Kimberly Mathewson, Psy.D.

1720 South Bellaire Street, Suite 808
Denver, CO 80222
303-909-5601

Patient Services Agreement

In order to provide you with the best service, and to meet the legal requirements of the State of Colorado, I would like to provide you with the following information:

***BASIC INFORMATION:**

Dr. Kim Mathewson's professional background includes a bachelor's degree from the University of Colorado in 2006, a master's degree in Clinical Psychology from the University of Denver in 2010, completion of a pre-doctoral clinical internship at the University of Denver Health and Counseling Center in 2013, and a doctorate degree in Clinical Psychology from the University of Denver in 2013. Dr. Mathewson is a licensed clinical psychologist and her license number is 4220.

Regulation of Psychotherapists in Colorado

DORA has the general responsibility of regulating the practice of licensed psychologists, licensed clinical social workers, licensed professional counselors, licensed marriage and family therapists, certified school psychologists, and unlicensed individuals who practice psychotherapy. The agency within DORA that has this responsibility is the Mental Health Section, 1560 Broadway, Suite 1370, Denver, CO 80202, (303) 894-7766.

The regulatory requirements for mental health professionals provide that a licensed clinical social worker, licensed marriage and family therapist, and licensed professional counselor must hold a masters degree in his or her profession and have two years of post-masters supervision. A licensed psychologist must hold a doctorate degree in his or her profession and have one year of post-doctoral supervision. A licensed social worker must hold a masters degree in social work. A psychologist candidate, marriage and family therapist candidate, and licensed professional counselor candidate must hold the necessary licensing degree and be in the process of completing the required supervision for licensure. A certified addiction counselor I (CAC I) must be a high school graduate and complete required training hours and 1,000 hours of supervised experience. A CAC II must complete additional required training hours and 2,000 hours of supervised experience. A CAC III must hold a bachelor's degree in behavioral health and complete additional required training hours and 2,000 hours of supervised experience. A licensed addiction counselor must have a clinical master's degree and meet the CAC III requirements. A registered psychotherapist is listed in the state's database and is authorized by law to practice psychotherapy in Colorado, but is not licensed by the state and is not required to satisfy any standardized educational or testing requirements.

You are entitled to receive information from me at any time about methods of therapy, the techniques used, the duration of therapy (if known) and the fee structure. You may seek a second opinion from another therapist or may terminate therapy at any time.

Dual roles, exploitation, and sexual intimacy are never appropriate in a professional relationship and should be reported to the Department of Regulatory Agencies, State Board of Psychologist Examiners.

***PSYCHOLOGICAL SERVICES:** Psychotherapy is a set of psychological interventions designed to help people resolve emotional, behavioral, and interpersonal problems and improve the quality of their lives. There are many different interventions I may use to help you with the problems that you hope to address. I specialize in Cognitive Behavioral Therapy (CBT). This type of therapy calls for a very active effort on your part. In order for the therapy to be most successful, it will be important for you to work on the things I talk about, both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience temporary uncomfortable feelings like sadness, guilt, anxiety, anger, frustration, loneliness, and helplessness. Especially when treating clients with anxiety disorders, I will often employ the technique of exposure therapy. Exposure therapy involves helping clients to gradually face their fears until their anxiety has reduced. Exposure therapy has been demonstrated in research to be very effective in reducing anxiety problems, but it does involve participating in exercises that elicit some anxiety. It is important to know that these exercises will be carefully designed together and agreed upon ahead of time, and you will never be forced to do an exposure that you don't want to do. Despite the possibility of some transient discomfort, psychotherapy has also been shown to have many benefits. Therapy may lead to better relationships, solutions to specific problems, improved coping skills, and significant reductions in feelings of anxiety and distress.

