New Client History Form

Name: _____ Age: _____ Date: _____

What are the reasons that you are seeking help at this time?

When did these symptoms/ problems begin?

What mental health treatment have you had in the past?

Has drug or alcohol use been a concern in the past?

Does your current use concern you or anyone else?

What is your desired outcome for therapy?

Who is your primary care physician?

Where did you grow up?

Are you currently employed?

Education (highest level achieved):

Relationship status:

Name of significant other:

If you have children, what are their names and age:

Does anyone else live in your home? If so, who?

Please check if you have experienced any of the following types of trauma or loss.

- ☐ Physical abuse
- ☐ Neglect
- ☐ Emotional abuse
- ☐ Sexual abuse/exploitation
- ☐ Witness to violence/death
- ☐ Loss of a loved one

Please provide any additional information or concerns that you feel would be helpful for me to know.

Jenny Booth, LCSW
Fanno Creek Clinic

Consent to Treatment and Information about my Practice

Welcome to my practice. This document contains important information about my professional services. Please read it carefully. We will review it together. Please ask me any questions which may arise or at any time in the future. When you sign this document, it will represent an agreement between us.

Psychotherapy:

By seeking therapy you are taking a courageous step toward making positive life changes. Because your life and experiences are unique, my approach to your treatment is guided by your individual goals and concerns. In an atmosphere of respect, acceptance, and compassion we will work collaboratively to address your concerns.

Psychotherapy has both benefits and risks. Since therapy often involves addressing painful aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, or frustration. This short term emotional discomfort may occur in the process of achieving long term improvement. However, psychotherapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness, and increased skills for managing stress. If, however, at anytime you feel that you are experiencing distressing "side effects" as a result of therapy it is important that you share this with me so that we can address your concerns and explore options.

If you are questioning the treatment approach or effectiveness, please advise me of this so that I can recommend appropriate alternatives. You always retain the right to request changes in treatment or to refuse treatment. I encourage you to discuss any questions, doubts, or preferences regarding your treatment at any time.

Confidentiality

Information about your treatment and anything discussed between us will be kept confidential and will not be shared without your written consent. A release of information must be signed by you before any information can be provided to or requested from other individuals or agencies.

Please note the following exceptions to this policy:

1.If there is an imminent threat of serious harm to you or another person.
2.If there is a suspicion of child and or elder abuse.
3. If we receive a court subpoena to provide records or testimony.
4. During an emergency situation where you are unable to give written or verbal consent but clinical information is needed to make a decision.
5. When required for billing by insurance companies.

The privacy of information that you provide is important to me and has specific protections under federal and state law. Attached is a "Notice of Privacy Practices" as required under the federal HIPAA law. The notice describes how health information about you may be used and disclosed with and without your specific authorization. Please review the Notice of Privacy Practices carefully. As indicated in the notice, law allows the report of abuse. By participating in treatment with me, you are adding your consent to the release of information, under such conditions outlined in the privacy notice.

Cancellations/Messages

Cancellation of scheduled appointments should be avoided. However, if you must cancel an appointment, then a **24 hours advance** is required to avoid a cancellation fee of $50.00. Some exceptions may be given consideration.You may phone in to cancel an appointment anytime day or night by calling our office number @ (**503) 452-0915**

Contacting me

I am often not immediately available by telephone. The best way to contact me during business hours is to contact the main clinic number at (503) 452-0915 and you will be directed to my practice support team and they will contact me if it is determined your concern cannot wait until our next appointment.

Please review the "Emergencies" section for crises that occur after hours or on the weekends.

Fees

You are responsible for all fees, even those your insurance company may fail to cover. It is recommended you contact your insurance company for clarification regarding your mental health benefits, i.e. number of visits, co-pays, etc.

Emergencies

I strive to be available to clients whenever there is an urgent situation. However if a crisis arises after business hours or on the weekend you may need to access emergency services. In the event of an emergency please call 911, call your county's crisis line, or go to the nearest emergency department.

Crisis Lines
Multnomah County: 503-988-4888
Washington County: 503-291-9111
Clackamas County: 503-655-8724
Call to Safety (formerly Women's Crisis Line) **1-888-235-5333**
Cascadia Walk in clinic (located at **2415 SE 43rd Ave**, near Division). Open daily from 7AM - 10:30PM.

Consent

Your signature indicates that you have read these policies as well as the HIPAA "Notice of Privacy Practices" and agree to enter into treatment under these conditions. Further, it indicates that you have had the opportunity to ask questions about the policies and HIPAA privacy notice and have had those questions answered to your satisfaction.

I have read and understand the above information related to confidentiality practices and office policies:

_____

Print Name

_____

Signature Date

_____

Jennifer Booth, LCSW

PLEASE COMPLETE THE PHQ-9 AND GAD-7

Patient Name: DOB: Date of Referral:

PHQ9 **Over the last two weeks how often have you been bothered by the following problems?**		**0** Not at all	**1** Several Days	**2** More than half the days	**3** Nearly every day
A	Little interest or pleasure in doing things	☐	☐	☐	☐
B	Feeling down, depressed, or hopeless	☐	☐	☐	☐
C	Trouble falling or staying asleep, sleeping too much	☐	☐	☐	☐
D	Feeling tired or having little energy	☐	☐	☐	☐
E	Poor appetite or overeating	☐	☐	☐	☐
F	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
G	Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
H	Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
I	Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐
Severity Score	Mild depression = 5 – 10 Moderate depression = 10 – 18 Severe depression = 19 – 27	Total Score:			
	If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

GAD7 **Over the last two weeks how often have you been bothered by the following problems?**	**0** Not at all	**1** Several Days	**2** Over than half the days	**3** Nearly every day
Feeling nervous, anxious, or on edge	☐	☐	☐	☐
Not being able to stop or control worrying	☐	☐	☐	☐
Worrying too much about different things	☐	☐	☐	☐
Trouble relaxing	☐	☐	☐	☐
Being so restless that it's hard to sit still	☐	☐	☐	☐
Becoming easily annoyed or irritable	☐	☐	☐	☐
Feeling afraid as if something awful might happen	☐	☐	☐	☐
Total Score (add your column scores)				
If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult