ADULT HISTORY QUESTIONNAIRE

Please answer as completely as you can, then return this form before your scheduled appointment along with a copy of your **picture ID**. Please email to admin@erptreatment.com.

Today's Date:	Appt. Date:	Appt. With:
How did you hear about?		Interested in: ☐ Online

PERSONAL INFORMATION

Patient's Name		Age	Date of Birth
Gender Assigned at Birth	Gender Identity		Pronouns
Sexual Preference ☐ Straight ☐ Gay ☐ Bi-sexual ☐ Asexual ☐ Other:			☐ Prefer Not to Answer
Address City, State, Zip			Social Security Number (Needed for insurance)
May we send discrete reminders via email? ☐ YES ☐ NO (Check boxes below and right where we can leave messages)			☐ Primary Email Address
☐ Home Phone	☐ Cell Phone	☐ Work Phone	☐ Secondary Email Address
Emergency Contact Name			Address
Relationship	Phone		City, State, Zip
Marital Status: ☐ Single ☐ Married ☐ Other:			
☐ Employed ☐ Full-time Student ☐ Part-time Student ☐ Unemployed ☐ Other:			
Children: ☐ YES ☐ NO If YES, Please List Ages:			
Religion			Ethnicity

What problem brought you to ERP Treatment and Counseling PA?			
When did it begin?	Is there a prior history of these episodes? ☐ YES ☐ NO If YES, how many?		
Does it Effect:	Relationships ☐ YES ☐ NO	Work ☐ YES ☐ NO	
	School ☐ YES ☐ NO	Leisure ☐ YES ☐ NO	
Name three (3) things you would like changed in your current situation:			
1.			
2.			
3.			

MENTAL HEALTH HISTORY

Have you ever had a significant period of time in which you have experienced:	
Serious Depression?	☐ YES ☐ NO If YES, explain:
Serious Anxiety?	☐ YES ☐ NO If YES, explain:
See or Hear Things others can't?	☐ YES ☐ NO If YES, explain:
Trouble Understanding, Concentrating or Remembering?	☐ YES ☐ NO If YES, explain:
Mood Swings? Irritability? Racing thoughts?	☐ YES ☐ NO If YES, explain:
Serious thoughts of Suicide?	☐ YES ☐ NO If YES, explain:
Self-harm (without intent to die)?	☐ YES ☐ NO If YES, what behaviors?
Have you experienced trauma or abuse? ☐ Physical ☐ Emotional ☐ Sexual ☐ Other Please Explain:	
What treatment(s) have you had in the past for these issues? (Provide medication information on page 3)	
☐ Talk Therapy Please Explain:	
☐ DBT Please Explain:	
☐ Hospitalization / Day Treatment Approx. Year and Reason:	
☐ ECT ☐ TMS ☐ SPRAVATO® Please Explain:	
Would you like us to obtain copies of your old records? ☐ YES ☐ NO If YES, please bring the provider's contact information to your appointment and ask to complete a “Release of Information” form.	

ERP Treatment
With Hope & Resolution

MEDICAL HISTORY

Present state of general physical health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor Current Weight?
Describe your present sleeping pattern (Hours per night, restful or not, problems getting to sleep, or waking early, etc.):
Did you have any medical problems during childhood or adolescence? ☐ YES ☐ NO If YES, please explain:
Do you have any current medical problems? ☐ YES ☐ NO If YES, please explain:
List any significant hospitalizations or surgeries:
Allergies: (☐ Check here if NONE)

MEDICATIONS ☐ Check here if attaching a separate list

LIST ALL *CURRENT* MEDICATIONS OR OVER THE COUNTER MEDICATIONS					Prescribed by:	
Medication	Dose	Frequency	How Long?	For	PCP	Psychiatrist
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐

LIST ANY *PREVIOUS* PSYCHIATRIC MEDICATIONS				Prescribed by:	
Medication	Highest Dose	Was it Effective?	Side Effects	PCP	Psychiatrist
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐

SUBSTANCE USE HISTORY (☐ Check here if None)

Indicate the amount and frequency of use of the following:				
	Currently using?	Amounts	Frequency	How Long?
Alcohol	☐ YES ☐ NO			
Nicotine	☐ YES ☐ NO			
Caffeine	☐ YES ☐ NO			
Marijuana	☐ YES ☐ NO			
Illicit Drugs	☐ YES ☐ NO			
Prescription Med. Abuse	☐ YES ☐ NO			
Indicate substance(s) of preference:				
Substance abuse treatment type & dates:				
Was this treatment prompted / ordered by criminal justice system? ☐ YES ☐ NO If YES, please explain:				