During your first few sessions, I will typically conduct an evaluation of your treatment needs. By the end of this evaluation process, I will be able to offer you some first impressions of what your therapy might include and a treatment plan to follow if you decide to continue with therapy. You are encouraged to evaluate this information along with your own opinions of whether you feel comfortable working with me. I recognize that therapy involves a commitment of time, money, and energy on your part, and I want you to feel comfortable with the treatment plan as I move forward. If you have questions about my procedures, I can discuss them as they arise. Should you request a second opinion or you feel that our clinic is not best suited to meet your needs, I will be happy to refer you to another mental health professional. In addition, I recognize that every therapist cannot specialize in every problem with which clients are struggling. If I feel that our areas of expertise do not match the problem with which you are struggling, I will refer you to another professional who I think is better suited to help you.

***CONFIDENTIALITY:** The information provided by you as a client during therapy sessions is legally confidential. This means that I cannot disclose information about you or your treatment to others without your permission. Under Colorado law however, there are certain specific limits to confidentiality (some of which are listed in section 12-43-218, and the Notice of Privacy Rights you were provided, as well as other exceptions in Colorado and Federal law.) If I am directed by a judge in a court of law to reveal information, then I must do so. I am required to report any suspected incident of child abuse or neglect, within the stipulations of state law, to law enforcement. I am required to report any threat of imminent physical harm by a client to law enforcement and to the person(s) threatened, including those identifiable by their association with a specific location or entity. I am required to initiate a mental health evaluation of a client who is imminently dangerous to self or to others, or who is gravely disabled, as a result of a mental disorder. I am required to report any suspected incident or exploitation of an at-risk elder abuse or neglect, within the stipulations of state law, to law enforcement. Finally, I am required to report any suspected threat to national security to federal officials. In addition, I am required to work with you closely to preserve your safety, and this may necessitate hospitalization in some cases. By Colorado law, parents/guardians have the right to request any written records kept about sessions and other contacts with clients below the age of 18. Further, if a client brings a malpractice suit or submits a grievance to the State Board of Psychologist Examiners, psychologists are permitted to disclose relevant clinical information to defend themselves. In addition, I occasionally find it helpful to consult with other health and mental health professionals about a case. The purpose of these consultations is to get input from other professionals about ways to improve your treatment. During consultation, I make every effort to not reveal the identity of my clients. The other professionals with whom I consult are also legally bound to keep the information confidential. Unless you object, I will only tell you about these consultations if I believe it is important to our work together.

***FEES:** My billing rate is $160.00 per 50-minute. Longer or shorter sessions are prorated based on this rate. If it is necessary that I travel for your treatment, I will charge the same rate for travel time. I also offer a sliding scale, please ask me for more information regarding this. Any phone call under 15 minutes will be free of charge, if the phone call lasts longer than 15 minutes, a fee of $60.00 per 15 minutes will be charged. If a report or letter is requested, I will bill the usual hourly rate. Payment is due at the time of service. Cash, check, or credit card payments are all acceptable forms of payment. There will be a $25.00 charge for checks drawn on insufficient funds. **I do not participate in any managed care or insurance agreements. This is a fee-for-service practice, so you (not your insurance company) are responsible**

for full payment of my fees. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. If you are using insurance, I will give you monthly billing statements so that you can be reimbursed by your insurance company. I recommend that you contact your insurance company to inquire about out-of-network coverage for mental health services. Because you will be paying me each session for their services, any later reimbursement from the insurance company should be sent directly to you. Please do not assign any insurance company payment to our practice. Additionally, I reserve the right to use a collection agency to collect fees that are more than 120 days past due, unless I have agreed on an alternative payment plan.

***PROFESSIONAL RECORDS:** The laws and standards of our profession require that psychologists keep Protected Health Information (PHI) about you in your clinical record. You may examine and/or receive a copy of this clinical record if you request it in writing. In unusual circumstances in which disclosure is reasonably likely to endanger the life or physical safety of you or another person, I may refuse your request. In those situations, you have a right to a summary and to have your record sent to another mental health provider. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in our presence, or have them forwarded to another mental health professional so you can discuss the contents. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.

