Teresa Arana-Wood, LCSW, LMFT 2971 E Copper Point Dr, STE 100 Meridian, ID 83642
Phone: (208) 376-5683 Fax: (208) 376-5690

Client Information

Name_____Date_____

Address_____

City_____ State_____ Zip_____

Home Phone_____ OK to leave message? Yes ▢ No ▢

Mobile Phone_____ OK to leave message? Yes ▢ No ▢

Work Phone_____ OK to leave message? Yes ▢ No ▢

Email Address_____ OK to send email appt reminder? Yes ▢ No ▢

Date of Birth_____ Birth Place_____

Age_____ Male ▢ Female ▢ Other ▢

Special Instructions/Other Phone Numbers_____

Years of Education Completed_____ Highest Degree Attained_____

Occupation_____Employer Name and Address _____

_____

Insurance Information (exactly as it appears on your card):

Insurance Company_____

Address_____

City_____ State_____ Zip Code_____

Name of Insured_____ Insured's Date of Birth_____

Your relationship to insured_____ Name of Insured's Employer_____

Insurance Policy #_____ Group #_____

Is your condition related to employment? Yes ▢ No ▢ Auto Accident? Yes ▢ No ▢ Other Accident? Yes ▢ No ▢

Have you billed insurance in the past year for counseling sessions as a client with another provider? Yes ▢ No ▢

Employee Assistance Program

Name of Employee Assistance Program (EAP)_____

EAP Authorization #_____# of sessions authorized_____

Referred by

Name_____ May we thank them? Yes ▢ No ▢

Emergency Contact Information

Name_____ Relationship to you_____

Address_____ City_____ State_____ Zip_____

Phone Mobile_____ Phone Work_____ Phone Home_____

Date of last Physical Exam_____ If you are currently taking any medications, please list:

(use back of form if necessary)

Medication_____ Dosage_____ Condition prescribed for_____ by_____

Medication_____ Dosage_____ Condition prescribed for_____ by_____

Medication_____ Dosage_____ Condition prescribed for_____ by_____

Medication_____ Dosage_____ Condition prescribed for_____ by_____

Do you have any allergies? Yes ▢ No ▢ If yes, please list_____

General state of health is: Excellent ▢ Good ▢ Fair ▢ Poor ▢

Please list any significant health problems_____

_____

Spouse or Partner

Current relationship status: single ▢ married ▢ partner ▢ significant other ▢ divorced ▢ widow/widower ▢

How many committed relationships have you been in?_____Number of times you have been married/partnered_____

First (first name only)_____Your age_____ Years together_____

Second (first name only)_____Your age_____ Years together_____

Third (first name only)_____Your age_____ Years together_____

If currently divorced or single, number of years since break-up or divorce_____

If applicable, reason for break-ups or divorce(s) (please include break-up/divorce dates)_____

_____

_____

Describe the quality of relationship with your present spouse/partner_____

_____

Current spouse/partner's name_____ Number of years together_____

Children: Name_____ Age_____ Name_____ Age___

Name_____ Age_____ Name_____ Age____

Name_____ Age_____ Name_____ Age____

Name_____ Age_____ Name_____ Age____

Please describe any custody and visitation arrangements for your minor children if they are not living with you full-time

_____

FAMILY OF ORIGIN HISTORY

Name Relation to you Current age (or age at death) Describe your relationship when you were a child

_____

_____

_____

How was your parent's relationship with each other?_____

Any significant events in childhood that have impacted you?_____

_____

_____

_____

Please check if you have experienced any of the following stressors in the last six months:

▢ Personal Illness	▢ Health problem in family	▢ Death of a friend	▢ Death of a family member
▢ Lack of employment	▢ Job dissatisfaction	▢ Job change	▢ Retirement
▢ Financial Problems	▢ Inadequate housing	▢ Homelessness	▢ Recent move
▢ New marriage	▢ New relationship	▢ Relationship discord	▢ Relationship separation
▢ Divorce	▢ New Child	▢ Discord with family	▢ Parenting difficulties
▢ Physical Abuse	▢ Sexual abuse	▢ Unhappy childhood	▢ Victim of a crime
▢ Educational problems	▢ Legal problems	▢ Inadequate healthcare	▢ Discrimination
▢ Loneliness	▢ Brain Injury	▢ Exposure to toxic chemicals	▢ Other-please specify

What would you like to change in your life and is there anything else you want the counselor to know?_____

_____

_____

Informed Consent and Disclosure

Thank you for choosing me as your Mental Health Care Provider. I am committed to giving you excellent mental health care. The following is a statement of informed consent and disclosure and includes my financial policy and other office policies, which I require that you read and sign prior to any treatment. If you have any questions about my financial or office policies or anything else, please do not hesitate to ask me.

