MD Therapists

MENTAL • EMOTIONAL • SPIRITUAL HEALTHCARE

1340 E Route 66 Suite 108 Glendora, CA 91740 626.863.3393

This questionnaire will help me get to know a little more about your situation and how I may be of help to you. If you feel uncomfortable with any question you may leave it blank and we can discuss it when we meet.

ADULT INTAKE FORM

Name:_____ Date:_____Physical Address: _____
Mailing Address: _____ Phone (Cell): _____

Messages okay?_____ Phone (Home): _____Messages okay?_____
Email (optional): _____ EMERGENCY CONTACT Name: _____
Relationship to Client:_____ Home Phone:_____ Work Phone:_____
Cell Phone:_____ F

FINANCIAL INFORMATION

How do you intend to pay for treatment? (cash, check, insurance):_____
Insurance Company: _____ Phone number: _____

Policy number:_____ Group number: _____

PERSONAL INFORMATION

Date of Birth: _____ Age: _____ Male or Female or Transgender
Identify as:_____ Religious Preference/Affiliation: _____ Race/Ethnicity: _____

Marital Status: Single Married Divorced Cohabitating Separated Widowed Other

If you have a partner or spouse, how long have you been together? _____ If you are divorced, when did you divorce? _____ If you are widowed, when and how did your spouse die? _____ If applicable, please list names and ages of your children: _____
_____
_____
_____

If applicable, please list the name and ages of the persons living in your home and your relationship with them: _____
_____
_____
_____

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Family/Social History

Where were you born? _____ Where did you grow up? _____ What is your mother's name? _____ Biological parent? Yes or No

If living, age and health status: _____
If deceased, year and cause of death: _____
What is your father's name? _____ Biological parent? Yes or No If living, age and health status _____

If deceased, year and cause of death _____

Did your parents marry? Yes or No Did your parents separate or divorce? Yes or No If yes, when? _____
With whom did you primarily live while growing up? (circle one) Both Parents Mother or Father
Other:_____

Please list the names and ages of your siblings:

_____

_____

Before the age of 16, to what degree did you experience the following?

0-None Not at all 1-Slight Rare, less than a day or two 2-Mild Several days

3-Moderate More than half the days 4-Severe Nearly every day

A chaotic home environment (e.g., frequent fighting, minimal structure, etc.) 0 1 2 3 4

Emotional reactions from your primary caregiver(s) that did not match the severity of what happened (e.g., extreme anger to a small mistake or minimal reaction to an abusive or harsh situation) 0 1 2 3 4 2

Emotional neglect, meaning your problems and experiences were ignored, and you felt that there was no attention or support from your primary caregiver 0 1 2 3 4

Psychological abuse at home (yelled at, falsely punished, subordinated to your siblings, or blackmailed) 0 1 2 3 4

Physical abuse (hit, kicked, beaten up or other types of physical abuse) 0 1 2 3 4

You were bullied, socially ostracized or had difficulties making friends 0 1 2 3 4

You were disciplined or reprimanded by teachers, including sent home, or suspended from school, etc.
0 1 2 3 4

You missed a lot of school 0 1 2 3 4

Financial hardship or strain 0 1 2 3 4

Any other details about your childhood or adolescence you'd like to share:

_____

Education and Employment History

Are you going to school now? Yes No Full-time_____ Part-time _____ If yes, where are you going to school? _____ Number of years of education completed _____ (Please count 1st grade as the 1st year, so if you completed 4 years of high school that is 12 years, completed 4 years of college is 16, etc.)

Did you ever receive any special education services (e.g. academic tutoring, IEP, classroom accommodations)? Yes No If yes, give details: _____

Are you working now? Yes or No Full-time or Part-time_____ If yes, what is your occupation: _____ If no, what was the last job you held: _____

Are you receiving or have you applied for medical leave or disability benefits? Yes or No

Have you ever received medical or disability benefits? Yes or No If yes, give details:

_____

CURRENT PROBLEMS AND TREATMENT HISTORY

Briefly describe the problem for which you are seeking counseling?

_____

_____

When did you start having these problems? _____

Have you ever had problems like this before? Yes or No If yes, when?

_____

What would you like to see happen as a result of counseling?

_____

_____

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Are you currently seeing another mental health professional? Yes or No If yes, indicate: Provider's name _____ Date treatment began_____

Have you previously been in psychotherapy or counseling, including individual, group, marital or family therapy? Yes or No If yes, please provide the following information: Date(s) of treatment Problem for which treatment was sought _____

Did you find it helpful? If yes, in what way was it helpful? If not, in what way was it unsatisfactory? Y / N Y / N

Have you ever made a suicide attempt? Yes or No

Have you ever purposely harmed yourself (cutting, burning, or other)? Yes or No

Have you ever been hospitalized for mental or emotional difficulties or for drug or alcohol abuse? Yes or No If yes, please complete the following chart.