***CANCELLATION POLICY:** Please contact me at least 24 hours ahead of time on the preceding business day if you need to cancel an appointment. Without this notice, you will be charged the full fee for that appointment.

***HOW TO REACH YOUR THERAPIST:** You can reach me by leaving a message on my confidential voice mail. I will return phone calls as soon as possible. Dr. Mathewson can be reached at 303-909-5601. This is not an emergency response system; it may be several hours or sometimes the next day before I will able to return your call. If I will be away from the office for an extended period of time, I will provide the contact information of a colleague providing coverage for my clients. **I do not offer after-hours or emergency services.** In the event of a psychiatric emergency, please call 911 or go to your nearest emergency room. You may also contact Colorado Crisis Services at 1-844-493-8255 (http://coloradocrisisservices.org), or the Suicide and Crisis Hotline at 303-860-1200 or the National Suicide Prevention Hotline at 1-800-SUICIDE or 1-800-273-TALK for immediate 24-hour assistance.

***FEEDBACK:** Your input in your treatment is invaluable. I have expertise in anxiety disorders and cognitive behavioral treatment, but YOU are the expert on you. Therefore, I hope that I can collaborate together to help you meet your goals. Please keep informed about what you feel works for you/does not work for you in our sessions. Please give me feedback about anything about our work together that causes you distress or makes you feel uncomfortable. You are welcome and encouraged to ask questions about my theory of psychotherapy, any of our clinic policies, your bill, or any other concerns that arise. The better informed you are, the more effective our work together will be.

I look forward to working with you!

Kim Mathewson, Psy.D.
Licensed Clinical Psychologist

303-909-5601
contact@drkimmathewson.com

Kimberly Mathewson, Psy.D.

1720 South Bellaire Street, Suite 808
Denver, CO 80222
303-909-5601

Informed Consent of Patient Services Agreement
(Minors under the age of 18)

I have read and understood the information outlined in the Patient Services Agreement and agree to its terms. I consent to treatment with Dr. Kim Mathewson, I have had all questions answered to my satisfaction. I have received a copy of this form for my own records.

I hereby acknowledge that I have received the provider's Notice of Privacy Rights.

_____ _____
Signature Date

_____ _____
Print name (if different from client's name) Relationship to Client

_____ _____
Print Client's name Client's Date of Birth

*If parents are separated or divorced and have joint custody/ medical decision-making of the client, then both parents' signatures are required. Only one parent's signature is required if parents are married to each other.

_____ _____
Additional Parent Signature Date

_____ _____
Print name Relationship to Client

Kimberly Mathewson, Psy.D.

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Cancellation Policy Agreement

I have a 24-hour cancellation policy, which means that any appointment cancelled with less than 24 hours notice will be charged the full fee for the appointment.

This means that if you cancel with less than 24 hours notice or do not show up for the appointment, I will automatically charge your credit card on file the full fee for the session. I require all clients to keep a credit card on file for this reason.

If you need to cancel your appointment and you give more than 24 hours notice, there is no charge. Therefore, in order to avoid being charged for a missed session, please remember to cancel at least 24 hours beforehand.

I always appreciate it when clients give plenty of notice for any appointments they need to change, as this gives us time to schedule those slots for other clients who want them.

Informed Consent of Cancellation Policy

I have read and understood the information outlined in the Cancellation Policy Agreement and agree to its terms. I understand and agree that my credit card on file will automatically be charged the full fee for any appointments cancelled with less than 24 hours notice.

_____ _____
Signature Date

_____ _____
Print name (if different from client's name) Relationship to Client

_____ _____
Print Client's name Client's Date of Birth

*If parents are separated or divorced and have joint custody/ medical decision-making of the client, then both parents' signatures are required. Only one parent's signature is required if parents are married to each other.

_____ _____
Additional Parent Signature Date

_____ _____
Print name Relationship to Client

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL (INCLUDING MENTAL HEALTH) INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN ACCESS THIS INFORMATION IF NEEDED. PLEASE REVIEW IT CAREFULLY.