The laws of the State of Idaho require that all licensed counselors provide clients at the beginning of treatment with accurate disclosure of information concerning their practice, including the right of clients to refuse treatment, the responsibility of clients for choosing the provider and treatment modality, and the extent of confidentiality (Chapter 34, Title 54-3410B, Idaho Code). Licensure of an individual under this chapter does not imply endorsement by the counselor licensing board nor effectiveness of treatment. The Idaho Counselor Licensing Board, through the Idaho Bureau of Occupational Licenses (Owyhee Plaza, 1109 Main St., STE 220, Boise, ID 83702) is responsible for licensure of counselors within the state of Idaho. Laura Cromwell is a licensed clinical professional counselor and holds a Master's of Counseling degree from the College of Idaho.

Confidentiality

Information disclosed within sessions is confidential and may not be revealed to anyone without your permission. The law provides for certain exceptional situations in which I am required to disclose information including when there is a reasonable suspicion of child abuse, elder or dependent-adult abuse, and when a client threatens violence to an identifiable victim. The law also requires me to break confidentiality when a client presents a danger of harm to others and when a client is likely to harm him/herself unless protective measures are taken. Clear risk of harm to others may include the risk of transmitting a life-threatening illness to an identifiable and uninformed third party. Disclosure may also be required in certain legal proceedings. If you have concerns about the content of our sessions and any legal proceedings in which you are involved or expect to be involved (e.g., child custody cases), please let me know. As part of my professional responsibility, I may also consult with other counseling professionals. Your name is not revealed. This allows you to receive the benefit of other professionals' expertise.

Our Professional Counseling Relationship

A counseling relationship is a professional relationship in which the counselor assists the client in exploring and resolving difficult life issues. Our sessions may be very intimate. However, it is important for you to realize that we have a professional, rather than a personal, relationship and our contact will be limited to the paid session you have with me. As a Licensed Clinical Social Worker, I will not barter for services or accept gifts or invitations. You will be best served by these professional standards. I am licensed by the State of Idaho to provide counseling services. My ethical code states that sexual intimacy is never appropriate with a client and should be reported to the licensing board. You also have a right to be a participant in treatment decisions, to seek a second opinion, to file a complaint without retaliation, and to refuse treatment. If you have any concerns or questions about my services, I urge you to discuss them with me. You may contact the licensing board at any time by calling (208) 334-3233 or by visiting their website at https://secure.ibol.idaho.gov/IBOL/BoardPage.aspx?Bureau=COU. Idaho Bureau of Occupational Licenses is located at 700 W. State Street, Boise, ID 83702

Counseling Process

I am dedicated to giving you the best care that I can. It is my conviction that for counseling to be effective, there needs to be a partnership between the counselor and client. As such, you will be expected to be actively involved in choosing the course of your treatment. It is impossible to guarantee any specific results regarding your goals for counseling or length of treatment. However, I assure you that my services will be rendered in a professional manner consistent with accepted ethical standards of practice as adopted by the American Clinical Social Worker Licensing Board.

Risks and Benefits

Counseling and psychotherapy are beneficial, but as with any treatment, there are inherent risks. During counseling, you will have discussions about personal issues, which may bring to the surface uncomfortable emotions such as anger, guilt and sadness. The benefits of counseling can far outweigh any discomfort encountered during the process. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem solving. While I cannot guarantee these benefits, I will do everything I can to work with you to attain your personal goals.

Counseling Approaches

I work with adults, individuals, and couples. My work with clients is informed by experience and training in anxiety, depression, couples counseling, and grief recovery. I have facilitated support groups for anxiety and depression as well as a support group for sexual minorities LBGTQ. My therapeutic orientation is Adlerian though I integrate techniques from many treatment modalities including but not limited to cognitive- behavioral, existential, solution-oriented, gestalt, rational-emotive, behavioral, insight oriented and emotionally focused couples counseling.

