Consent Form

Welcome to the Center for Counseling and Education, LLC. This document (the Agreement) contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail, and our practice is in general accordance with HIPAA policies. The law requires that we obtain your signature acknowledging that we have provided you with this information at the end of this session.

Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless we have taken action in reliance on it or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICALSERVICES

Therapy is a relationship between people that works in part because of the clearly defined rights and responsibilities held by each person. This frame helps to create the safety to take risks and the support to become empowered to create change. As a client in psychotherapy, you have certain rights and responsibilities that are important for you to know about. There are also legal limitations to those rights that you should be aware of. I, as your therapist, have corresponding responsibilities to you. These respective rights are described in the following section.

Psychotherapy has both benefits and risks. Risks sometimes include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness. Psychotherapy often involves discussing unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress, and resolutions to specific problems. But, there are no guarantees about what will happen. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things that we discuss outside of sessions.

The first few sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, I will be able to offer you some initial impressions of what our work may include. At that point, we will discuss your treatment goals and create a personalized, initial treatment plan, if you decide to continue. You should evaluate this information as well as your own assessment about whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have any questions about my procedures, we should discuss them whenever they arise.

APPOINTMENTS

I normally conduct an evaluation that will last from 1 to 4 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 45-minute session (one appointment hour of 45 minutes duration) per week at a time we agree on, although some sessions may be longer or more frequent.

CANCELLATION

Psychological services are most effective when meeting times are regular and consistent. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, it is required that you provide more than 24 hours' notice. If you miss a session without canceling, or cancel with less than 24 hours' notice, you will be charged our standard fee for the missed session. It is important to note that insurance companies do not provide reimbursement for cancelled sessions. In addition, you are responsible for coming to your session on time and at the time scheduled. If you are late, your appointment will still need to end on time.

FEES, BILLING, AND PAYMENT

Psychotherapy sessions are 45 minutes and billed at my standard fee available by request. Session fees are payable at time of service unless alternative arrangements have been arranged. Fees will be reevaluated periodically. Legal fees are not billable to insurance companies and will be charged to the patient directly (eg. court evaluations, court appearances). Should a balance accrue and no payment is received, we reserve the right to seek remuneration by any means legally possible including, but not limited to, the retention of a collection agency.

INSURANCE

The Center for Counseling and Education, LLC is out-of-network with insurance companies. This means that our services may be reimbursable if you have out-of-network coverage. We will provide you with a monthly statement upon your request that you may submit to your insurance to obtain out-of-network reimbursement. We can also submit insurance claims for you. Insurance companies require a formal diagnosis with their claims. Diagnoses are technical terms that describe the nature of your problems and whether they are short-term or long-term problems. Please bring up any questions you have about your diagnosis in session.

PROFESSIONAL RECORDS

I am required to keep appropriate records of the psychological services that I provide. Although psychotherapy often includes discussions of sensitive and private information, normally very brief records are kept noting that you have been here, what was done in session, and a mention of the topics discussed. You have the right to a copy of your file at any time. You have the right to request that a copy of your file be made available to any other health care provider at your written request. Your records are maintained in a secure location.

CONFIDENTIALITY

The confidentiality of all communications between a client and a therapist is generally protected by law and I, as your therapist, cannot and will not tell anyone else what you have discussed or even that you are in therapy without your written permission. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. With the exception of certain specific situations described below, you have the right to confidentiality of your therapy. You, on the other hand, may request that information is shared with whomever you choose and you may revoke that permission in writing at any time.

There are, however, several exceptions in which I am legally bound to take action even though that requires revealing some information about a patient's treatment. If at all possible, I will make every attempt to inform you when these will have to be put into effect. The legal exceptions to confidentiality include, but are not limited, to the following:

1. If there is good reason to believe you are threatening serious bodily harm to yourself or others. If I believe a client is threatening serious bodily harm to another, I may be required to take protective actions, which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization. If a client threatens harm to him/herself or another, I may be required to seek hospitalization for the client, or to contact family members or others who can provide protection.
2. If there is good reason to suspect, or evidence of, abuse and/or neglect toward children, the elderly or disabled persons. In such a situation, I am required by law to file a report with the appropriate state agency.
3. In response to a court order or where otherwise required by law.
4. To the extent necessary, to make a claim on a delinquent account via a collection agency.

