Center for Professional Psychology
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Dear Prospective Patient:

Thank you for the opportunity to work with you and/or your child. We look forward to providing you the highest level of clinical care and expertise. Enclosed in this packet is important information about the services offered and forms for you to complete in preparation for your initial appointment.

You will need to complete all of the enclosed paperwork and gather other records before we can determine if we have the appropriate provider and availability to set your first appointment. Please return these forms as soon as possible. Your forms will be reviewed by the provider you have indicated you wish to see. If you do not select a provider, all forms will be reviewed by a provider who specializes in the service you have requested. If for any reason you do not wish for a particular provider to review your paperwork, please indicate that on the first page when completing the forms. If for any reason, you are not established as a patient due to lack of availability or lack of appropriate expertise with your stated issue, this initial paperwork will be shredded and a permanent medical file will not be created. If you would like your paperwork returned to you at that time, please let our office manager know.

To assist you in preparing for the first appointment, a checklist of the materials needed is listed below:

Forms included in this packet:
__ Consent documentation
__ Contact Information Form
__ History Form (**child/adolescent version and adult version attached; please complete the appropriate form**)
__ Notice of Privacy Practices
__ Once an appointment is set, you will be provided a link to our patient portal
__ For your patient portal please use your person email, a secure password, and the 2-factor authentication
__ Private pay patients will have access to a Good Faith Estimate

Other materials needed for the first appointment that are not included in this packet:

__ Insurance card (if you would like assistance filing a claim with your insurance company)
__ Government ID for patient (acceptable identification includes: Driver's license, state-issued ID card, social security card, passport, etc.) – **Please note: This request for patient identification is required by HIPAA**
__ Copies of previous evaluations (if applicable)
__ Custodial documentation (if applicable)

We may also request additional records and materials in order to provide quality services. Please call if you have any questions or concerns or you may email our office manager at our secure email address: admin@centerforprofessionalpsych.com We want to make this a helpful experience for you. We truly appreciate the chance you have given us to be of professional service to you, and look forward to a successful relationship with you pending availability and expertise with your presenting concerns.

Sincerely,

Providers of the Center for Professional Psychology

Janissa D.Jackson, Ph.D., PLLC
Narissa R. Griffin, Ph.D., PLLC
Danielle Wheeler, LPC, LMFT
Danielle Litchford, LPC, LMFT
Bill Thornton, Ph.D., PLLC

Consent for Review of Initial Paperwork

I understand that my submitted paperwork will be reviewed by my requested provider or by a provider that provides the requested service unless I indicate that I do not want a particular provider to review my information.

Preferred Provider:

☐Janissa D.Jackson, Ph.D., PLLC
☐Narissa R. Griffin, Ph.D., PLLC
☐Danielle Wheeler, LPC, LMFT
☐Danielle Litchford, LPC, LMFT
☐Bill Thornton, Ph.D., PLLC

If applicable, I do not wish for _____ to review my paperwork for the following reason:

_____

_____
Signature of patient/Parent/Guardian Date

_____
Printed Name

Relationship to patient:
Signed by: ☐patient ☐guardian ☐personal representative

I understand that this initial paperwork does not formally establish me as a patient at the Center for Professional Psychology. Instead it is a way of ensuring that this clinic has the availability and expertise to meet my needs. If it is determined that this clinic cannot provide the appropriate level of care, my paperwork will be shredded unless I opt to pick it up at that time and appropriate referral sources will be suggested. If I am on a waiting list, my paperwork will be retained. Due to this being a screening measure, a permanent medical record will not be created.

_____
Signature of patient/Parent/Guardian Date

Acknowledgement for Receipt of Privacy Practices

I understand the limits of confidentiality, privacy policies, my rights, and their meanings and ramifications. My signature indicates I have received a copy of the office's privacy practices that will be applicable if I am established as a patient at the Center for Professional Psychology. This includes all information shared in session, via email, phone calls, and the portal provided.

Patient's name (please print): _____

Signature: _____ Date: _____/_____/_____

Signed by: ☐patient ☐guardian ☐personal representative

Consent to Obtain Benefit Information and Submit Private Health Information for Insurance Claims

I authorize the Center for Professional Psychology and it's providers to release any protected health information (PHI) necessary to obtain benefit information and process insurance claims. I also authorize my insurance carrier to make payments to my determined provider.

_____ _____
Signature of Insured/Representative Date

Emergency Plan

I consent to the providers of the Center for Professional Psychology to handle my Protected Health Information unless I have designated an exception in the event of an emergency in which I need to gain access to this information and Dr. Janissa Jackson (the primary privacy officer) or my selected provider is unavailable due to extenuating circumstances.

Patients Name_____ Date_____

Contact Information Form

Date_____ Patient's Social Security #_____ Chart #_____

Patient's First Name_____ Last Name_____ MI_____

Address_____ City_____ State_____Zip_____

Telephone (Home)_____ (Work)_____

Birthdate____/____/____ Age_____ Sex F M Gender F M Other_____Race_____

Name of Parent/Guardian_____Phone_____

Address_____ City_____ State_____ Zip_____

Person Responsible for Payment_____ Soc. Sec. #_____

Signature of Person Responsible for Payment **X**_____(Must be signed for services to begin)

Preferred email for communication: _____

Emergency Information

In case of emergency, contact:

Name (1) _____ Relationship_____ Phone_____Work_____

Address_____ City_____ State_____ Zip_____

Physician_____ Phone_____

Address_____ City_____ State_____ Zip_____

Psychiatrist_____ Phone_____

Address_____ City_____ State_____ Zip_____

Current Medications_____

Allergies_____

Employment Information (If patient is a child, use parent's employment)

Patient/Guardian: Place_____ Phone_____Hrs____

Spouse: Place_____ Phone_____Hrs____

Referral Source

How did you hear of my office (or from whom)?_____

Address_____City_____ State_____ Zip_____

Phone_____Relationship to referral source_____

Patient History (if the patient is <18 years of age)

Patient's name: _____Date: _____

Gender: ☐ F ☐ M Date of birth: _____ Age: _____ Grade in school: _____

Form completed by (if someone other than patient): _____

If you need any more space for any of the following questions please use the back of the sheet.

