McLaren Behavioral Medicine Medical Education

New Patient Packet

This packet contains:

- McLaren Family Practice Residency Program Behavior Medicine Education Appointment Sheet M-34625 (2/15)
- Consent for Treatment / Financial Authorization 17451 (1/10)
- Authorization to Release Information 17418 (5/13)
- Recipient Rights - Consent to Treatment - Client Confidentiality M-13070 (7/12)
- Health Screening Questionnaire - Adult M-13063 3 pages (3/05)
- Adult Social Intake 4 pages (3/05)

FLINT

McLaren Family Practice Residency Program
Behavior Medicine Education
G-3230 Beecher Road • Suite 1
Flint, Michigan 48532
(810) 342-5620

Barbara Wolf, Ph.D.
Director, Behavioral medicine Education

Appointment Date:

Appointment Time:

Please complete all forms and bring this packet with you to your first appointment. If it is not completed, you will not be able to see the doctor.

McLaren
FLINT
BEECH HILL CENTRE
3200 - 3230
Cancer Institute Admin Office
Bariatric Institute
Wound Care
Hyperbaric Oxygen Therapy
Sleep Diagnostic Center
Specialty Care Services
Medical Education Residencies
Pulmonary Associates, P.C.
G-3252

Flint River
BALLENGER HWY
McLaren
FAMILY MEDICINE
Medical Education Building
G-3230 Beecher Rd.
McLaren Proton Therapy Center
McLaren Cancer Institute
McLaren
FLINT
BEECHER ROAD
BALLENGER HWY
BEECHER ROAD

M-34625 (2/15)

McLaren Flint
FLINT, MICHIGAN 48532

CONSENT FOR TREATMENT/ FINANCIAL AUTHORIZATION

1. I understand that I have a condition requiring treatment and do hereby voluntarily consent to such routine diagnostic procedures, hospital care and medical treatment (including the administration of drugs and routine therapeutics) as deemed necessary or advisable by the physicians who treat me, their assistants or designees and hospital employees.

   I understand that I have a right to consent or refuse to consent to any proposed procedure or therapeutic course during my episode of care.

   I understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risk of injury, or even death. I acknowledge that no guarantees have been made to me as to the result of examination or treatment in this hospital.

   I understand that the physicians at this hospital may not be employees or agents of the hospital, but, rather may be independent contractors who have been hired to provide medical treatment. Further, I realize that among those who may attend to me at this hospital are medical, nursing and other health care personnel in training who, unless requested otherwise, may participate in patient care as a part of their education.

2. I agree that specimens of blood, urine and other bodily fluids, tissues or products may be taken and that routine diagnostic tests may be performed on these specimens per the physician's order. *I understand that in rare instances a person-to-person exposure may occur. If another person has a percutaneous, mucus membrane, open wound, or other exposure to my blood or other body fluids, the hospital may perform but not be limited to the following tests an HIV, hepatitis screens, and other blood borne pathogen tests as needed, without any additional consent.*

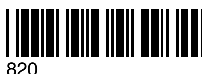
   NOTICE: The hospital may perform an HIV test upon me without any additional written consent, as stated in ACT 488 P.A. 1988, If a health professional or employee at the hospital has a percutaneous, mucus membrane, or open wound exposure to my blood or other body fluids.

3. I recognize that the Hospital/Clinic may release information from my medical record including: information about communicable diseases and serious communicable diseases and infections as defined by statute and Michigan Department of Public Health rules (which include Venereal Disease, Tuberculosis, Hepatitis B, Human Immuno-deficiency virus, Acquired Immunodeficiency Syndrome and Aids related complex); substance abuse treatment information protected by 42 Code of Federal Regulations Part 2; psychological and social services information including communications made by me to a psychologist or social worker to:

   a) any third party payor, or insurance company or other individual who may be responsible in whole or in part for paying my hospital bill so that the Hospital/Clinic may be paid for its services; and any independent auditors/reviewers retained by any third party payor, private health insurers or any employer providing health insurance benefits to me so that these independent auditors can analyze Hospital/Clinic charges as is necessary to obtain payment for the services and required review or audit of that payment by the payor.

   b) any health care facility or physician to which I am referred for continuity of care.

