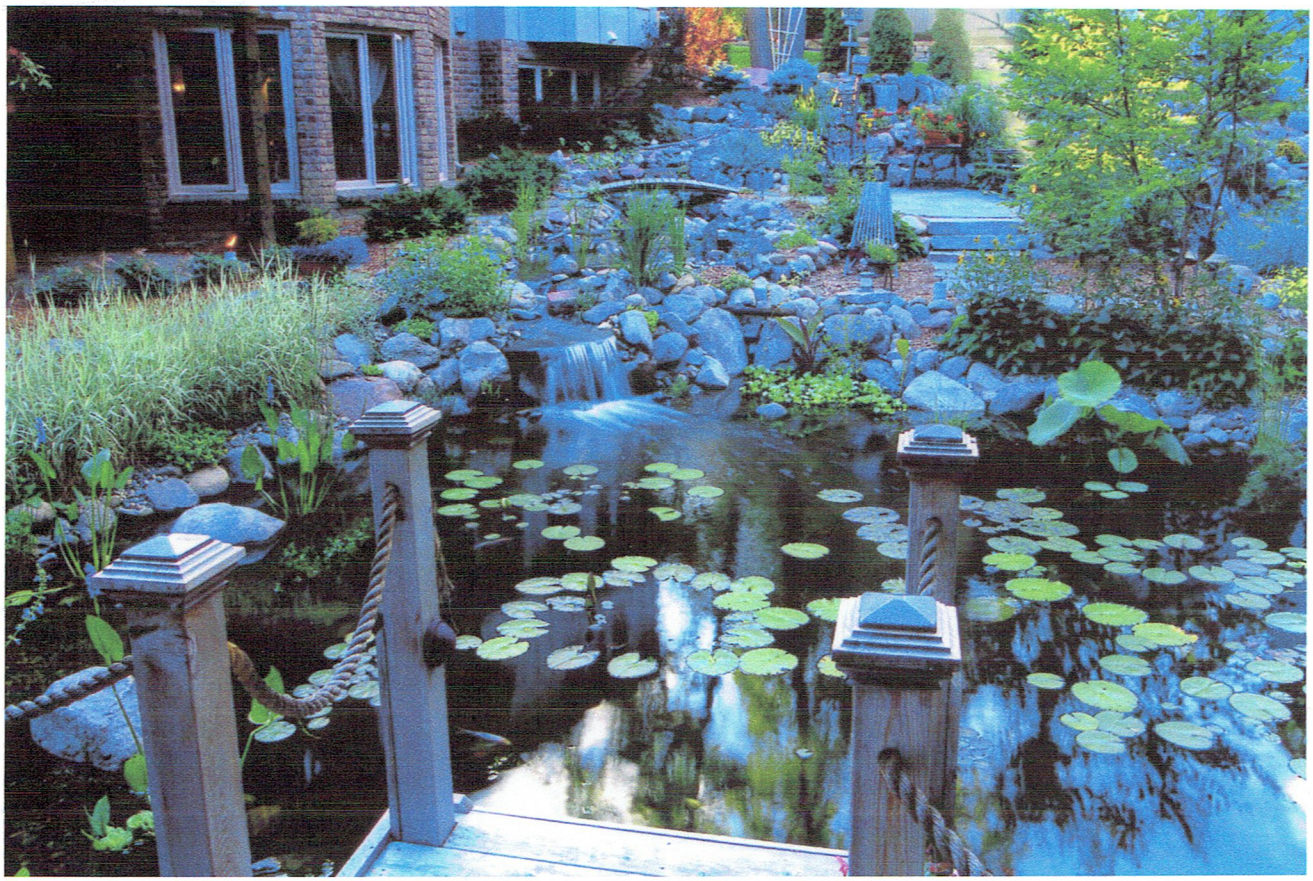
New Client Background Information Packet



for the office of:

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My goal in asking all of this information is to obtain a more complete understanding of you history and background. Your accurate and thorough completion of this form will facilitate your therapy. By answering the questions on your own time, therapy time will not need to be spent on these informational matters. All of the information that your provide us will be treated confidentially. If there is any question which you wish to decline answering, simply write no answer in the space provided.

