Share similar interests and values ____yes ____no

B) Not in a relationship☐
____ Single ____ Separated ____ Divorced ____ Widowed ____Other____________________________

PRIOR MENTAL HEALTH HISTORY

Have you ever had prior mental health treatment? ____yes ____no (If no, skip)
Date ____________
Was this person a: ____Psychiatrist ____Psychologist ____Clinical social worker ____Clinical Counselor
____Minister ____Other
Have you ever been hospitalized for emotional problems? ____yes ____no (If no, skip)
Name of hospital _________________________ Location ______________ Date______________ How long _____
Doctor who treated you__________________________________ Medications given ________________________
Do you still take any psychotropic medications? ____yes ____no Which ones? ___________________________

ALCOHOL/DRUG HISTORY

Do you have a history of alcohol/drug abuse? ____yes ____no (If no, skip)
If you are using alcohol or drugs has this resulted in:
____Marital problems
____Problems w/family, friend's
____Preoccupation w/alcohol, drugs
____DUI or DWI charges
____Memory Blackouts
____Periods of abstinence
____Financial problems
____Withdrawal symptoms
____Legal problems
____Physical problems
____Loss of control

LEGAL HISTORY ____yes ____no

Check those that apply to you:

____Trouble with law as a juvenile

____Trouble with the law as an adult

____Have legal matter pending

____Have you ever been in jail?

MEDICAL HISTORY

Date of last physical exam ____________________ Family physician ______________________________

Describe your chief medical/physical complaint(s) ____

____

Do you have any special problems with hearing, speech, vision? ____yes ____no

If yes, please explain ____

____

Are you on any medications? ____yes ____no

If so, please list: ____

____

Describe any side effects____

____

Do you have any allergies? ____yes ____no

If yes, please describe ____

List any serious illnesses, injuries, or surgeries_______________________________________

____

Place an X in the left column if this condition exists. In the right column write self, father, mother, brother, sister, aunt, uncle, etc.

____Alcoholism __________

____Allergies __________

____Developmental Disabilities __________

____Obesity __________

____Degenerative dis. __________

____Mental health probs. __________

____Suicide __________

____Cancer __________

____Diabetes __________

____Epilepsy __________

____High blood press. __________

____Heart trouble __________

____Other __________

MEDICAL CONDITIONS AND SYMPTOMS

Past/Now		Past/Now		Past/Now	
___ ___	Arthritis	___ ___	Can't work under pressure	___ ___	Distractibility
___ ___	Anxiety	___ ___	Color Blind	___ ___	Laxatives used
___ ___	Anger Outbursts	___ ___	Exhaustion	___ ___	Leg Cramps
___ ___	Asthma	___ ___	Fainting spells	___ ___	Loose bowel/gas often
___ ___	Backaches	___ ___	Fast pulse	___ ___	Loses temper easily
___ ___	Binging	___ ___	Heart medicine	___ ___	Moody often
___ ___	Barbiturates	___ ___	Hormones	___ ___	Memory problems
___ ___	Epilepsy	___ ___	Poor digestion	___ ___	Muscle twitching
___ ___	Cancer	___ ___	Poor appetite	___ ___	Much sweating
___ ___	Chronic Pain	___ ___	Treated for a mental cond.	___ ___	Moist palms
___ ___	Chest Pain	___ ___	Other drugs, alcohol	___ ___	Nervous breakdown
___ ___	Constipation	___ ___	Shaking	___ ___	Nervousness
___ ___	Depression	___ ___	Smoking packs/day ___	___ ___	Nerve Medication
___ ___	Diabetes	___ ___	Craving for sweets	___ ___	Overeating
___ ___	Diarrhea	___ ___	Fatigue	___ ___	Overworked
___ ___	Depersonalization	___ ___	Headaches	___ ___	Pain medication
___ ___	"Going Crazy" sensations	___ ___	Heart trouble	___ ___	Palpitation
___ ___	Difficulty going to sleep	___ ___	Hallucinations	___ ___	Perfectionist
___ ___	Difficulty staying asleep	___ ___	Hearing voices	___ ___	Stomach medicine
___ ___	Dizziness	___ ___	Hypertension	___ ___	Worries, feels insecure
___ ___	Drug reactions	___ ___	Hand tremors	___ ___	Reduced sex drive/lack of
___ ___	Early morning wakening	___ ___	Hay fever	___ ___	Upset stomach
___ ___	Emotional upsets	___ ___	Insulin medication	___ ___	Itchy skin

CURRENT SOURCES OF STRESS

Please list your most significant sources of stress or worry.

1. ______________________________

2. ______________________________

What is the main goal you wish to attain in seeking services? ______________________________

____

Envision how your life would be different if you could manage some of these problems better.

____

ADDITONAL INFORMATION: Please add any special information you feel which might be helpful in assisting in your treatment. ______________________________

____

Your signature below indicates that you understand the questions and could ask for assistance if needed.

______________________________ ______________________________

Client signature Date

CRISIS RESOURCES

24 HOUR CRISIS HOTLINES

- Crisis Intervention Services – Coleman Behavioral Health - (330) 296-3555
- Town Hall II- (330) 678-HELP
- Akron Children's Hospital Psychiatric Intake Response Center (PIRC) (330) 543-7472
- Crisis Text Line: Text "4HOPE" to 741741 within Ohio. Free and confidential.

EMERGENCY:

- 911

PSYCHIATRIC EMERGENCY SERVICES (WALK-IN):

Portage County:

- Crisis Intervention Services – Coleman Behavioral Health - (330) 296-3555

Summit County:

- Summa Akron City Hospital Emergency Room- (330) 375-3361
- Akron General Medical Center Emergency Room- (330) 344-6611
- Akron Children's Hospital Behavioral Health Emergency Service - (330) 543-7472

ANSWERING SERVICE:

- Kent Psychological Associates- (330) 376-6801

  (Answering service will take your information for one of our clinicians to call you back.)