Primary reason(s) for seeking services:

☐ Anger management ☐ Anxiety ☐ Coping ☐ Depression
☐ Eating disorder ☐ Fear/phobias ☐Mental confusion ☐ Sexual concerns
☐ Sleeping problems ☐ Addictive behaviors ☐ Alcohol/drugs ☐ Hyperactivity
☐ Attention problems ☐ Learning/School ☐ Motivation ☐ Developmental
☐ Autism ☐ Challenging behaviors (please specify): _____

Other mental health and/or behavioral concerns (specify): _____

_____

Family History

Parents

Are the child's parents married? ☐ Yes ☐ No

With whom does the child live at this time? _____

If not with both biological parents, please answer below:

Are parents divorced or separated? _____

If Yes, who has legal custody? _____

Patient's Mother

Name: _____ Date of Birth: _____ Occupation: _____

Where employed: _____ Work phone: _____

Mother's education: _____

Is the child currently living with mother? ☐Yes ☐ No

☐ Natural parent ☐ Step-parent ☐ Adoptive parent ☐ Foster home

☐ Other (specify): _____

Is there anything notable, unusual or stressful about the child's relationship with the mother?

☐ Yes ☐ No If Yes, please explain: _____

How is the child disciplined by the mother? _____

For what reasons is the child disciplined by the mother? _____

Patient's Father

Name: _____ Date of Birth: _____ Occupation: _____

Where employed: _____ Work phone: _____

Father's education: _____

Is the child currently living with father? ☐ Yes ☐ No

☐ Natural parent ☐ Step-parent ☐Adoptive parent ☐Foster home

☐Other (specify): _____

Is there anything notable, unusual or stressful about the child's relationship with the father?

☐ Yes ☐ No If Yes, please explain: _____

_____

How is the child disciplined by the father? _____

For what reasons is the child disciplined by the father? _____

Patient's Siblings and Others Who Live in the Household

Names of Siblings	Age	Gender	Lives	Quality of relationship with the patient
_____	___	☐ F ☐ M	☐ home ☐ away	☐ poor ☐ average ☐ good
_____	___	☐ F ☐ M	☐ home ☐ away	☐ poor ☐ average ☐ good
_____	___	☐ F ☐ M	☐ home ☐ away	☐ poor ☐ average ☐ good
_____	___	☐ F ☐ M	☐ home ☐ away	☐ poor ☐ average ☐ good
Others living in the household			Relationship (e.g., cousin, foster child)	
_____	___	☐ F ☐ M	_____	☐ poor ☐ average ☐ good
_____	___	☐ F ☐ M	_____	☐ poor ☐ average ☐ good
_____	___	☐ F ☐ M	_____	☐ poor ☐ average ☐ good
_____	___	☐ F ☐ M	_____	☐ poor ☐ average ☐ good

Comments: _____

_____

_____

Family Health History

Have any of the following diseases occurred among the child's blood relatives? (parents, siblings, aunts, uncles or grandparents) Check those which apply:

☐ Allergies	☐ Deafness	☐ Muscular Dystrophy
☐ Anemia	☐ Diabetes	☐ Nervousness
☐ Asthma	☐ Glandular problems	☐ Perceptual motor disorder
☐ Bleeding tendency	☐ Heart diseases	☐ Mental Retardation
☐ Blindness	☐ High blood pressure	☐ Seizures
☐ Cancer	☐ Kidney disease	☐ Spinal Bifida
☐ Cerebral Palsy	☐ Mental illness	☐ Suicide
☐ Cleft lips	☐ Migraines	☐ Other (specify): _____
☐ Cleft palate	☐ Multiple sclerosis	_____

Comments re: Family Health: _____

_____

Childhood/Adolescent History

Pregnancy/Birth

Has the child's mother had any occurances of miscarriages or stillborns? ☐ Yes ☐ No

If Yes, describe: _____

Was the pregnancy with child planned? ☐ Yes ☐ No Length of pregnancy: _____

Mother's age at child's birth: _____ Father's age at child's birth: _____

Child number __ of ___ total children.

While pregnant did the mother smoke? ☐Yes ☐ No If Yes, what amount: _____

Did the mother use drugs of alcohol? ☐ Yes ☐ No If Yes, type/amount: _____

While pregnant, did the mother have any medical or emotional difficulties? (e.g., surgery, hypertension,diabetes, medication) ☐ Yes ☐ No

If Yes, describe: _____

Length of labor: _____ Induced: ☐ Yes ☐ No Caesarean? ☐ Yes ☐ No

Baby's birth weight: _____ Baby's birth length: _____

Describe any physical or emotional complications with the delivery: _____

_____

Describe any complications for the mother or the baby after the birth: _____

_____

Length of hospitalization: Mother: _____ Baby: _____

Infancy/Toddlerhood Check all which apply:

☐ Breastfed	☐ Milk allergies	☐ Vomiting	☐ Diarrhea
☐ Bottle fed	☐ Rashes	☐ Colic	☐ Constipation
☐ Not cuddly	☐ Cried often	☐ Rarely cried	☐ Overactive
☐ Resisted solid food	☐ Trouble sleeping	☐ Irritable when awakened	☐ Lethargic

Developmental History Please note the age at which the following behaviors took place:

Sat alone: _____ Dressed self: _____

Took 1st steps: _____ Tied shoelaces: _____

Spoke words: _____ Rode two-wheeled bike: _____

Spoke sentences: _____ Toilet trained: _____

Weaned: _____ Dry during day: _____

Fed self: _____ Dry during night: _____

The child's development was: ☐ slow ☐ average ☐ fast

Age for following developments (fill in where applicable)

Began puberty: _____ Menstruation: _____

Voice change: _____ Convulsions: _____

Breast development: _____ Injuries or hospitalization: _____

Issues that affected child's development (e.g., physical/sexual abuse, inadequate nutrition, neglect, etc.)

