PRE-ASSESSMENT

(PLEASE NOTE: Information provided on this form is protected as confidential information.)

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

- ❏ NO
- ❏ YES (if so, please provide therapist/practitioner) : ______________________

Are you currently taking medication, any prescription medication and/or ever been prescribed medication?

- ❏ NO
- ❏ YES (if so, please list) : ____

How would you rate your current physical health? (Please circle one.)

Poor Unsatisfactory Satisfactory Good Very Good

How would you rate your current sleeping habits? (Please circle one.)

Poor Unsatisfactory Satisfactory Good Very Good

Are you currently experiencing overwhelming sadness, grief or depression?

- ❏ NO
- ❏ YES (if so, for approximately how long?) : ____________________________

Are you experiencing anxiety, panic attacks, or have any phobias?

- ❏ NO
- ❏ YES (if so, when did he/she begin experiencing this?) :

  ____

Do you have any substance problems?

- ❏ NO
- ❏ YES

Do you have problems in school or at home?

- ❏ NO
- ❏ YES (if so, please describe) : ____

What significant life changes or stressful events have you experienced lately?

____

What would you like to accomplish out of your time in therapy?

____

Please share any other information about you that you think is important for counseling:

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Insurance Authorization - I authorize the release of any medical or other information necessary to process insurance claims for services rendered. I also request payment of medical benefits to the undersigned physician or party who accepts assignments.

____
Initials

Consent for Treatment - I have been informed about the information contained in the document pertaining to treatment and agree to abide by its terms during our professional relationship. I understand that I am responsible for payment of any fees which insurance does not pay or cover.

____
Initials

South Carolina Privacy Notice Form - I have been informed about the information contained in the SC Privacy document and understand how the Health Insurance and Portability and Accountability Act (HIPAA) impacts clinical and medical information about me and how I can get access to this information. I am also aware that should I have any questions concerning this policy I am free to discuss them at our next session or at any time in the future.

____________________	____________________	________
Signature	Print Name	Date

____________________	____________________
Therapist Signature	Date