Heritage Behavioral Health Consultants

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Welcome to the practice of Heritage Behavioral Health Consultants. We are pleased you have chosen our office and will assure you that we are working with you in a caring and professional manner. Please take a few moments to read our office policies and do not hesitate to ask any questions you may have. These policies are further detailed in the Notice of Privacy Practices following this form.

OFFICE HOURS

Regular support staff hours are from 8:00am to 5:00pm Monday through Friday. Each clinician sets his or her own schedule and will work with you to schedule a mutually agreeable time.

SESSIONS

Full sessions are 45 minutes and half sessions are 25 minutes long. In order to ensure that your time is respected and waiting time does not interrupt your schedule or ours, every effort is made to start and stop on time. Extended sessions can be arranged when necessary, that will include an additional fee.

CANCELLATIONS

There is no charge for missed appointments **IF APPOINTMENT IS CANCELLED AT LEAST 24 HOURS IN ADVANCE**. If the appointment is for Monday, the cancellation may be made-by leaving a message with the answering service. **WE DO CHARGE FOR APPOINTMENTS NOT CANCELLED 24 HOURS IN ADVANCE.**

EMERGENCY SERVICES

In the event of a **medical emergency please call 911**, the Crisis Hotline (713-HOTLINE), or go to the nearest emergency room. Your clinician will usually be available to assist you personally should an emergency consultation be necessary: however, at times, a colleague may cover calls. you may reach us at (713)365-9015, leave a message and a call back number on your therapist's private voicemail and your therapist will be paged. If the consultation requires more tan 15 minutes, you may be billed for time.

NOTICE OF PRIVACY PROCEDURES

In accordance with the Health Insurance Portability and Accountability Act (HIPPA), Heritage Behavioral Health Consultants is required to: 1) maintain the privacy of your health information, 2) provide you with a Notice to our legal duties and privacy practices with respect to the information that we collect and maintain on you, 3) abide by the terms of the Notice, 4) notify you if we are unable to agree to a requested restriction, 5) accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations. Please refer to our **Notice of Privacy Practices** for detailed information.

FEES
Payment is due at the time of service rendered in the form of cash, check or credit card. We do not file insurance in this office; however for those clients that belong to an insurance company that wish to file, we will give you an itemized statement so that you can file it with your insurance company in order to have them reimburse you directly.

It is the policy of this practice to turn delinquent accounts over to collection after 90 days. If it becomes necessary to do this, there will be an additional 10% charge to the outstanding balance.

TYPES OF THERAPY AND ASSESMENTS
A variety of therapies are available depending on your needs and wishes. During your first visit, you and one of our clinicians will evaluate together what issues you wish to address and the type of therapy that would be most appropriate for you.

Please check each type of therapy or assessment you feel may be appropriate.

___ Marriage or Relationships Counseling
___ Individual Counseling
___ Parent Consultation
___ Family Therapy
___ Attention Deficit Disorder Assessment
___ Psychological Testing

PERSONAL RELATIONSHIPS
Our goal is that we will develop a positive, rewarding relationship. At this time, please take a few minutes to fill out the enclosed information so that we may better help you achieve your goals.

I HAVE READ AND FULLY UNDERSTAND THE **PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT** AND AGREE TO ITS TERMS.

Patient's Full Name (please print): _____

Signature: _____ Date: _____

I HAVE RECEIVED A **NOTICE OF PRIVACY PRACTICES** AND AGREE TO ITS TERMS.

Patient Signature: _____ Date: _____

Clinician Signature: _____ Date: _____

Adult Patient Information

Date: _____ Clinician Name: _____

Patient's Name: _____

D.O.B.:_____ Sex: M_____ F_____

Patient's Address: _____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell Phone: _____

Employer: _____ Occupation: _____

Business Address: _____

Wk Phone:_____ Email: _____

Emergency contact:_____ Phone: _____

Referred by: _____

Would you like an invoice after every visit? ☐Yes ☐No

Is it alright to leave a voicemail on your answering device? ☐Yes ☐No

At which phone number?☐ Home ☐ Cell ☐ Work

Would you like to keep your credit card info on file for ease of payment: Yes No

Card Holder Name: _____

Credit Card No.:_____

Exp. Date: _____ CVV Code: _____ (3 digit code on back of card)