   With respect to substance abuse information (if any), this consent may be revoked at any time, unless the Hospital/Clinic has already released information in reliance upon it, or if payment for services rendered would be interrupted by such revocation.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PT.

MR.#/RM.

DR.

McLaren Flint
FLINT, MICHIGAN 48532

4. I hereby assign payment directly to the Hospital/Clinic of the insurance benefits otherwise payable to me but not to exceed the balance due to the hospital's regular charges for this service.

5 I assume full financial responsibility for payment of all services provided to me, including any portion of my bill which is not paid by insurance, workers compensation or social agencies.

6. McLaren Regional Medical Center will not be liable (responsible) for any money or property of any kind retained by me or kept in my possession while I am at the hospital.

   McLaren Regional Medical Center advises that all patient valuables (i.e. jewelry, watches, credit cards, electronic devices, and money) be sent home whenever possible. When this is not possible, patients are encouraged to secure valuables in the hospital safe at any time during their admission.

   After 60 days, McLaren Regional Medical Center will dispose of all unclaimed property left at the medical center. Please call Security at (810) 342-3333, to claim any valuables after discharge.

7. If I possess Medicare [CHAMPUS] coverage, I have received a copy of "An Important Message from Medicare [CHAMPUS]".

8. I possess a Durable Power of Attorney for Health Care and/or Living Will.

   ☐ **Yes** ☐ **No** ☐ **Don't Know**

   If yes, I understand that it is my responsibility to provide the Hospital/Clinic with a current copy of my Durable Power of Attorney for Health Care and/or Living Will.

   For all Inpatients, I acknowledge receipt of advance directive information ("Michigan Notice to Patients" or "Decision" booklet) as required by the Patient Self Determination Act.

9. I have received a copy of the Hospital/Clinic Notice of Privacy Practices. ☐ Received today ☐ Previously received

________ **Initials**

This form has been fully explained to me and I am satisfied that I understand its content and significance.

Date Signed: ______________________

Signature of Patient: ______________________ Signature of Witness: ______________________

Signature of Spouse Accepting Financial Responsibility: ______________________ Signature of Witness: ______________________

(If patient is a minor or unable to consent, complete the following:)

Patient [is a minor _______ years of age] is unable to consent because ______________________

Signature of Legal Guardian or Closest Available Relative: ______________________ Signature of Witness: ______________________

MR.#/RM.
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MR.#/RM.

DR.

CONSENT FOR TREATMENT/
FINANCIAL AUTHORIZATION

17451 REV. 1/10

McLaren Health Care Corporation

Authorization to Release Information

Patient Name ____________________ Birth Date ____________________ Medical Record Number ____________________

Address ____________________

Telephone Number ____________________ Maiden/Other Names ____________________

I authorize ____________________ (name)
____________________ (address)
____________________ (city, state, zip)
____________________ (telephone/fax)

to release to ____________________ (name)
____________________ (address)
____________________ (city, state, zip)
____________________ (telephone/fax)
____________________ (email address)

Specific type of information to be disclosed: Date(s) of Service: ____________________

- ☐ History and Physical
- ☐ Operative Report
- ☐ Discharge Summary
- ☐ Physician's Notes
- ☐ Consultation Reports
- ☐ Therapy Notes
- ☐ Home Care Records
- ☐ Entire Medical Record
- ☐ Laboratory Results
- ☐ Billing Records
- ☐ Diagnostic Imaging (eg: X-Rays) reports from (date) ____________________
- ☐ Diagnostic Imaging (eg: X-Rays) films/CD from (date) ____________________
- ☐ Other ____________________

The purpose and need for disclosure:

- ☐ Continuation of Care
- ☐ Personal
- ☐ Insurance Billing
- ☐ Legal/Attorney
- ☐ Prefer not to answer
- ☐ Other ____________________

I understand that unless otherwise indicated or specified here, a request for disclosure or release of "all" or "any" medical records or health information may include information regarding drug and/or alcohol treatment, social service records, communications made to a social worker and information regarding serious communicable diseases and infections as defined by the Michigan Department of Public Health Code, which includes venereal disease, tuberculosis, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV).

I understand that any disclosure of information carries with it the potential for re-disclosure and that once disclosed to the individual or organization identified above, the information may not be protected by federal confidentiality rules.