5. To the extent necessary for emergency medical care to be rendered.

Finally, there are times when I find it beneficial to consult with colleagues and/or experts in particular treatment areas. We strive to provide the best possible service and believe that professional supervision and consultation is an important part of our practice. Your name and unique identifying characteristics will not be disclosed if consultations occur with anyone other than my Clinical Supervisor and our Clinical Director. The consultant is also legally bound to keep the information confidential.

CONTACTING ME

I am often not immediately available by telephone. While I am usually in the office during normal business hours, I do not answer the phone when I am with a client. If you need to reach me between sessions, or in an emergency, you have the right to a timely response. You may leave a message with the office at 856-985-9091 at any time and your call will be returned as soon as possible or by the next business day under normal circumstances. After business hours Monday through Friday, I check my voicemail for messages for the last time at 8:00 PM.

On weekends, I typically check for messages midday and at 8:00 PM for the last time. I will only return a call on a weekend or after 8:00 PM if the matter is urgent and cannot wait until the next business morning. If you require an immediate response and it is before 8:00 PM, please be sure to say so and leave a phone number where you can be reached and I will make every attempt to get in touch with you as soon as possible. But, for any number of unseen reasons, if you do not hear from me or I am unable to reach you, it remains your responsibility to take care of yourself until such time as we can talk. Do no use E-mail for emergency/urgent situations. If you are in a crises, DO NOT HESITATE to call 911 if immediate attention is needed. I will make every attempt to inform you in advance of any planned absences, and provide you with a name and phone number of the Therapist covering the practice. If you are not able to reach me, you may contact our Director, Meg Clark Soriano, MA, LPC, ACS, RPT-S at 856-985-9091 (office) or
609-923-2032 (cell).

OTHER RIGHTS

You have the right to considerate, safe, and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment.

You have the right to ask questions about any aspect of the therapy and about my specific training and experience. You have the right to expect that I will not have social or sexual relationships with clients or with former clients.

If you are unhappy with what is happening in therapy, I hope you'll talk with me so that I can respond to your concerns. Such criticism will be taken seriously and with care and respect. You may also request that I refer you to another therapist and are free to end therapy at any time. You are also able to speak with our Director, Meg Clark Soriano, MA, LPC, ACS, RPT-S at 856-985-9091 (office) or 609-923-2032 (cell)

CONSENT TO PSYCHOTHERAPY

Your signature below indicates that you have read this Agreement and agree to its terms. It also serves as an acknowledgment that you have received the HIPAA Notice Form described and attached below.

Date: _____

Name:_____

Signature: _____

1.Please sign and return this page acknowledging your acceptance of the terms and receipt of the Consent and HIPAA notice forms. Keep the Consent and HIPPA Notice forms for you records.

2. Fill out Information and Biographical Forms attached below and return to your therapist at your first appointment.

NOTICE OF PRIVACY PRACTICES

Center for Counseling and Education, LLC
19 E Main Street
Marlton, NJ 08053

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Center for Counseling is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about the privacy practices at Center for Counseling, please contact:

Privacy Officer: Meg Clark Soriano
Street Address: 19 E Main Street
City, State, Zip: Marlton, NJ 08053
Phone Number: 856-985-9091
Effective Date of This Notice: April 14, 2003

YOUR INFORMATION IS CONFIDENTIAL

Your information is important and confidential. Our ethics and policies require that your information be held in strict confidence.

'HIPAA PRIVACY RULE"

A federal regulation, known as the "HIPPA Privacy Rule", requires that we provide detailed notice in writing of our privacy practices.

WHO WILL FOLLOW THIS NOTICE

- Any health care professional authorized to enter information into Center for Counseling chart.
- All departments and units of Center for Counseling
- Any member of a volunteer group we allow to help you while you are our patient.
- All employees, staff and other Center for Counseling personnel

OUR PLEDGE REGARDING MENTAL HEALTH INFORMATION

We understand that mental health information about you and your health is personal. We are committed to protecting mental health information about you. We create a record of the care and services you receive at the Center for Counseling. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by Center for Counseling, whether made by Center for Counseling personnel or your personal doctor.

This notice will tell you about the ways in which we may use and disclose mental health information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of mental health information.

We are required by law to:

- make sure that mental health information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to mental health information about you; and
- follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION

The following categories describe different ways that we use and disclose mental health information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. We may use mental health information about you to provide you with mental health treatment or services. We may disclose mental health information about you to doctors, nurses, technicians, mental health students, or other Center for Counseling personnel who are involved in taking care of you at Center for Counseling. We also may disclose mental health information about you to people outside the Center for Counseling who may be involved in your mental health care after you leave the Center for Counseling, such as family members, clergy or others we use to provide services that are part of your care.

