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Michigan Limited Licensed Psychologist, - License Number:
6301003019 Licensed Masters Social Worker, - License Number:
6801017205

Licensed Professional Counselor, - License Number 6401002630
Academy Member of Certified Clinical Mental Health Counselors

OUTPATIENT SERVICES CONTRACT

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions that you might have so that we can discuss them in our next meeting. Once you sign this document, it will constitute as a binding agreement between us. The last page will be kept at my office. You might wish to retain the remaining pages for future use.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personality of both the therapist and the patient and the particular issues that the patient brings. There are a number of different approaches that can be utilized to address the issues you wish to address. It is unlike visiting a medical doctor, psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work both during our sessions and on your own at home.

Psychotherapy has both risks and benefits. It is vital to understand that risks sometimes include experiencing new or uncomfortable levels of feelings such as sadness, guilt, anxiety, anger and frustration, loneliness or helplessness, as Psychotherapy often requires recalling unpleasant aspects of your history. In marital psychotherapy couples sometimes divorce. Psychotherapy has also been shown to have benefits for individuals who undertake it. It often leads to a significant reduction in feelings of distress, and better relationships and resolutions of specific problems. But there are no guarantees as to what will happen.

By the end of the evaluation I will be able to offer you some initial impressions of what our work will include, and an initial treatment plan if you decide to continue. You should evaluate this information along with your own assessment about whether you feel comfortable working with me. Therapy involves a large commitment of time, money and energy, so you should be very careful about the therapist you select. When and if you have questions about my procedures, we should discuss them as they arise. If your doubts persist, I will be happy to help you secure an appropriate consultation with another mental health professional. If you would like a referral for a medication evaluation I will help you seek such if we see this as appropriate.

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MENTAL HEALTH

There are different specialty skills in the training of each mental health professional. Psychologist, Social Worker or Counselor, each credential has its own scope of practice based upon their education and experience. In Michigan, psychologists are either "fully licensed" to practice at the independent level in private practice or "limited license" to practice under the supervision of a fully licensed psychologist in private practice. Fully licensed psychologists have completed a Doctorate degree in psychology, philosophy or education and have passed a written exam to prove their knowledge. Prior to 1978, the practicing graduate degree in psychology was a Masters degree. Training for limited licensed and fully licensed psychologists include extensive course work in human development, psychopathology, psychotherapy, personality, and psychological assessment. Psychologists also have supervised clinical experience in their graduate training.

The bachelor's and master's social worker are licensed This means that only the individuals who are licensed can be called social workers and that the tasks defined by the Public Health Code as social work have to be done by licensed social workers

To provide better distinction between the experienced practitioner and the "new" practitioner, a limited license was created at each level of practice. This limited license allows the individual licensee to practice the activities/functions of the full registrant/licensee while under the supervision of the full licensee. For example, an individual who has completed their bachelor degree in social work would like to have a chance to practice what they have learned but they need to have guidance in their early stages. The limited bachelor's license provides them with the opportunity to perform bachelor social worker tasks while under the guidance and supervision of a master's social worker. At the completion of 2 years (4,000 hours) of supervised practice, the individual is ready to be a licensed bachelor's social worker.

Additionally, the legislation provided for a distinction between the master's social worker who is mainly doing private practice activities and one-on-one counseling and the master's social worker who is focusing on macro activities such as running a community agency, The master's social worker license will now be designated in either clinical practice or macro practice. The initial license will be issued for only one area of practice but the second area can be acquired with the completion of experience under a master's social worker in that area of practice.

Limited Master's Social Worker License requirements include:

- 4,000 hours at no more than 2,000 hours per year after degree completed
- Limited License issued for 1 year and renewed for not more than 6 years
- Supervision by master's social worker — same designation as limited e.g. macro supervisor for macro experience and clinical supervisor for clinical experience
- Work for at least 16 but no more than 40 hours per week
- Supervisory review required of at least 4 hours per month in group or individual settings but at least 1 hours must be individualized review
- 50% of the supervision should include individual contact during which active functions and records of limited licensee are reviewed.