I understand that I have a right to revoke this authorization at any time by sending a written revocation to the organization's HIPAA/Privacy Officer. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization is in effect for no more than 60 days after date it was signed unless otherwise specified. Upon conclusion of that time period, this authorization is automatically revoked and no further disclosure of the patient's information is permitted.

I understand that I need not sign this form in order to ensure treatment, payment for treatment, or enrollment or eligibility for health benefits.

____________________ Signature of Patient or Legal Representative ____________________ Date

____________________ If Signed by Legal Representative, State Relationship to Patient

____________________ Signature of Witness ____________________ Date

AUTHORIZATION TO RELEASE HEALTH INFORMATION

17418 Rev. 5/13

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PT.

MR.#/P.M.

DR.

McLAREN FLINT
Flint, Michigan

RECIPIENT RIGHTS – CONSENT TO TREATMENT – CLIENT CONFIDENTIALITY

I understand that I have rights as a recipient of service, including confidentiality of my records.

I consent to mental health treatment and/or substance abuse treatment as recommended by my therapist. I understand I will participate in the development of my treatment plan and that I am free to withdraw my consent and discontinue treatment at any time.

The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by Federal law and regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug abuser, UNLESS:

1. The patient consents in writing;
2. The disclosure is allowed by a court order; or
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

No physical violence, verbal abuse, carrying a weapon, or engaging in illegal acts is allowed on the premises. Persons who are violent while at the clinic may be subject to prosecution for assault or other criminal charges and may be terminated from the program.

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program, or about any threat to commit such a crime.

Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under State law and appropriate State or local authorities.

I have read this agreement. I had the opportunity to ask questions which have been answered to my satisfaction. I understand and agree to the conditions appropriate State or local authorities.

I have read this agreement. I had the opportunity to ask questions which have been answered to my satisfaction. I understand and agree to the conditions specified herein and have been given a copy of this signed agreement.

______________________________ ______________
Client or Legal Guardian Signature Date

______________________________ ______________
Therapist's Signature Date

**RECIPIENT RIGHTS –
CONSENT TO TREATMENT –
CLIENT CONFIDENTIALITY**
M-13070 (7/12)

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PT.

MR.#/RM.

DR.

HEALTH SCREENING QUESTIONNAIRE - ADULT

Instructions: This information is used by staff members to help assess your needs, and to complete the intake process, as required by accreditation and licensure. Please fill this out as fully and openly as possible. We are aware that this is sensitive information, and assure you that all information is strictly confidential. Completing this form is not designed to replace regular contact with your primary care physician, and may not be reviewed by a physician. Your therapist can assist you with a referral for primary medical care, if indicated or requested.

NAME____ BIRTH DATE _____________

Please CIRCLE the appropriate answer:

Is your current health: EXCELLENT GOOD AVERAGE FAIR POOR

Do you have a family physician? YES NO

Physician's name and address:____

____

When and where was your last physical exam? ____

____

Describe any current medical complaints or concerns:______________________________________

____

Have you ever been diagnosed with any of the following:

Disease of your LIVER, LUNG, HEART, STOMACH, CIRCULATION, DIABETES HYPOGLYCEMIA, CANCER, HIGH BLOOD PRESSURE, HEPATITIS,
OTHER ____

____

Is there a family history of the above diseases? If so, which disease(s)? _________________________

____

What allergies do you have? ____

What medication, if any, are you allergic to? ____

____

Have you ever been prescribed medication for any of the following problems? If yes, please list name of medication:

- ☐ Sleep ______________________ ☐ Emotional ________________________
- ☐ Psychiatric __________________ ☐ Nerves ___________________________
- ☐ Addiction __________________________________

Have you been recently diagnosed with an infection for which you have been prescribed an antibiotic? (Please detail) ____

____

Have you ever had an injury or illness that caused loss of consciousness? ____ Yes _____ No: ________

PT.

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DR.

Please circle the following symptoms that apply to you.

WOMEN ONLY Date of last menstrual period____________________________

YES NO severe cramping at or around period?
YES NO premenstrual symptoms (irritability, depression, aches and pains, breasts tenderness, moodiness, cravings bloating, etc.)?
YES NO have you ever had any surgery (tubal ligation, hysterectomy, etc..)?
YES NO are you pregnant?
YES NO discharge from vagina?
YES NO lumps in breast?
YES NO birth control pills?
YES NO other contraceptives (IUD, foam, condoms, etc.)?
YES NO spotting between periods?