Client Rights: You have the right to:

1. Request that your records be sent to another professional or agency. Your request will be fulfilled with promptness upon receipt of your written request for transfer of information, provided there is no outstanding balance on your account.
2. Leave the premises at any time. You are not to be detained against your wishes unless you are a danger to yourself or others.
3. Participate in developing an individual plan of treatment.
4. Receive an explanation of services in accordance with the treatment plan.
5. Participate voluntarily in and to consent to treatment.
6. Object to, or terminate or refuse any service you do not want, and to discontinue any services you have already started. However, if you choose to discontinue treatment against professional advice, a notification to that effect could be placed in your records. In the event of court-ordered clients, the terms of the court may supersede this right.
7. Have access to your records.
8. Receive clinically appropriate care and treatment that is suited to your needs and skillfully, safely, and humanely administered with full respect for your dignity and personal integrity.
9. Be treated in a manner which is ethical and free from abuse, discrimination, mistreatment, and/or exploitation.
10. Be free to report grievances regarding services or staff to your counselor or the Idaho Bureau of Occupational Licenses.
11. Be treated by staff that is sensitive to your cultural background and beliefs.
12. Be afforded privacy.
13. Be informed of expected results of all therapies prescribed, including possible adverse effects.
14. Request another therapist
15. Request that another clinician review your records for a second opinion.
16. Know that one parent at least must be involved in the therapy of any minor children.

Professional Fees

$135 per 60 minute initial intake and new client consultation

$135 per 60 minute session for individual, couple, or family counseling

$135 per 45 minute session for individual, couple, or family counseling

$110 for a 30 minute session for individual, couple or family counseling

$135 per hour for copying and mailing client records to another professional

$135 per hour for written reports, prepared documents, or consultation (over 10 minutes) with another professional at your request, depending on type and purpose

$250 - $450 per hour for preparation and attendance at legal court proceedings, including when called by another party.

$25 service fee for a returned check

Fee Change

While I rarely raise professional fees during the course of counseling, there may be an occasion where this will be necessary. If this occurs, I will let you know of the fee change and when it will occur as soon as possible. In any event, I will not raise fees more than once per year so you can be assured that if there is an increase, it won't change again for at least one year.

Full payment is due at the time of service by cash or check. Debit or credit cards may be used when service is available. I will bill your insurance company as a courtesy to you, but as your coverage is based on a contract between you and your insurer, you are responsible for any fees or portions of fees not covered by your insurance company. I encourage you to contact your insurance company before the first session and ask them what benefits you may expect. If for any reason your insurance company does not pay for my services as you expect they will, you are responsible for payment in full to me. Insurance companies rarely pay 100% of the fees you incur for my service and you are responsible for paying any co-pays and deductibles at the time of your session. Please confirm with your insurance company their policy related to counseling services provided by a "licensed clinical social worker" (LCSW) and your copay and deductible amounts for these services. If you are using Employee Assistance Program (EAP) benefits, it your responsibility to provide me with an authorization number and the number of sessions covered prior to your first appointment. Please remember that I may be required by your insurance company to provide confidential information about you and your case if you choose to use your insurance company or Employee Assistance Program for payment for my services.

Telephone Calls and Writing

If you are experiencing a life-threatening emergency, call 911 or have someone take you to the nearest emergency room for help. Phone consultation for check-in calls and reading of writings or messages of 5 minutes or less in duration will not be added to your billing. Consultation calls and reading time longer than 5 minutes will be billed at the normal prorated service rate. If you must get a message to me, the best way is to leave a voice message. I cannot guarantee a quick reply due to the nature of my practice, but will get back to you as soon as I can. You need to be aware that I do not provide any crisis or emergency services.

Special Reports, Services, and Letters

Occasionally it is necessary for me to write special letters or reports or provide other services on a client's behalf. I am glad to comply with such requests. There is a fee charged based upon the type and purpose as well as the length of time required for the service.

Counseling and Technology

Email

Since email is not totally secure and sometimes unreliable, I use email with caution and urge you to do the same. If you choose to use electronic messages, please be brief and don't include anything you wouldn't want others to read just in case there is a security breach. If you imagine the possibility of you (or me) losing our computer or smart phone and someone else reading your message, you will know the reason to be extra cautious when communicating electronically.