I. **USES AND DISCLOSURES OF PROTECTED INFORMATION**

A. General Uses and Disclosure Not Requiring Client's Consent. The provider will use and disclose protected information in the following ways.

1. **Treatment.** Treatment refers to the provision, coordination, or management of health care (including mental healthcare) and related services by one or more health care providers. For example, the provider will use your information to plan your course of treatment. As to other examples, the provider may consult with professional colleagues or ask professional colleagues to cover calls or the practice for the provider and will provide the information necessary to complete those tasks.
2. **Payment.** Payment refers to the activities undertaken by a health care provider (including a mental health provider) to obtain to provide reimbursement for the provision of health care. The provider will use your information to develop accounts receivable information, bill you, and with your consent, provide information to your insurance company or other third party payer for services provided. The information provided to insurers and other third party payers may include information that identifies you, as well as your diagnosis, type of service, date of service, provider name/identifier, and other information about your condition and treatment. If you are covered by Medicaid, information will be provided to the State of Colorado's Medicaid program, including, but not limited to your treatment, condition, diagnosis, and services received.
3. **Health Care Operation.** Health Care Operations refers to activities undertaken by the provider that are regular functions of management and administrative activities of the practice. For example, the provider may use of disclose your health information in the monitoring of service quality, staff evaluation, and obtaining legal services.
4. **Contacting the Client.** The provider may contact you to remind you of appointments and to tell you about treatments or other services that might be of benefit to you.
5. **Required by Law.** The provider will disclose protected health information when required by law or necessary for health care oversight. This includes, but is not limited to: (a) reporting child abuse or neglect; (b)when court ordered to release information; (c)when there is a legal duty to warn or take action regarding imminent danger to others; (d) when the client is a danger to self or others or gravely disabled; (e)when a coroner is investigating a client's death; or (f) to health oversight agencies for oversight activities authorized by law and necessary for the oversight of health care system, government health care benefit programs, or regulatory compliance.
6. **Crimes on the premises of observed by the provider.** Crimes that are observed by the provider or the provider's staff; crimes that are directed toward the provider or the provider's staff, or crimes that occur on the premises will be reported to law enforcement.
7. **Business Associates.** Some of the functions of the provider may be provided by contracts with business associates. For example, some of the billing, legal, auditing, and practice management services may be provided by contracting with outside entities to perform those services. In those situations, protected health information will be provided to those contractors as is needed to perform their contracted tasks. Business Associates are required to enter into an agreement maintaining the privacy of the protected health information released to them.

8. **Research.** The provider may use or disclose protected health information for research purposes if the relevant limitations of the Federal HIPAA Privacy Regulation are followed. 45 CFR 164.512 (i).
9. **Involuntary Clients.** Information regarding clients who are being treated involuntarily, pursuant to law, will be shared with other treatment provides, legal entities, third party payers and others, as necessary to provide the care and management coordination needed.
10. **Family Members.** Except for certain minors, incompetent clients, or involuntary clients, protected health information cannot be provided to family members without the client's consent. In situations where family members are present during a discussion with the client, and it can be reasonably inferred from the circumstances that the client does not object, information may be disclosed in the course of that discussion. However, if the client objects, protected health information will not be disclosed.
11. **Emergencies.** In life threatening emergencies, the provider will disclose information necessary to avoid serious harm or death.

B. **Client Authorization or Release of Information.** The provider may not use or disclose protected health information in any other way without a signed authorization or release of information. When you sign an authorization, or release of information, it may later be revoked, provided that the revocation is in writing. The revocation will apply, except to the extent the provider has already taken action in reliance thereon.

II. YOUR RIGHTS AS A CLIENT

A. Access to Protected Health Information. You have the right to inspect and obtain a copy of the protected health information the provider has regarding you, in the designated record set. However, you do not have the right to inspect or obtain a copy of psychotherapy notes. There are other limitations to this right, which will be provided to you at the time of your request, if relevant, along with the appeal process available to you. To make a request, ask your therapist.