Licensed professional counselors (or in some states "licensed clinical professional counselors" or "licensed mental health counselors") provide mental health and substance abuse care to millions of American.

Licensed professional counselors (LPCs) are masters-degreed mental health service providers, trained to work with individuals, families, and groups in treating mental, behavioral, and emotional problems and disorders. LPC's make up a large percentage of the workforce employed in community mental health centers, agencies, and organizations, and are employed within and covered by managed care organizations and health plans. LPC's also work with active duty military personnel and their families, as well as veterans.

LPC education and training standards for licensure are on par with those of the other two master's level mental health providers (clinical social workers and marriage and family therapists). State licensure requirements for professional counselors typically include:

- Possession of a master's or doctoral degree in counseling from a national or regionally accredited institution of higher education, including an internship and coursework on human behavior and development, effective counseling strategies, ethical practice, and other core knowledge areas:
 - Completion of a minimum of 3,000 hours of post-master's degree supervised clinical experience, performed within two years, and periodic completion of continuing education credits/hours after obtaining licensure:
 - Passage of the National Counselor Examination (NCE) or a similar state-recognized exam:
- e Adherence to a strict Code of Ethic and recognized standards of practice, as regulated by the state's counselor licensure board.

There are certification programs available for the counselor as well. The Certified Mental Health Counselor is the highest level available. This credential includes an examination in a variety of areas, including principles of theory. It requires years of supervisory experience as well as recommendations from colleagues.

I have a Masters of Arts Degree in Clinical Psychology from Central Michigan University. My background includes psychotherapy and counseling in a variety of facilities such as community mental health agencies and private outpatient psychiatric facilities. I have taught college level psychology at Oakland University, Central Michigan University and Oakland Community College. My experience ranges from children as young as 5 years old to adults in their 70's to 80's. I work with families, individuals, couples and groups. I am licensed in the State of Michigan as a Limited License Psychologist, Licensed Professional Counselor, Licensed Masters Social Worker and a member of the National Board of Certified Counselors. I am also an Academy Member of the National Board of Certified Clinical Mental Health Counselors. I am affiliated and active with the American Psychological Association, American Mental Health Counselors Association, North American Association of Masters in Psychology, Michigan Association of Professional Psychologists, Michigan Psychological Association and Michigan Counseling Association. I have been a member of the board of the Michigan Association of Professional Psychologists for a

number of years as an officer and chairperson, and was recently that organization's president I practice under the company name of Mental Health Resource Associates, P.C. I am not affiliated with any other psychotherapy clinic and/or individual practitioner.

MEETINGS

My normal practice is to conduct an evaluation that will last from 2 to 4 sessions. During that time, we can both decide whether I am the best person to provide the services you need in to meet your treatment objectives. Many people decide within the first month or so whether or not they wish to

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continue. If they choose to continue, my patients are seen up to years at a time. If psychotherapy is initiated, I will usually schedule one session (one appointment hour is forty-five minute duration) per week at a mutually agreed time, although sometimes sessions will be longer or more frequent, You are responsible for payment at the time services are rendered. Once this appointment hour is scheduled, you will be expected to pay for it unless you provide 48 hours advance notice of cancellation, (unless we both agree that you were unable to attend due to circumstances beyond your control). If it is possible, I will find another time to reschedule the appointment.

FEES

My hourly fee is \$ 260.00. In addition to weekly appointments, it is my practice to charge this amount on a prorated basis for other professional services you may require, such as, report writing, telephone conversations which last longer than 15 minutes, attendance at meetings or consultations with other professionals which you have authorized, preparation of records or treatment summaries or the time required to perform any other services which you may request of me. In unusual circumstances, you may become involved in a litigation which may require my participation. You will be expected to pay for the professional time required even if I am compelled to testify by another party. Because of the complexity and difficulty of legal involvement. I charge \$ 500.00 per hour in preparation for and attendance at any legal proceeding.