_____

_____

Education

Current school: _____ School phone number: _____

Type of school: ☐ Public ☐ Private ☐ Home schooled ☐Other (specify): _____

Grade: _____ Teacher: _____ School Counselor: _____

In special education? ☐ Yes ☐ No If Yes, describe: _____

In gifted program? ☐ Yes ☐ No If Yes, describe: _____

Has child ever been held back in school? ☐ Yes ☐ No If Yes, describe: _____

Which subjects does the child enjoy in school? _____

Which subjects does the child dislike in school? _____

What grades does the child usually receive in school? _____

Have there been any recent changes in the child's grades? ☐ Yes ☐ No

If Yes, describe: _____

Has the child ever undergone psychological testing? ☐ Yes ☐ No

If Yes, describe: _____

Check the descriptions which specifically relate to your child.

Feelings about School Work:

☐ Anxious ☐ Passive ☐ Enthusiastic ☐ Fearful

☐ Eager ☐ No expression ☐ Bored ☐ Rebellious

☐ Other (describe): _____

Approach to School Work:

☐ Organized ☐ Industrious ☐ Responsible ☐ Interested

☐ Self-directed ☐ No initiative ☐ Refuses ☐ Does only what is expected

☐ Sloppy ☐ Disorganized ☐ Cooperative ☐ Doesn't complete assignments

☐ Other (describe): _____

Performance in School (Parent's Opinion):

☐ Satisfactory ☐ Underachiever ☐ Overachiever

☐ Other (describe): _____

Child's Peer Relationships:

☐ Spontaneous ☐ Follower ☐ Leader ☐ Difficulty making friends

☐ Makes friends easily ☐ Long-time friends ☐ Shares easily

☐ Other (describe): _____

Who handles responsibility for your child in the following areas?

School: ☐ Mother ☐ Father ☐ Shared ☐ Other (specify): _____

Health: ☐ Mother ☐ Father ☐ Shared ☐ Other (specify): _____

Problem behavior:☐ Mother ☐ Father ☐ Shared ☐Other (specify): _____

If the child is involved in a vocational program or works a job, please fill in the following:

What is the child's attitude toward work? ☐ Poor ☐ Average ☐ Good ☐ Excellent

Current employer: _____ Position: _____ Hours per week: ____

How have the child's grades in school been affected since working? ☐ Lower ☐ Same ☐ Higher

How many previous jobs or placements has the child had? _____

Usual length of employment: _____ Usual reason for leaving: _____

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, school activities, scouts, etc.)

Activity	How often now?	How often in the past?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical/Physical Health

☐ Abortion	☐ Hayfever	☐ Pneumonia
☐ Asthma	☐ Heart trouble	☐ Polio
☐ Blackouts	☐ Hepatitis	☐ Pregnancy
☐ Bronchitis	☐ Hives	☐ Rheumatic Fever
☐ Cerebral Palsy	☐ Influenza	☐ Scarlet Fever
☐ Chicken Pox	☐ Lead poisoning	☐ Seizures
☐ Congenital problems	☐ Measles	☐ Severe colds
☐ Croup	☐ Meningitis	☐ Severe head injury
☐ Diabetes	☐ Miscarriage	☐ Sexually transmitted disease
☐ Diphtheria	☐ Multiple sclerosis	☐ Thyroid disorders
☐ Dizziness	☐ Mumps	☐ Vision problems
☐ Ear aches	☐ Muscular Dystrophy	☐ Wearing glasses
☐ Ear infections	☐ Nose bleeds	☐ Whooping cough
☐ Eczema	☐ Other skin rashes	☐ Other
☐ Encephalitis	☐ Paralysis	_____
☐ Fevers	☐ Pleurisy	

List any current health concerns: _____

_____

List any recent health or physical changes: _____

_____

Nutrition

Meal	How often (times per week)	Typical foods eaten	Typical amount eaten
Breakfast	____ / week	_____	☐ No ☐ Low ☐ Med ☐ High
Lunch	____ / week	_____	☐ No ☐ Low ☐ Med ☐ High
Dinner	____ / week	_____	☐ No ☐ Low ☐ Med ☐ High
Snacks	____ / week	_____	☐ No ☐ Low ☐ Med ☐ High

Comments: _____

Most recent examinations

Type of examination	Date of most recent visit	Results
Physical examination		
Dental examination		
Vision examination		
Hearing examination		

Current prescribed medications	Dose	Dates	Purpose	Side effects

Current over-the-counter meds	Dose	Dates	Purpose	Side effects

Chemical Use History

Does the child/adolescent use or have a problem with alcohol or drugs? ☐ Yes ☐ No

If Yes, describe: _____

_____

Counseling/Prior Treatment History

Information about child/adolescent (past and present):

