REIF BEHAVIORAL SOLUTIONS

Applying the Science of Psychology to Life

Patient Name: _____ Date: _____

Patient Birthdate: _____ Patient Gender: _____M _____ F

Patient Address: _____

_____

Patient Social Security Number: _____-_____-_____

Patient Phone Numbers: (_____)_____-_____ (_____)_____-_____ (_____)_____-_____
Home **Work** **Cell**

Patient Status: _____ Single _____ Married _____ Full-time Student
_____Employed _____ Child _____ Part-time Student

Name of Insurance Company: _____

Do you intend to file insurance claims for treatment?: _____

If yes, do you know what documentation your insurance company is requesting? _____
_____

****Please be reminded that this is a fee for service practice. Payment is expected upon completion of each session. You will be provided with necessary paperwork to file a claim on your own if you so choose. ********

How did you hear about Reif Behavioral Solutions? Is there someone we can thank for referring you?
_____

Emergency Contact Information:

Emergency Contact: _____ Relationship: _____

Emergency Telephone Numbers: (_____)_____-_____ (_____)_____-_____ (_____)_____-_____
Home **Work** **Cell**

Agreement to Pay for Professional Services

I request that the therapist named below provide professional services to me or to _____, who is my _____, and I agree to pay this therapist's fee of $ 175 per session for these services.

I agree that this financial relationship with this therapist will continue as long as the therapist provides services or until I inform him or her, in person or by phone or mail,that I wish to end it. I agree to meet with this therapist at least once before stopping therapy. I agree to pay for services provided to me (or this client) up until the time I end the relationship.

I agree that I am responsible for the charges for services provided by this therapist to me (or this client), although other persons or insurance companies may make payments on my (or this client's) account. I understand that I will be charged for the full SESSION, NOT JUST THE CO-PAY for any sessions cancelled less than 24 hours in advance.

I have also read this therapist's "Client Information Contract" and agree to act according to everything stated there, as shown by my signature below and on the brochure.

_____ _____

Signature of client (or person acting for client) Date

_____

Printed name

I, the therapist, have discussed the issues above with the client (and/or the person acting for the client). My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Signature of therapist Date

❑ Copy accepted by client ❑ Copy kept by therapist

Consent to Treatment

I acknowledge that I have received, have read (or have had read to me), and understand the "Client Information Contract" brochure and/or other information about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I know that I must call to cancel an appointment at least 48 hours (2 days) before the time of the appointment. If I do not cancel and do not show up, I will be charged for that appointment.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

My signature below shows that I understand and agree with all of these statements.

_____ _____

Signature of client (or person acting for client) Date

_____ _____

Printed name Relationship to client (if necessary)

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Signature of therapist Date

❑ Copy accepted by client ❑ Copy kept by therapist

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.

PATIENT HISTORY FORM

1. What kind of problems are you having? _____

_____

2. When did these problems first start? _____

_____

3. What methods (if any) have you used to resolve these problems? _____
4. Have you ever had any treatment/therapy for depression, addictions or emotional problems? Yes No

5. Years of High School _____ Graduated? Yes No
   Years of College _____ Graduated? Yes No
   Highest degree obtained _____

6. The longest ***job*** you ever held was _____

_____

7. Military Experience? Yes No Branch for _____ years _____ Discharge

8. Religious affiliation: _____ Regular attendance? Yes No

9. Have you ever had any ***legal problems*** (including DUI's), trouble with the police, or juvenile authorities?
   (if yes, please explain) _____

10. What situations may be causing ***stress*** in your life currently? (e.g. illness, job, recent loss, family fights)

_____

11. How well do you think you are ***coping***? (e.g. fair, poorly, well, very well) _____

_____

12. Please list your ***strengths***, interests and things that make you proud: _____

_____

13. Please list below everyone who is living in the home:

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

14. Have any of your blood relatives had any ***emotional or addictive*** problems? (if yes, who and what were the problems?) _____

