Christopher O'Connor, LLC
Dr.OConnor@OConnorEvaluations.Com
www.OConnorEvaluations.com

DEMOGRAPHIC INFORMATION FORM

Please fill out the following information to help us better understand you and provide appropriate mental health services:

Name: _____

Date of Birth: _____ Age: _____ Gender: _____

Race/Ethnicity: _____

Primary Language: _____ Other Languages: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Email: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone Number: _____

Health Insurance Provider: _____ Policy Number: _____

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Are you currently taking any medications? _____

Do you have any allergies? _____

Do you have any medical conditions or disabilities? _____

Have you received mental health treatment before? _____

If yes, please provide the name and contact information of your previous mental health provider(s):

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Is there anything else you would like us to know about you? _____

_____

_____

_____

_____

_____

Thank you for taking the time to fill out this form.

CLIENT'S BILL OF RIGHTS IN MENTAL HEALTH TREATMENT

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As a client of [mental health provider name: _____] you have the following rights:

1. The right to receive respectful and humane treatment, free from any form of discrimination or harassment.

2. The right to receive information about your diagnosis, treatment plan, and any alternative treatments that may be available.

3. The right to participate in making decisions about your treatment, including the right to refuse treatment.

4. The right to privacy and confidentiality of your mental health information, except as required by law or authorized by you.

5. The right to access your mental health records and to request that any inaccurate or incomplete information be corrected.

6. The right to be informed of any fees or costs associated with your treatment, and to receive a detailed explanation of your bill.

7. The right to file a complaint or grievance about any aspect of your treatment without fear of retaliation.

8. The right to be informed of your right to contact your state's mental health agency for assistance in exercising your rights.

If you have any questions or concerns about your rights as a client of [_____], please do not hesitate to ask.

[Provider signature: _____]

[Date: _____]

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH INFORMATION

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I, [patient name: _____], hereby authorize.

[therapist/mental health provider: _____ name] to disclose the

following mental health information to [recipient name]: _____

- [Description of the information to be disclosed, such as diagnosis, treatment plan, medications, etc.:_____

_____

_____

_____

_____

_____

_____

_____]

This authorization is valid for the period of [date range or end date: _____],

unless I revoke it earlier. I understand that I may revoke this authorization at any time by providing

written notice to [therapist/mental health provider name: _____],

except to the extent that action has already been taken in reliance on this authorization.

I understand that the recipient of this information may redisclose it, and that the information may no longer be protected by federal or state confidentiality laws.

SUICIDE RISK SAFETY PLAN

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Name: _____ Date: _____

Warning Signs:

What are the warning signs that suggest you may be at risk for suicide? (e.g., feeling hopeless, having thoughts of suicide, experiencing a change in appetite, etc.)

1. _____

2. _____

3. _____

Coping Strategies:

What are some healthy coping strategies you can use to manage your emotions and reduce your suicide risk? (e.g., talking to a friend, engaging in physical activity, practicing mindfulness, etc.)

1. _____

2. _____

3. _____

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Social Contacts:

Who are the people you can turn to for support when you are feeling overwhelmed and at risk for suicide? (e.g., family members, friends, mental health professionals, etc.)

1. _____

2. _____

3. _____

Professional Resources:

What are the professional resources you can use in case of a crisis or emergency? (e.g., National Suicide Prevention Lifeline, your therapist's contact information, hospital emergency room, etc.)

1. _____

2. _____

3. _____

Environmental Safety:

What are the environmental factors that you can modify to reduce your suicide risk? (e.g., removing access to lethal means, avoiding high-risk situations, etc.)

1. _____

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2. _____

3. _____

Emergency Plan:

What is your emergency plan in case you are at immediate risk for suicide? (e.g., calling 911, going to the nearest emergency room, contacting a crisis helpline, etc.)

1. _____

2. _____

3. _____

Please keep this safety plan with you at all times in case of a crisis. If you are experiencing severe distress or suicidal thoughts, immediately contact one of the resources listed above or seek emergency medical attention.

Client Signature: _____ Date: _____

Mental Health Provider Signature: _____ Date: _____

Witness: _____ Date: _____