General Information

Name _____

Address _____
(street)

_____
(city) (state) (zip)

Phone #(s) work: _____ home: _____

Best place to call you _____ Best time to call you _____

Present Age: _____ Date of Birth: _____ Marital status: _____

Referred by: _____

Your occupation: _____

Name of your physician: _____ Date of last physical: _____

Name of your psychiatrist: _____ Date of last visit: _____

Are you currently suffering from any significant illness or medical problem?

Please list any prescribed or non-prescribed medications you currently take & dosage:

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Third Party Payment Information

If you are planning to submit your therapy sessions to your insurance company for reimbursement, I will need the following information.

Name of Insurance Company _____

Insurance Company Address _____

City_____State_____Zip Code_____

Attention:_____Insurance Phone # ( )_____

Full Name of Insured (Policyholder) _____

Policy ID Number _____Group Number _____

Date of Birth of Person Receiving Services_____

Date of Birth of Policyholder _____

Please note:

The use of a third party to pay for therapy sessions requires that the insurance company be involved in the ongoing therapy process. They have the right to know the diagnosis of your condition. They have the right to know how serious your present symptoms are. They have the right to know how we are working on the issue and to decide if they will cover that type of treatment plan. And they have the right to timely updates on our work, and, in some cases, to have complete copies of your therapy file.

Insurance companies have a right to this information because they are paying for your therapy. But you need to consider that their rules about confidentiality may be different than those of therapists. To be sure as to where your records are going, and who will have access to those records are going, and know who will have access to those records, so please talk with your insurance company about their policy regarding such matters and ask what precautions they take to prevent your information from being released without your specific consent.

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Limitations to Confidentiality

As a client receiving psychological services delivered by a licensed psychologist in the State of Minnesota, you are entitled to have any and all information relating to your history, your personal data, and the work done in this office kept confidential unless you agree to release that information in writing.

However, there are exceptions to confidentiality that you need to be aware of. The State of Minnesota has legislated three exceptions to your protection of confidential material:

1) I cannot keep confidential any information concerning the physical or emotional abuse of children. If you provide me with any information that suggests a child has been or will be harmed, I am required by law to notify the appropriate authorities.

2) I cannot keep confidential any information concerning your intention to harm yourself. If you provide me with any information that suggests you intend to harm yourself, I am required by law to notify the appropriate authorities and your family members.

3) I cannot keep confidential any information concerning your intention to harm another person. If you provide me with any information that suggests your intend to harm another person, I am required by law to notify the appropriate authorities and the person in danger.

4) I cannot keep confidential any information concerning any ethics violation involving another therapist, psychiatrist, or health care provider. If I learn about such violations, I am required by my Code of Ethics to report such violations to the appropriate professional board for inquiry.

In the event that you ask for a third party payer to pay for your psychological services, you need to know that your insurer reserves the right to request your record, ask for reports concerning your case, and even to ask for all files related to your psychological work.

I have read the limits of confidentiality and understand the limits placed on you as a psychologist.

Signature _____ Date _____

What is the nature of the problem that brought you into therapy at this time?

_____

_____

_____

How severe is this problem? (Mark an "x" on the continuum at the appropriate spot)

mildly upsetting	moderately troublesome	severe	very severe	totally incapacitating

Have you consulted anyone else about your present problem? (other therapists, doctors, or chiropractors)

_____

_____

_____

Check any of the following that apply to you:

__ Headaches
__ Palpitations
__ Bowel disturbances
__ Anger
__ Feel tense
__ Depressed
__ Unable to relax
__ Can't make friends
__ Can't keep a job
__ Financial problems
__ Nightmares
__ Dizziness
__ Stomach Trouble
__ Can't make decisions
__ Take sedatives
__ Feel panicky
__ Conflict
__ Suicidal ideas
__ Overambitious
__ Inferiority feelings
__ Memory problems
__ Shy with people
__ Fainting spells
__ Anxiety
__ No appetite
__ Insomnia
__ Alcoholism
__ Tremors
__ Take drugs
__ Allergies
__ Fatigue
__ Lonely
__ Sexual problems