15. Have any of your blood relatives had ***heart problems*** or died suddenly from unknown causes? (if yes, who and describe the problem)

16. List any current or past ***medical problems***: (e.g. anemia, cancer, diabetes, alcoholism, liver disease, high blood pressure, headaches, stomach aches, heart problems, drug problems, sexual problems, surgery, etc.) Please note "past," if you no longer have that problem

17. List any family medical problems that you feel may be relevant: _____

18. Do you or have you engaged in any "high risk" activities for HIV infection (AIDS)? _____

19. Any current medication or treatments? _____

Medication	Amount	Times Per Day	Reason	Doctor

20. Do you use ***drugs and/or alcohol*** now, or have you in the past? _____

21. Have you ever ***fainted or blacked out*** after being hit in the head, had seizures, or seen a Neurologist? _____

22. How would you describe your ***diet***? _____

How many ***caffeinated beverages*** do you drink per day?

12 oz. beverages (e.g. Coke)_____ Cups of Coffee_____ Cups of Tea_____

23. ***For women only*****:** Last menstrual period: _____ Any menopausal symptoms or date of menopause: _____

PMS symptoms? _____ Method of birth control? _____

# of live births: _____ # of pregnancies: _____

24. Was there anything unusual about your own birth or your mother's pregnancy with you? _____

25. During the first six years of your life, did you have a problem with ***growth, eating, or coordination***? _____

26. List any serious medical problems: Birth - Age 3: _____
    Age 3 - 5: _____
    Age 5 - 18: _____

27. Did you have any difficulty adjusting to being ***away from home***? (when you started school, pre-school, went to camp, overnight to the house of a friend or relative, moved away to college, got married) _____

28. List any serious ***losses, abuse, or other painful experiences***: _____
    _____

29. At what age did you first decide there may a ***problem*** and why? _____
    _____

30. Describe your ***temperament***: _____

31. Did you go through a ***parental divorce or separation***? If so, what year? _____

32. Describe your relationship with your ***family of origin***: _____

33. Describe your ***support system***: _____

34. What would you like to accomplish in therapy? _____
    _____

35. Please indicate and rate severity (1-4)

1 - None	**2 - Mild**	**3 - Moderate**	**4 – Severe**
____Depression		_____Lack of Friends	_____Marriage/relationship issues
____Anxiety		_____Controlling stress	_____Loneliness
____Sexuality/sexual issues		_____Family conflict	_____Loss of a loved one
____Problems coping		_____Abuse/victimization	_____Behavioral problems
____Problems at school		_____Problems at work	_____Eliminating a drug/alcohol habit
____Financial problems		_____Legal matters	_____Eliminating another habit (overspending, overeating, etc)

Other: _____

36. Past psychiatric admissions/alcohol or drug treatment

Most recent:

Date:_____ Length of stay:_____

Type of admission (impatient, partial hospitalization, day treatment): _____

Others: _____

37. ***Past outpatient therapy***: Therapist(s) Start and end dates

38. Please indicate how the issue(s) for which you are seeking treatment are affecting the following areas of your life:

	No effect	**Little effect**	**Some effect**	**Much effect**	**Significant effect**	**N/A**
Marriage/Relationship	1	2	3	4	5	6
Family	1	2	3	4	5	6
Job/School Performance	1	2	3	4	5	6
Friendships	1	2	3	4	5	6
Financial Situation	1	2	3	4	5	6
Physical Health	1	2	3	4	5	6
Anxiety level/nerves	1	2	3	4	5	6
Mood	1	2	3	4	5	6
Eating Habits	1	2	3	4	5	6
Sleeping Habits	1	2	3	4	5	6
Sexual Functioning	1	2	3	4	5	6
Ability to Concentrate	1	2	3	4	5	6
Ability to Control Temper	1	2	3	4	5	6
Spirituality	1	2	3	4	5	6