Phone

Conversations by cell phone or cordless phones may be picked up by people in the area. The safest phone call is from one old-fashioned corded phone to another. I realize that we rely on mobile and cordless phones so just know that they may not be totally secure. When we have a phone call, be sure that you can't be overheard. **If you need to cancel your appointment within the 24-hour time limit, definitely use the phone so I will get the message right away. Only a phone message will be considered for official notification of cancellation.**

Social Networking and Computer Contact

I usually don't "friend" anyone who is or has been a client of mine to respect your privacy. If you want to show me something on Facebook, on your blog, or any other social media, you can share it with me during our session. I realize some of my clients drive long distances so I will sometimes use the phone or Skype to work with clients, but only for very rare and special circumstances on a pre-arranged basis. Again, please know that confidentiality cannot be assured when using this type of technology.

Litigation Limitation

I do not do court work (such as, but not limited to, testifying in divorce and custody disputes, injuries, lawsuits, etc…) If you need these services I will give you referrals to forensic psychologists who specialize in these cases. My desire is to protect your counseling from the intrusiveness of legal proceedings.

Confidentiality - Your counselor cannot release any information about you without your written permission (exceptions to this such as child or elder abuse, danger to self or others are explained above).
Confidentiality in Couples' Therapy - Your counselor cannot release records unless both clients give written permission.

To be in counseling with me, you must agree that neither you nor your attorney, nor anyone else acting on your behalf, will call on any counselor at this practice to testify in court or at any other proceeding, nor will a disclosure of counseling or treatment records be requested for legal proceedings.

This is in your best interest because:

1. If you place your mental status at issue in litigation initiated by you, the defendant (other side) has the right to obtain your counseling records an/or testimony by your counselor. Your adversary would have the right to know everything you've talked about in counseling.
2. Forensic psychology (custody evaluations, workers comp, lawsuits, etc.) is not an area of expertise for me.
3. If you are involved in legal proceedings, a subpoenaing a counselor without forensic expertise to testify could hurt your case more than help. Forensic psychologists do assessments (not counseling or psychotherapy) and are trained as expert witnesses.
4. The goals of legal proceedings (winning a case) are inconsistent with the goals of ongoing counseling (exploring conflicted emotions and behavior in a safe, protected place). Whenever possible, counselors are required to avoid dual roles, which may interfere with the client's counseling.
5. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. These fees are listed above.

I understand and agree to this litigation limitation

_____ _____

Signature of Client **Date**

Cancellations and Missed Appointments

Please make every effort to keep your scheduled appointment. This practice respects my time and allows me to use that time to see other clients who are in need. **Unless I hear from you by phone at least 24 hours in advance, I will, unfortunately, have to charge you a fee for a missed or cancelled appointment.** When appropriate, telephone sessions can sometimes be done in place of the scheduled in-person session. **Cancellations need to be made by calling and leaving a message. (208) 376-5683**

INITIAL HERE_____

_____

My signature below indicates that I understand and agree to these terms and those on the Informed Consent and Disclosure and I am giving my consent for treatment. I understand and agree to comply with these policies and have been given a copy of this policy. I understand that I must call at least 24 hours in advance of my appointment to avoid paying the full fee for a missed or late cancelled appointment. I understand I am financially responsible for payment of services rendered to me and will pay for all services rendered and any legal expenses incurred should this account be turned over to another party for collection. I give my consent to share confidential information with all persons mandated by law, the counselor and agency that referred me, the insurance carrier responsible for my mental health care benefits and payment for those services, and financial information forwarded to another party for collection. I am releasing and holding harmless Teresa Arana-Wood, LCSW, LMFT from any departure from my right of confidentiality that may result.

_____

Print Client Name

_____ _____

Client Signature (14 years and older must sign) Date

If financially responsible person is different than above, please complete the following:

_____

Print Financially Responsible Party's Name

_____ _____

Financially Responsible Party's Signature Date

Financially Responsible Party's Address (if different from above)_____

City_____ State_____ Zip_____

2971 E Copper Point Drive, Suite 100, Meridian ID 83713
ph. 208 376-5683 fax 208 376-5683

Summary Notice of HIPAA Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

SUMMARY OF YOUR PRIVACY RIGHTS

We may use your health information to treat you, to get paid, to tell you about other health benefits & services, to tell family and friends about you in an emergency, to avert threats to health and safety reasons, for military purposes, for worker's compensation requests, for lawsuits, for law enforcement requests, for national security reasons, for coroner, medical examiner or funeral director use.

