PORTLAND DBT INSTITUTE, INC
5200 SW MACADAM AVENUE, STE 580 PORTLAND, OREGON 97239

PHONE: (503) 231-7854 **FAX: (503) 231-8153**

CLIENT INFORMATION SHEET
(Please be sure to fill out this form entirely, indicating N/A if not applicable)

*Client Name____ *DOB__________S.S. #_________________
Age________ *Gender________ *Marital Status_________ Sexual Orientation_________ *Military Status_________
*Home Address____________________________________ City__________________ State____ Zip___________
*Home/Cell Phone____________________ Work Phone________________ Can we leave a message? ____ yes ____ no
Email Address____Preferred contact method ____ phone ____ email

Job Title____________________________________ Employer____
Work Address____
Work Phone __________________________________ Can we leave a message? _____ yes ____ no

Students: Grade ________ School________________________ School Counselor______________________________
Address____Phone_____________________

*Primary Physician_____________________________________ Date of last visit_________ ☐No Primary Physician
Address____Phone______________________________
*Emergency Medical Provider Name and Contact Number(s):____
____

*Dental Provider Name and Contact Number(s):____
____

Psychiatric Prescriber __________________________________ Date of last visit_________ ☐ No Psychiatric Prescriber
Address ____ Phone_____________________________

Who referred you to this office? ____
Address____Phone______________________________
Reasons for referral? ____
____
____

*Emergency Contact____________________________________ Relationship____________________________
*Address____
*Home/Cell Phone_______________________________________ Work Phone______________________________

If child or teen:
*Legal Guardian Name______________________________________ DOB __________S.S. # _________________
*Relationship to client: Parent ____Other____ (check one) If other, specify relationship________________________
*Address____
*Phone (home) _________________________________ (work) ____

Client or authorized person's signature: I authorize Portland DBTI to make contact with the referral source, my physician and my prescriber, for purposes of treatment planning and coordination of care.

____ ____________________________
Signature Date

____
Printed Name

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INSURANCE INFORMATION FORM

PRIMARY INSURANCE
Subscriber's name___________________________________ DOB_______________SS#_______________________________
Address____City_______________State_____ Zip__________________
Client's relation to insured_______________________________________ Phone: _________________________________
Insured's employer____

Primary insurance company____
Address____City_______________State_____ Zip_____________
Phone____
Identification #_________________________________ Group #__________________________________
Deductible amount $________ Deductible met? __ Yes __ No
If no, how much left? $____________________ Pre-existing policy? ____Yes ____No

Effective Date____
Preauthorization required? ____ Yes ____ No
Name and number of contact for preauthorization____
Limits of mental health benefit? ____Yes ____No _______ sessions per year $_______ per year
Mental health benefit currently available ____all ____ or part
If part, how much left? $________

The Portland DBT Institute has my permission to bill my insurance company. I authorize the program to release any information necessary to process my claims. I further authorize that my insurance benefits be paid directly to the program.

Name:____ Relation to Client:____________________________

Signature:____ Date______________________

Effective 4-1-2009:

Primary and Secondary Insurance: As a courtesy, we will bill your primary insurance for services rendered. You will be required to pay the balance remaining after your primary insurance has paid. We do not bill secondary insurance. However, we will be happy to provide you with a statement for your secondary insurance should you wish to recover your out-of-pocket expenses directly from them.

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CLIENT'S RIGHTS AND RESPONSIBILITIES

Clients receiving treatment at the Portland DBT Institute have the right to:

1. Choose from available services and supports, those that are consistent with the ISSP ("Individual Service and Support Plan" or Treatment Plan) and provided in the most integrated setting in the community and under conditions that are least restrictive to the individual's liberty, that are least intrusive to the individual and that provide for the greatest degree of independence.
2. Be treated with dignity and respect.
3. Participate in the development of a written ISSP, receive services consistent with that plan and participate in periodic review and reassessment of service and support needs, assist in the development of the plan, and to receive a copy of the written ISSP.
4. Have all services explained, including expected outcomes and possible risks.
5. Confidentiality, and the right to consent to disclosure in accordance with ORS 107.154, 179.505, 179.507, 192.515, 192.507, 42 CFR Part 2 and 45 CFR Part 205.50.
6. Give informed consent in writing prior to the start of services, except in a medical emergency or as otherwise permitted by law. Minor children may give informed consent to services in the following circumstances:
   a. Under age 18 and lawfully married.
   b. Age 16 or older and legally emancipated by the court.
   c. Age 14 or older for outpatient services only. For purposes of informed consent, outpatient service does not include service provided in residential programs or in day or partial hospitalization programs.
7. Inspect their Individual Service Record in accordance with ORS 179.505.
8. Not participate in experimentation.
9. Receive medication specific to the individual's diagnosed clinical needs.
10. Receive prior notice of service conclusion or transfer, unless the circumstances necessitating service conclusion or transfer pose a threat to health and safety.
11. Be free from abuse or neglect and to report any incident of abuse or neglect without being subject to retaliation.
12. Have religious freedom.
13. Be free from seclusion and restraint, except as regulated in OAR 309-032-1540(9).
14. Be informed at the start of services, and periodically thereafter, of the rights guaranteed by this rule.
15. Be informed of the policies and procedures, service agreements and fees applicable to the services provided, and to have a custodial parent, guardian, or representative, assist with understanding any information presented.
16. Have family involvement in service planning and delivery.
17. Make a declaration for mental health treatment, when legally an adult.
18. File grievances, including appealing decisions resulting from the grievance.
19. Exercise all rights set forth in ORS 109.610 through 109.697 if the individual is a child, as defined by these rules.
20. Exercise all rights set forth in ORS 426.385 if the individual is committed to DHS.
21. Exercise all rights described in this rule without any form of reprisal or punishment.

In addition, adult clients receiving treatment at the Portland DBT Institute have the responsibility to:

1. Be on time for appointments and call their therapist with 24 hours notice if there is a need to cancel.
2. Provide, to the extent possible, information that their therapist needs in order to provide psychological and other behavioral health services to you.
3. Participate, to the degree possible, in understanding their psychological/behavioral health condition and develop mutually agreed upon treatment goals.
4. Follow the plans and instructions for care that are agreed upon with their therapist.
5. Review their insurance benefit booklet or call their insurance customer relations representative to make sure services are covered under their plan and follow plan requirements to have services properly authorized.
6. Pay all agreed upon out-of-pocket charges and fees, as negotiated with their therapist and outlined in their treatment plan, providing such fees are in compliance with their insurance company contract.

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INFORMED CONSENT STATEMENT & OFFICE POLICY

The following statement answers some important and frequently asked questions concerning our program. If you have further questions after reading this, or other concerns not covered here, feel free to ask your therapist about them at your first appointment. Please keep one copy of this statement for your records. The original, signed and dated, will be kept in your file. It is very important that you read the entire statement carefully before signing.

Service Delivery Policies and Procedures

After completing a mental health assessment you will be provided information on service options. These include but are not limited to: 1) No treatment indicated, 2) treatment indicated but not with Portland DBTI (referrals provided if available), or 3) one or some combination of the following: individual therapy, family therapy, group therapy, and medication management. After your assessment you also have the right to be informed of your mental health diagnosis, as well as the right to discontinue treatment at any time. However, we encourage you to discuss the latter choice openly with your therapist first. Similarly, your therapist may need to terminate your treatment if, in his or her judgment, you are not benefiting from treatment or are non-compliant with treatment requirements. A full copy of all our service delivery policies and procedures including those pertaining to cultural competence, family involvement, and developmentally appropriate services will be made available to you upon request.

