

***Amy Gaines, LCSW, LLC***

***Telephone: (601)937-2041***

***amylgaines@icloud.com***

**FOR INDIVIDUAL ADULT PATIENTS**

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEALTH AND MEDICAL**

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any medical problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

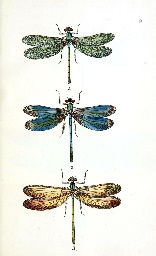
Please list any current medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When are you available for a weekly appointment?

Monday – Saturday: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Time you are available for appointment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



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**CONSENT FOR TREATMENT**

Any psychotherapy is a working relationship between you and your therapist. Each member of this cooperative relationship has certain responsibilities. Your therapist will contribute their knowledge, skills, expertise, and clinical skills to ensure success in the therapeutic process. You, as the patient, have the responsibility to bring an attitude of collaboration and commitment to the therapeutic process. While there are no guarantees regarding the outcome of treatment, your commitment may increase the likelihood of satisfactory experience.

**CONFIDENTIALITY**

1. Communication between you and your therapist is confidential. This means that your therapist will not discuss your case orally or in writing without your expressed written permission.
2. Your therapist has an ethical and legal obligation to break confidentiality under the following circumstances:
3. If there is a reason to believe there is an occurrence of child, elderly, or dependent adult abuse or neglect.
4. If there is reason to believe that you have serious intent to harm yourself, someone else, or property by a violent act you may commit.
5. If you disclose and/or acknowledge that you knowingly develop, duplicate, print, download, live-stream, or access through any electronic or digital media or exchanges, a film, photograph, or video in which a child is engaged in an act of obscene sexual conduct.
6. If you introduce your emotional condition into a legal proceeding.
7. If there is a court order for release of your records.

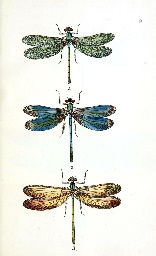
**THERAPIST AVAILABILITY AND AFTER-HOURS EMERGENCIES**

Therapists check voicemail messages during normal business hours of 8-5. Voicemail messages left outside of normal business hours of operation will be answered the following business day. If you have an emergency that needs immediate attention you may need to seek assistance at the nearest emergency services department.

**ADDITIONAL RIGHTS AND RESPONSIBILITIES**

In addition to your right to confidentiality, you have the right to end your therapy at any time, for whatever reason and without obligation except for any payment of fees for services already provided when applicable. You have the right to question any aspect of your treatment with your therapist. You also have the right to expect that your therapist will maintain professional and ethical boundaries by not entering any other personal, financial, or professional relationship with you.

The therapist reserves the right to discontinue therapy at any time, including, but not limited to, a violation by you of this Consent for Treatment, a change or reevaluation by your therapist of your therapeutic needs, the therapist’s ability to address those needs, or other circumstances that lead the therapist to conclude in its sole absolute discretion that your therapy needs would be better served at another therapy center. Under such circumstances, your therapist will suggest an appropriate therapist or therapy agency.



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**CONSENT TO BILL**

Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize the release of any medical or other information necessary to process this claim.

Your signature below indicates that you have read and understand this information and give permission to provide therapy services and that this contract is binding for all future sessions you may have with this entity.

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CLIENT NAME: ­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SYMPTOM ASSESSMENT**

* **Please give as accurate account as you can of information and/or if you have any questions or concerns, we invite you to discuss them with your intake counselor. Checkmark all concerns or items that apply to you.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **I AM EXPERIENCING….** | **NEVER** | **SELDOM** | **OFTEN** | **ALWAYS** | **FOR HOW LONG?** |
| Frequent worry or tension |  |  |  |  |  |
| Fear of many things |  |  |  |  |  |
| Discomfort in social situations |  |  |  |  |  |
| Feelings of guilt |  |  |  |  |  |
| Phobias: Unusual fears about specific things |  |  |  |  |  |
| Panic attacks: Sweating, trembling, shortness of breath, heart palpitations |  |  |  |  |  |
| Recurring, distressing thoughts about a trauma |  |  |  |  |  |
| “Flashbacks” as if reliving the traumatic event |  |  |  |  |  |
| Avoiding people/places associated with trauma |  |  |  |  |  |
| Nightmares about traumatic experience |  |  |  |  |  |
|  |  |  |  |  |  |
| **I AM FEELING….** | **NEVER** | **SELDOM** | **OFTEN** | **ALWAYS** | **FOR HOW LONG?** |
| Decreased interest in pleasurable activities |  |  |  |  |  |
| Social isolation, loneliness |  |  |  |  |  |
| Suicidal thoughts |  |  |  |  |  |
| Bereavement of feelings of loss |  |  |  |  |  |
| Change in sleep (too much or not enough) |  |  |  |  |  |
| Normal daily tasks require more effort |  |  |  |  |  |
| Sad or hopeless about the future |  |  |  |  |  |
| Excessive feelings of guilt |  |  |  |  |  |
| Low self-esteem |  |  |  |  |  |
|  |  |  |  |  |  |
| **I NOTICE….** | **NEVER** | **SELDOM** | **OFTEN** | **ALWAYS** | **FOR HOW LONG?** |
| I am angry, irritable, hostile |  |  |  |  |  |
| I feel euphoric, energized and overly optimistic |  |  |  |  |  |
| I have racing thoughts |  |  |  |  |  |
| I need less sleep than usual |  |  |  |  |  |
| I am more talkative |  |  |  |  |  |
| My moods fluctuate; go up and down |  |  |  |  |  |
|  |  |  |  |  |  |
| **I HAVE….** | **NEVER** | **SELDOM** | **OFTEN** | **ALWAYS** | **FOR HOW LONG?** |
| Memory problems or trouble concentrating |  |  |  |  |  |
| Trouble explaining myself to others |  |  |  |  |  |
| Problems understanding what others tell me |  |  |  |  |  |
| Intrusive or strange thoughts |  |  |  |  |  |
| Obsessive thoughts |  |  |  |  |  |
| Been hearing voices when alone |  |  |  |  |  |
| Problems with my speech |  |  |  |  |  |
| Risk taking behaviors |  |  |  |  |  |
| Compulsive or repetitive behaviors |  |  |  |  |  |
| Been acting without concern for consequence |  |  |  |  |  |
| Been physically harming myself |  |  |  |  |  |
| Been violent toward other(s) |  |  |  |  |  |