	Yes	No	When	Where	Reaction or overall experience
Counseling/Psychiatric treatment	☐	☐			
Suicidal thoughts/attempts	☐	☐			
Drug/alcohol treatment	☐	☐			
Hospitalizations	☐	☐			

Behavioral/Emotional

Please check any of the following that are typical for your child:

- ☐ Affectionate
- ☐ Aggressive
- ☐ Alcohol problems
- ☐ Angry
- ☐ Anxiety
- ☐ Attachment to dolls
- ☐ Avoids adults
- ☐ Bedwetting
- ☐ Blinking, jerking
- ☐ Bizarre behavior
- ☐ Bullies, threatens
- ☐ Careless, reckless
- ☐ Chest pains
- ☐ Clumsy
- ☐ Confident
- ☐ Cooperative
- ☐ Cyber addiction
- ☐ Defiant
- ☐ Depression
- ☐ Destructive
- ☐ Difficulty speaking
- ☐ Dizziness
- ☐ Drugs dependence
- ☐ Eating disorder
- ☐ Enthusiastic
- ☐ Excessive masturbation
- ☐ Expects failure
- ☐ Fatigue
- ☐ Fearful
- ☐ Frequent injuries
- ☐ Frustrated easily
- ☐ Gambling
- ☐ Generous
- ☐ Hallucinations
- ☐ Head banging
- ☐ Heart problems
- ☐ Hopelessness
- ☐ Hurts animals
- ☐ Imaginary friends
- ☐Impulsive
- ☐ Irritable
- ☐ Lazy
- ☐ Learning problems
- ☐ Lies frequently
- ☐ Listens to reason
- ☐ Loner
- ☐ Low self-esteem
- ☐ Messy
- ☐ Moody
- ☐ Nightmares
- ☐ Obedient
- ☐ Often sick
- ☐ Oppositional
- ☐Over active
- ☐ Overweight
- ☐ Panic attacks
- ☐ Phobias
- ☐ Poor appetite
- ☐ Psychiatric problems
- ☐ Quarrels
- ☐ Sad
- ☐ Selfish
- ☐ Separation anxiety
- ☐ Sets fires
- ☐ Sexual addiction
- ☐ Sexual acting out
- ☐ Shares
- ☐ Sick often
- ☐ Short attention span
- ☐ Shy, timid
- ☐ Sleeping problems
- ☐ Slow moving
- ☐ Soiling
- ☐ Speech problems
- ☐ Steals
- ☐ Stomach aches
- ☐ Suicidal threats
- ☐ Suicidal attempts
- ☐ Talks back
- ☐ Teeth grinding
- ☐ Thumb sucking
- ☐ Tics or twitching
- ☐ Unsafe behaviors
- ☐ Unusual thinking
- ☐ Weight loss
- ☐ Withdrawn
- ☐ Worries excessively
- ☐Other: _____
  _____

Please describe any of the above (or other) concerns: _____

How are problem behaviors generally handled? _____

_____

What are the family's favorite activities? _____

_____

What does the child/adolescent do with unstructured time? _____

_____

Has the child/adolescent experienced death? (friends, family pets, other) ☐ Yes ☐ No

At what age? ____ If Yes, describe the child's/adolescent's reaction: _____

_____

Have there been any other significant changes or events in your child's life? (family, moving, fire, etc.)

☐ Yes ☐ No If Yes, describe: _____

_____

Are you (on behalf of your child) or your child involved in any legal proceedings? (custody, probation, etc.)

_____

_____

_____

Any additional information that you believe would assist me in understanding your child/adolescent?

_____

_____

_____

Any additional information that would assist me in understanding current concerns or problems?

_____

_____

_____

What are your goals for the current consultation, evaluation, or therapy request? _____

_____

What family involvement would you like to see? _____

_____

Do you believe the child is suicidal at this time? ☐ Yes ☐ No

If Yes, explain: _____

_____

(ONLY COMPLETE IF THE PATIENT IS OVER THE AGE OF 18, OTHERWISE LEAVE BLANK)

Patient History Form – Adult Version

Patient's name:_____ Date: _____

Gender: ☐ F ☐ M Date of birth: _____ Age: _____

Form completed by (if someone other than Patient): _____

If you need any more space for any of the questions please use the back of the sheet.

Primary reason(s) for seeking services:

☐ Anger management ☐ Anxiety ☐ Coping ☐ Depression
☐ Eating disorder ☐ Fear/phobias ☐ Mental confusion ☐ Sexual concerns
☐ Sleeping problems ☐ Addictive behaviors ☐ Alcohol/drugs ☐ Psychosis
☐ ADHD ☐ Relationship problems
☐ Other mental health concerns (specify): _____

Type of therapy seeking: ☐ Individual ☐ Couples ☐ Family ☐Psychological Testing

If seeking **couples** or **family therapy**, please provide the following information for others that will be attending sessions:

Name Date of Birth Gender Insurance Carrier

_____
_____
_____
_____

Family Information

			Living		Living with you	
Relationship	Name	Age	Yes	No	Yes	No
Mother			☐	☐	☐	☐
Father			☐	☐	☐	☐
Spouse			☐	☐	☐	☐
Children			☐	☐	☐	☐
			☐	☐	☐	☐

Significant others (e.g., brothers, sisters, grandparents, step-relatives, half-relatives. Please specify relationship.

