LISA PEARSON, PhD, LPC-S, MRE
Counseling and Psychotherapy for Adults and Adolescents

713-562-2622

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Patient Registration

Patient's name: _____

DOB: _____ Gender: _____

Patient's address:

Home phone: _____ Cell/work phone: _____ Email: _____

Employer: _____ Occupation _____

Business address: _____

Emergency contact: _____ Phone number: _____

Is it alright to leave a voicemail/text on your answering device? _____

If so, at which number(s)? Home Work Cell

Insurance information

Health insurance company: _____

ID #: _____ Group #: _____

Provider/Precertification/Mental Health/Substance abuse phone # (back of card):

_____

Educational history

High school: _____

College: _____

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Treatment History

Have you ever received counseling services before?

When From whom For what problem With what results

Current medications (name, dosage if known, reason for taking)

Marital status:

Married/partnered Divorced Separated Single/Dating

Do you have children, and, if so, how many? _____

Legal history:

Are you presently suing anyone, or thinking of suing someone? _____

Is your reason for seeking counseling related to an accident or injury? _____

Is this appointment required by court/police/probation/ parole / work? _____

If you answered yes to any of the questions above, please explain.

Are there any other legal involvements that might have affected your or a significant other's functioning, relevant for psychotherapy treatment purposes?

Is there anything else you feel may be important for your therapist to know?

Patient signature: _____ Date: _____

LIMITS ON PATIENT CONFIDENTIALITY

We are required to disclose confidential information if any of the following conditions exist:

1. You are a danger to yourself or others.
2. You seek treatment to avoid detection or apprehension or enable anyone to commit a crime.
3. Your therapist was appointed by the courts to evaluate you.
4. Your contact with your therapist is for the purpose of determining sanity in a criminal proceeding.
5. Your contact is for the purpose of establishing your competence.
6. The contact is one in which your psychotherapist must file a report to a public employer or as to information required to be recorded in a public office, if such report or record is open to public inspection.
7. You are under the age of 16 years and are the victim of a crime.
8. You are a minor and your psychotherapist reasonably suspects you are the victim of child abuse.
9. You are a person over the age of 65 and your psychotherapist believes you are the victim of physical abuse. Your therapist may disclose information if you are the victim of emotional abuse.
10. You die and the communication is important to decide an issue concerning a deed or conveyance, will or other writing executed by you affecting as interest in property.
11. You file suit against your therapist for breach of duty or your therapist files suit against you.
12. You have filed suit against anyone and have claimed mental/emotional damages as part of the suit.
13. You waive your rights to privilege or give consent to limited disclosure by your therapist.
14. Your insurance company paying for services has the right to review all records.

*If you have any questions about these limitations, please discuss them with your therapist.

Signature: _____ Date: _____

I am consenting to my (or my dependent) receiving outpatient treatment.

Signature: _____ Date: _____

I _____

BRIEF PATIENT HEALTH QUESTIONNAIRE (Brief PHQ)

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability unless you are requested to skip a question.

Name_____ **Age**_____ **Sex:** ☐ **Female** ☐ **Male** **Today's Date**_____

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?

		Not at all	Several days	More than half the days	Nearly every day
a.	Little interest or pleasure in doing things	☐	☐	☐	☐
b.	Feeling down, depressed, or hopeless	☐	☐	☐	☐
c.	Trouble falling or staying asleep, or 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	☐	☐	☐	☐

2. Questions about anxiety.

		NO	YES
a.	In the last 4 weeks, have you had an anxiety attack—suddenly feeling fear or panic?	☐	☐
	If you checked "NO," go to question 3.		
b.	Has this ever happened before?	☐	☐
c.	Do some of these attacks come suddenly out of the blue—that is, in situations where you don't expect to be nervous or uncomfortable?	☐	☐
d.	Do these attacks bother you a lot or are you worried about having another attack?	☐	☐
e.	During your last bad anxiety attack, did you have symptoms like shortness of breath, sweating, your heart racing or pounding, dizziness or faintness, tingling or numbness, or nausea or upset stomach?	☐	☐

3. If you checked off any problems on this questionnaire so far, 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**

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4. In the last 4 weeks, how much have you been bothered by any of the following problems?

		Not bothered	Bothered a little	Bothered a lot
a.	Worrying about your health	☐	☐	☐
b.	Your weight or how you look	☐	☐	☐
c.	Little or no sexual desire or pleasure during sex	☐	☐	☐
d.	Difficulties with husband/wife, partner/lover, or boyfriend/girlfriend	☐	☐	☐
e.	The stress of taking care of children, parents, or other family members	☐	☐	☐
f.	Stress at work outside of the home or at school	☐	☐	☐
g.	Financial problems or worries	☐	☐	☐
h.	Having no one to turn to when you have a problem	☐	☐	☐
i.	Something bad that happened recently	☐	☐	☐
j.	Thinking or dreaming about something terrible that happened to you in the past—like your house being destroyed, a severe accident, being hit or assaulted, or being forced to commit a sexual act	☐	☐	☐

5. In the last year, have you been hit, slapped, kicked, or otherwise physically hurt by someone, or has anyone forced you to have an unwanted sexual act?