B. Amendment of Your Record. You have the right to request that the provider amend your protected health information. The provider is not required to amend the record if it is determined that the record is accurate and complete. There are other exceptions, which will be provided to you at the time of your request, if relevant, along with the appeal process available to you. To make a request, ask your therapist.

C. Accounting of Disclosures. You have the right to receive an accounting of certain disclosures the provider had made regarding your protected health information. However, that accounting does not include disclosures that were made for the purposes of treatment, payment, or health care operations. In addition, the accounting does not include disclosures made to you, disclosures made pursuant to a signed Authorization, or disclosures made prior to April 14, 2003. There are other exceptions that will be provided to you should you request an accounting. To make a request, ask your therapist.

D. Additional Restrictions. You have the right to request additional restrictions on the use of disclosure of your health information. The provider does not have to agree to that request, and there are certain limits to any restriction, which will be provided to you at the time of your request. To make a request, ask your therapist.

E. Alternative Means of Receiving Confidential Communications. You have the right to request that you receive communications of protected health information from the provider by alternative means, or alternative locations. For example, if you do not want the provider to mail bills or other materials to your home, you can request that this information be sent to another address. There are limitations to the granting of such requests, which will be provided t you at the time of the requested process. To make a request, ask your therapist.

F. Copy of This Notice. You have the right to obtain another copy of this Notice upon request.

III. ADDITIONAL INFORMATION

A. Privacy Laws. The provider is required by State and Federal Law to maintain the privacy of protected health information. In addition, the provider is required by law to provide clients with notice of the provider's legal duties and privacy practices with respect to protected health information. That is the purpose of this Notice.

B. Terms of the Notice and Changes to the Notice. The provider is required to abide by the terms of this Notice, or any amended Notice that may follow. The provider reserves the right to change the

terms of its Notice and to make the new Notice provisions effective for all protected health information that it maintains. When the Notice is revised, the revised Notice will be posted at the provider's service delivery sites and will be available upon request.

C. Complaints Regarding Privacy Rights. If you believe the provider has violated your privacy rights, you have the right to complain to the provider. Your therapist is the person designated within the practice to receive your complaints. You also have the right to complain to the United States Secretary of Health and Human Services, by sending your complaint to:

Office of Civil Rights
U.S. Department of Health &Human Services
200 Independence Avenue, S.W.
Room 515F HHH Bldg.
Washington, DC. 20201

D. Additional Information. If you desire additional information about your privacy rights, ask your therapist.

E. Effective Date. This Notice is effective April 14, 2003

Kimberly Mathewson, Psy.D.

1720 South Bellaire Street, Suite 808
Denver, CO 80222
303-909-5601

HIPAA RECEIPT
NOTICE OF PRIVACY PRACTICES
Minors under the age of 18

Client's Name: _____

Date of Birth: _____

I have received this practice's Notice of Privacy Practices written in plain language. This Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice. I have received information about my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information residing at, or controlled by this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____ Date: _____

Relationship to patient (if signed a parent or guardian): _____

*If parents are separated or divorced and have joint custody/ medical decision-making of the client, then both parents' signatures are required. Only one parent's signature is required if parents are married to each other.

_____ _____
Additional Parent Signature Date

_____ _____
Print name Relationship to Client

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303-909-5601

Surprise/Balance Billing Disclosure Form

Surprise Billing – Know Your Rights

Beginning January 1, 2020, Colorado state law protects you* from "surprise billing," also known as "balance billing." These protections apply when:

- You receive covered emergency services, other than ambulance services, from an out-of-network provider in Colorado, and/or

- You unintentionally receive covered services from an out-of-network provider at an in-network facility in Colorado

What is surprise/balance billing, and when does it happen?