For Payment. We may use and disclose mental health information about you so that the treatment and services you receive at Center for Counseling may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about treatment you received at Center for Counseling; your health plan will pay us or reimburse you for the treatment. We may also tell your health plan about a. treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations. We may use and disclose mental health information about you for Center for Counseling operations. These uses and disclosures are necessary to run Center for Counseling, and make sure that all of our patients receive quality care. For example, we may use mental health information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine mental health information about many patients to decide what additional services Center for Counseling should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, mental health students, and other Center for Counseling personnel for review and learning purposes. We may also combine the

mental health information we have with mental health information from other Center for Counseling to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of mental health information so others may use it to study health care and health care delivery without learning who the specific patients are.

Appointment Reminders. We may use and disclose mental health information to contact you as a reminder that you have an appointment for treatment or mental health care at Center for Counseling

Treatment Alternatives. We may use and disclose mental health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services. We may use and disclose mental health information to tell you about health-related benefits or services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. We may release mental health information about you to a friend or family member who is involved in your mental health care. We may also give information to someone who helps pay for your care.

As Required By Law. We will disclose mental health information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose mental health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

SPECIAL SITUATIONS

Military and Veterans. If you are a member of the armed forces, we may release mental health information about you as required by military command authorities. We may also release mental health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release mental health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose mental health information about you for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems as with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose mental health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose mental health information about you in response to a court or administrative order. We may also disclose mental health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release mental health information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at the Center for Counseling; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

National Security and Intelligence Activities. We may release mental health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose mental health information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release mental health information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to

provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

YOUR RIGHTS REGARDING MENTAL HEALTH INFORMATION ABOUT YOU.

You have the following rights regarding mental health information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy mental health information that may be used to make decisions about your care. Usually, this includes mental health and billing records, but does not include psychotherapy notes.

To inspect; and copy mental health information that may be used to make decisions about you, you must submit your request in writing to Center for Counseling If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to mental health information, you may request that the denial be reviewed. Another licensed health care professional chosen by Center for Counseling, will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. If you feel that mental health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for Center for Counseling

To request an amendment, your request must he made in writing and submitted to Center for Counseling In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support, the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the mental health information kept by or for Center for Counseling;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Right to Request Restrictions. You have the right to request a restriction or limitation on the mental health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the mental health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a treatment you had. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to Center for Counseling In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about mental health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to Center for Counseling. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

To obtain a paper copy of this notice contact our office.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for mental health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the facility.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with Center for Counseling, or with the Secretary of the Department of Health and Human Services. To file a complaint with Center for Counseling, contact Meg Clark Soriano at 856-985-9091. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF MENTAL HEALTH INFORMATION

Other uses and disclosures of mental health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose mental health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose mental health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Center for Counseling and Education, LLC

Today's Date: _____Forms completed by: _____

Client Information

Name:_____
First Last M.I.

Address:_____
Street and Number City State Zip

Date of Birth: ____/____/____ Age: _____Social Security No.:_____-____-_____

Gender: _____ Race: _____ Grade:_____

Home Phone: _____ Cell Phone:_____Work Phone: _____
Do we have your permission to call the above numbers? _____yes _____no
Do we have your permission to leave a message if necessary? _____yes _____no
If not, please specify: _____

Email address: _____
Did someone refer you? Yes/No If yes, who? _____
May we send a thank you to who ever referred you? Yes/No

Emergency Contact Name: _____

Phone: _____ Relationship to client: _____

Billing Information

Responsible Party #1
Name: _____ _____ _____
First Last M.I.

Address: _____
Street and Number City State Zip

Home Phone: _____ Work Phone: _____ Cell: _____

Responsible Party #2
Name: _____ _____ _____
First Last M.I.

Address: _____
Street and Number City State Zip
Home Phone: _____ Work Phone: _____ Cell: _____

Insurance Information

Our office does not file insurance claims so you will be responsible for filing and obtaining reimbursement. Our office will provide a receipt with the necessary information. You are expected to pay in full at the time of service. We ask that you fill out the insurance portion so that we may have this on file for future reference. Thank you for your cooperation.