When were you hospitalized?

For how long?

Reasons for hospitalization or partial hospitalization Was it voluntary? Y / N Y / N Y / N

Do you currently take medications or supplements to treat mental/emotional difficulties or substance. If so please list to the best of your ability: _____

Medication Name Dosage/ Frequency When started?

Name of Prescriber Prescribed for what symptoms?

Please list medications you have taken previously to treat mental or emotional difficulties or drug or alcohol abuse: _____

_____

Do any biological relatives have any history of psychiatric, emotional and/or substance use problems?

Do any of your family members Hyperactivity/attention deficit disorder (ADHD) Alcohol or drug abuse, Panic attacks or phobias or anxiety Depression Schizophrenia Bipolar disorder Neurological condition? If so, please list who they are to you and their diagnosis:

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MEDICAL HISTORY

Have you ever had any serious, chronic or recurrent health problems or disabilities? Yes or No If yes, please describe: _____

_____

Have you ever had a head injury? Yes or No If yes, please describe: _____

_____

Are you currently taking medications for any physical health problems? Yes or No If yes, please explain:
Medication Name When Started? _____
Prescribed for what symptoms? _____

Have you been hospitalized for any physical problems? Yes or No. If so, please include the dates and reason for hospitalization:

_____

_____

When was your last physical examination by a physician? _____ Do you have any additional medical concerns not listed above? _____

Do you exercise? Yes or No If yes: how many times per week? ____how many minutes on average? ____ mins.

OTHER INFORMATION

Have you ever been involved in a lawsuit? Yes or No If yes, please describe the circumstances and give dates:

_____

Have you ever been arrested? Yes or No If yes, please describe the circumstances and give dates:

_____

Have you experienced any particular sources of stress in the last year? Yes or No

If yes, please explain: _____

_____

Are there any other health care professionals (e.g. physicians, psychotherapists) who have information that might help in your treatment? Yes or No

Is there any other information that you would like me to know?

_____

_____

Diagnostic Screening Tool

Section I: Mood During the past MONTH, how much have you been bothered by the following problems?

0-None Not at all 1-Slight Rare, less than a day or two 2-Mild Several days

3-Moderate More than half the days 4-Severe Nearly every day

1. Feeling more irritated, grouchy, or angry than usual? 0 1 2 3 4 2.
2. Feeling so good, excited, or hyper that other people thought you were not your normal self or you got into trouble? 0 1 2 3 4 3.
3. Sleeping less than usual, but still had a lot of energy? 0 1 2 3 4 4.
4. Starting lots more projects than usual or doing more risky things than usual? 0 1 2 3 4

At any time in your life, how much have you ever been bothered by the following problems?

5. Little interest or pleasure in doing things 0 1 2 3 4 6.
6. Feeling down, depressed, or hopeless 0 1 2 3 4 7.
7. Feeling more irritated, grouchy, or angry than usual 0 1 2 3 4 8.
8. Sleeping less than usual, but still have a lot of energy 0 1 2 3 4 9.
9. Starting lots more projects than usual or doing more risky things than usual 0 1 2 3 4
10. 10. Thoughts of actually hurting yourself 0 1 2 3 4

Section II: Sleep During the past MONTH, how much (or how often) have you been bothered by the following problems?

11. Persistent difficulty falling asleep or staying asleep? 0 1 2 3 4 8
12. Daytime problems related to trouble sleeping, such as fatigue, increased irritability, or trouble concentrating? 0 1 2 3 4 13.
13. Worry or distress about your sleep? 0 1 2 3 4
14. How many hours of sleep do you get in an average night? _____

Section III: Anxiety During the past MONTH, how much (or how often) have you been bothered by the following problems?

14. Having a panic attack that came out of the blue (a sudden, unpredicted onset of intense fear or discomfort accompanied by intense bodily sensations and an intense urge to flee that reached its peak intensity within several minutes)? 0 1 2 3 4

15. Persistent concern about having a panic attack, worry about the implications or consequences of the attack, or a significant change in behavior related to the attacks? 0 1 2 3 4

16. Avoiding or feeling afraid of being in places or situations in which you may experience panic symptoms (e.g., being in crowds, standing in line, being in open spaces, or traveling on buses or trains or airplanes)? 0 1 2 3 4

17. Avoiding or feeling very fearful in social or performance situations (e.g., public speaking, parties, dating) because you think you will humiliate or embarrass yourself or be judged negatively by others? 0 1 2 3 4

18. Avoiding or feeling very fearful in relation to other things or situations such as flying, seeing blood, getting an injection, heights, small enclosed places, or certain kinds of animals or insects? If so, what do you fear/avoid: 0 1 2 3 4

19. Worrying excessively, more days than not, about a several events/activities and finding it difficult to control the worry? 0 1 2 3 4

20. Unpleasant thoughts, urges, or images that repeatedly enter your mind? 0 1 2 3 4

21. Feeling driven to perform certain behaviors or mental acts over and over again? 0 1 2 3 4

Trauma

Have any of the following events ever happened to you? Yes or No If Yes, at what age?