**CLIENT NAME: ­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SYMPTOM ASSESSMENT (CONTINUED)**

* **Please give as accurate account as you can of information and/or if you have any questions or concerns, we invite you to discuss them with your intake counselor. Checkmark all concerns or items that apply to you.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **I USE THE FOLLOWING….** | **NEVER** | **SELDOM** | **OFTEN** | **ALWAYS** | **FOR HOW LONG?** |
| Alcohol |  |  |  |  |  |
| Nicotine (Cigarettes, Tobacco) |  |  |  |  |  |
| Marijuana |  |  |  |  |  |
| Cocaine |  |  |  |  |  |
| Opiates |  |  |  |  |  |
| Sedatives |  |  |  |  |  |
| Hallucinogens |  |  |  |  |  |
| Stimulants |  |  |  |  |  |
| Methamphetamines |  |  |  |  |  |
|  |  |  |  |  |  |
| **MY EATING INVOLVES….** | **NEVER** | **SELDOM** | **OFTEN** | **ALWAYS** | **FOR HOW LONG?** |
| Restriction of food consumption |  |  |  |  |  |
| Bingeing and Purging |  |  |  |  |  |
| Binge Eating |  |  |  |  |  |
| A lot of weight loss or weight gain |  |  |  |  |  |
|  |  |  |  |  |  |
| **I HAVE….** | **NEVER** | **SELDOM** | **OFTEN** | **ALWAYS** | **FOR HOW LONG?** |
| Concern about my sexual function |  |  |  |  |  |
| Discomfort engaging in sexual activity |  |  |  |  |  |
| Questions about my sexual orientation |  |  |  |  |  |
|  |  |  |  |  |  |
| **EMPLOYMENT AND SELF-CARE….** | **NEVER** | **SELDOM** | **OFTEN** | **ALWAYS** | **FOR HOW LONG?** |
| I have problems getting/keeping a job |  |  |  |  |  |
| I have problems paying for basic expenses |  |  |  |  |  |
| I am afraid of becoming homeless |  |  |  |  |  |
| I have problems accessing/obtaining healthcare |  |  |  |  |  |

**PERSONAL AND FAMILY HISTORY**

Have you or a family member ever been hospitalized because of a mental illness? YES \_\_\_\_\_ NO \_\_\_\_\_

Does anyone in your family have a mental illness? YES \_\_\_\_\_ NO \_\_\_\_\_

Has anyone in your family ever attempted or committed suicide? YES \_\_\_\_\_ NO \_\_\_\_\_

Does anyone in your family have a substance abuse problem? YES \_\_\_\_\_ NO \_\_\_\_\_

Have you ever been arrested? YES \_\_\_\_\_ NO \_\_\_\_\_

If “yes” to any of the above, please briefly explain the circumstance and how you feel it continues to impact your life.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CLIENT NAME: ­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CLIENT ID #: ­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CIRCLE THE NUMBER WHICH YOU FEEL BEST DESCRIBES THE LEVEL YOU ARE CURRENTLY AT:**

1. ***How well you are doing on your job:***

**0 1 2 3 4 5 6 7 8 9**

**Not Cannot Serious Moderate Mild No**

**Working Function Problems Problems Problems Problem**

1. ***How well you are doing in your marital/significant other relationship:***

**0 1 2 3 4 5 6 7 8 9**

**N/A Cannot Serious Moderate Mild No**

**Function Problems Problems Problems Problem**

1. ***How well you are doing in your family relationships:***

**0 1 2 3 4 5 6 7 8 9**

**N/A Cannot Serious Moderate Mild No**

**Function Problems Problems Problems Problem**

1. ***How well you are doing in relationships with people outside your family:***

**0 1 2 3 4 5 6 7 8 9**

**N/A Cannot Serious Moderate Mild No**

**Function Problems Problems Problems Problem**

1. ***Please rate your current physical health:***

**0 1 2 3 4 5 6 7 8 9**

**Very Poor Excellent**

1. ***Please rate your general happiness and well-being:***

**0 1 2 3 4 5 6 7 8 9**

**Very Poor Excellent**