Primary Insurance:

Insurance Company: _____ Plan Name: _____

Address: _____
Street and Number

_____
City State Zip

Policy #:_____ Group: _____ Insured's ID #:_____

Phone Number: _____ Fax Number: _____

Insured Information

Name of Person Insured: _____ _____ ____
First Last MI

SSN: ____-____-____ Home Phone: _____ Work Phone: _____

Insured's Address: _____
Street and Number City State Zip

Birth Date: ____/____/____ Gender: ____Male ____Female

Center for Counseling and Education

Biographical Information Form—Adult

Instructions: To assist us in helping you, please fill out this form as fully and openly as possible. All private information is held in strictest confidence within legal limits. If certain questions do not apply to you, leave them blank.

Identifying Information

Name: _____ Soc. Sec. #:_____

Sex: ____ Age: ____ D.O.B.: _____ Ethnicity: _____ Religion: _____

Address:_____ Phone #: _____

Cell phone: _____Work phone: _____
Do we have your permission to call the above number? _____Yes____No
Do we have your permission to leave a message if necessary? _____Yes____No
If not, please specify: _____

Email address: _____

How did you hear about Center for Counseling? _____
May we send a thank you to the person who referred you?____Yes____No

Emergency Contact Information:
Name: _____ Relationship: _____
Address: _____ ___
Street & Number City State Zip
Years of education: _____ _____
Occupation: _____Business Phone:_____
Present Marital Status:

_____ 1) never married
_____ 2) engaged to be married
_____ 3) married now for first time
_____ 4) married now after first time
_____ 5) separated
_____ 6) divorced and not remarried
_____ 7) widowed and not remarried
_____ 8) other (specify) _____

FAMILY MEMBERS LIVING IN HOUSEHOLD:

Name	Relation to client	Date of birth	Occupation	Education

RELEVANT OTHERS LIVING OUTSIDE HOUSEHOLD:

Name	Relation to client	Date of birth	Whereabouts or other comments

Counseling History

Are you receiving counseling services at present? Yes____ No____
If yes, please briefly describe:_____

Have you received counseling in the past? Yes_____ No_____
If yes, please briefly describe: _____

What is (are) your main reason(s) for this visit? _____

How long has this problem persisted? _____
Under what conditions do your problems usually get worse?_____

Under what conditions are your problems usually improved? _____

Medical History

Physician's name: _____
Address: _____
List any major illnesses and/or operations you have had: _____

List any hospitalizations:_____

List any physical concerns you are having at present: (e.g., high blood pressure, headaches, dizziness, etc):

List any other physical concerns you have experienced in the past: _____

When was your most recent complete physical exam? _____
Results of physical exam: _____

On average how many hours of sleep do you get daily?_____

Do you have trouble falling asleep at night? __No __Yes If Yes, describe: _____

Have you gained/lost over ten pounds in the past year? __Yes __No __gained __lost
If yes, was the gain/loss on purpose? __Yes __No

Describe your appetite (during the past week):___ poor appetite____ average appetite____ large appetite

What medications (and dosages) are you taking at present, and for what purpose:

Medication	Purpose

Family History

Mother's age: _____ If deceased, how old were you when she died? _____
Father's age: _____ If deceased, how old were you when he died? _____
If your parents are separated or divorced, how old were you then? _____
Number of brother(s) _____ Their ages _____ _____ _____ _____ _____ _____
Number of sister(s) _____ Their ages _____ _____ _____ _____ _____ _____
I was child number _____ in a family of _____ children.
Were you adopted or raised with parents other than your natural parents? Yes___ No ___
Briefly describe your relationship with your brothers and/or sisters: _____
_____
_____
_____

Which of the following best describes the family in which you grew up?

WARM AND ACCEPTING				AVERAGE				HOSTILE AND FIGHTING
1	2	3	4	5	6	7	8	9

Which of the following best describes the way in which your family raised you?

ALLOWED ME TO BE VERY INDEPENDENT				AVERAGE				ATTEMPTED TO CONTROL ME
1	2	3	4	5	6	7	8	9

YOUR MOTHER (or mother substitute)
Briefly describe your mother: _____
_____

How did she discipline you? _____
_____

How did she reward you? _____
_____

How much time did she spend with you when you were a child? _____
_____ much _____ average _____ little

Your mother's occupation when you were a child: _____

_____ stayed home _____ worked outside part-time _____ worked outside full-time

How did you get along with your mother when you were a child?

_____ poorly _____ average _____ well

How do you get along with your mother now?