If you are seen by a health care provider or use services in a facility or agency that is not in your health insurance plan's provider network, sometimes referred to as "out-of-network," you may receive a bill for additional costs associated with that care. Out-of-network health care providers often bill you for the difference between what your insurer decides is the eligible charge and what the out-of-network provider bills as the total charge. This is called "surprise" or "balance" billing.

When you CANNOT be balance-billed:

Emergency Services

If you are receiving emergency services, the most you can be billed for is your plan's in-network cost-sharing amounts, which are copayments, deductibles, and/or coinsurance. You cannot be balance-billed for any other amount. This includes both the emergency facility where you receive emergency services and any providers that see you for emergency care.

Nonemergency Services at an In-Network or Out-of-Network Health Care Provider

The health care provider must tell you if you are at an out-of-network location or at an in-network location that is using out-of-network providers. They must also tell you what types of services that you will be using may be provided by any out-of-network provider.

You have the right to request that in-network providers perform all covered medical services. However, you may have to receive medical services from an out-of-network provider if an in-network provider is not available. In this case, the most you can be billed for **covered** services is your in-network cost-sharing amount, which are copayments, deductibles, and/or coinsurance. These providers cannot balance bill you for additional costs.

Additional Protections

- Your insurer will pay out-of-network providers and facilities directly.

· Your insurer must count any amount you pay for emergency services or certain out-of-network services (described above) toward your in-network deductible and out-of-pocket limit.

· Your provider, facility, hospital, or agency must refund any amount you overpay within sixty days of being notified.

· No one, including a provider, hospital, or insurer can ask you to limit or give up these rights.

If you receive services from an out-of-network provider or facility or agency OTHER situation, you may still be balance billed, or you may be responsible for the entire bill. If you intentionally receive nonemergency services from an out-of-network provider or facility, you may also be balance billed.

If you want to file a complaint against your health care provider, you can submit an online complaint by visiting this website: https://www.colorado.gov/pacific/dora/DPO_File_Complaint.

If you think you have received a bill for amounts other than your copayments, deductible, and/or coinsurance, please contact the billing department, or the Colorado Division of Insurance at 303-894-7490 or 1-800-930-3745.

*This law does NOT apply to ALL Colorado health plans. It only applies if you have a "CO-DOI" on your health insurance ID card.

Please contact your health insurance plan at the number on your health insurance ID card or the Colorado Division of Insurance with questions.

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Client Information Form

The following information will help your teen's therapist in formulating a treatment plan. This information about your teen allows us to spend our time in session focusing on what is most important. ***It may be helpful for your teen to fill out portions of this form, as we ask questions about his or her own experiences. You may wish to ask your teen to read over this form and fill out part or all of the following questions.*** *The questions are worded so that either a parent or the teen can complete them; if parents complete these questions, please fill them out on behalf of your teen. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy. Please print out this form and bring it to your first session. Thank you, and I look forward to working with your teen.*

Client's Name: _____
(Last) (First) (MI)

Today's Date ____/____/_____ Birth Date: _____ /_____ /_____ Age: _____

Address:
_____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: _____ May I leave a message? □Yes □No

Cell Phone: _____ May I leave a message? □Yes □No

E-mail: _____ May I email you? □Yes □No

Please be aware that email is not a secure form of communication and your confidentiality cannot be assured. We recommend limiting email communication to scheduling and logistical issues rather than discussing clinical matters.

Person to contact in case of an emergency:

_____ _____ _____
(Name) (Person's relationship to client) (Phone)

IF CLIENT IS UNDER THE AGE OF 18, PLEASE PROVIDE ADDITIONAL INFORMATION ABOUT PARENT(S)/ GUARDIANS BELOW

Name(s): _____

Relationship: _____

Address: _____

_____

Home Phone: _____ May I leave a message? □Yes □No

Cell Phone: _____ May I leave a message? □Yes □No

E-mail: _____ May I email you? □Yes □No

Please be aware that email is not a secure form of communication and your confidentiality cannot be assured. We recommend limiting email communication to scheduling and logistical issues rather than discussing clinical matters.