Experiencing or witnessing an event that involved actual or threatened death or serious injury to yourself or another person

Were you sexually abused, meaning touched or having to touch someone in a sexual way against your will (Sexual assault or rape)

If you checked any of the above, has that experience led to any of the following? (please check if so)

_____ Repeated involuntary memories, dreams, or flashbacks of the traumatic event

_____ Avoiding people, places, activities, objects, or situations that remind you of what happened

Section IV: Substance Use

Please specify quantity/frequency (e.g., 2 glasses of wine per day) of most frequent and current use for each of the following:

Substance Most frequent use Current use Quantity/Frequency Quantity/Frequency

Caffeine (e.g., coffee, black tea, dark chocolate)

Tobacco (e.g., cigarettes, cigars, chewing tobacco)

Alcohol (e.g., beer, wine, hard liquor)

Sedatives (e.g., Valium, Xanax, Klonopin, Ambien, Sonata, Lunesta, barbiturates, Ativan, Halcion, Restoril)

Cannabis (e.g., marijuana, hashish, THC, pot, grass, weed) Stimulants (e.g., amphetamine, speed, crystal meth, dexadrine, Ritalin, ice)

Opioids (e.g., heroin, morphine, opium, Methadone, Darvon, codeine, Percodan, Demerol, Dilaudid, oxycontin, oxycodone, hydrocodone, vicodin)

Cocaine (e.g., crack, speedball)

Hallucinogens (e.g., LSD, mescaline, peyote, psilocybin, STP, mushrooms, Ecstasy, MDMA)

PCP (e.g., angel dust, Special K)

Other (e.g., steroids, nonprescription sleep or diet pills, cough syrup)

Have you ever felt you ought to cut down on your drinking or substance use?

Have people annoyed you by criticizing your drinking or substance use?

Have you ever felt bad or guilty about your drinking or substance use?

Have you ever had a drink or used substances first thing in the morning to steady your nerves or to get rid of a hangover?

Section V: Additional History

At any time in your life, how much (or how often) have you ever been bothered by the following problems?

0-None Not at all 1-Slight Rare, less than a day or two 2-Mild Several days

3-Moderate More than half the days 4-Severe Nearly every day

1. Feeling preoccupied with a perceived defect in your appearance (e.g., your height, the shape of your nose, hair loss, your complexion) 0 1 2 3 4 2.
2. Dissatisfaction with my weight 0 1 2 3 4 3.
3. Weighing much less than other people thought you ought to weigh and worrying about becoming fat 0 1 2 3 4
4. Eating large amounts of food and feeling you cannot control how much you are eating 0 1 2 3 4
5. Making yourself vomit, use laxatives, or exercise a lot to prevent weight gain 0 1 2 3 4
6. Persistent difficulties with paying attention, being easily distracted, losing things, or organizing tasks or activities 0 1 2 3 4
7. Feeling restless when you're sitting still, interrupting others, blurting out things you wish you could take back, difficulty doing leisure activities quietly, or acting without thinking 0 1 2 3 4
8. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs) 0 1 2 3 4
9. Feeling that your illnesses are not being taken seriously enough 0 1 2 3 4
10. Hearing things other people couldn't hear, such as voices even when no one was around 0 1 2 3 4
11. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking 0 1 2 3 4
12. Recurrently pulling out your hair or picking at your skin to the degree that you experience noticeable hair loss or bleeding or disfigurement from skin picking 0 1 2 3 4
13. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home) 0 1 2 3 4
14. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories 0 1 2 3 4
15. Not knowing who you really are or what you want out of life 0 1 2 3 4
16. Not feeling close to other people or enjoying your relationships with them 0 1 2 3
17. What psychiatric diagnoses, if any, have you ever received?

_____

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AGREEMENT FOR SERVICE / INFORMED CONSENT

This document contains important information about my professional services and business policies, including limits of confidentiality. Please read it carefully. When you sign this document, it will represent an agreement between us. Therapist Background and Qualifications. I have a Master of Arts in Clinical Psychology. I have a License to practice as a Marriage and Family Therapist (LMFT107359). I am also certified by the Academy of Cognitive Therapy, as a cognitive behavioral therapist. Cognitive Behavioral Therapy (CBT) is a form of therapy that is active, collaborative, goal-oriented and is based on the cognitive model. That means we will work together to understand the role that our thoughts, beliefs, emotions, and behaviors play in our current struggles. In addition to support and insight, CBT offers clients specific strategies, skills and tools that you can use to make changes, relieve suffering, and achieve your goals. My practice focuses primarily on individual adults and adolescents ages twelve and older.

