

J Hayes MS,LPC,NCC Informed Consent for Treatment

Informed Consent: This document certifies that I give my permission for Joseph D. Hayes MS,LPC,NCC. to provide counseling/psychotherapeutic treatment to myself and/or my spouse and/or child/children and/or family members. I certify that I am legally able to place myself or the minor I have brought with me into mental health treatment.

According to Texas State Law, limitations of confidentiality exist within the client and counselor relationship. Breach of confidentiality can occur if:

- (1) Client informs counselor that he plans to inflict harm on him/herself or someone else. (I will follow the duty to warn if I believe there is reason to believe)
- (2) Client reports child abuse or neglect of a child, or allegations of placing a child in harms way. (It is not my position to determine if abuse or neglect happened, just to report suspected, alleged or informed.)
- (3) Client reports elderly abuse or neglect or discloses knowledge of harm/manipulation of an Elderly citizen.
- (4) Records will be turned over to the courts if subpoenaed. (Civil or Criminal)
- (5) Couple/Married clients will both have the right to obtain all the records if they attended counseling together, Other than at Joseph D. Hayes discretion in doing so, the releasing of records creates harm to a Parent child relationship (Even if a divorce occurs)

Psychotherapy Notes may be withheld from parents or clients at the discretion of Joseph D. Hayes, if in his opinion releasing such notes could harm any child parent relationship or effect the therapeutic relationship or possible due harm to client.

Counseling Services will be rendered in a professional manner, consistent with the Professional Board of Examiners of Counselors. Clients are responsible for setting and making appointments on a timely basis. Client can be referred to other counselors if he/she misses two or more appointment times. If client doesn't set up an appointment within 6 weeks of his/her last appointment, then the client will be automatically discharged from treatment. Client is to cancel the appointment by calling (903) 285-5121 or faxing 1-888-257-6008

Benefits and Risks: There are no guarantees of therapeutic outcomes, behavioral changes or any implied form of success in undergoing in person or online/telehealth through DOXY.ME counseling/treatment services with Joseph D. Hayes MS,LPC,NCC

Your insurance is billed as convenience to you. **If for any reason they do not pay for the services, then you are responsible for the charges.** I Joseph D. Hayes have the right to turn any delinquent account over to a collection agency for service. Furthermore, some health insurance requires a mental health diagnosis & referral from a PCP to pay for services. You are solely responsible for getting the PCP referral or contacting Insurance to see if one is needed to pay for services with Joseph D. Hayes.

FEEs for individual counseling are \$100 per session (50min) or as negotiated on the sliding scale fee of _____ per session. Court work is billed at a rate of \$500 per day plus expenses and a deposit of \$1500 is expected in 1 week after being subpoena by your legal counsel or other parties legal counsel, courts or any legal authority about you or your involvement, or family.

Online Informed Consent Addendum
For Telehealth/Online Services

“The same informed consent issues as the original informed consent on page 1 of 2 are included & agreed too with this signing of this addendum as included page 2 of 2 with page 1 of 2 if telehealth/online electronic counseling services are sought and rendered.”

Online Risks

Confidentiality (1) No confidentiality can be guaranteed as per meeting with a client online creates unique risks, such as services being overheard in client’s environment, captured internet transmissions, emails misaddressed and sent and or any other party tampering with client’s equipment. I deliver services on a HIPAA approved server DOXY.ME, then if interruptions (transmission difficulty) I will call back twice. If unsuccessful we can then just use voice through cell phone to cell phone to complete the session or reschedule for remainder of appointment time.

(2) Please try to find a private space, where interruptions and no other parties will interfere.

(3) No one has permission nor will record the session without expressed written consent of both the counselor and the client. This unauthorized recording is forbidden and if violated is immediate means for discharge, referral and possible legal actions.

(4) Emails usually are replied to within 72 hours, so no emergency emails. Calling the 24/7 crisis line is referred on any emergency. 1-877-466-0660 if unable then call 911.

Online therapy creates a different platform, so clinical expectations are different through tele health/online counseling. I prefer to see more complex, serious cases in person, so if I at my own discretion feel your needs are better served in person, I have the right to discontinue the telehealth and see you in person. If that is not possible the client agrees to accept a referral to another counselor from Joseph D Hayes MS,LPC,NCC.

Crisis response: I have the right to notify the authorities or any party that can intervene with safety if in my discretion the client is in crisis such as examples but not limited to suicidal, homicidal, self-harm or putting children or elderly in harm’s way, at risk, suspected alleged abuse or exploitation.