CURRENT RELATIONSHIPS

Name of Spouse, Children, Others living with you	Relationship	Age	Quality of Relationship	Mental Disorder?
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
If YES, which mental disorders?				
Any significant issues with your children as they were growing up?				
Currently?				
Who is your support system / provides guidance?				
With whom do you spend most of your leisure time with? ☐ Family ☐ Friends ☐ Alone ☐ Other:				
Favorite activity or hobby?				
☐ Never Married ☐ Married If so, how long? _____ ☐ Separated ☐ Widowed ☐ Divorced ☐ Living Together If so, how long? _____ Long-term relationship (not living together?) ☐ YES ☐ NO				
Date of present marriage or date you began living with your present partner:				
What are your feelings about the above relationship in general?				
How is the sexual relationship?				
Describe your partner's characteristics as a person:				
Previously Married? ☐ YES ☐ NO If YES, please list length of marriage				
If YES, any Conflicts with Ex-spouse? ☐ YES ☐ NO			Children? ☐ YES ☐ NO	
If YES to either, please explain:				

CHILDHOOD / FAMILY HISTORY

Names of your Parents and Siblings	Relationship	Age	Quality of Relationship	Mental Disorder?
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO

If YES, what type of mental health issues?	
List any other relatives with a history of emotional or mental disorder or suicide (include diagnosis and treatment if known):	
Have any of your relatives ever had a serious problem with drugs or alcohol? ☐ YES ☐ NO ☐ Unknown	
If YES, which relative:	Substance(s):
If YES, which relative:	Substance(s):
How was your relationship with your mother / female caregiver growing up?	
Currently?	
How was your relationship with your father / male caregiver growing up?	
Currently?	
How did your parents / caregivers get along with each other while you were growing up?	
Currently?	
How was your relationship with your siblings / other children growing up?	
Currently?	

BIRTH / DEVELOPMENTAL HISTORY

Did your mother use alcohol or drugs during pregnancy?	☐ YES ☐ NO ☐ Unknown
Did your mother have any problems during pregnancy?	☐ YES ☐ NO ☐ Unknown
Did your mother have any problems during labor or delivery?	☐ YES ☐ NO ☐ Unknown
Did you have any problems immediately after birth?	☐ YES ☐ NO ☐ Unknown
Did you have any developmental delays?	☐ YES ☐ NO ☐ Unknown
If YES to any, explain:	

EDUCATION

Did you have any specific learning issues in school?	☐ YES ☐ NO ☐ Unknown
Were You: ☐ Frequently Absent ☐ Suspended ☐ Expelled ☐ Bullied	
If YES to any, explain:	
Highest level of Education:	Degree:

MILITARY HISTORY (☐ Check here if None)

Have you served in the military? ☐ YES ☐ NO If YES, how long?	
Type of Discharge:	☐ Combat Exposure ☐ Traumatic Experiences ☐ Service-connected Disabilities
Explain:	

EMPLOYMENT

What has been your usual employment pattern in the past 5 years? ☐ Full-time (35+hrs per week) ☐ Part-time ☐ Military Service ☐ Student ☐ Retired ☐ Disability ☐ Unemployment ☐ Other:	
Current Occupation:	Employer:
How long have you worked at your present job?	Is it ☐ Full-time ☐ Part-time
How satisfied are you with your present job?	
Any significant problems in past or present job situations?	
How are your work relationships: With fellow Employees?	
With Supervisors?	With Subordinates?
Are you or have you been on: ☐ Social Security Disability (SSD) ☐ Supplemental Security Income (SSI) ☐ Workers Comp	
How many people depend on your income?	

LEGAL HISTORY (☐ Check here if None)

Any past or present litigation or legal problems? ☐ YES ☐ NO If YES, please explain:				
How many times have you been arrested and / or charged with any of the following?				
	Major Driving Violation		Burglary or Robbery	Other:
	Driving While Intoxicated		Weapons Offense	
	Public Intoxication		Assault	
	Disorderly Conduct		Parole / Probation Violation	
	Drug Charges		Contempt of Court	
	Shoplifting		Domestic Violence	
Have you ever been ordered by the court for treatment? ☐ YES ☐ NO If YES, please explain:				
Have you ever been? ☐ Incarcerated ☐ Arrested ☐ Community Service ☐ Treatment Programs ☐ Probation ☐ Other, please explain:				
Dates of Incarceration		Reason		

MARK AVAILABILITY FOR INDIVIDUAL / GROUP THERAPY:

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Morning							
Afternoon							
Evening							

Thank you for completing this detailed form. It will be saved in your clinic record and is kept confidential.

Please return via email to admin@erptreatment.com along with a scan of your picture ID.