BILLING AND PAYMENT

You will be expected to pay for each session at the time it is held, unless we agree otherwise or you have insurance coverage requiring another arrangement. Payment schedules for other professional services will be agreed at the time services are requested. I charge \$35.00 for all returned items such as personal checks that do not clear the bank and \$10.00 service fee for all credit or debit card payments. You will receive monthly statements at no cost. I will be happy to provide an additional itemized statement for a charge of \$25.00.

In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or installment payment plan. These fee adjustments are based upon payment in full and your accounts being maintained as current zero balances. In the event that you are unable to pay when services are rendered your fees will be assessed at the standard office fees at this time of \$250.00 for an individual session and \$80.00 for a group therapy session. In the event that we must change your fee there will also be a 10% handling fee for making such arrangements.

If your account is more than 90 days in arrears and suitable arrangements for payment have not been agreed to, I have the option of assessing interest on your unpaid balance or using legal means to secure payment, including collection agencies or small claims court (If such legal action is necessary, the costs of bringing that proceeding will be included in that claim). In most cases, the only information I will release about a patient's treatment would be the patient's name, the nature of the service and the amount due.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources are available to pay for your treatment. If you have a health benefits policy, it will usually provide some coverage for mental health treatment. I will provide you with whatever assistance I can, including facilitating a receipt for the benefits to which you are entitled, as well as filling out appropriate forms. You however, and not your insurance company are responsible for full payments of the fee to which we have agreed. Therefore, it is important that you find out exactly what mental health services are covered by your insurance policy it is advisable to carefully read the mental health services section in your insurance coverage booklet. If you have questions, you should call your plan and inquire. If necessary to resolve confusion, I, or my office personnel may be able to call your carrier on your behalf.

The escalation of the cost of health care has resulted in increasing level of complexity about insurance benefits which sometimes makes it difficult to determine exactly how much mental health coverage is available. "Managed Health Care Plans" such as HMO's and PPO's often require

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advance authorization before they will provide reimbursement for mental health services. These plans are often oriented towards a short term treatment approach designed to resolve specific problems that are interfering with ones usual level of functioning. It may be necessary to seek additional approval after a certain number of sessions. In my experience, while quite a lot can be accomplished in short term therapy, many patients feel that more services are necessary after insurance benefits expire. Some managed care plans will not allow me to provide services to you once your benefits are no longer available. (If this is the case, i will do my best to find you another provider who will help you continue your psychotherapy.)

You should be aware that most insurance agreements require you to authorize me to provide a clinical diagnosis, and sometimes additional information such as a treatment plan or summary, or in rare cases, a copy of the entire record. This information will become part of the insurance company files, and, in all probability, some of it will be computerized. All insurance companies claim to keep such information confidential, but once it is in their I have no control over their procedures. (In some cases they may share the information with a national medical information data bank.) upon request, I will provide you with a copy of any report submit.

You will receive a receipt (Fee - Tickets) and/or monthly statements that will have the necessary information to submit to your insurance company. I am generally a non-participating provider with most insurance companies. This means you should make arrangements for reimbursement with your insurance company rather than me doing so.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if the insurance benefits run out before you feel you are ready to end our sessions. it is important to remember you always have the right to pay for your sessions yourself and avoid the complexities which are described above.

THE BENEFITS OF PRIVATE PAY

In order to maximize the quality of treatment, I believe in the philosophy of individualized private confidential professional treatment. HMO's tend to place limits upon a patient's treatment as to the number of visits will be "allowed" and how long and what types of treatment may be offered. . Containment of costs, not necessarily the quality of care. gets emphasized.

I believe that psychotherapy is a very personal and different experience for each individual. I attempt to develop a treatment strategy that is tailored to each individual patient's needs.

I generally choose not to participate in health care networks as I believe that the quality of the therapist/patient relationship is sacrificed.