Client/Guardian

Date

Counselor

Date

Joseph D. Hayes MS, LPC, NCC
106 S. Jefferson Suite 103, Mt Pleasant Texas, 75455
903-285-5121, Fax 1-888-257-6008
Joseph D Hayes MS,LPC,NCC

HIPAA NOTICE OF PRIVACY PRACTICES

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control protected health information. "Protected Health information" is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Use and Disclosures of PHI

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the reception desk where you will be asked to sign your name. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors and organ donation: research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke the authorization, at any time, in writing, except that your physician or the physician's practice has taken action in reliance on the use or disclosure indicated in the authorization.

Your Rights

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply

You have the right to request to receive confidential communications from us alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we made, if any, of your protected health information.

We reserve the right to amend or modify our privacy policies and practices and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

COMPLAINTS

If you would like to submit a complaint to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. We may not retaliate against you in any way for filing a complaint.

This notice was published and became effective on September 1, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer Joseph Hayes MS, LPC, NCC.

The Signature below is only acknowledgement that you have received the Notice of our Privacy Practices.

Print Name Date

Signature Witness Signature

Joseph D. Hayes MS,LPC,NCC.

106 S. Jefferson Suite 103, MP. TX (903) 285-5121

Basic Client Information

Name _____ DOB _____ Age _____

Mailing Address _____

Gaudian/Parents _____ & _____

Phone _____ Email _____

Who Referred _____ Insurance type _____

Why are you seeking counseling? _____

Medications _____

Is there anything you need or will need other than counseling? (Such as letter of fitness for work, probation, court, divorce, custody or evaluation report of any type including disability)

If an assessment of any form is requested, Joseph Hayes MS,LPC,NCC. Requires 6 sessions prior to rendering any recommendations

Anything else you think is important that I need to know prior to accepting case?

Joseph D. Hayes MS, LPC, NCC. Does NOT take court cases of any nature. If you have legal issues criminal, civil or divorce, I can happily make a referral to another LPC. CL _____

Client _____ Date _____

Client Signing states agreement & accuracy of provided information.

Adult Self-DISCLOUSER Screener

Name: _____ DOB: _____ SS# _____

Work _____ DI#: _____

Person providing information: _____ Date: _____

Part 1

- Have you recently hit, or been physically aggressive with spouse, family or peers?

Yes _____ NO _____ If yes when, who, & what?

_____Where authorities called? _____

- Have you recently threatened to harm self or attempted to hurt self or someone else?

Yes _____ NO _____ If yes when, who, & what?

- Has your child ever attempted to run away from home or school or spouse wants to separate?

- Are you capable of independently completely caring for yourself? (Financially, emotionally & physically) _____ What are some emotional issues that have been treated in the past?

Part 2- Medical Necessity

- Have you ever been to a professional due to emotional or behavioral issues? (This includes counseling) Yes _____ NO _____ If yes when, who, & what?

Diagnosis: _____ By Whom _____

- What medications do you currently take? (Please include amounts prescribed)

- Do you receive Social Security/Disability benefits for any condition? _____

- What symptoms or behaviors do you exhibit that makes you feel you would benefit from this counseling? _____

Frequency? _____ How do they affect daily functioning? _____

Any medical issues that I need to be informed about? _____ Please list below:

Part 3- Psychological History

List all mental health treatment- outpatient, inpatient, medication management- dates and outcomes

Part 4- Social/ Family History

- Current Family and Significant Relationships:

- Who all lives in your home and include ages?

- How do you relate to others (adults and children): _____

- Have or are there any recent issues at home that may affect your emotional or behavioral functioning? _____

- Have any major events such as divorce, moving, or death of a loved one recently happened in your life? Yes_____ NO_____ If yes when, who, & what? _____

- Do you have any concerns about cultural, ethnic, spiritual, or religious issues? _____
-

- Are there any current legal issues affecting you? _____

- What does you like to do for fun? _____

- Any history of abuse? _____

Part 5- Medical/Developmental

- History of serious illness or injury? _____
-

- Medical problems: _____

- Does you have or had any allergic reactions to anything? _____.