Check any of the following words that apply to you:

__ worthless
__ Life is empty
__ Incompetent
__ Evil
__ Agitated
__ Lonely
__ Worthwhile
__ Attractive
__ Dumb
__ Dangerous
__ Generally happy
__ caretaker
__ Useless
__ Inadequate
__ Naive
__ Morally wrong
__ Horrible thoughts
__ Unloved
__ Misunderstood
__ Sympathetic
__ Confident
__ A liar
__ A problem solver
__ resentful
__ Nobody
__ Stupid
__ Guilty
__ Depressed
__ Ugly
__ Confused
__ Restless
__ Intelligent
__ Considerate
__ Suicidal
__ Isolated
__ completely alone

Family History

Father: Living or deceased? _____
If deceased, your age at time of his death? _____
Cause of death? _____
If alive, his present age? _____

His occupation _____ General Health _____

Mother: Living or deceased? _____
If deceased, your age at time of his death? _____
Cause of death? _____
If alive, his present age? _____

Her occupation _____ General Health _____

If your parents are alive, what is your present relationship with them? _____

_____

_____

_____

About your siblings

of brothers _____ Current ages _____

# of sisters _____ Current ages _____

What is your present relationship with your siblings? _____

_____

_____

Who are the most important people in your life at present? _____

_____

_____

Past Therapy History

Have you ever been in therapy before? _____

_____

With Whom? _____ When? _____

What was the nature of the problem that led you to start therapy? _____

Do you feel your therapy was successful? _____

In that experience, what did you like about the therapy? _____

In that experience, what didn't you like about the therapy? _____

Sexual History

Have you ever experienced any problems or concerns with your sexuality?

In general, how would you describe your sexual life?

If you would like any change in your sexual life, what would it be?

Have you ever experienced a traumatic sexual event?

Relationship History

Name of significant other _____ His/Her Occupation: _____

Are you married? _____ Living Together? _____ If so, how long did you know each other before you committed to each other _____

In what areas are you and your partner compatible? _____

_____

In what areas are you and your partner incompatible? _____

_____

How do you get along with your partner's parents? _____

How many children do you have [ ] Please list their names, sex, and ages:

_____ _____

_____ _____

_____ _____

Do any of your children pose special problems? If yes, please elaborate. _____

_____

_____

Give brief details concerning any miscarriages, abortions, or losses of your children.

_____

_____

_____

Do your children live with you? _____ Full time? _____ Part-time? _____

If your children are older, are any of them married? _____

_____

Are any of them parents? _____

_____

_____

How many grandchildren do you have? [ ]

Experiences of Trauma or Victimization

An important issue we may talk about in therapy is any experience you have had in which you felt victimized, traumatized, or at risk in some way because of the dangerous, aggressive, violent, or predatory behavior of another person or persons. If you have any history like this, please let me know when you feel comfortable enough to do so--either on this form or in a therapy session.

Have you been the victim of emotional abuse?_____ As a child? _____ As an adult? _____

Have you been the victim of physical abuse? _____ As a child? _____ As an adult? _____

Have you ever experienced any of the following situations? Please check any you know about and are willing/needing to talk about.

_____rape

_____incest

_____abduction

_____mugging

_____armed robbery

_____stalking

_____obscene phone calls

_____therapy abuse

_____accident in which you were seriously injured

_____combat experience

_____participation in or encounter with gang members

_____fraternity/sorority hazing

_____any form of ritual abuse

_____unusual teasing, rough physica; play, or taunting

_____victimization by a cult

_____inappropriate sexual touch by a teacher, troop leader, coach or religious leader

_____medical procedure which you regard have having been traumatic

Thank you for taking the time to complete this form for me. Please know that I will read it over carefully, and that I will protect the confidentiality of this information. At any time, during the course of therapy, you can add information or update this form.

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