Adult Intake Questionnaire

Your Name: _____

Address: _____

Phone: (Home) _____ (Work) _____

(Cell)_____ (Other, please specify) _____

Email: _____

Emergency Contact: (Name) _____

(Phone) _____ (Relationship) _____

Referred by _____ Phone_____

REIMBURSEMENT The monthly statement you will receive can be forwarded to your insurance company to request reimbursement. If you would like your social security number included on this statement, please include it here:

_____

Please mail the monthly statement to the following address (circle one): Home Business Other

_____

_____

Age: _____ Gender: _____ Date of birth: _____

Ethnicity (circle one): Caucasian African American Hispanic Asian

Other: _____

Religious background: Protestant Catholic Jewish Muslim Buddhist No affiliation

(circle one) Other: _____

Marital status: Single, never married Married Separated Divorced

(circle one) Widowed Cohabiting

If you divorced, when did you divorce your previous partner? _____

How long were you married? _____

If you are widowed, when did your spouse die? _____

Education: (number of years completed) _____

Occupation: _____

Are you working now? No Yes (circle one) If yes, circle one: Full-time Part-time

Are you going to school now? No Yes (circle one) If yes, circle one: Full-time Part-time

Names of persons living in your home and your relationship to them:

Name	**Relationship**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Spouse/partner's occupation, if applicable:_____

Please provide the following information about your family:

Mother Name: _____

If deceased, year and cause of death: _____

If living, age and health status: _____

If living, where does she live now? _____

Her occupation (past and/or present): _____

Father Name: _____

If deceased, year and cause of death:_____

If living, age and health status: _____

If living, where does he live now? _____

His occupation (past and/or present): _____

Siblings:

Name	Age	Occupation	Where does s/he live?
_____			
_____			
_____			
_____			

Where did you grow up?_____

Were your parents ever separated? Yes No (circle one) If yes, when?_____

Did your parents get divorced? Yes No (circle one) If yes, when? _____

Did they remarry? Yes No (circle one) If yes, when? _____

At what age did you move out of your parents' home? _____

What is the highest degree you earned in school? _____ When? _____

Did you ever leave a school you were enrolled in prior to completion? Yes No (circle one)

If yes, give details: _____

Did you ever receive any special education services (e.g. academic tutoring, IEP, classroom accommodations, etc.)?

Yes No (circle one) If yes, give details: _____

_____

If you were physically disciplined as a child, were you ever injured as a result? Yes No (circle one)

Did your parent or a person taking care of you ever purposefully injure you in other circumstances (that is, when you were not being disciplined)? Yes No (circle one)

Did you ever have sexual contact with someone else that you did not want? Yes No (circle one)

Have you experienced or witnessed any traumas (events that felt life-threatening)? Yes No (circle one)

Have you experienced physical or sexual abuse or assaults? Yes No (circle one)

Please provide some general information on your work history:

Type of job held How long?

_____

_____

_____

If you have a partner or spouse, how long have you been together? _____

Please list names and ages of your children, if applicable:

Name	Age	Biological?	Name	Age	Biological?
		Y/N			Y/N
		Y/N			Y/N

Please describe, briefly, the problem(s) that bring you in to see me.

What are the symptoms, how intense are they, and how often do they occur?

_____

_____

_____

_____

Have there ever been problems like this before? Yes No (circle one)

If yes, when? _____

Are you presently seeing another therapist? Yes No (circle one)

If yes, please give us the following information:

Therapist's name: _____ Date treatment began: _____

Therapist's address:_____

Therapist's phone number: _____

Have you previously been in psychotherapy or counseling, including individual, group, marital or family therapy?

Yes No (circle one)

If yes, please give us the following information:

Therapist's name(s), phone number(s) and address(es): _____

_____

_____

Date(s) of treatment : _____

Problem for which treatment was sought:_____

If you have been in psychotherapy before, was it helpful? Yes No (circle one)

If yes, in what way was it helpful? _____

If not, in what way was it unsatisfactory? _____

Has hospitalization or partial hospitalization for mental or emotional difficulties ever been recommended for you?

Yes No (circle one) If yes, when and why? _____

Have you ever been hospitalized or participated in a partial hospitalization program for mental or emotional difficulties?

Yes No (circle one) If yes, when and why? _____

Was the hospitalization voluntary? Yes No (circle one)

Has a physician/psychiatrist ever recommended that you take medication for mental or emotional difficulties (e.g. Prozac, Xanax, etc.)? Yes No (circle one)

If yes, what medications were recommended, when and for what symptoms?

_____

Have you ever taken medications for mental or emotional difficulties prescribed by a physician/psychiatrist?

Yes No (circle one)

If yes, what medications were prescribed, when and for what symptoms?