NO	YES
☐	☐

6. What is the most stressful thing in your life right now? _____

7. Are you taking any medication for anxiety, depression, or stress?

NO	YES
☐	☐

8. FOR WOMEN ONLY: Questions about menstruation, pregnancy, and childbirth.

a. Which best describes your menstrual periods?

☐ **Periods are unchanged** ☐ **No periods because pregnant or recently gave birth** ☐ **Periods have become irregular or changed in frequency, duration, or amount** ☐ **No periods for at least a year** ☐ **Having periods because taking hormone replacement (estrogen) therapy or oral contraceptives**

		NO (or does not apply)	YES
b.	During the week before your period starts, do you have a serious problem with your mood—like depression, anxiety, irritability, anger, or mood swings?	☐	☐
c.	If YES, do these problems go away by the end of your period?	☐	☐
d.	Have you given birth within the last 6 months?	☐	☐
e.	Have you had a miscarriage within the last 6 months?	☐	☐
f.	Are you having difficulty getting pregnant?	☐	☐

PHYSICAL SYMPTOMS (PHQ-15)

During the <u>past 4 weeks</u>, how much have you been bothered by any of the following problems?

	Not bothered at all (0)	Bothered a little (1)	Bothered a lot (2)
a. Stomach pain	☐	☐	☐
b. Back pain	☐	☐	☐
c. Pain in your arms, legs, or joints (knees, hips, etc.)	☐	☐	☐
d. Menstrual cramps or other problems with your periods ***WOMEN ONLY***	☐	☐	☐
e. Headaches	☐	☐	☐
f. Chest pain	☐	☐	☐
g. Dizziness	☐	☐	☐
h. Fainting spells	☐	☐	☐
i. Feeling your heart pound or race	☐	☐	☐
j. Shortness of breath	☐	☐	☐
k. Pain or problems during sexual intercourse	☐	☐	☐
l. Constipation, loose bowels, or diarrhea	☐	☐	☐
m. Nausea, gas, or indigestion	☐	☐	☐
n. Feeling tired or having low energy	☐	☐	☐
o. Trouble sleeping	☐	☐	☐

(For office coding: Total Score T_____ = _____ + _____)

Patient Name:_____ Date:_____

The Mood Disorder Questionaire

Instructions: Please answer each question to the best of your ability.

	YES	NO
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	○	○
...you were so irritable that you shouted at people or started fights or arguments?	○	○
...you felt much more self-confident than usual?	○	○
...you got much less sleep than usual and found you didn't really miss it?	○	○
...you were much more talkative or spoke much faster than usual?	○	○
...thoughts raced through your head or you couldn't slow your mind down?	○	○
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	○	○
...you had much more energy than usual?	○	○
...you were much more active or did many more things than usual?	○	○
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	○	○
...you were much more interested in sex than usual?	○	○
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	○	○
...spending money got you or your family into trouble?	○	○
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	○	○

3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? *Please circle one response only.*

No Problem Minor Problem Moderate Problem Serious Problem

4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	○	○
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	○	○

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TREATMENT CONTRACT

The therapist and I have discussed my / my child's case, and I was informed of the risks, approximate length of treatment, and the possible consequences of the treatment decided upon. Treatment typically includes intervention for the purpose of

- Stabilization
- Decrease and relieve symptoms
- Improve coping, problem solving, and use of resources
- Skill development
- Grief resolution
- Stress management
- Behavior modification and cognitive restructuring
- Other _____

While I expect benefits from this treatment, I fully understand and accept that, because of factors beyond our control, such benefits and outcomes cannot be guaranteed.

I understand that the therapist is not providing emergency service, and I have been informed of whom/where to call in an emergency or outside of business hours.

I understand that regular attendance of sessions will produce the maximum possible benefits, but that I/we are free to discontinue treatment at any time, by notifying the therapist in person, by phone, or in writing. I further understand that I may be charged a $60.00 "no show" fee in the event I fail to attend a scheduled session with less than twenty-four hours notice.

I have been informed of the limits of confidentiality.

I am not aware of any reason that I/we/he/she should not proceed with psychotherapy, and I/we/he/she agree to participate fully and voluntarily.

I have had an opportunity to discuss all of the aspects of treatment fully, have had my questions answered, and I agree to comply with treatment. I authorize the above named clinician to administer treatment to me or my child.

I understand that the fee for a forty-five-minute psychotherapy session is $140.00, payable in full at the time service is rendered. If I am using my health insurance coverage, I will pay the required copay and/or full fee up to the amount of any deductible required by my insurance company, at the time of each session. I understand that I am responsible for any portion of the fees not covered or reimbursed by my health insurance.

Name of patient: _____

Signature of **patient / parent / guardian**: _____

Signature of **psychotherapist**: _____

Date: _____