You have the right to review and get a copy of your medical and billing records (but not psychotherapy notes), change your medical record if you think it's wrong, get a list of with whom we share your health information, ask us to limit the information we share, ask for a copy of our privacy notice, complain in writing if you believe your privacy rights have been violated, request alternative forms of communication.

COMPLAINTS - If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services at: Office for Civil Rights Region 10, U.S. Department of Health and Human Services, 2201 Sixth Avenue - M/S: RX-11 Seattle, WA 98121-1831, Voice Phone (800) 368-1019, FAX (206) 615-2297, TDD (800) 537-7697

To file a complaint with Teresa Arana-Wood, LCSW, LMFT, contact Teresa Arana-Wood, LCSW, LMFT. ***You will not be penalized for filing a complaint.***

I acknowledge receipt of the Teresa Arana-Wood, LCSW, LMFT “Notice of Privacy Practices.”

Client Signature: _____ Date: _____

Printed Name: _____

Relation:_____ Printed Name: _____
(if other than client)

Signature: _____ Date: _____

Client declined to sign receipt (staff signature): _____

Client unable to sign (witness signature): _____

Clinical History Form

Briefly describe the reason(s) you are seeking counseling:_____

_____

_____

About how long have you been concerned about this? ▢ 1 month ▢ 2-3 months ▢ 6 months ▢ 1 year ▢ Other

Symptoms Screener

For the questions below, select one option for each question that best represents your answer.

OVER THE PAST TWO WEEKS, HAVE YOU:	**Not at all**	**1-2 days**	**3-5 days**	**Daily**
Experienced sadness, weepyness, or crying spells?	▢	▢	▢	▢
Felt hopeless, pessimistic or discouraged about the future?	▢	▢	▢	▢
Not been able to enjoy things?	▢	▢	▢	▢
Felt tired, slowed down or had no energy?	▢	▢	▢	▢
Lacked motivation or interest in doing things?	▢	▢	▢	▢
Had difficulty falling asleep or frequent waking/sleeping too much?	▢	▢	▢	▢
Had difficulty making decisions or concentrating?	▢	▢	▢	▢
Experienced increased/decreased appetite?	▢	▢	▢	▢
Felt guilty or worthless?	▢	▢	▢	▢
Felt like you wanted to die or wished you were dead?	▢	▢	▢	▢
Seriously considered or planned to end your own life?	▢	▢	▢	▢
Felt restless, worried, or nervous?	▢	▢	▢	▢
Had headaches, stomachaches or pain?	▢	▢	▢	▢

How much distress would you say these symptoms cause you? ▢ A lot ▢ A Little ▢None ▢Other

HISTORY OF RECREATIONAL DRUG USE

	Yes	**No**	**Age of First Use**	**Age of Last Use**	**Method**
Amphetamines/Speed					
Barbiturates					
Heroin					
Narcotics (Vicodin, Oxy)					
Cocaine					
LSD, Ecstasy, Bath Salts					
Cannabis/Marijuana					
Benzodiazepines					
PCP					
Adderall (non-prescribed)					

In the past twelve months, have you used drugs for anything other than medical reasons? ▢Yes ▢No

Have you ever experienced withdrawal symptoms when you stopped taking drugs? ▢Yes ▢No

HISTORY OF RECREATIONAL ALCOHOL USE

	Yes	No
Do you regularly drink alcohol (including beer and wine)?	▢	▢
Has your drinking ever caused problems between you and family members or close relationships?	▢	▢
Have you tried to cut back or stop drinking but not been successful?	▢	▢
Have you drank alcohol and been hungover while working, going to school or taking care of your children?	▢	▢
Have you ever been in trouble with the law because of drinking?	▢	▢
Have you ever experienced withdrawal symptoms when you stopped drinking?	▢	▢

SELF-HARM

Have you ever cut yourself or hurt yourself intentionally? ▢ Yes ▢ No

If yes, please describe:_____

_____

PSYCHIATRIC HISTORY

Have you ever used counseling services in the past? ▢ Yes ▢ No

Name of Counselor:	Primary Reason	Location	Was it helpful?
			▢ Yes ▢ No
			▢ Yes ▢ No

Have you had a previous diagnosis of:

▢ Anxiety ▢ Depression ▢ Panic ▢ ADHD ▢ OCD ▢ Bipolar ▢ Anorexia ▢ Bulimia ▢ PTSD ▢ Alcoholism

Have you ever been hospitalized for psychiatric reasons? ▢ Yes ▢ No

When/Dates	Location	Purpose	Length of stay

Have you ever attempted suicide? ▢ Yes ▢ No If yes, then:

Dates	Method	Lethality (required medical intervention?)