Risks and Benefits of Therapy. Participating in therapy can result in a number of benefits to you, including a deeper understanding of yourself and your personal goals, improved relationships with others, and resolution of the specific concerns that are your motivation for beginning therapy. However, therapy can have risks as well as benefits. While the primary goal of therapy may be to improve your well-being, it can also result in considerable discomfort. You may experience uncomfortable feelings such as sadness, guilt, anger, shame, frustration, loneliness, and helplessness. Should you have any concerns regarding your progress in therapy, it is important to let me know.

Records and Record Keeping. The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, or I can prepare a summary for you instead.

Confidentiality. The information disclosed by you in therapy is generally confidential and will not be released to others without your written consent. However, there are a few exceptions.

Exceptions to confidentiality, include:

• If there is reason to believe a child, elderly person, or dependent adult is or has been abused.

• If you threaten to commit serious bodily harm to yourself or another person.

• If I am presented with a subpoena or court order that has been signed by a judge.

In any of the above circumstances, I will only reveal the minimum information that is necessary, and I will do my best to inform you of the information being disclosed and to whom it will be provided before I do so.

Minors and Confidentiality. If you are a minor, under the age of 18, your parents may be legally entitled to some information about your therapy. I will discuss with you and your parents what information is appropriate for them to receive and which issues are more appropriately kept confidential.

Fee and Fee Arrangements. A standard session is 50 minutes and the standard fee is $125.00. Sessions longer than 50-minutes are charged for the additional time. If I need to adjust my fees in the future, you will be notified of any fee adjustment in advance. Sliding scale fees are available on a limited basis. All fees are due at the time of service. Please ask if you wish to discuss a written agreement that specifies an alternative payment procedure. If for some reason you find that you are unable to continue paying for your therapy, please let me know. I would be happy to help you to consider any options that may be available to you at that time.

Insurance. Currently, I am a contracted provider with the Beacon Value Options (a supplier to Kaiser) and MHN (division of Health Net) and Anthem Blue Cross have agreed to a specified fee. I am not a contracted provider with any additional insurance companies at this time. If your insurance plan provides reimbursement for out-of-network providers, I can provide you with a statement (referred to as a Superbill) , which you can submit to your insurance company to receive some insurance reimbursement, depending upon your benefits. You should be aware that insurance companies require that some clinical information is shared in order to reimburse for services.

All insurance companies require a clinical diagnosis. Some may require additional information such as treatment plans or treatment summaries. In these instances, I will disclose the minimum amount of information required for the requested purpose. You should also be aware that you are responsible for verifying and understanding the limits of your insurance coverage, and that you are responsible for any and all fees not reimbursed by your insurance company. Please let me know if you have any questions or concerns.

Cancellation Policy. Standard policy for most therapists, myself included, is a 24-hour cancellation policy. If you do not show up for your scheduled therapy appointment, and have not notified me at least 24- hours in advance, payment will be required for the full cost of the session. A total of two missed appointments without prior notification may lead to ending the therapy relationship. If your sessions are covered by insurance and you miss the appointment, you will be billed for a $80 fee. INSURANCE CANNOT BE BILLED FOR MISSED APPOINTMENTS)

Therapist Availability and Emergencies. I will make every effort to return calls within 24 hours (or by the next business day), but cannot guarantee your call will be returned immediately. I am unable to provide 24-hour crisis service. In the event that you are feeling unsafe or require immediate medical or psychiatric assistance, please call 911, LA County 24 hour Crisis LINE: 800-854-7771, or go to the nearest local emergency room.

Social Media and Telecommunication. Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). I 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.

Electronic Communication. I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. Threats to confidentiality include, but are not limited to:

1)the transmission may be intercepted; 2) 14 the transmission may be sent to the wrong recipient; and 3) the e-mail or text message may be accessed by an unauthorized person.

If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, I will do so. While I may try to return messages in a timely manner, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

Termination of Therapy. Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment, after appropriate discussion with you, if I determine that the psychotherapy is not being effectively used or if you are in default on payment. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. You also have the right to terminate therapy at your discretion. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified psychotherapists. You may also choose someone on your own or from another referral source. Should you fail to schedule an appointment for four consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued.

CONSENT TO TREATMENT I, _____, have read Agreement for Services/Informed Consent. In signing below, I consent to treatment and agree to abide by its terms during the course of therapy.

Patient Name (please print)

_____ Signature of Patient

(or authorized representative) Date