___ Please check here if this individual is the financially responsible party

Name(s): _____

Relationship: _____

Address: _____

_____

Home Phone: _____ May I leave a message? □Yes □No

Cell Phone: _____ May I leave a message? □Yes □No

E-mail: _____ May I email you? □Yes □No

Please be aware that email is not a secure form of communication and your confidentiality cannot be assured. We recommend limiting email communication to scheduling and logistical issues rather than discussing clinical matters.

___ Please check here if this individual is the financially responsible party

BACKGROUND INFORMATION

How did you learn about my practice?: _____

What prompted you to seek therapy? _____

Has your teen ever been diagnosed with a mental health issue? _____

_____

Has your teen had previous psychotherapy? □Yes □No

If yes, why?_____

If yes, when, and with whom?_____

Is your teen currently taking prescribed psychiatric medications? □Yes □No

If Yes, please list names and doses:

_____

If No, has your teen been prescribed psychiatric medication previously? □Yes □No

Is your teen having current suicidal thoughts? □ Frequently □ Sometimes □ Rarely □ Never

If yes, has your teen recently done anything to hurt themself? □Yes □No

Has your teen had suicidal thoughts in the past? □ Frequently □ Sometimes □ Rarely □ Never

If you checked any box other than "never", when did your teen have these thoughts?_____

Did your teen ever act on them? □Yes □No

Is your teen having current homicidal thoughts (i.e., thoughts of hurting someone else)?
□Yes □No

Has your teen previously had homicidal thoughts? □Yes □No

If yes, when?_____

HEALTH INFORMATION

How is your teen's physical health currently? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Date of last physical examination _____

Please list any chronic health problems or concerns (e.g. asthma, hypertension, diabetes, headaches, stomach pain, seizures, etc.):

_____

_____

Any Allergies? □Yes □No If yes, please list:_____

Current Medications:_____

Hours per night you (or your teen) normally sleeps _____

Is your teen having any problems with sleep habits? □Yes □No

If yes, check all that apply:

□ Sleeping too little □ Sleeping too much □ Can't fall asleep □ Can't stay asleep

Does your teen exercise regularly? □Yes □No

If yes, how many times per week? _____ For how long? _____

If yes, what does he or she do for exercise? _____

Any difficulty with appetite or eating habits? □Yes □No

If yes, check where applicable:
□ Eating less than normal □ Eating more than normal □ Binging □ Purging □ Restricting

Has your teen experienced significant weight change in the last 2 months? □Yes □No

Does your teen use alcohol? □Yes □No

If yes, what is your frequency?

□ once a month □ once a week □ daily □ daily, 3 or more □ intoxicated daily

Does your teen engage in recreational drug use? □ Daily □ Weekly □ Monthly □ Rarely □ Never

If you checked any box other than "never," which drug(s)? _____

Does your teen smoke cigarettes? □Yes □No

If yes, how many cigarettes per day?_____

Does your teen drink caffeinated drinks or use caffeine pills? □Yes □No

If yes, # of sodas per day_____ cups of coffee per day_____ caffeine pills per day _____

Has your teen ever had a head injury? □Yes □No

If yes, when and what happened?_____

In the last year, has your teen or your family experienced any significant life changes or stressors?

_____

_____

*Note: use rating scale with a "yes" response only.

Is your teen/child **now** experiencing:			*Rating Scale 1-10 (10 =worst)
Depressed Mood or Sadness	yes	no	_____
Irritability/Anger	yes	no	_____
Mood Swings	yes	no	_____
Rapid Speech	yes	no	_____
Racing Thoughts	yes	no	_____
Anxiety	yes	no	_____
Constant Worry	yes	no	_____
Panic Attacks	yes	no	_____
Phobias	yes	no	_____
Sleep Disturbances	yes	no	_____
Hallucinations	yes	no	_____
Paranoia	yes	no	_____
Poor Concentration	yes	no	_____
Alcohol/Substance Abuse	yes	no	_____
Frequent Body Complaints (e.g., headaches)	yes	no	_____
Eating Disorder	yes	no	_____
Body Image Problems	yes	no	_____
Repetitive Thoughts (e.g., Obsessions)	yes	no	_____
Repetitive Behaviors (e.g., counting)	yes	no	_____
Poor Impulse Control (e.g., ↑ spending)	yes	no	_____
Self Mutilation	yes	no	_____
Sexual Abuse	yes	no	_____
Physical Abuse	yes	no	_____
Emotional Abuse	yes	no	_____