			Living		Living with you	
Relationship	Name	Age	Yes	No	Yes	No
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐

Marital Status (more than one answer may apply)

☐ Single
☐ Divorce in process: length of time: _____
☐ Unmarried, living together: Length of time: _____
☐ Legally married: Length of time: _____
☐ Separated: Length of time: _____
☐ Divorced: Length of time: _____
☐ Widowed: Length of time: _____
☐ Annulment: Length of time: _____
Total number of marriages: _____
Assessment of current relationship (if applicable): ☐ Good ☐ Fair ☐ Poor

Parental Information

☐ Parents legally married ☐ Mother remarried Number of times: _____
☐ Parents have ever been separated ☐ Father remarried Number of times: _____
☐ Parents divorced

Special circumstances (e.g., raised by person other than parents, information about spouse/children not living with you, etc.): _____

Development

Are there special, unusual, or traumatic circumstances that affected your development?
☐ Yes ☐No
If Yes, please describe: _____
Has there been history of child abuse? ☐Yes ☐ No
If Yes, which type(s)? ☐ Sexual ☐ Physical ☐ Verbal
If Yes, the abuse was as a: ☐ Victim ☐ Perpetrator
Other childhood issues: ☐ Neglect ☐ Inadequate nutrition
Other (please specify): _____
Comments re: childhood development: _____

Social Relationships

Check how you generally get along with other people: (check all that apply)

☐ Affectionate ☐ Aggressive ☐ Avoidant ☐ Fight/argue often ☐ Follower
☐ Friendly ☐ Leader ☐ Outgoing ☐ Shy/withdrawn ☐ Submissive
☐ Other (specify): _____

Sexual orientation: _____ Comments: _____
Sexual dysfunctions? ☐ Yes ☐ No
If Yes, describe: _____
Any current or history of being as sexual perpetrator? ☐ Yes ☐ No
If Yes, describe: _____

Cultural/Ethnic

To which cultural or ethnic group, if any, do you belong? _____
Are you experiencing any problems due to cultural or ethnic issues? ☐Yes ☐ No
If Yes, describe: _____
Other cultural/ethnic information: _____

Spiritual/Religious

How important to you are spiritual matters? ☐ Not ☐ Little ☐ Moderate ☐ Much
Are you affiliated with a spiritual or religious group? ☐Yes ☐ No
If Yes, describe: _____
Were you raised within a spiritual or religious group? ☐ Yes ☐ No
If Yes, describe: _____
Would you like your spiritual/religious beliefs incorporated into the counseling?
☐ Yes ☐ No
If Yes, describe: _____

Legal

Current Status

Are you involved in any active cases (traffic, civil, criminal)? ☐ Yes ☐ No
If Yes, please describe and indicate the court and hearing/trial dates and charges: __
_____
Are you presently on probation or parole? ☐ Yes ☐ No
If Yes, please describe: _____

Past History

Traffic violations: ☐ Yes ☐ No DWI, DUI, etc.: ☐ Yes ☐ No
Criminal involvement: ☐Yes ☐ No
Civil involvement: ☐ Yes ☐ No

If you responded Yes to any of the above, please fill in the following information.

Charges	Date	Where (city)	Results

Education

Fill in all that apply: Years of education: _____
Currently enrolled in school? ☐ Yes ☐ No
☐ High school grad/GED
☐ Vocational: Number of years: _____ Graduated: ☐Yes ☐ No
Major:_____
☐ College: Number of years: _____ Graduated: ☐Yes ☐ No
Major: _____
☐ Graduate: Number of years: _____ Graduated: ☐Yes ☐ No
Major: _____
Other training: _____
Special circumstances (e.g., learning disabilities, gifted): _____

Employment

Begin with most recent job, list job history:

Employer	Dates	Title	Reason left the job	How often miss work?

Currently: ☐ FT ☐ PT ☐ Temp ☐ Laid-off ☐ Disabled ☐ Retired
☐ Social Security ☐ Student
☐ Other (describe): _____

Military

Military experience? ☐Yes ☐No Combat experience? ☐ Yes ☐ No
Where: _____
Branch: _____ Discharge date: _____
Date drafted: _____ Type of discharge: _____
Date enlisted: _____ Rank at discharge: _____

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

Activity	How often now?	How often in the past?

Medical/Physical Health

☐ AIDS	☐ Dizziness	☐ Nose bleeds
☐ Alcoholism	☐ Drug abuse	☐ Pneumonia
☐ Abdominal pain	☐ Epilepsy	☐ Rheumatic Fever
☐ Abortion	☐ Ear infections	☐ STD's
☐ Allergies	☐ Eating problems	☐ Sleeping disorders
☐ Anemia	☐ Fainting	☐ Sore throat
☐ Appendicitis	☐ Fatigue	☐ Scarlet Fever
☐ Arthritis	☐ Frequent urination	☐ Sinusitis
☐ Asthma	☐ Headaches	☐ Smallpox
☐ Bronchitis	☐ Hearing problems	☐ Stroke
☐ Bed wetting	☐ Hepatitis	☐ Sexual problems
☐ Cancer	☐ High blood pressure	☐ Tonsillitis
☐ Chest pain	☐ Kidney problems	☐ Tuberculosis
☐ Chronic pain	☐ Measles	☐ Toothache
☐ Colds/Coughs	☐ Mononucleosis	☐ Thyroid problems
☐ Constipation	☐ Mumps	☐ Vision problems
☐ Chicken Pox	☐ Menstrual pain	☐ Vomiting
☐ Dental problems	☐ Miscarriages	☐ Whooping cough

☐ Diabetes ☐ Neurological disorders ☐Other (describe): _____
☐ Diarrhea ☐ Nausea _____

List any current health concerns: _____

List any recent health or physical changes: _____

_____

Nutrition

Meal	How often (times per week)	Typical foods eaten	Typical amount eaten
Breakfast	___ / week	_____	☐ No ☐ Low ☐ Med ☐ High
Lunch	___ / week	_____	☐ No ☐ Low ☐ Med ☐ High
Dinner	___ / week	_____	☐ No ☐ Low ☐ Med ☐ High
Snacks	___ / week	_____	☐ No ☐ Low ☐ Med ☐ High