Credit Card Billing Address: _____

Signature: _____

Indicate which of the following symptoms you have experienced

- ☐ Fatigue/ lack of energy
- ☐ Weakness
- ☐ Lack of Sleep
- ☐ Sleeping too much
- ☐ Increase/Decrease of appetite
- ☐ Increase/Decrease in weight
- ☐ Repetitive/senseless thoughts
- ☐ Repetitive/senseless behavior
- ☐ Sad/down in the dumps
- ☐ Depressed
- ☐ Irritability/anger
- ☐ Nervousness
- ☐ Fearful feelings
- ☐ Frequent crying
- ☐ Frequent negative thinking
- ☐ Frequent thoughts of death
- ☐ Suicidal thoughts
- ☐ Homicidal thoughts
- ☐ Fainting/ feeling faint
- ☐ Tremors
- ☐ Trembling/shakiness
- ☐ Seizure/convulsions
- ☐ Skin rash
- ☐ Aggressive/violent behavior
- ☐ Seeing things that are not real
- ☐ Hearing things that are not real
- ☐ Difficulty making decisions
- ☐ Difficulty concentrating
- ☐ Memory problems
- ☐ Worthless feelings
- ☐ Excessive guilt feelings
- ☐ Helplessness
- ☐ Hopeless feelings
- ☐ Sweating
- ☐ Dizziness/light headedness
- ☐ Unsteady feelings
- ☐ Jumpiness
- ☐ Keyed up/ on edge
- ☐ Restlessness
- ☐ Constant worry
- ☐ Panic
- ☐ Feeling life not worth living
- ☐ Increase/decrease in sex drive
- ☐ Fear of going crazy
- ☐ Fear of dying
- ☐ Feeling of unreality
- ☐ Feeling in dream-like state
- ☐ Isolation/withdrawal
- ☐ Double vision
- ☐ Difficulty in focusing vision
- ☐ Eye pain
- ☐ Eye discomfort in bright light
- ☐ Sinus pain or congestion
- ☐ Increase/decrease in tearing
- ☐ Increase in sensitivity to sounds
- ☐ Ear infections
- ☐ Joint pains or stiffness
- ☐ Backache
- ☐ Muscle tension
- ☐ Muscle pain/soreness
- ☐ Swelling of hands/feet/ankles
- ☐ Leg cramps
- ☐ Numbness/tingling in limbs
- ☐ Foot problems
- ☐ Trouble walking
- ☐ Balance problems
- ☐ Cold/clammy hands
- ☐ Unable to sit still
- ☐ Chest pain/discomfort
- ☐ Palpitations
- ☐ Difficulty swallowing
- ☐ Nausea
- ☐ Diarrhea
- ☐ Constipation
- ☐ Vomiting
- ☐ Food intolerance
- ☐ Fear of losing bowel control
- ☐ Inability to control bowels
- ☐ Shortness of breath
- ☐ Dry mouth
- ☐ Unusual taste sensation
- ☐ Inability to control urine
- ☐ Penile/vaginal sores
- ☐ Penile/vaginal discharge

☐ Difficulty in sexual frustration ☐ Other: _____
☐ Breast discharge

Chief Concern: Please describe the main reason that you here today: _____

_____

Educational History:
High School(s): _____
College(s): _____

Treatment History:
Have you ever received psychological, psychiatric or counseling services before?
☐ **Yes** ☐ **No**

When	**From whom**	**For what problem**	**With what results**

Have you ever taken medications for psychiatric or emotional problems?
☐ **Yes** ☐ **No**

When	**From whom**	**For what problem**	**With what results**

Personal History:
What is you marital status? ☐Married ☐Divorced ☐Separated ☐ Widow/Widower
☐ Single ☐Dating

Do you have children, and if so, how many? _____
How many times have you been married? _____ # of Years Married _____

Please describe the following relationships in your family of origin:

Your parents' relationship with each other: _____
_____

You relationship with each parent and with other adults present: _____

_____

_____

Your relationship to your brothers and sisters, in the past and present: _____

_____

_____

Family History:
In either side of biological parents, is there any history of the following

- ☐ **Alcoholism** _____
- ☐ **Allergies** _____
- ☐ **Anxiety** _____
- ☐ **ADHD** _____
- ☐ **Asthma** _____
- ☐ **Bowel Disease** _____
- ☐ **Cancer** _____
- ☐ **Compulsions**_____
- ☐ **Depression** _____
- ☐ **Diabetes** _____
- ☐ **Drug Abuse** _____
- ☐ **Emphysema** _____
- ☐ **Epilepsy** _____
- ☐ **Heart Disease** _____
- ☐ **HIV** _____
- ☐ **Hormone Disorders** _____
- ☐ **Learning Disabilities** _____
- ☐ **Suicide/ Attempts** _____
- ☐ **High Blood Pressure** _____
- ☐ **Kidney Disease** _____
- ☐ **Liver Disease** _____
- ☐ **Physical Abuse** _____
- ☐ **Phobias** _____
- ☐ **Psychiatric Hospitalization** __
- ☐ **Rage** _____
- ☐ **Schizophrenia** _____
- ☐ **Sexual Abuse** _____
- ☐ **Thyroid Disease** _____
- ☐ **Tremors or tics** _____
- ☐ **Ulcers** _____
- ☐ **Other** _____