CONTACTING ME

I am often not immediately available by telephone. While am in my office Monday through Friday, I usually will not answer the phone when I am with a patient. When unavailable, my telephone is either answered by my secretary or answering services that will insure that receive the message. will make every effort to return your call the same day, with the exception of weekends and holidays. If you are difficult to reach, please leave some times when you will be available. In case of an emergencyt you can try me at my home number; however, if you cannot reach me. you should call your family physician or the emergency room at the nearest hospital and ask for the Psychologist or Psychiatrist on call.

If I am unavailable for an extended time, I will provide you with the name of a trusted colleague whom you can contact if necessary.

RECORDS

Both law and the standards of my profession require that I keep appropriate treatment records. You are entitled to receive a copy of the records. If you wish, I can also prepare an appropriate summary. Because these are professional records, they can be misinterpreted and/or upsetting. If you wish to see your records, I recommend that you review them in my presence so that we can discuss what they contain. Patients will be charged an appropriate fee for any preparation time which is required to comply with all information requests. However, I am sometimes willing to conduct such a meeting without charge.

MINORS

If you are under 18 years of age, please be aware that the law may provide your parents with the right to examine your treatment records. It is my policy to request an agreement from parents consent to give up access to your records. If they agree, I will provide them only with the general information on how your treatment is proceeding. Unless I feel that there is a high risk that you will seriously harm yourself or another, in which case I will notify them of my concern. I will also provide them with a summary of your treatment when it is complete. Before giving them any information, I will discuss the matter with you and do the my best to resolve any objections you may have about what I am prepared to discuss. If you are from a home where there has been a divorce, I require consent from the parent(s) who maintain legal custody.

CONFIDENTIALITY

In general, the confidentiality of all communications between a patient and a mental health professional is protected by law, I can release information about our work to others only once I have received your written permission, however, there are a number of exceptions.

Group psychotherapy requires all patients maintain confidentiality of all communications. All of the groups I conduct require members to abide by this understanding. Even so, I cannot be certain what fellow members discuss outside of treatments. If this is a concern for you, be certain that the majority of patients do fine without being involved in group psychotherapy.

Electronic media allows us to facilitate our communications at a faster rate. I often return telephone calls through cellular phones and accept and reply to electronic mail (E-mail) and Facsimile. While these forms of communication are certainly personalized, I cannot insure that others through either "Hacking" on E-mail, and receiving inappropriate faxes, or listening on radio waves of cellular phones will be completely confidential. I will assume you approve of the use of cellular phones and/or E-mails and faxes unless you notify me and we can discuss alternatives.

In most judicial proceedings, you have the right to prevent me from providing any information about your treatment. However, in some circumstances such as child custody proceedings and proceedings in which your emotional condition is an important element, a judge may require my testimony if he/she determines that resolution of the issues before him/her demands it.

There are some situations in which I am legally required to take action to protect others from harm even though that requires revealing some information about a patient's treatment.

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If I believe that a child, an elderly person, or a disabled person is being abused, I must file a report with the appropriate state agency.

If I believe that a patient is threatening serious bodily harm to another, I am required to take protective actions, which may include notifying the potential victim, notify the police, or seeking appropriate hospitalization.

If a patient threatens to harm him/herself, I may be required to seek hospitalization for the patient, or to contact family members or others who can help provide protection.

These situations have rarely arisen in my practice. Should such a situation occur, I will make every effort to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult about a case with other professionals. In these consultations, I make every effort to avoid revealing the identity of my patients. The consultant is, of course, also legally bound to keep the information confidential. Unless you object, I will not tell you about these consultations unless I feel that it is important to our work together. As a Michigan Limited License Psychologist, I will be periodically consulting with a Licensed Psychologist. Your case may or may not be involved in this consultation.

While this written summary of exceptions to confidentiality should prove helpful in informing you of the potential problems, it is important that we discuss any questions or concerns you may have at our next meeting. As you might suspect, the laws governing these issues are quite complex and I am not an attorney. While I am happy to discuss these issues with you, should you need specific advice, formal legal consultation may be desirable. If you request, I will provide you with relevant portions or summaries of the applicable state laws governing these issues.