_____ poorly _____ average _____ well

Did your mother have any problems (e.g., alcoholism, violence, etc.) that may have affected your childhood development? Yes _____ No _____
(If yes, please describe) _____
_____

Is there anything unusual about your relationship with your mother?
Yes _____ No _____ (If Yes, please describe) _____
_____

YOUR FATHER (or father substitute)

Briefly describe your father: _____

_____

How did he discipline you? _____

How did he reward you? _____

_____

How much time did he spend with you when you were a child?

_____ much _____ average _____ little

Your father's occupation when you were a child: _____

_____ stayed home _____ worked outside part-time _____ worked outside full-time

How did you get along with your father when you were a child? _____

_____ poorly _____ average _____ well

How do you get along with your father now?

_____ poorly _____ average _____ well

Did your father have any problems (e.g. alcoholism, violence, etc.) that may have affected your childhood development? Yes_____ No_____

(If yes, please describe)_____

Is there anything unusual about your relationship with your father? No _____ Yes _____

(If yes, please describe)_____

_____

Thoughts and Behaviors

Please check how often the following thoughts occur to you:

1)	Life is hopeless.	____Never	____Rarely	____Sometimes	____Frequently
2)	I am lonely.	____Never	____Rarely	____Sometimes	____Frequently
3)	No one cares about me.	____Never	____Rarely	____Sometimes	____Frequently
4)	I am a failure.	____Never	____Rarely	____Sometimes	____Frequently
5)	Most people don't like me.	____Never	____Rarely	____Sometimes	____Frequently
6)	I want to die.	____Never	____Rarely	____Sometimes	____Frequently
7)	I want to hurt someone.	____Never	____Rarely	____Sometimes	____Frequently
8)	I am so stupid.	____Never	____Rarely	____Sometimes	____Frequently
9)	I am going crazy.	____Never	____Rarely	____Sometimes	____Frequently
10)	I can't concentrate.	____Never	____Rarely	____Sometimes	____Frequently
11)	I am so depressed.	____Never	____Rarely	____Sometimes	____Frequently
12)	God is disappointed in me.	____Never	____Rarely	____Sometimes	____Frequently
13)	I can't be forgiven.	____Never	____Rarely	____Sometimes	____Frequently
14)	Why am I so different?	____Never	____Rarely	____Sometimes	____Frequently
15)	I can't do anything right.	____Never	____Rarely	____Sometimes	____Frequently
16)	People hear my thoughts.	____Never	____Rarely	____Sometimes	____Frequently
17)	I have no emotions.	____Never	____Rarely	____Sometimes	____Frequently
18)	Someone is watching me.	____Never	____Rarely	____Sometimes	____Frequently
19)	I hear voices in my head.	____Never	____Rarely	____Sometimes	____Frequently
20)	I am out of control.	____Never	____Rarely	____Sometimes	____Frequently

Please comment (e.g., examples, frequency, duration, effects on you) about each of the above thoughts that occur frequently or are a concern to you. Use the back of this sheet if necessary.

_____
_____
_____
_____

Symptoms

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

_____ aggression	_____ fatigue	_____ sexual difficulties
_____ alcohol dependence	_____ hallucinations	_____ sick often
_____ anger	_____ heart palpitations	_____ sleeping problems
_____ antisocial behavior	_____ high blood pressure	_____ speech problems
_____ anxiety	_____ hopelessness	_____ suicidal thoughts
_____ avoiding people	_____ impulsivity	_____ thoughts disorganized
_____ chest pain	_____ irritability	_____ trembling
_____ depression	_____ judgment errors	_____ withdrawing
_____ disorientation	_____ loneliness	_____ worrying
_____ distractibility	_____ memory impairment	_____ other (specify)
_____ dizziness	_____ mood shifts	_____
_____ drug dependence	_____ panic attacks	_____
_____ eating disorder	_____ phobias/fears	_____
_____ elevated mood	_____ recurring thoughts	_____

Please give examples of how each of the symptoms that you checked impairs your ability to function (e.g., socially, emotionally, occupationally, physically, etc.). Use the back of this sheet if necessary.

_____
_____

List your five greatest strengths:

1) _____
2) _____
3) _____
4) _____
5) _____

List your five greatest weaknesses:

1) _____
2) _____
3) _____
4) _____
5)_____

List your main social difficulties: _____
_____
_____

List your main love and sex difficulties: _____
_____
_____

List your main difficulties at school or work: _____
_____

_____

List your main difficulties at home: _____
_____
_____

List your behaviors that you would like to change: _____
_____
_____
_____

Additional information you believe would be helpful: _____
_____
_____
_____
_____
_____
_____
_____