Present Relationships:

How do you get along with your present spouse or partner if you have one? _____

_____

Please list your spouse/partner's physical health problems, chemical use, and mental or emotional difficulties if any: _____

How do you get along with your children if you have any? _____

_____

Please list your children's physical health problems, chemical use, and mental or emotional difficulties if any: _

_____

Your most important friends, past and present:

Name **Good Parts of Relationship** **Bad Parts of Relationship**

_____

_____

_____

Personal Abuse History:

☐ **I was not abused in any way** ☐ **I was abused** ☐ **I am not sure if I was abused**

If you know you were abused, please list all incidents below using the following letters:
P = physical, such as being shoved, hit, or beaten.
S = Sexual, such as touching/molesting, fondling, or intercourse
N = Neglect, such as failure to feed, shelter, or protect you
E = emotional, such as humiliation, verbal attacks

Your age **Kind of abuse** **Effects on you** **Did you tell anyone?** **Consequences of telling**

_____

_____

_____

Substance Use:

Have you ever felt the need to cut down on your drinking?	☐ Yes	☐ No
Have you ever felt annoyed by criticism of your drinking?	☐ Yes	☐ No
Have you ever felt guilty about your criticism of your drinking?	☐ Yes	☐ No
Have you ever taken a morning "eye-opener"?	☐ Yes	☐ No

How many drinks (beer, wine, or hard liquor) do you consume each week, on average? _____

_____

How much tobacco do you smoke or chew each week? _____

Which drugs (not including prescription medications) have you used in the last 10 years? _____

_____

Please provide details about your use of these drugs or other chemicals, such as amounts, how often do you use them, their effects, and so forth: _____

_____

Legal History:

Are you presently suing anyone or thinking of suing anyone? ☐ Yes ☐ No
Is your reason for coming to see us related to an accident or injury? ☐ Yes ☐ No
Is your appointment required by a court/police/probation/office/parole? ☐ Yes ☐ No
If you answered yes to any of the above questions, please explain: _____

_____

_____

Your current attorney's name: _____ Phone: _____

Please list all the contacts with the police, courts, and jails/prisons you have had. Include all open charges and pending ones using the following letters:
Jurisdiction: (F=Federal, S = State, Co = County, Ci = City)
Sentence: Time served and type of sentence (AR = accelerated or alternate resolution, CS = community service, F = fine, I = incarceration, Pr = probation, Po = parole, O = other, R = restitution)

Date Charge Jurisdiction Sentence Probation/Parole Officer Your Atty's Name

_____

_____

_____

Are there any other legal involvements that we should know about? _____

_____

Current medications:

Name Dosage Reason for taking

_____

_____

_____

Other:

Is there anything else you feel is important for your therapist to know that we have not asked about on these forms?

_____

_____

_____

Patient Signature: _____ **Date:** _____

Health Assessment Patient Questionnaire

Name: _____ Date: _____

Background Information

Age: _____ Birth date: _____ Preferred phone number: _____

E-mail: _____ Occupation: _____

Work hours: _____ Marital status: _____

Highest level of education: _____

Please list the people in your household and their relationships to you: _____

_____

General Health Information

Physician's name: _____ Physician's phone: _____

Physician's address: _____

Date of most recent physical exam: _____ Date of most recent blood tests: _____

How do you rate your health? _____ Poor _____ Fair _____ Good _____ Excellent

Height: _____ Weight: _____

Review of Systems (circle all that you currently have or are concerned about)

Respiratory

Shortness of breath	Emphysema	Disturbed sleep
Coughing	Snoring	Sleep apnea
Asthma or wheezing	Daytime sleepiness	History of pneumonia, chronic bronchitis, or COPD

Cardiovascular

High blood pressure	Heart murmur	Ankle or feet swelling
Heart disease/heart attack	Irregular heartbeat or palpitations	Varicose veins
Congestive heart failure	Chest pain or discomfort	Blood clots or clotting disorders

Gastrointestinal

Nausea/vomiting	Ulcer disease	Diarrhea
Abdominal/stomach pain	Rectal bleeding or blood in stools	Gallbladder disease/gallstones
Heartburn/acid reflux	Hemorrhoids	Celiac disease
Belching/burping	Constipation	Hernia