Possibilities, Risks and Benefits

The goal of mental health treatment is to decrease targeted symptoms. There are some risks to treatment: Symptoms can worsen before they improve or may persist even after treatment is complete. New symptoms or treatment issues may emerge during the course of treatment. Progress related to mental health symptoms or issues can result in changes that have the potential to disrupt life patterns or interpersonal relationships. Psychiatric medication, if prescribed, can have side effects that may need monitoring or management. There are also benefits to treatment: Individuals participating in mental health treatment often learn skills to help cope with difficult emotions, change destructive patterns of thinking, improve interpersonal communication and demonstrate a positive impact overall behavior and personal wellness. DBT research finding regarding treatment benefits can be found on the Behavioral Tech, LLC website at www.behavioraltech.org or ask your therapist for information specific to Portland DBTI's treatment outcome research.

Complaints and Grievances

Any client who has a grievance arising from their treatment at Portland DBTI may present their grievance, verbally or in writing, to their therapist or a program manager. This individual will investigate the nature of the grievance and seek to reach an acceptable and reasonable resolution in a timely manner. If the client is dissatisfied with the resolution suggested, he/she may submit the grievance in writing, to the Clinical Operations Manager, and the Clinical Operations Manager will follow PDBTI policies and procedures to respond. All clients and their parents (or legal guardians where appropriate), will be offered a copy of our grievance policy at the time of their first appointment. All grievances will be kept confidential unless the law requires that they be disclosed, and if disclosure is so required, they will be disclosed to as few persons as possible. The receipt, investigation and action taken regarding the grievance shall be documented in the client's chart.

Additionally, clients are encouraged to take their grievance outside the program (e.g., to a licensing board, a state professional organization, a client rights advocacy group, the state insurance commissioner) if at any point they feel it is necessary to do so. To file grievances with county entities clients may contact:

Multnomah County: Customer Service phone #503-988-3999 ext.24424, fax# 503-988-3137
Clackamas County: Customer Service phone # 503-742-5335, fax# 503-742-5304
Washington County: Customer Service phone # 503-846-4554, fax # 503-846-4560

Confidentiality

We abide by the laws and ethical principles that govern privilege and confidentiality. We will not disclose to anyone anything you tell us, not even the fact that you are a client in the program, without your written permission via a signed release of information form. There are a few exceptions to this standard:

1. It is legally required of us that we act to prevent physical harm to yourself or others when there is "clear and imminent" danger of that happening.
2. We are legally required to report cases of ongoing child, elder and disabled abuse.
3. We will tell the police and courts about any crime by a client committed at our program, or against any person who works for us, or about any threat to commit such a crime.
4. We may have to release clinical information regarding you to insurance carriers as required for payment or review of a claim.
5. We may have to release your records when ordered to do so by court subpoena. However, we will discuss the details of privilege with you beforehand and request a written release from you if we judge this to be in your best interest.
6. Occasionally, we may use a fax machine or email to send treatment plans, and other evaluations to your insurance company, specific agencies or other providers. Although we make every attempt to safeguard this information, faxed and emailed information is not necessarily guaranteed confidential.
7. PDBTI staff consult together weekly about your treatment progress. If we need to consult outside our program, we would obtain your permission first and be careful to conceal your name or other identifying information.

Appointments and Cancellations

Individual sessions are arranged by appointment only. We will meet you at the exact time agreed upon. If we are late, we will make up the missed time or prorate your bill. If you are late, we will charge the full fee and you will lose that portion of time from your session. Cancellation of sessions should be avoided. If you need to cancel an individual therapy appointment, you will not be charged if you notify your therapist 24 hours in advance. If you no-show/no-call or late-cancel an appointment, you will be charged the full fee. Where 24 hour notice is given, the charge for a missed group session is $30.00. No show/no call or late cancelled group sessions are charged at the full rate. Fees charged for missed sessions are not reimbursable by insurance companies. Per OMAP requirements, OHP clients will not be assessed out-of-pocket charges including missed session fees and insurance past due amounts. Cancellations can be phoned into the office any time, day or night. Please be aware voicemail messages are date and time stamped. If you miss four consecutive sessions (no show or cancellation of scheduled individual or group sessions), regardless of the reason or notice given, you will be out of the program. You may reapply for services after what would have been your graduation from Phase I of the program (approximately a six month period).