- Did you meet developmental milestones on time: _____

Part 6- Educational

- Have you ever been retained a grade in school? _____

- What type of grades did you get in school? _____

• Were you in any special classes at school? _____

• Anything else you would like the therapist to address. _____

NOTE ANY OF THESE PROBLEMS YOU MAY HAVE, OR MAY HAVE EXPERIENCED BELOW: THEN EXPLAIN:

DELUSIONS/Hallucinations: _____

DEPRESSION: _____

ANXIETY: _____

Panic Attacks: _____

ODD BEHAVIOR: _____

ODD BELIEFS: _____

OBSESSIONS: _____

DEPENDENCY: _____

SLEEP ISSUES: _____

EATING DISORDERS: _____

PARANOIA: _____

FATIGUE: _____

SUICIDAL THOUGHTS: _____

SELF HARMING BEHAVIORS/CUTTING: _____

ANGER: _____

VIOLENCE RELATED BEHAVIOR: _____

CRIMINAL ACTIVITY/ PROBATION: _____

BLACK OUTS: _____

ALCOHOL/SUBSTANCE ABUSE: _____

GRIEF/DIVORCE: _____

CONFUSION: _____

MEMORY ISSUES: _____

FEARS: _____ PANIC ATTACKS: _____

HYPERACTIVITY/ INABILITY TO FOCUS: _____

SCHOOL, SOCIAL OR WORK: _____

MARITAL/RELATIONSHIP ISSUES: _____

ANY OTHER CONDITION OR SUBJECT THAT I NEED TO KNOW AS A THERAPIST?

Parents names and SS# and whose name is on the insurance or names responsible for the bill/ Holder of insurances. _____

REFERRED BY: _____

CLIENTS LEGAL GUADIAN/SELF OR

Parent: _____ Date _____

Counselor who obtained information:

_____ Date _____

Fees for services at Confidential Counseling Services / Joseph D. Hayes
MS,LPC,NCC.

Individual Services:

\$100 per 50 min session. *For (Individual Counseling)*

\$125 per 50 min session *for (couple counseling)*

\$500 for subpoenas or court appearance per day, no matter which party subpoenas me. The \$500 fee applies if I testify or not or if court is cancelled. (A payment plan can be arranged prior to court with a down payment and contract. This responsibility is part of my evaluation of a person's character as I believe people know the gist of their problems and know that it is a possibility that others may become a part of their legal issues.

Written Reports are \$100. Payment in advance as to report may or may not be what the client desires.

Phone consultation or internet webcam is billed at \$100 per 50 min.

NO Shows are billed at \$15. A No show is no call, no show or an appointment that is not given at least 24-hour notice. No services other than termination with referral will be provided until the No show \$15 fee is paid. This means another appointment will not be scheduled until client comes and pays fee. If you have a standing appointment, then you must call and acknowledge No show and intent to pay on next appointment or your time will be given to other party.

Drug and alcohol evaluation are \$150. They include administering the SASSI, SADD and DAST. A verbal interview and a written evaluation of results with recommendations.

Beck Depression Inventory is a onetime fee of \$20 (Usually it is given more than once throughout treatment but with just a 1-time charge).

Brief Couple Therapy is \$450: Consists of 6 sessions for addressing issues to assist both clients. (Depression, Anger Management, Stress, Divorce and Marital Communication) This is prepaid for this exclusive deal, if clients cancel or just quit and they want a prorated refund; then the normal charges of \$125 a 50 min session apply to any session delivered. (2 sessions would be \$250 taken from the \$450=\$200 refund.) Sessions need to be completed no later than 60 days. _____initial if using this program as it is understood there is no insurance billing/or paperwork to submit to insurance.

BY signing I agree to all the above fees and conditions of such fees.

Client

DATE

COUNSELOR/CONSULTANT

DATE

Confidential Counseling Services

106 Jefferson Suite 110, Mt. Pleasant Texas 75455, 903-285-5121

Consent For Release of Confidential Information

I _____, hereby authorize C.C.S. / Joseph D.

Hayes to release to _____ the following

Initialed Information BY WRITTEN &/OR VERBAL COMMUNICATION from my clinical records:

____ ATTENDENCE ____ PROGRESS NOTES ____ REPORTS

____ DIAGNOSIS ____ PROGNOSIS ____ RECOMMENDATIONS

____ REFERRALS ____ EVALUATIONS ____ ANY/ALL/ABOVE

____ OTHER SPECIFIED _____

The purpose of the discloser authorized herein is to provide the recipient with the information from the clients records with regards to attendance and progress in treatment. This discloser is a condition of:

____ VOLUNTEER ____ PROBATION ____ PAROLE

____ COURT SENTENCE ____ PRETRIAL RELEASE

____ TEXAS REHABILITATION COMMISSION

This Release is from this date _____ to the expiration date of _____.