Comments: _____

Current prescribed medications	Dose	Dates	Purpose/Side effects
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Current over-the-counter meds	Dose	Dates	Purpose/Side effects
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you allergic to any medications or drugs? ☐ Yes ☐ No

If Yes, describe: _____

_____

	Date	Reason	Results
Last physical exam	_____	_____	_____
Last doctor's visit	_____	_____	_____
Last dental exam	_____	_____	_____
Most recent surgery	_____	_____	_____
Other surgery	_____	_____	_____
Upcoming surgery	_____	_____	_____

_____

Family history of medical problems: _____

_____

Please check if there have been any recent changes in the following:

☐ Sleep patterns ☐ Eating patterns ☐ Behavior ☐ Energy level
☐ Physical activity level ☐ General disposition ☐ Weight ☐ Nervousness/tension

Describe changes in areas in which you checked above: _____

_____

Chemical Use History

	Method of use and amount	Frequency of use	Age of first use	Age of last use	Used in last 48 hours		Used in last 30 days	
					Yes	No	Yes	No
Alcohol					☐	☐	☐	☐
Barbiturates					☐	☐	☐	☐
Valium/Librium					☐	☐	☐	☐
Cocaine/Crack					☐	☐	☐	☐
Heroin/Opiates					☐	☐	☐	☐
Marijuana					☐	☐	☐	☐
PCP/LSD/Mescaline					☐	☐	☐	☐
Inhalants					☐	☐	☐	☐
Caffeine					☐	☐	☐	☐
Nicotine					☐	☐	☐	☐
Over the counter					☐	☐	☐	☐
Prescription drugs					☐	☐	☐	☐
Other drugs					☐	☐	☐	☐

Substance of preference

1. _____ 3. _____
2. _____ 4. _____

Substance Abuse Questions

Describe when and where you typically use substances: _____

Describe any changes in your use patterns: _____

Describe how your use has affected your family or friends (include their perceptions of your use): _____

Reason(s) for use:

☐ Addicted ☐ Build confidence ☐ Escape ☐ Self-medication

☐ Socialization ☐ Taste ☐Other (specify): _____

How do you believe your substance use affects your life? _____

Who or what has helped you in stopping or limiting your use? _____

Does/Has someone in your family present/past have/had a problem with drugs or alcohol?

☐ Yes ☐ No If Yes, describe: _____

Have you had withdrawal symptoms when trying to stop using drugs or alcohol? ☐ Yes ☐ No

If Yes, describe: _____

Have you had adverse reactions or overdose to drugs or alcohol? (describe): _____

Have drugs or alcohol created a problem for your job? ☐ Yes ☐ No

If Yes, describe: _____

Counseling/Prior Treatment History

Information about Patient (past and present):

	Yes	No	When	Where	Your reaction to overall experience
Counseling/Psychiatric treatment	☐	☐			
Suicidal thoughts/attempts	☐	☐			
Drug/alcohol treatment	☐	☐			
Hospitalizations	☐	☐			
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	☐	☐			

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

☐ Aggression
☐ Alcohol dependence
☐ Anger
☐ Antisocial behavior
☐ Anxiety
☐ Avoiding people
☐ Chest pain
☐ Cyber addiction
☐ Depression
☐ Disorientation
☐ Distractibility
☐ Dizziness
☐ Drug dependence
☐ Eating disorder
☐ Elevated mood
☐ Fatigue
☐ Gambling
☐ Hallucinations
☐ Heart palpitations
☐ High blood pressure
☐ Hopelessness
☐ Impulsivity
☐ Irritability
☐ Judgment errors
☐ Loneliness
☐ Memory impairment
☐ Mood shifts
☐ Panic attacks
☐ Phobias/fears
☐ Recurring thoughts
☐ Sexual addiction
☐ Sexual difficulties
☐ Sick often
☐ Sleeping problems
☐ Speech problems
☐ Suicidal thoughts
☐ Thoughts disorganized
☐ Trembling
☐ Withdrawing
☐ Worrying
☐ Other (specify): _____

Briefly discuss how the above symptoms impair your ability to function effectively: _____

Any additional information that would assist me in understanding your concerns or problems:

What are your goals for therapy? _____

Do you feel suicidal at this time? ☐ Yes ☐ No

If Yes, explain: _____

IF you feel you need immediate care please call the National Suicide Prevention Hotline at 800-273-8255, call 911, or go directly to your nearest emergency room as we do not provide emergency care.

Privacy Policies
Center for Professional Psychology

Janissa D. Jackson, Ph.D., PLLC, Narissa R. Griffin, Ph.D. PLLC

Danielle Wheeler, LMFT, LPC, Danielle Litchford, LMFT, LPC, Bill Thornton, Ph.D., PLLC

Current Privacy Officer: Janissa D. Jackson, Ph.D.

This form describes the confidentiality of your medical records, how the information is used, your rights, and how you may obtain this information.
My Legal Duties

Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI*" refers to information in your health record that could identify you.
- "*Treatment, Payment and Health Care Operations*"
  - *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
  - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- *Treatment is not* defined as reviewing prospective patient intake paperwork or provision of a good faith estimate although this information is treated with the utmost care. If a patient is screened and not deemed appropriate for the services provided at the Center for Professional Psychology, the patient will then be given the option of retaining their intake paperwork or it will be shredded at that time with appropriate referrals provided "*Use*" applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

State and Federal laws require that I keep your medical records private. Such laws require that I provide you with this notice informing you of my privacy of information policies, your rights, and my duties. I am required to abide these policies until replaced or revised. I have the right to revise my privacy policies for all medical records, including records kept before policy changes were made. Any changes in this notice will be made available upon request before changes take place.