Form Completed by: (Print Name) Date

ERP Treatment
With Hope & Resolution

SELF-RATED SYMPTOM QUESTIONNAIRE (DSM-5)

Name: _____ Age: _____ Sex: _____ Date: _____

	The questions below ask about things that might have bothered you. **For each question, mark the number that best describes how much (or how often) you have been bothered by each problem during the past TWO (2) WEEKS.**		**0 None** Not at all	**1 Slight** Rare, less than a day or two	**2 Mild** Several days	**3 Moderate** More than half the days	**4 Severe** Nearly every day	**Highest Domain Score** (Clinician)
I	1.	Little interest or pleasure in doing things?						
	2.	Feeling down, depressed, or hopeless?						
II	3.	Feeling more irritated, grouchy, or angry than usual?						
III	4.	Sleeping less than usual, but still have a lot of energy?						
	5.	Starting lots more projects than usual or doing more risky things than usual?						
IV	6.	Feeling nervous, anxious, frightened, worried, or on edge?						
	7.	Feeling panic or being frightened?						
	8.	Avoiding situations that make you anxious?						
V	9.	Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?						
	10.	Feeling that your illnesses are not being taken seriously enough?						
VI	11.	Thoughts of actually hurting yourself?						
VII	12.	Hearing things other people couldn't hear, such as voices even when no one was around?						
	13.	Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?						
VIII	14.	Problems with sleep that affected your sleep quality over all?						
IX	15.	Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?						
X	16.	Unpleasant thoughts, urges, or images that repeatedly enter your mind?						
	17.	Feeling driven to perform certain behaviors or mental acts over and over again?						
XI	18.	Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?						
XII	19	Not knowing who you really are or what you want out of life?						
	20.	Not feeling close to other people or enjoying your relationships with them?						
XIII	21.	Drinking at least 4 drinks of any kind of alcohol in a single day?						
	22.	Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?						
	23.	Using any of the following medicines ON YOUR OWN, that is, without doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?						

PRACTICE AND FINANCIAL AGREEMENT

The following pages provide important information about our practice. Please review and then remove the last two pages from the packet and keep for your future reference.

By initialing below, you acknowledge that you:

_____ Have been made aware of your rights and responsibilities as a client.

_____ Have been informed of practice specific information and given an orientation to services.

_____ Are aware of ERP Treatment and Counseling PA privacy practices and know you can ask for a detailed description.

_____ Understand confidentiality and the limits of it as it pertains to adults and minors.

_____ Have reviewed and understand the ERP Treatment and Counseling PA financial agreement and how to contact the billing department with questions or issues.

_____ Give permission to bill your insurance and agree to pay out of pocket costs (toward deductibles, copays, coinsurance fees, previous missed appointment fees, or additional service fees as listed in the agreement) at the time of the appointment.

My signature below indicates my understanding of the above policies and I consent to treatment at ERP Treatment and Counseling PA. I understand I can ask for further information and retain the ability to terminate my consent at any time.

_____

Print Patient Name

_____

Patient/Legal Guardian Signature Date

PRACTICE ORIENTATION AND AGREEMENT

Your Rights and Responsibilities as a Client:

- You have the right to receive services from clinicians who adhere to the professional code of ethics of their respective disciplines.
- You have the right to receive services in accordance with Federal and State regulations and accreditation standards governing behavioral health programs.
- You have the right to privacy and confidentiality regarding the services you receive. All information about you and your treatment, whether written or oral, is protected under Federal and State laws, including the HIPAA Privacy Act. Information may be disclosed for various reasons including: to provide treatment, for payment purposes, health care operations, appointments, as required by law, public health, descendants, health and safety, and workmans' compensation. (Detailed description provided upon request)
- You have the responsibility to provide informed consent to services offered to you.
- You have the responsibility to follow our Financial Agreement. (Detailed on the following page)

Services Offered:

ERP Treatment and Counseling PA offers an array of mental health services. These services include: individual psychotherapy, ERP treatment, ERP group therapy, family therapy, and marital therapy. Appointments will be online. Your clinician will provide you with a detailed description of the nature of services, expected benefits, and potential risks.

Minors and Parents:

If you are under 18 years of age (and are not emancipated), or a parent, you should be aware that the law may allow parents to examine their child's treatment records. You should also be aware that clients over age 14 can consent to (and control access to information about) their own mental health treatment (although that treatment cannot extend beyond 12 sessions or 4 months). ERP Treatment and Counseling PAs policy is to request (but not require) an agreement from any client between ages 14 and 18 and their parents ("Adolescent Informed Consent" form), allowing clinicians to share general information with parents about attendance at scheduled sessions and progress in treatment.

FINANCIAL AGREEMENT

Standard fees for services are available upon request. By signing the Practice and Financial Agreement Form (the first page of this packet), you indicate that you understand that these are the charges established for services by ERP Treatment and Counseling PA and these charges will be charged directly to you through automatic bill processing. You may submit for reimbursement, but there is no guarantee of reimbursement. **Ultimately, it is your responsibility to understand ERP Treatment and Counseling PA's charges for your individual services.**

Please keep in mind all payments are due at the time of service. A credit card will be required to be on file as long as you are a patient of ERP Treatment and Counseling PA. For any requested letters, form completions, and phone consultations which require your therapist to spend additional time outside of your appointment you may be charged up to $150 an hour. Your credit card will be charged for any outstanding balances. Statements and receipts are only given upon request.