Genitourinary

Difficulty urinating	Inability to empty bladder fully	Sexual problems
Urinary incontinence (leaking urine)	Recurrent urinary tract infections (UTIs)	Abnormal menstrual periods
	Infertility	Enlarged prostate

Musculoskeletal

Aching muscles or joints	Lower back pain/disc problems	Arthritis

Endocrine

Diabetes mellitus	Thyroid disease	High triglycerides
High cholesterol	Gout	

Skin and Hair

Skin sores or infections (boils, ulcers, skin fold irritations)	Chronic rashes or dermatitis or eczema	Excessive facial/ body hair (women only)
Bruises easily		

Other

Low energy level	Obsessive-compulsive disorder (OCD)	Binge eating
Depression		Bulimia
Bipolar disorder	Psychological or psychiatric care	Anorexia
Attention deficit disorder (ADD) or attention deficit and hyperactivity disorder (ADHD)	History of child abuse, rape, or molestation	Anemia
		Headaches or migraines
Anxiety disorder or panic attacks	History of being subjected to any physical or verbal abuse	

Cancer (list type): _____

Other serious medical conditions (list types): _____

Do you have a family history of any of the following? (Circle all that apply)

High blood pressure, high blood cholesterol, diabetes, thyroid disease, obesity, heart disease, cancer, other (list):

_____

List the types of surgeries you have had: _____

_____

How often do you use tobacco? _____ How often do you drink alcohol? _____

How many hours of sleep do you average per night? __ _ __ Is your sleep restful? Yes No

On a scale from 1 (low stress) to 5 (high stress), how would you rate your daily stress level?

1 2 3 4 5

How do you cope with stress in your daily life? _____ _____ _____ _____

_____

Please list any religious practices that affect your health care or diet:

_____

List all prescription and over-the-counter medications that you currently take (include the dosages):

_____

_____

_____

List all vitamins, minerals, supplements, and herbs that you take:

_____

_____

On a scale of 1 (not ready) to 5 (very ready), how ready are you to make lifestyle changes?

1 2 3 4 5

On a scale of 1 (not at all confident) to 5 (very confident), how confident are you to make lifestyle changes?

1 2 3 4 5

What makes it hard for you to lose weight and keep it off? _____

_____

_____

Nutrition Information

What one or two things would you like to change about your diet? _____

_____

In the following chart, describe when and what you usually eat in a typical day. (Write "None" if you do not eat that meal or snack.)

Meal	Time	Foods Eaten/Amount
Breakfast		
Snack		
Lunch		
Snack		
Dinner		
Snack		

Physical Activity Information

What is the most physically active thing you do in an average day? _____

_____

What, if any, regular exercises do you do? How often and for how long do you participate? _____

_____

Do you know of any reason(s) why you should not do physical activity? If yes, please explain the reasons.

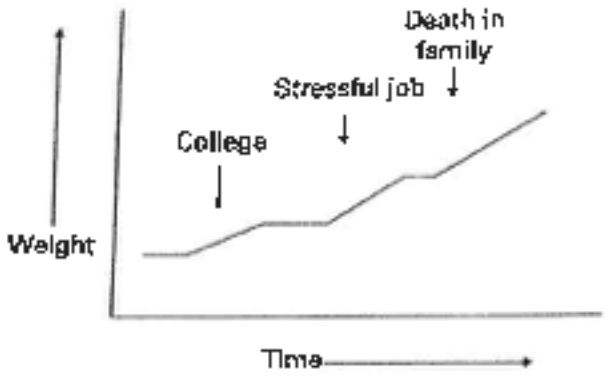
_____

_____

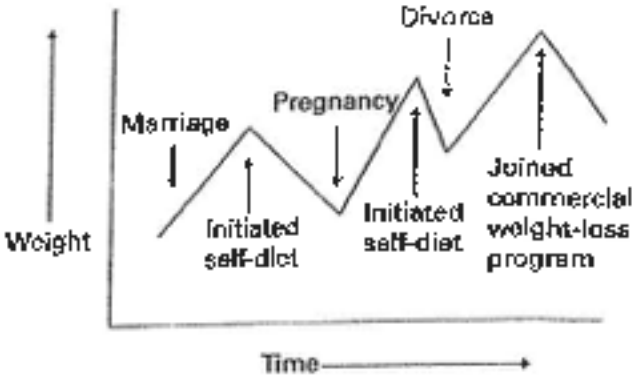
Weight History Graph

Most people can relate changes in their weight to different life events. The following graphs illustrate two examples of how people have gained weight.

Progressive (or Ratcheting) Weight Gain



Weight Cycling or "Yo-Yo" Weight Gain



Please draw a graph of your weight gain. Mark *life events* and *diet attempts* that have contributed to your current weight.