ALL CLIENTS SIGN BELOW I understand that this is a health screening questionnaire, and that it is NOT a complete evaluation of my health status or needs. I will see my primary care physician or other medical practitioner if I am having problems, or will ask my therapist for a referral.

Client Signature____ Date______________________________

YES NO sore breasts?
YES NO skin rash?
YES NO always thirsty
YES NO yellow jaundice
YES NO swollen glands?
YES NO frequent headaches?
YES NO dizzy spells/lightheadedness
YES NO diarrhea?
YES NO numbness?
YES NO toothache?
YES NO difficulty speaking?
YES NO epileptic?
YES NO constantly hungry?
YES NO severe headaches?
YES NO pain when urinating?
YES NO weight gain?
YES NO bleeding gums?
YES NO difficulty hearing?
YES NO sore throat?
YES NO blood in urine?
YES NO sore/painful genitals?
YES NO sexual transmitted diseases which one ______________________
YES NO asthma?
YES NO have you ever been informed that you are HIV+ or have AIDS, or have been exposed to the AIDS virus?

YES NO do you eat regularly three times daily?

What do you usually eat at:
Breakfast_____________________________________
Lunch____
Dinner_______________________________________
Snacks_______________________________________

YES NO frequent cough?
YES NO weight loss?
YES NO always tired?
YES NO night sweats?
YES NO have you ever lived or been close with anyone who has/had tuberculosis?
YES NO have you ever been diagnosed with tuberculosis? when? __________ where treated__________
YES NO bleeding problems?
YES NO sickle cell anemia?
YES NO stomach ulcers?
YES NO heartburn?
YES NO blood in stool?
YES NO do you believe you have or ever have had an eating disorder?
YES NO does you diet include a preference of sweets (cookies, ice cream, chocolate candy, cake, donuts, etc.)?

THERAPISTS COMMENTS (ON “YES” RESPONSES): ____

____

____ ________

TO BE COMPLETED BY THE THERAPIST:

YES NO Client recently in detoxification or residential program?
If Yes, where?________________________________ when? Month_________________ Year___________

Observation of condition: ____

☐ Immediate need for referal to Dr.__________________ ☐ Patient currently under care of Dr. __________________

Comments: ____

____

Therapist Signature________________________

Date ______________________

HEALTH SCREENING QUESTIONNAIRE - ADULT M-13063 page 2 Rev. (3/05)

PT.

MR.#/RM.

DR.

WOMEN ONLY

Date of last menstrual period______________________

YES NO severe cramping at or around period?
YES NO premenstrual symptoms (irritability, depression, aches and pains, breasts tenderness, moodiness, cravings bloating, etc.)?
YES NO have you ever had any surgery (tubal ligation, hysterectomy, etc..)?

YES NO sore breasts?

YES NO are you pregnant?
YES NO discharge from vagina?
YES NO lumps in breast?
YES NO birth control pills?
YES NO other contraceptives (IUD, foam, condoms, etc.)?
YES NO spotting between periods?

ALL CLIENTS SIGN BELOW I understand that this is a health screening questionnaire, and that it is NOT a complete evaluation of my health status or needs. I will see my primary care physician or other medical practitioner if I am having problems, or will ask my therapist for a referral.

Client Signature______________________________ Date______________________

TO BE COMPLETED BY THE THERAPIST:

YES NO Client recently in detoxification or residential program?

If Yes,
where?____

when? Month______________________ Year______________________

Observation of condition: ____

____

____

____

____

Comments: ____

____

____

____

Therapist Signature______________________________ Date ______________________

ADULT SOCIAL INTAKE

If you need help reading or writing, take this form to the from desk and they will arrange for someone to help you. It is very important that your therapist understand your needs. We are aware that this is sensitive information and assure you that all information is confidential. Please answer the questions as honestly as you can. If a question doesn't apply, write "NA." If you don't know an answer, write unknown. Your therapist will review this questionnaire with you.