The contents of material disclosed to us in an evaluation, intake, or therapy session are covered by the law as private information. I respect the privacy of the information you provide us and I abide by ethical and legal requirements of confidentiality and privacy of records.

Use of Information
Information about you may be used by the personnel associated with my office for diagnosis, treatment planning, treatment, and continuity of care. I may disclose it to health care providers who provide you with treatment, such as doctors, nurses, mental health professionals, and mental health students and mental health professionals or business associates affiliated with my office such as billing, quality enhancement, training, and audits. In any disclosure, the minimum necessary will be disclosed in order to protect the privacy of the patient.

Both verbal information and written records about a patient cannot be shared with another party without the written consent of the patient or the patient's legal guardian or personal representative. It is the policy of my office not to release any information about a patient without a signed release of information except in certain emergency situations or exceptions in which patient information can be disclosed to others without written consent. Some of these situations are noted below, and there may be other provisions provided by legal requirements.

Duty to Warn and Protect
When a patient discloses intentions or a plan to harm another person or persons, the health care professional is required to report this information to legal authorities and may need to seek hospitalization for the patient. In cases in which the patient discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the patient.

Public Safety

Health records may be released for the public interest and safety for public health activities, judicial and administrative proceedings, law enforcement purposes, serious threats to public safety, essential government functions, military, and when complying with worker's compensation laws. This could include Health Oversight Activities such as receiving a subpoena from the Arkansas Board of Examiners in psychology.

Abuse

If a patient states or suggests that he or she is abusing a child or vulnerable adult, or has recently abused a child or vulnerable adult, or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities. If a patient is the victim of abuse, neglect, violence, or a crime victim, and their safety appears to be at risk, I may share this information with law enforcement officials to help prevent future occurrences and capture the perpetrator. This applies to adult and domestic abuse as well..

For Operations

I may use and give information about you to make sure that the services and benefits you get are correct and of high quality. I may share your health information with business partners who perform work for my office and I require that my business partners use the same level of privacy and security as I do when handling your health information.

Judicial and Administrative Proceedings

If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information without the written authorization of you or your legally appointed representative or a court order. The privilege does not apply when you are being evaluated by a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

In the Event of a Patient's Death

In the event of a patient's death, the spouse or parents of a deceased patient have a right to access their child's or spouse's records.

Professional Misconduct

Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor patients or patients of any age having a legal guardian, the legal guardian retains the right to access the patient's records. Appropriate procedures to ensure the authority of that legal guardian will be made such as requesting court documentation.

Worker's Compensation/Specialized Government Functions

In the event that an employer seeks treatment on behalf of a patient, certain information is typically required to be reported to that employer. The patient must review and choose to authorize this information if it is required for payment. This does not apply to any psychotherapy notes. Furthermore, at times release of information is required by government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

Other Provisions

When payment for services are the responsibility of the patient, or a person who has agreed to providing payment, and payment has not been made in a timely manner, collection agencies may be utilized in collecting unpaid debts or I may elect to pursue small claims court. The specific content of the services (e.g., diagnosis, treatment plan, progress notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the patient's credit report may state the amount owed, the time-frame, and the name of the office or collection source.

Insurance companies, managed care, and other third-party payers are given information that they request regarding services to the patient. Information which may be requested includes type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, and summaries. The minimum necessary will be carefully determined by the treating psychologist.

Information may be disclosed to other entities that have a formal business associate contract with, in which they promise to maintain the confidentiality of this data except as is specifically allowed in the contract or otherwise specified by the law. If you wish, you may request and obtain a list of all current business associate contracts.

Information about patients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the patient, or any identifying information, is not disclosed. Clinical information about the patient is discussed.

In the event in which my office must telephone the patient for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please notify me in writing where I may reach you by phone and how you would like me to identify myself. For example, you might request that when I phone you at home or work, I do not say the name of my office or the nature of the call, but rather my first name only. If this information is not provided to me (see first page of new patient paperwork), I will adhere to the following procedure when making phone calls: First I will ask to speak to the patient (or guardian) without identifying my full name. If the person answering the phone asks for more identifying information I will say that it is a personal call. I will not identify my office (to protect confidentiality). If I reach an answering machine or voice mail I will follow the same guidelines.

In providing an email to be assigned for our secure patient portal, it is recommended that a patient use a personal email and take special care that their user name and password are kept private as PHI may be stored within the portal to be easily accessed by the patient. Two factor authentication is recommended as an additional security measure.

Your Rights

You have the right to request to review or receive your medical files. The procedures for obtaining a copy of your medical information is as follows. You may request a copy of your records in writing with an original (not photocopied) signature. If your request is denied, you will receive a written explanation of the denial. Records for non-emancipated minors must be requested by their custodial parents or legal guardians. The charge for this service is $.15 per page, plus postage or if requested electronically, only the cost of the appropriate jump drive device will be assessed.

You have the right to cancel a release of information by providing me with written notice. If you desire to have your information sent to a location different than the address on file, you must provide this information in writing.

You have the right to restrict which information might be disclosed to others.

You have the right to request an amendment to your records. This request will be considered and a response will be given to you in writing as well as an explanation of your additional rights if this amendment is denied by the psychologist.

You have the right to request that information about you be communicated by other means or to another location. This request must be made to me in writing.

You have the right to disagree with the medical records in my files. You may request that this information be changed. Although I might deny changing the record, you have the right to make a statement of disagreement, which will be placed in your file.