Telephone Calls and Emergencies

Our voice mail service enables you to call our office at any time, day or night, and leave a message for a return call. We check our phone messages at least twice a day, including weekends, and return calls as soon as possible. When your individual therapist is not available, he/she will leave a phone number where he/she can be reached or will arrange for substitute coverage. In the case of a life-threatening emergency, page your individual therapist immediately. He/she should return your call within the hour. If you are unable to reach your individual therapist, page your skills group leader, and if you are unable to reach your skills group leader, page your individual therapist's supervisor. If you are unable to reach these Portland DBTI contacts call the Crisis Line at 503-988-4888 (Multnomah County), 503-291-9111 (Washington County), or 503-655-8401 (Clackamas County), or go to the nearest hospital emergency room.

Safety Policy

Portland DBT staff and client safety are of utmost importance. As such, any act of aggression to self, others or property while on site shall be reported as a critical incident to a program manager and/or the director. A corrective action plan will be implemented to address the incident which may involve a written apology, compensation for damages, taking legal action, and/or immediate termination of Portland DBTI services. Please note that minors must be accompanied by a responsible adult at all times while on Portland DBTI premises and that it is his/her responsibility to monitor the actions and whereabouts of the minor at all times.

Fees and Payment

There are charges for all program services, including therapy, consultations, preparation of special reports or treatment summaries, or other services you may request. We do not have a sliding fee scale, but do offer a few low fee slots for clients in financial hardship. Financial policy and procedures including program fees will be provided to you at the point of referral and/or intake. Once informed, you will be asked to sign a form indicating acknowledgement and agreement with Portland DBTI's financial policies and procedures. We require that you inform us immediately of any change in your insurance plan or benefit coverage, including OHP. If for any reason, your insurance does not cover services rendered, you are responsible for your bill. If you have questions about your insurance benefit coverage it is your responsibility to contact your insurance company for information and clarification.

As a client participating in comprehensive DBT treatment or EST (Enhanced Skills Training), you are also considered a "member". The membership cost of $75.00 is a required fee essential to offset the cost of DBT services and materials, as well as the extensive staff training and supervision that is not reimbursed by commercial insurance. This fee will not be charged until you have committed to treatment at PDBTI and will be collected upon registration for group. As with any outstanding balance, you will receive a statement reflecting this charge until it is paid in full. Clients with the Oregon Health Plan do not have to pay the membership fee as a benefit of their plan coverage.

Portland DBTI reserves the right to change terms or parts of this consent at any time. We will post any changes in our waiting room with ample notice.

By signing below, I am indicating I have read, understand, and agree to the information presented in this informed consent.

____

Client Printed Name

______________________________ ______________

Client Signature Date

______________________________ ______________

Witness Date

I have reviewed the posted HIPAA privacy act and a copy has been made available to me.

______**Initial**

I have reviewed the posted Advanced Directive Act and a copy has been made available to me.

______**Initial**

I have reviewed the posted Summary of Service Delivery Policies and Procedures and a copy is available to me.

______**Initial**

I have received a copy of the Client Rights and Responsibilities and have had my rights fully explained and my questions answered.

____

Client Printed Name

______________________________ ______________

Client Signature Date

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PATIENT EMAIL AND TEXT MESSAGE CONSENT FORM

Patient name: _________________________
Email: _______________________________
Text message number(s):_______________
____

1. RISK OF USING EMAIL AND/OR TEXT MESSAGE

Transmitting patient information by email or text has a number of risks that patients should consider before using email or text. These include, but are not limited to, the following risks:

a) **The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") recommends that E-mail that contains protected health information be encrypted. Emails and test message sent from Portland DBT Institute (PDBTI) are not encrypted, so they may not be secure.** Therefore it is possible that the confidentiality of such communications may be breached by a third party.
b) Email/texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
c) Senders can easily misaddress an email/text.
d) Email /text is easier to falsify than handwritten or signed documents.
e) Backup copies of email/text may exist even after the sender or the recipient has deleted his or her copy.
f) Employers and on-line services have a right to inspect email or text transmitted through their systems.
g) Email/text can be intercepted, altered, forwarded, or used without authorization or detection.
h) Email/text can be used to introduce viruses into computer systems.
i) Email/text can be used as evidence in court.