Your signature below indicates that you have read the information in the Outpatient Services Contract in your possession, understand it, and agree to abide by its terms during our professional relationship. You herewith consent to initiate and continue psychotherapy treatment and/or psychiatric and psychological evaluations at Mental Health Resource Associates, P.C.

DATE:

PATIENT

_____ DATE:

PSYCHOTHERAPIST

Mental Health Resource Associates, P.C.
31275 Northwestern Hwy, Suite 120
Farmington Hills, MI 48334
248-932-7799

WAIVER OF CLINICAL RECORD

I _____, request that Richard Kay, MA of Mental Health Resource Associates, PC wave the detailed documentation in my clinical mental health record.

I _____ understand that financial business records are going to be maintained for up to seven years for adults or three years for minors. All clinical mental health records, and financial business records, past the aforementioned time period will be destroyed.

I am aware that I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment. If I refuse to sign this authorization and have previously authorized my mental health provider of services to disclose information about me to a third party, my provider has the right to decide not to treat me or accept me as a client in their practice.

I accept this request _____ Date _____

I do not accept this request _____ Date _____

MENTAL HEALTH RESOURCE ASSOCIATES, P.C.
PATIENT INFORMATION

Today's Date: _____

Patient's Name: _____

Date of Birth: _____

Address: _____

Age: _____

City _____ State _____ Zip Code _____

Sex: _____

Marital Status: _____ Single

_____ Married

_____ Divorced

_____ Separated

_____ Remarried

_____ Widowed

Home Phone: _____

Home Fax: _____

Social Security Number: _____

Employer: _____

Occupation: _____

Address: _____

Work Phone: _____

City _____ State _____ Zip Code _____

Work Fax: _____

Email: _____

Cell Phone: _____

*Check the boxes where confidential information/messages may be communicated to you _____

Person responsible for payment _____

Relationship: _____

Social Security Number: _____

Home Phone : _____

Employer: _____

Occupation: _____

Address: _____

Work Phone: _____

City _____ State _____ Zip Code _____

Fax Phone: _____

Cell Phone _____

IT IS MY POLICY THAT THE PARENT ACCOMPANYING THE CHILD FOR TREATMENT WILL BE HELD RESPONSIBLE FOR ALL OUTSTANDING CHARGES. GENERALLY I AM A NON-PARTICIPATING CLINIC. IF THERE IS COVERAGE, YOU SHOULD MAKE ARRANGEMENTS FOR REIMBURSEMENT OF CHARGES WITH YOUR INSURANCE COMPANY.

INSURANCE INFORMATION

Company Name: _____

Name of Insured: _____

Relationship to Patient: _____

Group#/ID# _____

Contract # _____

Service Code: _____

REFERRED By: _____

Physician's Name: _____

Date of Last Exam: _____

Address: _____

Phone: _____

MENTAL HEALTH RESOURCE ASSOCIATES, P.C.

PATIENT INTAKE FORM A (PLEASE COMPLETE ALL QUESTIONS)

Case # _____

Today's Date: _____

Patient' full Name: _____ Date of Birth: _____
Last First Maiden

PRESENT STATUS

Why did you seek treatment at this time? _____

What do you expect from your treatment here? _____

Describe your present emotional state and feelings about being here today? _____

Please rate any of the problem areas that are of concern to you by circling the appropriate number (0, 1, 2, or 3).

