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 1week 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.

Child/Adolescent Screener

Name: _____DOB: _____SS#_____

School_____ Grade: _____Parents & DOB_____

Person providing information: _____ Date: _____

Part 1

- Has your child recently hit, or been physically aggressive with you, family or peers? Yes_____ NO_____ If yes when, who, & what?
  _____
  _____
- Has your child recently threatened to harm self or attempted to hurt self? Yes_____ NO_____ If yes when, who, & what?
  _____
  _____
- Has your child ever attempted to run away from home or school? _____
  _____
- Is your child capable of independently completely caring for all his or her personal hygiene issues that may arise?_____

Part 2- Medical Necessity

- Has your child ever been to a professional to diagnose them due to emotional or behavioral issues? (This includes counseling) Yes_____ NO_____ If yes when, who, & what?
  _____
  _____Diagnosis:
  _____
- What medications does your child currently take?
  _____
  _____
- Does your child receive Social Security/Disability benefits for any condition? _____
  _____
- What symptoms or behaviors does your child exhibit that makes you feel he would benefit from this counseling? _____
  _____
  Frequency? _____ How do they affect daily functioning? _____
  _____

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 the home with the child? _____
- How does your child relate to others (adults and children): _____
  _____
- Have or are there any recent issues at home that may affect your child's emotional or behavioral functioning?_____
  _____
- Have any major events such as divorce, moving, or death of a loved one recently happened in your child's 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 the child? _____
- What does your child like to do for fun? _____
- Any history of abuse? _____

Part 5- Medical/Developmental

- History of serious illness or injury?_____
  _____
- Medical problems:_____
- Does your child have or had any allergic reactions to anything?_____.
- Did your child meet developmental milestones on time: _____

Part 6- Educational

- Has your child ever been retained a grade in school? _____
- What type of grades does your child get in school?_____
- Is your child in any special classes at school? _____
- Any thing else you would like the therapist to address. _____

  _____

CHECK ANY OF THESE PROBLEMS YOUR CHILD HAS OR MAY HAVE BELOW: THEN EXPLAIN:

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: _____
MEMORY ISSUES: _____
FEARS: _____
HYPERACTIVITY: _____

Anything or other condition that was not mentioned please list.

_____
_____

Parents names and SS# and who's name is on the insurance or insurances._____
_____

Clients Legal Gaurdian/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

Consent For Release of Confidential Information

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

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_____ _____

Client/Parent/Managing Conservator Date 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, MP TX. 75455, 903-285-5121
Joseph D. Hayes MS,LPC,NCC.

Declaration of the Fact of Non-Dual Relationship.

Understanding that the City of Mount Pleasant Texas is a small community to where it is not uncommon to know people by their name, but not actually know them or have any sort of relationship with them. By signing below, I am swearing under oath of telling the truth that I in way form, fashion or color have nor had any dual relationship with Mr. Joseph D. Hayes. Understanding that just knowing who a person is or his family members or attending a public event and seeing him in passing is not considered a dual relationship. Mr. Hayes has two children, so he is popular as he has ran for public office, served as an enrollment counselor at the local community college and has been involved in local sports as a coach and referee. By signing below states that you as a client express that you **in NO shape, color or form have or have had a dual relationship with Licensed Professional Counselor Joseph D. Hayes.** (An example of dual relationships, but not limited to are: **personal friends** (such as knowing phone numbers, calling ,visiting homes, going out to places together or work friend bonding relationships) **intimate** (Past dating, marriages, or blood relations), **business** (Any financial trading of services in last two years), or any relationship that would *give power to Mr. Hayes over the client*. (Such as teacher over my son or family, Spouses & immediate family members of current clients or personal friends). Dual Relationships are to be avoided and if one were to arise during treatment, then you as a client understand that termination of services and a referral would be warranted.

_____***You also agree if you are doing couple counseling, I follow a model of seeing both clients for equal number of individual sessions prior & decided upon by co treatment agreement between clients and therapist with the goal to build up to couple sessions. If the need arises to stop in between couple sessions and return to individual, then both clients still must do equal number of sessions before returning to couple sessions.***

_____

Client Signing in agreement to all above statements Date

_____

Counselor Signing in agreement 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 CONSERNING 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,SCHOOLFRIENDS)_____

_____

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_____