I understand that my records are protected under Federal regulations governing Confidentiality of Patient Records, 42 CFR Part 2 and cannot be disclosed with out written consent unless otherwise provided for in the regulation. I understand I may revoke this request at any time (preferably in a formal written request or oral in emergency with written follow up) except to the extent that action has been taken in reliance on it.

Consent for release of information automatically expires 60 days after termination of treatment.

Client/Parent/Managing Conservator Date

Counselor

Date

Confidential Counseling Services

106 Jefferson Suite 110, Mt. Pleasant Texas 75455, 903-285-5121

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Counselor

Date

Confidential Counseling Services

106 Jefferson Suite 110, MP TX. 75455, 903-285-5121

Joseph D. Hayes MS,LPC,NCC.

Texas State Board of Examiners of Professional Counselors Complaint Process & Treatment INFO.

(1) An individual who wishes to file a complaint against a Licensed Professional Counselor may write to:

Complaints Management and Investigative Section

P.O. Box 141369

Austin, Texas 78714-1369

or call 1-800-942-5540 to request the appropriate form or obtain more information. *This number is for complaints only.*

(2) In the event of my death, counseling records will be with my son Thomas Hayes 877 FM 2882, MT. Pleasant TX. 75455. Being that he is not a counselor, an order to turn over copies of the records by the local Judge would be needed before he can copy the records and give to my previous clients.

(3) You the client agree to give me (Joseph D. Hayes) a certified mailed letter of request for requested records. Also send a check in the amount of \$35 for expenses. Client is in agreement that after I received the request in writing and the paid \$35 fee, I will reply within ten business days concerning record request or production.

(4) Records will be destroyed after 6 years of last client appearance. Children's records whom were in counseling will have the five years start on their 18th birthday and records will be destroyed on their birthday of 23 years old.

(5) **No guarantees concerning effectiveness or outcomes of counseling/ undergoing treatment are implied by Joseph D. Hayes. Counseling is an inexact science and makes no warranties as to outcome be it positive or negative.** No one can guarantee human behavior, thoughts or perception of feelings.

(6) A copy of this form will be given upon request.

(7) If you become a danger to yourself or others, then you will need to call 911. Joseph Hayes does not do crisis counseling. Nor does he check email, voicemail or letters written to him and placed in his office on a timely basis. Any out cries of suicidal behavior, homicide, self harming or threats in any form or fashion, upon discovery by Mr. Hayes will immediately warrant a counselor and patient relationship terminated with treatment only continuing as a referral to another practitioner or facility.

(8) The counseling treatment may be terminated by the counselor Joseph Hayes MS, LPC,NCC. perception in doing so is the appropriate action, even if you the client or another professional disagree with the action.

Sign below in agreement

Client

Date

Counselor

Date

Confidential Counseling Services
106 Jefferson Suite #110, Mount Pleasant Texas 75455
(903) 285-5121

The below statements are crucial for treatment and it is of the highest importance that this information be answered honestly.

1. I have not been convicted of any sexual crime with a child or adult? _____
2. I am not in therapy with any other counselor or mental health professional?
_____ if so then who? _____
3. I will cooperate with all physicians orders including taking prescribe medications as directed by the physician? _____
4. I am not in any legal trouble or custody dispute? _____
5. I agree to update any information that I have furnished upon changes. _____
6. I represent that I am legally authorized to enter myself into treatment or represent that I am the parent, or legal guardian having full legal rights granted by the courts to enter the accompanying minor into counseling treatment _____.

By signing this page reflects that I have been honest and forth coming with all the correct information. By signing also signifies that the client is in agreement with all the below statements as interpreted by Joseph D. Hayes. If there are questions about interpretations the client must ask Mr. Hayes to clarify before acceptance by signing.

I agree to not file suit against Joseph D. Hayes or any family members for services provided as a counselor/hypnotherapist. If there is a disagreement then I waive all filing of civil suit but will abide by hiring a mediator as a resolution agent or filing with the Texas Department of Human Services *Complaints Management and Investigative Section*
P.O. Box 141369
Austin, Texas 78714-1369
or call 1-800-942-5540 to request the appropriate form or obtain more information.

I agree to pay Joseph D. Hayes \$500 per day for any subpoena court appearance. I will put down \$1500 as a resource for Mr. Hayes to draw his expenses and fees prior to the court date. This includes getting subpoenaed by any party other than CPS and in any civil, family or criminal court of law.