_____

Are you currently using any prescribed medications? Yes No (circle one)

Please indicate what medications you are taking:

Medication	Dosage	When started	Prescriber

Have you ever used any drugs or medications other than as prescribed? (This includes prescription medications, marijuana, PCP, LSD, amphetamines, barbiturates, cocaine, opiates, prescribed drugs (e.g. valium), Ecstasy and others)

Yes No (circle one) Are you currently using? Yes No (circle one)

If yes, please check which ones and fill out the requested information:

Type	Frequency/amount	Duration	How taken

If you have used any substances listed above, do you feel they have caused any problems in your work, school or relationships? Yes No (circle one)

If yes, please explain: _____

Do you drink alcohol? Yes No (circle one)

If yes, please answer the following questions:

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

Yes No (circle one)

Have people annoyed you by criticizing your drinking?

Yes No (circle one)

Have you ever felt bad or guilty about your drinking?

Yes No (circle one)

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

Yes No (circle one)

How much alcohol do you drink? _____drinks per _____

Do you feel your drinking has caused any problems in your work, school or relationships? Yes No (circle one)

If yes, please explain: _____

_____

Has treatment for drug or alcohol abuse ever been recommended to you?

Yes No (circle one)

If yes, please describe the circumstances and give dates.

_____

_____

Have you ever been treated for drug or alcohol abuse?

Yes No (circle one)

If yes, please describe the provider and program, give dates and describe the outcome.

_____

_____

Have you ever had a physical fight with anyone, including your spouse or partner (including throwing things, hitting, shoving, etc.)? Yes No (circle one)

Do you currently have, or have you had in the past, any serious, chronic or recurrent health problems or disabilities? Yes No (circle one)

If yes, please describe: _____

List dates of any hospitalizations you have had for physical problems:

Date Problem

_____

_____

_____

When was your last physical examination by a doctor? _____

What was the outcome? _____

Do any biological relatives have any history of psychiatric or emotional problems? Yes No

If yes, which family members and what types of problems?

_____

_____

Have you ever been involved in a lawsuit?

Yes No (circle one)

If yes, please describe the circumstances and give dates.

_____

_____

Have you ever been arrested for a crime?

Yes No (circle one)

If yes, please describe the circumstances and give dates.

_____

_____

Have you experienced any particular sources of stress in the last year?

Yes No (circle one)

If yes, please explain: _____

Are there any other health care professionals (e.g. physicians, psychotherapists, etc.) whom you feel might have information that would help in your treatment?

Yes No (circle one)

If yes, please give details: _____

_____

_____

_____

Is there any other background information you think would be helpful for me to know?

Yes No (circle one)

If yes, please explain: _____

_____

_____

_____

_____ _____

Signature Date

DASS21

Name: *Date:*

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree, or a good part of time
3 Applied to me very much, or most of the time

1	I found it hard to wind down	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I found it difficult to work up the initiative to do things	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I experienced trembling (eg, in the hands)	0	1	2	3
8	I felt that I was using a lot of nervous energy	0	1	2	3
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting agitated	0	1	2	3
12	I found it difficult to relax	0	1	2	3
13	I felt down-hearted and blue	0	1	2	3
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15	I felt I was close to panic	0	1	2	3
16	I was unable to become enthusiastic about anything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life was meaningless	0	1	2	3
22	I thought about death or suicide	0	1	2	3
23	I wanted to kill myself	0	1	2	3

TREATMENT/ EVALUATION AGREEMENT

This document contains important information about the professional services and business policies of Cannon Thomas, Ph.D. Please read it carefully and discuss any questions you have with Dr. Thomas.

ASSESSMENT AND TREATMENT: Dr. Thomas will provide an assessment of your difficulties and available treatment options. If he recommends and you agree, he will provide cognitive-behavior therapy or another evidence-based treatment, shown in controlled outcome studies to be effective for a particular problem or disorder. (Dr. Thomas will review the outcome data most pertinent to your situation upon request.) However, no guarantees can be made regarding the success of treatment. Treatment can be time-consuming and stressful; it can bring on strong feelings, such as anger, frustration, sadness, or anxiety, and may result in changes that were not originally intended (such as divorce or remaining in a relationship you believed you would leave). There is a small risk that your condition will worsen due to treatment. After meeting with you to assess your situation, Dr. Thomas will offer, if you would like, an estimate of the number of sessions of treatment he recommends for you. For most patients, this ranges between 5 and 50 sessions. Dr. Thomas' estimate of the duration of treatment is only an estimate, and no guarantees can be made as to the length of treatment required.

ALTERNATIVE TREATMENTS: Many options to the treatment that Dr. Thomas can provide are available, including other types of psychotherapy, group, couple, or family therapy, and, in many cases, medications. Testing and other formal evaluation procedures can be helpful in some cases; and, if Dr. Thomas recommends this in your case, he will let you know what his recommendation is and the reasons for it.

You are entitled to ask questions about all aspects of treatment. Dr. Thomas will help you secure a consultation with another mental health professional whenever you request it or he recommends it.

TRAINING AND EXPERIENCE: Dr. Thomas is a psychologist licensed to practice in California. He graduated from the University of Virginia with a Ph.D. in Clinical Psychology in 2001. He received postdoctoral training at Stanford University in the Behavioral Medicine division of the Department of Psychiatry.