Keep in mind that all appointments need to be cancelled with a 24-hour business day notice in order to not be subjected to a missed appointment fee, which can be up to $150. Please contact your individual provider for more information about missed appointment fees and decide if cancellation fees are charged or waived. Payment of missed or late cancelled appointments are to be paid before your next service with ERP Treatment and Counseling PA treatment.

Please remove these last 2 pages and keep for future reference

CREDIT/DEBIT/HSA AUTHORIZATION

FOR USE AS A CARD ON FILE (COF)

I authorize ERP Treatment and Counseling PA to keep my card information on file and to use it automatically to keep my balance current. This includes paying for therapy, group therapy, and missed appointments fees. Charges may be submitted to insurance by patient but are not guaranteed coverage. A receipt/notification will not be provided unless requested.

Patient Name

Name on Card (if different)

Card Number

Expiration | Zip Code | CVV Code (3-digit or 4-digit for Amex)

Signature of Authorized User | COF Agreement Signing Date

This is the easiest and most efficient way to maintain your balance in order to continue treatment at the office.

Please email scanned or filled out pdf to admin@erptreatment.com.

ERP Treatment
With Hope & Resolution

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient Name: _____ Birth Date: _____

Other Names Used in Treatment: _____

I authorize the disclosure of records about me (or my minor child) between:

ERP Treatment and Counseling PA
Attention:
2301 Okeechobee Rd, #7
Fort Pierce, FL 34949
Phone: 248-342-9254
Email: admin@erptreatment.com

AND

Physician / Organization:
Attention:
Address:
City, State, Zip:
Phone:
Fax:

Information may include any of the following:

Alcohol or drug abuse, or mental health treatment as defined by the Michigan Department of Public Health Code 1989, No. 174. This includes venereal disease, tuberculosis, HIV, AIDS, and hepatitis.

Specific type of information to be disclosed: (Check all that apply to person/organization listed above)

- ☐ Identifying Information
- ☐ Appointment Information
- ☐ Assessment
- ☐ Dates and/or Completion of Tx
- ☐
- ☐ Emergency Contact
- ☐ Financial/Insurance Information
- ☐ Lab Results
- ☐ Discharge Summary
- ☐ Progress Notes
- ☐ Progress Report
- ☐ Psychiatric Evaluation
- ☐ Psychiatric Med. Reviews
- ☐ Psychological Testing
- ☐ Thank You Letter
- ☐ Treatment Plans
- Urine Drug Screens
- ☐ Other: _____

Purpose and need for such disclosure: (Check all that apply to person/organization listed above)

- ☐ After Care Planning
- ☐ Assessment of Patient
- ☐ Continuity Care
- ☐ Disability Benefits
- ☐ Driver's License Appeal
- ☐ Educational Planning/Placement
- ☐ Employer Request/Job Stability
- ☐ Family Involvement
- ☐ Insurance Benefits
- ☐ Legal Services/Compliance
- ☐ Payment
- ☐ Pre-Employment Screening
- ☐ Referral for Services
- ☐ Social Security Benefits
- ☐ Treatment Planning
- ☐ Workers' Comp. Benefits
- ☐ Other: _____

_____

Revocation of Authorization

This Authorization may be revoked by me at any time by my written notice to the named individual or organization (listed above), except to the extent that the person or organization which is to make the disclosure has already taken action in reliance upon it.

Continued on Page 2

Without expressed revocation, this consent expires for the following reason(s), whichever is later (Check one box):

☐ Date: (One year from discharge unless otherwise specified) _____

☐ Event: _____

☐ Condition: Once information is disclosed, no further information can be disclosed pursuant to this consent.

Redisclosure: While ERP Treatment and Counseling PA does not condone the redisclosure of information to another party, there is the possibility that information released to another could be redisclosed without further consent.

Patient Signature	Date
Parent / Legal Guardian Signature	Date

SELF PAY AGREEMENT

PATIENT NAME:_____ DATE:_____

Online Support Groups with ERP Treatment & Counseling

OPTION 1: I agree to pay Self Pay Rate which is a flat fee of $100 paid in full the day of service. _____ (initial)

OPTION 2: I have agreed to the Discounted Self Pay Rate of $90 per support group session as a prepay amount for the total of 10 support group sessions, totaling $900.00. _____ (initial)

I understand I will not be using my medical insurance for billing for any sessions. I understand I am free to send in my receipt for possible reimbursement. There is ***no guarantee*** for reimbursement.

Patient Signature:_____
Date of Agreement: _____