2. CONDITIONS FOR THE USE OF EMAIL/TEXT

PDBTI cannot guarantee but will use reasonable means to maintain security and confidentiality of email/text information sent and received. Patients must acknowledge and consent to the following conditions:

a) **Email is not appropriate for urgent or emergency situations. PDBTI cannot guarantee that any particular email will be read and responded to within any particular period of time.**
b) **Text messages may be used (at the therapists discretion) to initiate coaching calls with the therapist. However, the content of urgent phone coaching typically occurs over direct voice-to-voice communications.**
c) **All clinically relevant email/text will typically be printed and filed in the patient's medical record.**
d) Practice will not forward patient identifiable emails/texts outside of the Practice without the patient's prior written consent, except as authorized or required by law.
e) In the event that the patient does not comply with the conditions herein, Practice may terminate patient's privilege to communicate by email/text with Practice.

3. PATIENT ACKNOWLEDGMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email/text between PDBTI and me, and consent to the conditions and instructions outlined, as well as any other instructions that the PDBTI may impose to communicate with patient by email/text. If I have any questions, I may inquire with the Practice Privacy Officer.

Patient signature________________________________

Date _____________________________________

Would you like to receive appointment reminders via email? ____ Yes ____ No

Would you like to receive appointment reminders via text message? ___ Yes ___ No

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FINANCIAL POLICY

In the interest of a cooperative working relationship between Portland DBTI and our clients, please carefully read the financial policy as described below. If you have any questions or concerns regarding this policy, we encourage you to speak with your therapist at your first appointment.

Client Membership Fees and Out- of -Pocket Expenses:
Client out-of-pocket expenses such as membership fees, deductibles, co-payments, and co-insurances are due at the time of service. All clients in EST or comprehensive DBT treatment are considered members of our program. The membership fee is due at the time of group registration. Clients with the Oregon Health Plan are not required to pay the membership fee as a benefit of their coverage. A credit card authorization form must be signed prior to treatment for all outstanding balances (clients with OHP coverage are excluded from this requirement).
Initial_____

Insurance Billing: As a courtesy to clients, we will bill your primary insurance for services rendered providing you submit all the necessary information enabling us to do so. Please be aware that no-show/late cancellation fees and parent group sessions are not billed to insurance and are due by the client on or before your next scheduled appointment.

Secondary Insurance: We do not bill secondary insurance. However, we will be happy to provide you with a statement for your secondary insurance company should you wish to recover your out-of-pocket expenses directly from them.

Insurance Delinquent Balances: We consider it our responsibility to provide clients and their families with quality care. In exchange, we ask that clients work with their insurance companies to compensate us in a timely manner for services rendered. While we do our best to collect on all insurance claims, in the end, we cannot accept responsibility for continued follow up on past due claims or negotiating a disputed claim. Thus, we require that insurance balances past due by 90 days and/or equal to or greater then $2000.00 be paid by the client in full in order to continue services. You will be given adequate notice and referral options should your treatment at PDBTI be postponed until delinquent insurance balances have been resolved. **Initial_____**