COMMENTS
(Therapist Only)

Name: ____________________________________ Age:_______ Sex:________ Race: ____

What problems are you needing help with today? ______________________________________

____

What changes do you hope for as a result of treatment? ________________________________

____

What might get in the way of you meeting your goals? __________________________________

____

Have you ever been involved in therapy before? ☐ Yes ☐ No

If yes, please explain when & where: ____

RELATIONSHIPS

	Name	Age	Living	(or) Date Deceased
Father:	____________________	______	☐	______________
Mother:	____________________	______	☐	______________
Step-Father:	____________________	______	☐	______________
Step-Mother:	____________________	______	☐	______________

Are (or were) your parents: ☐ Married ☐ Separated ☐ Divorced ☐ Never Married

What is/was communication like with your parents? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please list brothers, sisters, step-brothers, step-sisters:

Name	Age	Relationship
____________________	________	______________
____________________	________	______________
____________________	________	______________

Who are you living with now?

What were your family relationships like? (cooperative, argumentative, distant, close, etc.)

____

Have you ever witnessed or experienced abuse? (emotional, physical, or sexual) ☐ Yes ☐ No

If yes please explain: ____

What did you see as the strength of your family? _______________________________________

____

What did you see as the limitations of your family?

____

Can you share personal problems with anyone in your family of origin? ☐ Yes ☐ No

If yes, who? ____

Are members of your current family supportive of you getting treatment? ☐ Yes ☐ No

Whom?______________________________

____

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DR.

Has anyone in your family experienced the following?

☐ Emotional problems ☐ Depression ☐ Anxiety ☐ Anger problems ☐ Suicide attempts
☐ Gambling problems ☐ Relationship problems ☐ Abuse problems ☐ Alcohol/Drug problems

Did anyone in your family receive treatment for any of the above problems? ☐ Yes ☐ No
If yes, please describe:____
List marriages and/or significant relationships you have had:

Name	Married	Living Together	Girl/boy Friend	Length of Relationship
_______________	☐	☐	☐	__________
_______________	☐	☐	☐	__________
_______________	☐	☐	☐	__________

Please list your children and indicate if they are your natural, adopted or a stepchild.

Name	Age	Natural	Adopted	Step
____________________________	____	☐	☐	☐
____________________________	____	☐	☐	☐
____________________________	____	☐	☐	☐

Are your children experiencing any emotional or alcohol or drug problems? ☐ Yes ☐ No
If yes, what are they and are they getting help? _______________________________________
____
To whom are you closest to in your family? ____

RECREATION (check all that apply)

☐ Involved in sports ☐ Involved in clubs/groups ☐ Hunting, fishing, camping ☐ Exercise regularly
☐ Spend time watching TV ☐ Playing electronic games or internet or computer use
☐ Please list hobbies: ____
Are you frequently bored? ☐ Yes ☐ No Please explain: ______________________________
Has your use of free time changed? ☐ Yes ☐ No Please explain: ______________________
Are drugs/alcohol often involved in your recreational or hobby activities? ☐ Yes ☐ No

SEXUALITY (Do you consider yourself)

☐ Heterosexual (opposite sex) ☐ Gay/Lesbian (same sex) ☐ Bisexual (both sexes) ☐ Unsure
At what age was your first sexual experience? ____
Is there any area of your sexuality with which you are not comfortable? ☐ Yes ☐ No
Please describe: ____
Have you ever considered that some experiences meant you were sexually abused? ☐ Yes ☐ No
Please check all that apply:
☐ Sexually active now ☐ Have had unprotected sex ☐ have unanswered questions about sex
☐ Sexually active in past ☐ Use birth control ☐ Experienced sexually transmitted disease
☐ Concerned about sexually transmitted diseases
Please describe any other sexual concerns:
____
____

COMMENTS
(Therapist Only)

PT.

MR.#/RM.

DR.

LEGAL (check all that apply)
Have you had any arrests, misdemeanors, felonies, parole/probation violations or incarcerations as either a youth or an adult? ☐ Yes ☐ No If yes, please describe:

____

____

What is your current legal status? ☐ No problems ☐ Problems
☐ On tether until______________ ☐ License suspended/revoked until ____________________
☐ Awaiting trial or sentencing ______________ ☐ On Probation/Parole until________________
Name and phone number of Parole/Probation Officer __________________________________