You have the right to restrict disclosure of PHI to a health plan if you pay out of pocket in full for the healthcare service.

You have the right to be notified if there is a breach of any unsecured Protected Health Information.

You have the right to know what information in your record has been provided to whom. Request this in writing.

You must sign an authorization before we can release your PHI for any uses or disclosures not described in this privacy notice.

You have the right to a Good Faith Estimate of cost if you are a cash paying patient and not billing a third party.

You will be given a written copy of this notice.

Complaints

If you have any complaints or questions regarding these procedures, please contact your service provider directly or Dr. Jackson who serves as the privacy officer. We will get back to you in a timely manner. For psychologists, you can also contact the state psychological association and speak to the chairperson of the ethics committee. The number is (501) 614-6500. He or she can help clarify your concerns or tell you how to file a complaint. You may also contact the Arkansas Psychology Board (501-682-6167). For counselors, please contact the Arkansas Board of Examiners in Counseling (501-683-5800). These are the organizations that license those of us in the independent practice of psychology and professional counseling respectively. You may also submit a complaint to the Secretary of the U.S. Dept. of Health and Human Services(1-800-368-1019). If you file a complaint I will not retaliate in any way.

Private Practice Social Media Policy

This document outlines office policies related to use of Social Media. Please read it to understand how we at Center for Professional Psychology conduct ourselves on the Internet as mental health professionals and how you can expect us to respond to various interactions that may occur between us on the Internet.

If you have any questions about anything within this document, we encourage you to bring them up during your next visit. As new technology develops and the Internet changes, there may be times when we need to update this policy. If we do so, we will notify you in writing of any policy changes and make sure you have a copy of the updated policy.

FRIENDING

We do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). We believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

FOLLOWING

Our primary concern is your privacy. You are welcome to use your own discretion in choosing whether to follow us on Facebook.

Note that we will not follow you back. We do not follow current or former clients on blogs or Twitter. Our reasoning is that we believe casual viewing of clients' online content outside of the therapy hour can create confusion in regard to whether it's being done as a part of your treatment or to satisfy our personal curiosity. In addition, viewing your online activities without your consent and without our explicit arrangement towards a specific purpose could potentially have a negative influence on our working relationship. If there are things from your online life that you wish to share with us, please bring them into your sessions where we can view and explore them together, during the therapy hour.

INTERACTING

Please do not use SMS (mobile phone text messaging) or messaging on Social Networking sites such as Twitter, Facebook, or LinkedIn to contact us. These sites are not secure and we may not read these messages in a timely fashion. Do not use Wall postings, @replies, or other means of engaging with us in public online if we have an already established client/therapist relationship. Engaging with us this way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart. If you need to contact us between sessions, the best way to do so is by phone, secure email or vial the patient portal.

USE OF SEARCH ENGINES

It is NOT a regular part of our practice to search for clients on Google or Facebook or other search engines. Extremely rare exceptions *may* be made during times of crisis. If we have a reason to suspect that you are in danger and you have not been in touch with us via our usual means (coming to appointments, phone, or email) there *might* be an instance in which using a search engine (to find you, find someone close to you, or to check on your recent status updates) becomes necessary as part of ensuring your welfare. These are unusual situations and if we ever resort to such means, we will fully document it and discuss it with you at your next appointment.

GOOGLE READER

We do not follow current or former clients on Google Reader and we do not use Google Reader to share articles. If there are things you want to share with us that you feel are relevant to your treatment whether they are news items or things you have created, we encourage you to bring these items of interest into our sessions.

BUSINESS REVIEW SITES

You may find our psychology practice on sites such as Yelp, Healthgrades, Yahoo Local, Bing, or other places which list businesses. Some of these sites include forums in which users rate their providers and add reviews. Many of these sites comb search engines for business listings and automatically add listings regardless of whether the business has added itself to the site. If you should find our listing on any of these sites, please know that our listing is NOT a request for a testimonial, rating, or endorsement from you as our client.

The American Psychological Association's Ethics Code states under Principle 5.05 that it is unethical for psychologists to solicit testimonials: "Psychologists do not solicit testimonials from current therapy clients/patients or other persons who because of their particular circumstances are vulnerable to undue influence."

Of course, you have a right to express yourself on any site you wish. But due to confidentiality, we cannot respond to any review on any of these sites whether it is positive or negative. We urge you to take your own privacy as seriously as we take our commitment of confidentiality to you. You should also be aware that if you are using these sites to communicate indirectly with us about your feelings about our work, there is a good possibility that we may never see it.

If we are working together, we hope that you will bring your feelings and reactions to our work directly into the therapy process. This can be an important part of therapy, even if you decide we are not a good fit. None of this is meant to keep you from sharing that you are in therapy with us wherever and with whomever you like. Confidentiality means that we cannot tell people that you are our client and our Ethics Code prohibits us from requesting testimonials. But you are more than welcome to tell anyone you wish that you see a therapist here, or how you feel about the treatment we have provided to you, in any forum of your choosing.

If you do choose to write something on a business review site, we hope you will keep in mind that you may be sharing personally revealing information in a public forum. We urge you to create a pseudonym that is not linked to your regular email address or friend networks for your own privacy and protections.

LOCATION-BASED SERVICES

If you use location-based services on your mobile phone, you may wish to be aware of the privacy issues related to using these services. We do not place our practice as a check-in location on various sites. However, if you have GPS tracking enabled on your device, it is possible that others may surmise that you are a therapy client due to regular check-ins at our office on a weekly basis. Please be aware of this risk if you are intentionally "checking-in" from our office.