Client Delinquent Balances: Client balances (not owing by insurance) are due in full within 30 days of receiving your monthly statement. During treatment, clients that have patient balances exceeding $500.00 must be paid in full in order to continue receiving services. You will be given adequate notice and referral options should your treatment at PDBTI need to be postponed until delinquent patient balances have been resolved. Please be advised that accounts past due by 90 days, unless payment arrangements have been made with the billing department, may be sent to collections. As a courtesy to clients, a collections warning letter is sent indicating the status of your account. You will be given 10 working days to respond to this notice before action is taken. If you discontinue treatment at any time and your account is delinquent or assigned to collections, you will not be allowed to come back to the program until your balance has been paid in full. Further, if you name PDBTI as a debtor when filing bankruptcy you will not be able to return for services. **Initial_____**

Client Refunds: Client refunds are issued the 15th of every month once your account has been cleared. In other words, even if you have money on account, refunds will not be issued until after your insurance has paid in full.

Receipts: Receipts will be provided at the time of payment. We recommend that you maintain a record of your visits and payments for any reimbursement that your employer or others may require.

Returned Checks: There is a $25.00 processing fee on returned checks. We require that your returned check amount plus the processing fee be paid in full on or before your next scheduled appointment.

OHP Clients: Per OMAP requirements, OHP clients will not be assessed out-of-pocket charges including missed session fees and insurance past due amounts. However, if an OHP client's insurance balance is past due by 90 days and/or is equal to or greater then $2000.00, treatment may be interrupted until the insurance problem has been resolved.

Signing below indicates 1) I have read Portland DBTI's financial policy, 2) I understand Portland DBTI's financial policy, and 3) I agree to Portland DBTI's financial policy.

Financially Responsible Party:

Name: ______________________________ Relation to Client: ______________________________

Signature: ______________________________ Date: ______________________________

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PORTLAND DBT INSTITUTE, INC: AUTHORIZATION OF DEBIT/CREDIT CARD

Cardholder Name: ____

Date of Birth: __________________ Phone: _______________________________________

Street Address: ____

City: ___________________________State: ____________ Zip: ______________________

CREDIT CARD #: ____
(Visa or MC *only*)

EXP. DATE: ____________________ (**Please attach a copy of the front and back of the card.**)

I, __________________________ authorize Portland DBT Institute, Inc to charge the credit card as named above for health services rendered to __________________________________.

Services that may be charged to this credit card include, but are not limited to the following:

- Mental Health Assessment
- Individual Therapy
- Family Therapy
- Group Therapy
- Parent Group
- Med Management
- Nutrition Management
- Case Management Services
- Consultation
- Missed Session
- Co-pay
- Deductible

Charges will be made at the time of service or monthly for balance due. This agreement will expire after treatment is terminated and no further charges are incurred.

______________________________________ ________________________________
Cardholder Signature Date

____
Cardholder Printed Name

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CLIENT SELF-REPORT FORM

Name: ____________________________ **Date:** _________________

Please check items that you consider problematic:

☐ Distractibility	☐ Panic attacks	☐ Impulsivity	☐ Reoccurring nightmares
☐ Sadness/depression	☐ Fear of being away from home	☐ Compulsive behavior	☐ Intrusive thoughts/images
☐ Hopelessness	☐ Anxiety/worry	☐ Hyperactivity	☐ Sleep difficulties
☐ Sleep problems	☐ Obsessive thoughts	☐ Irritability/anger	☐ Hypervigilance
☐ Change in appetite	☐ Social discomfort	☐ Aggression	☐ Flashbacks
☐ Loss of pleasure	☐ Suspicion/paranoia	☐ Frequent arguments	☐ Avoidance of certain people, places, situations
☐ Crying spells	☐ Visual hallucinations	☐ Sexual Problems	☐ Increased startle response
☐ Seasonal mood changes	☐ Racing thoughts	☐ Computer addiction	☐ Feeling detached/unreal
☐ Thoughts of death	☐ Hearing voices	☐ Relationship problems	☐ Losing time/dissociation
☐ Low self worth	☐ Poor memory/concentration	☐ Problems with pornography	☐ Wide mood swings
☐ Fatigue	☐ Homicidal thoughts	☐ Gambling problems	☐ Excessive energy
☐ Withdrawal from people	☐ Self-harm	☐ Work/school problems	☐ Alcohol/drug abuse
☐ Guilt/shame	☐ Loneliness	☐ Eating problems	☐ Other:
☐ Lack of motivation	☐ Boredom	☐ Parenting problems	