PSYCHIATRIC HISTORY

Mother	Father	Siblings	Extended Family/Grandparents
▢ ADD/ADHD	▢ ADD/ADHD	▢ ADD/ADHD	▢ ADD/ADHD
▢ Alcohol Addiction	▢ Alcohol Addiction	▢ Alcohol Addiction	▢ Alcohol Addiction
▢ Substance Abuse	▢ Substance Abuse	▢ Substance Abuse	▢ Substance Abuse
▢ Anxiety	▢ Anxiety	▢ Anxiety	▢ Anxiety
▢ OCD	▢ OCD	▢ OCD	▢ OCD
▢ Depression	▢ Depression	▢ Depression	▢ Depression
▢ Bipolar	▢ Bipolar	▢ Bipolar	▢ Bipolar
▢ Eating Disorder	▢ Eating Disorder	▢ Eating Disorder	▢ Eating Disorder
▢ PTSD	▢ PTSD	▢ PTSD	▢ PTSD
▢ Schizophrenia	▢ Schizophrenia	▢ Schizophrenia	▢ Schizophrenia
▢ Anger Management	▢ Anger Management	▢ Anger Management	▢ Anger Management
▢ Personality Disorder	▢ Personality Disorder	▢ Personality Disorder	▢ Personality Disorder
▢ Attempted Suicide	▢ Attempted Suicide	▢ Attempted Suicide	▢ Attempted Suicide
▢ Completed Suicide	▢ Completed Suicide	▢ Completed Suicide	▢ Completed Suicide
▢ Other:	▢ Other:	▢ Other:	▢ Other:

GENERAL SOCIAL HISTORY

Which best describes your social situation?
▢ Supportive Social Network ▢ Close to family of origin ▢ Distant from family of origin ▢ Feeling lonely/isolated
▢ No Friends ▢ Conflict with family members

Current Occupational Status
▢ Employed full-time ▢ Employed part-time ▢ Unemployed/Longest period of Unemployment:
▢ Part-time student ▢ Full-time student ▢ Disability ▢ Other:

History of Intimate Relationships
▢ Married 1x ▢ Significant relationships/never married ▢ Single, never married
▢ Divorced/Not remarried ▢ Divorced/Remarried ▢ Other:

Satisfaction with Current Intimate Relationship
▢ Satisfied ▢ Somewhat unsatisfied ▢ Unsatisfied ▢ Other:

MEDICAL HISTORY

Primary Care

Primary Care Physician:_____

Office Address:_____

Office Phone Number:_____

Current/Past Medical Conditions

▢ Heart Disease	▢ Anemia	▢ Headaches/ Migraines	▢ Stroke	▢ Arthritis	▢ Hepatitis
▢ Shortness of Breath	▢ Asthma	▢ Diabetes	▢ Kidney Problems	▢ Cancer	▢ Menstrual Problems
▢ High Cholesterol	▢ Hormone Imbalance	▢ Dementia	▢ Liver Problems	▢ Thyroid	▢ Sleep Apnea
▢ High Blood Pressure	▢ Seizure/Epilepsy	▢ Head Trauma	▢ Ulcers	▢ Fibromyalgia	▢ Smoke

▢ Other:

Family History of Illness/Disease

▢ None	▢ Cancer	▢ Asthma	▢ Heart Disease
▢ Diabetes	▢ High Blood Pressure	▢ Thyroid	▢ Epilepsy
▢ Dementia/Alzheimers	▢ Hormone Imbalance	▢ Migraines	▢ Other:

Current Psychiatric Care

▢ Psychiatrist ▢ Developmental Therapy ▢ Case Management ▢ Service Coordination ▢ CBRS ▢ Other:		
Name of Provider/s	Location	Phone Number