VOCATIONAL HISTORY

Are you currently in school? ☐ Yes ☐ No What was the last grade your completed? ________
Do you have any current educational goals? ____
Did you participate on extracurricular activities, such as sports or choir? ☐ Yes ☐ No
Please list: ____
Did you get along with your teachers and classmates? ☐ Yes ☐ No
Do you feel you have a learning problem? ☐ Yes ☐ No
Did you ever repeat a grade? ☐ Yes ☐ No
What were your grades like? ☐ Above Average ☐ Average ☐ Below Average
What was your attendance like? ☐ Never Absent ☐ Occasionally Absent ☐ Frequently Absent
Please describe additional training you've had: _______________________________________
Do you have a job now? ☐ Yes ☐ No ☐ Full-time ☐ Part-time
Jobs held in the last five years: Time in each:

____ __________________

____ __________________

What is your job attendance like? ☐ Above Average ☐ Average ☐ Below Average
What do you like most about your job? ____
What do you like least about your job? ____
Is there another occupation you would prefer? ☐ Yes ☐ No If so, what? __________________
Are your co-workers supportive of your getting help? ☐ Yes ☐ No
If you are not working but would like to be, what are your plans to get a job? ________________

____

Describe any current job or school problems: ____
Are you experiencing any financial problems? ☐ Yes ☐ No
Have you had miliary service experience? ☐ Yes ☐ No
Have you completed combat duty? ☐ Yes ☐ No
Branch of service:_________ Years of service_________ Reason for Separation:______________

PEER RELATIONSHIPS (which best describes your friendships)

☐ Don't have any ☐ Supportive ☐ Legal problems ☐ Emotional problems ☐ Gambling centered
☐ Temper problems ☐ Athletic ☐ Followers ☐ Alcohol/drug centered ☐ Angry with me
☐ Caring ☐ Problematic ☐ Spiritual ☐ Popular ☐ Unpopular

Other information about friends that you think is important?______________________________
Please list first name of a few of the friends who are most important to you?

Name	Length of time known
______________________________	__________________________
______________________________	__________________________

COMMENTS
(Therapist Only)

ADULT SOCIAL INTAKE

M-13062 page 3 Rev. (3/05)

PT.

MR.#/RM.

DR.

Do you talk about problems with your friends? ☐ Yes ☐ No

Who do you trust the most in your life right now? ____

Who in your life might be available to support you in your treatment?

DEVELOPMENTAL (As a youth, did you experience any of the following?)

	AGE		AGE		AGE
☐ Serious accident	____	☐ Hospitalizations	____	☐ Sexual abuse	____
☐ Trouble with police	____	☐ Shyness	____	☐ Suicide attempt(s)	____
☐ Head Injury	____	☐ Suicidal thoughts	____	☐ Physical abuse	____
☐ Running away	____	☐ Witnessed abuse	____	☐ Visual problems	____
☐ Growth concerns	____	☐ Violence problems	____	☐ Depression problems	____
☐ Behavior problems	____	☐ Pregnancy(s)	____	☐ Gang involvement	____
☐ Abortion(s)	____	☐ Sleeping problems	____	☐ Self esteem problems	____
☐ Fear problems	____	☐ Hearing problems	____	☐ Gambling problems	____
☐ Stuttering	____	☐ Emotional abuse	____	☐ Cult/satanic experiences	____
☐ Eating problems	____	☐ Speech problems	____		

Who or what has been the most influential in your life? ________________________________

Are you aware of any major difficulties at the time of your birth or early infancy? ☐ Yes ☐ No

As a youth did you belong to any formal or informal groups? ☐ Yes ☐ No

Describe ____

SPIRITUAL

☐ I believe in God/High Power ☐ I don't believe in God/Higher Power

☐ I attend church/temple/mosque ☐ I don't attend church/temple/mosque

What values and/or spiritual beliefs are important to you? ________________________________

____

MORE ABOUT YOU

How do you feel most of the time? ____

When I feel mad I... ____

When I feel sad I... ____

When I feel glad I... ____

When I feel afraid I.. ____

How have you been affected positively or negatively by tour race, nationality, cultural or background?

____

Have you ever-attended self-help or support groups? ☐ No ☐ Yes

Please explain ____

Is there anything else you would like your therapist to know about you?

____

____

____

____

________________________________ ________________________

Client Signature Date

STOP HERE

COMMENTS
(Therapist Only)

PT.

MR.#/RM.

DR.