	<u>Not a problem</u>	<u>Mild</u>	<u>Moderate</u>	<u>Severe</u>	
Anxiety fears worries	0	1	2	3	
Depression sadness	0	1	2	3	
irritable hostile angry feelings	0	1	2	3	
feeling guilty or shameful	0	1	2	3	
suicidal or self destructive thoughts	0	1	2	3	
Physical stress (headaches					
stomach pains muscle tension etc.)	0	1	2	3	
sleep problems	0	1	2	3	
eating problems	0	1	2	3	
Alcohol or other drug concerns	0	1	2	3	
shyness, not being assertive	0	1	2	3	
loneliness	0	1	2	3	
self confidence / self acceptance	0	1	2	3	
sexual matters	0	1	2	3	
gay/lesbian issues	0		1	2	3
disturbing thoughts, fantasies					
or dreams	0	1	2	3	
Relationship with friends	0	1	2	3	
Relationship with spouse/partner	0	1	2	3	
Relationship with parents	0	1	2	3	
Relationship with siblings	0	1	2	3	
Relationship with children	0		1	2	3
Loss/death of significant person	0	1	2	3	
Difficulties at work	0	1	2	3	
Difficulties at school	0	1	2	3	
Procrastination, getting motivated	0	1	2	3	
Stage fright/test anxiety	0	1	2	3	
career decisions	0	1	2	3	

Briefly describe the problem that you are most concerned about working on while here.

Where and with whom are you living before coming here? _____

Describe your personal strengths: _____

Describe your personal weaknesses: _____

Are you: Married _____ Single _____ Divorced _____ Widowed _____
Separated _____ Living with someone _____

How long? _____

Are you remarried? Yes _____ No _____

If yes, please list in chronological order the following:

_____	_____	_____
Name of Spouse	Date of Marriage	Date of Divorce
_____	_____	_____
Name of Spouse	Date of Marriage	Date of Divorce
_____	_____	_____
Name of Spouse	Date of Marriage	Date of Divorce

Reason for divorce(s)/separation: _____

Are you subject to depression? Yes _____ No _____

Please describe briefly: _____

Have you ever been treated for depression? Yes _____ No _____

If so, please describe briefly (psychotherapy, chemotherapy, other) : _____

Have you ever used chemicals, including alcohol, to overcome pain or depression? Yes _____ No _____

If yes, list drugs, chemicals used: _____

Have you ever thought of or attempted suicide? Yes _____ No _____

If so, please explain: _____

Have you ever thought of or ever voluntarily did physical harm to yourself? Yes _____ No _____

If so, please explain: _____

Have you ever been in counseling or psychotherapy before? Yes _____ No _____

If yes, please describe what you feel you may have accomplished previously: _____

Name of Agency, Counselor, Hospital

Date

Problem/Diagnosis

Residential Outpatient/Inpatient

PERSONAL HISTORY

Where were you born and raised? _____

By whom? _____

any religious preference in the home you grew up in? _____

Mother's Name _____ age _____ Your age at their death, if deceased? _____
Education? _____ Occupation? _____

Father's Name _____ age _____ Your age at their death, if deceased? _____
Education? _____ Occupation? _____

Please describe you parents and their relationship. If divorced, when and what do you know about it? _____

List any step or foster parents and a brief description of your relationship: _____

List sisters/brothers including deceased, step-siblings or foster. Describe relationship or feelings toward each: _____

Any family deaths that affected you ? Yes _____ No _____
Describe: _____

Were you a victim of sexual or physical abuse? Yes _____ No _____
Describe: _____

Any other crisis or losses (witnessed violence, tragedy, Death of a pet, etc.) ? Yes _____ No _____
Describe: _____

Who in particular were/are you close to in your family of origin? Describe: _____

Do you have any children? Name	Age	Yes _____ Sex	No _____ deceased/step Biological/foster	Brief description of relationship
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Are there any particular problem related to your children? Yes _____ No _____
 If yes, please describe: _____

Did/do any of your family members use alcohol/drugs Yes _____ No _____
 If so, who and with what effects? _____

What recreation or leisure activities did your family of origin share? Describe: _____

List favorite hobbies or form of recreation: _____

How have you been spending your free time? _____

Do you exercise? Yes _____ No _____ If yes describe: _____

Do you have any physical limitations or handicaps? Yes _____ No _____
 Describe: _____

Do you have hypoglycemia, anorexia, bulimia, or sickle cell anemia? Yes _____ No _____
 If so, explain: _____