Has your teen/child experienced **in the past**: *Rating Scale 1-10 (10 =worst)

Depressed Mood or Sadness	yes	no	_____
Irritability/Anger	yes	no	_____
Mood Swings	yes	no	_____
Rapid Speech	yes	no	_____
Racing Thoughts	yes	no	_____
Anxiety	yes	no	_____
Constant Worry	yes	no	_____
Panic Attacks	yes	no	_____
Phobias	yes	no	_____
Sleep Disturbances	yes	no	_____
Hallucinations	yes	no	_____
Paranoia	yes	no	_____
Poor Concentration	yes	no	_____
Alcohol/Substance Abuse	yes	no	_____
Frequent Body Complaints (e.g., headaches)	yes	no	_____
Eating Disorder	yes	no	_____
Body Image Problems	yes	no	_____
Repetitive Thoughts (e.g., Obsessions)	yes	no	_____
Repetitive Behaviors (e.g., counting)	yes	no	_____
Poor Impulse Control (e.g., ↑ spending)	yes	no	_____
Self Mutilation	yes	no	_____
Sexual Abuse	yes	no	_____
Physical Abuse	yes	no	_____
Emotional Abuse	yes	no	_____

OCCUPATIONAL, EDUCATIONAL, LEGAL INFORMATION:

What grade is your teen/child in? _____

What school does your teen/child attend? _____

Is your teen/child currently enrolled in special education (IEP or 504 plan)? If yes, on what basis has the school granted these additional accommodations?

_____

In general, how does your teen/child perform academically? _____

Has your teen/child ever been diagnosed with a learning disability or ADHD? _____

_____

Does your teen/child have a job? □Yes □No

If yes, where? _____

Does your family or your child have any legal concerns? □ Yes □ No

If yes, please explain:_____

RELIGIOUS/SPIRITUAL INFORMATION:

Do you consider yourself (or your teen/child) to be religious or spiritual? □Yes □No

If yes, what is your family's/ your teen's faith? _____

How important is your (or your teen/child's) faith or spirituality in everyday life?
_____

_____

FAMILY HISTORY:

Are your (or your teen/child's) parents: □ together
□ divorced (if so, when?_____)
□ remarried
□ unmarried
□ deceased, if yes whom_____ age at death_____

Number of siblings:_____ Ages:_____

FAMILY MENTAL HEALTH HISTORY:
Has anyone in your (or your teen/child's) family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

Difficulty		Family Member(s)
Depression	yes/no	_____
Bipolar Disorder	yes/no	_____
Anxiety Disorders	yes/no	_____
Panic Attacks	yes/no	_____
Schizophrenia	yes/no	_____
Alcohol/Substance Abuse	yes/no	_____
Eating Disorders	yes/no	_____
Learning Disabilities	yes/no	_____
Trauma History	yes/no	_____
Suicide Attempts	yes/no	_____
Psychiatric Hospitalizations	yes/no	_____

OTHER INFORMATION:

Is your teen/child satisfied with your social situation/interpersonal relationships?
□Yes □No

If no, please explain why:

What do you consider to be your (or your teen/child's) strengths?

What do you like most about yourself (or your teen/child)?

What are your (or your teen/child's) overall goals for therapy?

What do you feel you (or your teen/child) need to work on first?

Is there anything else you would like me to know?

Thank you for completing this form. Please feel free to let me know if you have any questions prior to our meeting. I look forward to working with you.