Additional symptoms or problems:

Previous or current diagnoses:

Please check areas that are affected by the above items:

☐ Hygiene	☐ Finances/ housing	☐ Sexual activity	☐ Recreational activities
☐ Relationships	☐ Work/school	☐ Health	☐ Handling daily tasks

History of problem:

Time period	**Details of problem**
Childhood	
Adolescence	
Young adulthood	

Adulthood	

Current treatment: ☐**No current treatment**

Provider	Name	Contact information	Summary of treatment (e.g. length of time, progress thus far)
Therapist			
Prescriber			
Treatment programs			
Community resources			

Previous treatment: ☐**No previous treatment**

Provider/program	Dates seen	Outcome

Psychiatric hospitalizations: ☐**No psychiatric hospitalizations**

Hospital	Dates	Reason

High risk behavior:

Suicidal behavior: ☐No suicidal behavior

☐	Frequent and severe
☐	Mild/moderate and occasional
☐	Frequent morbid, but not suicidal thoughts/images
☐	Current plan for suicide including timeline. Details:
☐	Gun in home or easy access

Suicide attempt (date/age)	Circumstances?	Treatment received

Self-harm behavior	☐No self-harm behavior
Type of self harm behavior	☐Cutting ☐Burning ☐Head banging ☐ Hitting self ☐Scratching ☐Other:
Circumstances?	

Aggressive behavior	☐No aggressive behavior
Type of aggressive behavior	☐Physical aggression toward others ☐Verbal aggression toward others ☐Destruction of property ☐ Cruelty toward animals ☐Other:
Circumstances?	

Trauma:	☐ **No trauma**
Type of trauma	☐Sexual abuse ☐Physical abuse ☐Emotional abuse ☐ Neglect ☐Other:
Circumstances?	

Legal history:	☐**No legal history**		
☐On probation	☐ Convicted of felony	☐Involved in custody case	☐Legal charges
☐Convicted of misdemeanor	☐ Involved in divorce	☐ DUII	☐ Other:
Circumstances?			

Substance use/abuse:	☐**No substance use/abuse**
Current substance use/abuse	☐Alcohol ☐Marijuana ☐Cocaine ☐Methamphetamines ☐Ecstasy ☐Heroin ☐Inhalants ☐LSD ☐Steroids ☐Prescription medications, Type:
Quantity of substance use/abuse	Amount and frequency:
History of substance use/abuse	When started and how long:
Previous treatment	☐Outpatient ☐Residential ☐Day Treatment ☐Other:
Family history	☐Father ☐Mother ☐Siblings ☐Grandparents ☐Aunts/Uncles ☐Other:

Do you have withdrawal symptoms when not using substance (e.g. physical cravings, illness, anxiety)?
☐No ☐Yes, details:

Have you built tolerance for the substance (i.e. do you need to use more to get the same effect)?
☐No ☐Yes, details:

Do you have problems due to substance use (e.g. work, relationships, health, legal)?
☐No ☐Yes, details:

Medical/Developmental status:

Height:	Weight:
General medical concerns (e.g. cancer, arthritis, heart, thyroid, neurological disease)	☐No ☐Yes, details:
Prenatal complications	☐No ☐Yes, details:
History of head trauma	☐No ☐Yes, details:
History of major accidents/illnesses	☐No ☐Yes, details:
Allergies (i.e. to food or medications)	☐No ☐Yes, details:
General medical illnesses that run in your family	
Other notes about your health	
Primary care provider	Name: Last visit:

Prescription medications ☐**No prescription medications**

Medication	Dosage	Duration	Prescribed by

Is there anything else you want your therapist to know about you?

What are your goals for treatment?