Are you aware of any medical condition that may effect your emotional state? Yes _____ No _____
 If so, please describe: _____

MEDICAL HISTORY

Allergies to drugs or other items? Yes _____ No _____
 Specify: _____

Recent loss of consciousness? Yes _____ No _____
 Specify: _____

Seizures? Yes _____ No _____
Specify: _____

Any history of overdose of drugs or withdrawal symptoms? Yes _____ No _____
Specify/describe: _____

Recent vomiting, constipation and/or diarrhea? Yes _____ No _____
specify: _____

Any history of blackouts? Yes _____ No _____
specify _____

Recent tremors? Yes _____ No _____
Specify: _____

Please circle Any of the following illnesses, conditions or symptoms. State the treatments received and dates.

AIDS	Dizziness	Heart Trouble	Physical defects
arthritis	Emphysema	Hepatitis	Pneumonia
Asthma	Encephalitis	High blood pressure	Rheumatic fever
Bronchitis	Epilepsy	Hyperactive	Spinal meningitis
cancer	Fatigue	Jaundice	Stomach problems
chicken pox	gonorrhea	Kidney disease	tuberculosis
chronic colds	glandular disorder	measles	ulcers
diabetes	glaucoma	mumps	whooping cough
diphtheria	headaches		

Medication, treatment, date: _____

Are any of the above presently active? Yes _____ No _____
Specify: _____

Any blood relatives with the above illnesses? Yes _____ No _____
Specify: _____

serious medical injuries in the past? Yes _____ No _____
Specify: _____

Hospitalizations other than psychiatric (include procedures and/or operations): _____

Medications prescribed: _____

Any psychiatric hospitalizations/ treatments? Yes _____ No _____
Specify: _____

Medications prescribed: _____

Family history of psychiatric intervention or treatment? Yes ____ No ____
specify _____

Pregnancies/miscarriages/ abortions? Yes ____ No ____
Specify : _____

Rapid weight loss/gain in the past? Yes ____ No ____
explain: _____

Insomnia Yes ____ No ____ How many hours of sleep do you get _____
Specify: _____

Smoke cigarettes? Yes ____ No ____ Amount? _____ -

any chest pain? Yes ____ No ____ specify _____

Any current pain ? Yes ____ No ____ specify _____

VOCATIONAL INFORMATION

What is your usual occupation? _____

List any special training, qualifications or licensing? _____

Are you employed? _____ Occupation? _____

How long at present job? _____ Do you like your job? _____

Do you get along with your co-workers? _____

List your employment for the past ten (10) years:

Company	Occupation	how long	why terminated/left
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

EDUCATIONAL BACKGROUND

School	Years	Degree	Major
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Discipline at school and home (type and consistency): _____

FINANCIAL INFORMATION

Source/amount of income? _____

Are you in debt? Yes _____ No _____

How much? _____ To whom? _____

Financial problem areas (behind in payments, bankruptcy, other): _____

ADDICTION HISTORY

Do you believe you have an addiction problem (substance abuse): Yes _____ No _____

If so, please describe briefly: _____

Did /do you ever drink alone? Yes _____ No _____

If yes, how often? _____

Do you believe you can control your drinking consistently? Yes _____ No _____

When did you have your last drink of alcohol? _____

Where and when did/do you usually drink? _____

Age at time of first drink? _____ First intoxication? _____

Drinking preference: What kind? _____

Quantity? _____

Frequency? _____

Have you ever been involved in a 12-step program (A.A., A.C.O.A., N.A., ect.)? Yes _____ No _____

If yes, please describe. Include when and how long was your longest dry period, when and how did you return to drinking:

DRUG HISTORY

Drugs used Age at first use First problem Quantity Frequency

Drug preference: _____

Any accidental or intentional overdose? Yes _____ No _____ When? _____

Describe briefly: _____

Usual place(s) of use: _____

Longest clean period: _____

Date of last use: _____

Have you ever lost love or support due to your drinking or drug use at any time? Yes _____ No _____

Please explain: _____