THE PATIENT'S ROLE: You are expected to play an active role in your treatment, including working with Dr. Thomas to outline treatment goals and completing questionnaires at the beginning of treatment and periodically during treatment to assess progress. You will be asked to complete homework assignments between sessions. If at any point you are unhappy about the progress, process, or outcome of the treatment, please discuss this with Dr. Thomas in an attempt to resolve any difficulties that have arisen and to arrive at a treatment plan that better meets your needs.

THE PATIENT'S RIGHTS: A document entitled "Patient's Bill of Rights," from a publication by the California Department of Consumer Affairs, is attached. Please read it carefully and raise with Dr. Thomas any questions you have about it.

HOURS/AVAILABILITY: Dr. Thomas is usually available for therapy sessions on weekdays between 10AM and 7PM. Therapy sessions are usually scheduled as 50-minute sessions weekly, or as your treatment needs dictate and you and Dr. Thomas agree. In the event of an emergency, Dr. Thomas is available by mobile phone at 415-595-8748. In addition, in a crisis,

you can contact your primary care physician, the local emergency room, or crisis intervention services. When Dr. Thomas is out of town, he will let you know and he will give you the name and telephone number of another therapist who will be available.

CONFIDENTIALITY: The confidentiality of communications between the patient and therapist is important and, in general, is legally protected. Dr. Thomas will make every effort to keep the results of all your evaluation and treatment strictly confidential, as is required by law. Information about you will be released by Dr. Thomas only with your written permission, with the following exceptions:

- when there is suspected elder, dependent adult, or child abuse or neglect.
- when, in Dr. Thomas' judgment, you are in imminent danger of harming yourself or are unable to provide basic care for yourself.
- If you communicate to Dr. Thomas a serious threat of physical violence against another person, Dr. Thomas is required by law to inform both potential victims and legal authorities.
- if Dr. Thomas is ordered by a court to release information as part of a legal proceeding.
- as otherwise required by law.

In the event group therapy services are provided, you are expected to keep materials shared in the group confidential. Dr. Thomas cannot be held responsible for a breach of confidentiality on the part of group members.

If you elect to seek reimbursement from an insurance company for your treatment, Dr. Thomas will provide you with a monthly statement you can submit to your insurance company. Most insurance companies require information about your diagnosis, the type of service provided (e.g., 50-minute individual psychotherapy session), the date of the session, and the fee, and Dr. Thomas will include this information on your statement. In some cases, insurance companies will require that the provider send information about the patient's diagnosis and treatment plan, progress reports, and other records. Please be aware that when information is sent to an insurance company, Dr. Thomas has no control over who sees it. Almost all insurance companies state that they will keep the information confidential, but Dr. Thomas cannot assure that they will do so. Some share the information they receive with a national medical information data bank for the purposes of deciding eligibility for future life, disability, health, and other insurance. Before Dr. Thomas sends any information to an insurance company, he will talk with you about what he has written and he will obtain your written permission to provide information to your insurance company. You do have a choice about whether to release the information requested by an insurance company, but if you refuse to consent to releasing it, most insurance programs will not pay for services.

RECORD-KEEPING: Dr. Thomas maintains a clinical chart for each client. Information in the chart includes a description of your condition, your treatment goals, your treatment plan and progress in treatment, dates of and fees for sessions, and notes describing each therapy session. Dr. Thomas also keeps records of any consent, release, assessment, insurance, or other forms completed in the course of your treatment. Clinical records are stored in a locked cabinet.

AUDIOTAPING: You may wish to audiotape therapy sessions so you can review them at a later date. If so, you may bring a tape to the session.

RESEARCH, WRITING, TEACHING, CONSULTATION: Dr. Thomas conducts research, training, and supervision, and he writes for professional and lay audiences. Dr. Thomas may also wish to consult with other professionals about treatment planning for your case. Your signature below gives Dr. Thomas permission to use information about you and your treatment in any of these ways, provided that he takes reasonable efforts to protect your identity.

FEES: Dr. Thomas' fee is $200 per 50-minute session. Longer or shorter sessions are generally prorated from this base fee. There is of course no charge for brief phone consultation. Phone therapy sessions will be billed at the standard rate.

PAYMENT: Dr. Thomas will send you a statement in the first week of every month. Payment is due within 14 days of receiving the statement. The statement will include all information necessary for submitting a claim to an insurance company, if you choose to do so.

CANCELLATIONS AND MISSED APPOINTMENTS: In order to avoid being billed for an appointment, please cancel 24 hours prior to your appointment time. Please be aware that insurance companies will not generally reimburse for a missed session.

REIMBURSEMENT: You are responsible for collecting reimbursement from your insurance company or other source.

ENDING TREATMENT: I understand that I may withdraw from treatment at any time. I understand that Dr. Thomas recommends that I discuss my plan to terminate treatment with him before taking action, so that he has an opportunity to offer his recommendations, describe any potential consequences to ending treatment at that time, and offer referral options if they are needed.

I have read and understood this agreement and the Patient Bill of Rights and I have had my questions answered to my satisfaction. I accept, understand, and agree to abide by the contents and terms of this agreement and consent to participate in evaluation and/or treatment.

Name of patient (please print): _____

Signature of patient: _____

Date: _____