Client in agreement to all terms above Date

Counselor/Witness Date

Joseph Hayes LPC Counseling Intake

FULL LEGAL NAME: _____ DOB: _____

SS# _____ DL#: _____ VERIFIED BY JH _____

TELEPHONE #: _____ CELL# _____

WORK #: _____ MESSAGE#: _____

PHYSICAL ADDRESS: _____

HOW DID YOU HEAR ABOUT MY SERVICES: _____

WHAT BRINGS YOU TO COUNSELING? _____

DESIRED RESULT/OUTCOME/EXPECTATION OF COUNSELING:

WHAT MEDICATIONS ARE YOU PRESCRIBED AND BY WHO? _____

_____ ARE YOU COMPLIANT ON TAKING THEM? _____

ANY PRIOR TREATMENT? _____ WHEN WHERE AND WHAT KIND? _____

INTAKE CONTINUED

WHAT HAS WORKED IN THE PAST AND WHAT HASN'T CONCERNING TREATMENT OR WITH PRESENTING ISSUES? _____

LIST ANY ADDITIONAL CONCERNS (I.E. DIVORCE, PROBATION, DEATH, ANY FORM OF SEXUAL ABUSE, SPOUSAL ABUSE, SUICIDE ATTEMPTS CPS INVESTIGATIONS, TERMINAL ILLNESS ECT). _____

LIST EVERYONE THAT LIVES IN YOUR HOME AND THEIR RELATIONSHIP:

DO YOU BELIEVE YOU NEED HELP OR OTHER PEOPLE BELIEVE YOU DO?

EXPLAIN: _____

ARREST HISTORY: _____

CONVICTIONS: _____

DO YOU DRINK ANY FORM OF ALCOHOL? _____ DO YOU USE DRUGS? _____

LIST PATTERNS WITH AMOUNT OF ALCOHOL CONSUMPTION OR DRUG USE AMOUNT AND METHODS _____

IF INVOLVED WITH THE LEGAL SYSTEM HOW MANY POSITIVE U.A. _____

INTAKE CONTINUED

FAMILY HISTORY: (ANY PROBLEMS) _____ WHAT _____

RELATIONSHIP HISTORY WITH MOM: _____

RELATIONSHIP HISTORY WITH DAD: _____

RELATIONSHIP HISTORY WITH SIBLINGS: _____

RELATIONSHIPS/MARRIAGES: _____

SEXUAL PROBLEMS/INFIDELITY: _____

RELATIONSHIP WITH CHILDREN: _____

ANY HISTORY OF ABUSE? _____ WHAT, WHEN, WHO _____

DID YOU HAVE PROBLEMS AS A CHILD? (HOME, SCHOOL, FRIENDS) _____

DO YOU HAVE EMPLOYMENT ISSUES? (JOB HOPING, FIRED, ECT) _____

_____ FINANCIAL ISSUES _____

FINAL PAGE OF INTAKE

DO YOU BELIEVE YOU ARE STABLE? _____ IF NO WHY NOT? _____

MENTAL ISSUES:

TIME? _____ WHO ARE YOU? _____ WHERE ARE YOU? _____

DO YOU SEE THINGS OTHER PEOPLE DON'T CLAIM TO SEE? _____ IF SO WHAT? _____

DO YOU HEAR VOICES TALKING TO YOU? _____ IF SO WHAT DO THEY SAY? _____

THIS SECTION IS FOR THE COUNSELOR TO FILL OUT DURING THE INITIAL SESSION BY VERBALLY INTERVIEWING CLIENT

DELUSIONS/Hallucinations: _____

DEPRESSION: _____

ANXIETY: _____

ODD BEHAVIOR: _____

ODD BELIEFS: _____

OBSESSIONS: _____

DEPENDENCY: _____

SLEEP ISSUES: _____

EATING DISORDERS: _____

PARANOIA: _____

FATIGUE: _____

SUICIDAL THOUGHTS: _____

ANGER: _____

VIOLENCE: _____

CRIMINAL ACTIVITY: _____

BLACK OUTS: _____

CONFUSION: _____

MID-LIFE: _____

MEMORY ISSUES: _____

FEARS: _____

HYPERACTIVITY: _____

ANY PREVIOUS DIAGNOSIS / ISSUES OR PERTNIENT TOPICS THAT WAS NOT ASKED ABOVE: _____

BY SIGNING BELOW, I CONFIRM THIS INFROMATION IS ACCURATE.

CLIENT _____ DATE _____

