

EMOTIONAL/PSYCHIATRIC HISTORY

Has the client had outpatient psychotherapy? No Yes *If yes, please explain below:*

Previous Provider Name and Agency: _____

City: _____ State: _____ Phone No. (____) _____

Month/Year: ____/____ to Month/Year: ____/____ Diagnosis: _____

Treated for: _____ Beneficial? No Yes

PRESENTING PROBLEM

Please check all that are areas of concern for the client:

- | | |
|---|--|
| <input type="checkbox"/> Addiction and/or Substance Abuse | <input type="checkbox"/> Medical Issues |
| <input type="checkbox"/> Anger Management Problems | <input type="checkbox"/> Memory Problems |
| <input type="checkbox"/> Anxiety, Stress, and/or Panic | <input type="checkbox"/> Mood Problems/Mood Swings |
| <input type="checkbox"/> Attachment Problems | <input type="checkbox"/> Obsessions and/or Compulsions |
| <input type="checkbox"/> Behavior/Conduct Problems | <input type="checkbox"/> Parenting |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Relationship Concerns/Conflict |
| <input type="checkbox"/> Domestic Violence | <input type="checkbox"/> Sexual Concerns and/or Dysfunction |
| <input type="checkbox"/> Eating Problem/Disorder | <input type="checkbox"/> Sleep Difficulties/Disturbance |
| <input type="checkbox"/> Grief/Loss | <input type="checkbox"/> Social Discomfort/Isolation |
| <input type="checkbox"/> Irritability/Agitation | <input type="checkbox"/> Suicidal and/or Homicidal Thoughts* |
| <input type="checkbox"/> Low Self-Esteem | <input type="checkbox"/> Trauma |

Does the client have additional primary concerns or symptoms not previously identified in the prior list? No Yes *If yes, please explain below:*

*** Suicidal and/or Homicidal Thoughts**

If the client is experiencing suicidal and/or homicidal thoughts at this time, please explain below:

Victim of Abuse

Has the client ever been a victim of physical, emotional, and/or sexual abuse? No Yes

If yes, feel free to explain below:

MEDICAL HISTORY

Overall, how is the client's current health? Excellent Good Fair Poor

Has the client received a thorough medical exam within the past year? No Yes

If yes, please complete the following information:

Provider: _____ Month/Year of Exam: ____/____

Findings: Normal Abnormal *If abnormal, explain below:*

Has the client had any serious accidents, surgeries, and/or hospitalizations within the past year? No Yes *If yes, please explain below:*

Females Only:

Is the client pregnant? N/A No Yes

If so, how far along is the pregnancy? _____ weeks/months

MEDICATION INFORMATION

Is the client currently taking any medication? No Yes If yes, explain below:

Medication Name _____	Dosage _____	Prescribed For _____	No <input type="checkbox"/> Yes <input type="checkbox"/> Beneficial?
Medication Name _____	Dosage _____	Prescribed For _____	No <input type="checkbox"/> Yes <input type="checkbox"/> Beneficial?
Medication Name _____	Dosage _____	Prescribed For _____	No <input type="checkbox"/> Yes <input type="checkbox"/> Beneficial?
Medication Name _____	Dosage _____	Prescribed For _____	No <input type="checkbox"/> Yes <input type="checkbox"/> Beneficial?
Medication Name _____	Dosage _____	Prescribed For _____	No <input type="checkbox"/> Yes <input type="checkbox"/> Beneficial?
Medication Name _____	Dosage _____	Prescribed For _____	No <input type="checkbox"/> Yes <input type="checkbox"/> Beneficial?

Does the client have any additional issues or concerns not previously identified by any of the prior questions? If so, please explain below:

INFORMED CONSENT

The client requests and consents to the following services:

- Mental health evaluation
- Counseling/Psychotherapy (individual, couples, family, or group)
- Psychosexual evaluation, interpretation of results, & preparation of reports
- Substance abuse/addiction evaluation, interpretation of results, & preparation of reports
- Family systems evaluation, interpretation of results, & preparation of reports
- Child custody evaluation, interpretation of results, & preparation of reports
- Educational services
- Other services: _____

The client understands that s/he may withdraw from treatment at anytime. However, if the client decides to do this, the client will discuss that plan with the representative of Compass Professional Services LLC before acting on it. Compass Professional Services LLC has further disclosed to the client scheduling, fees, and policies regarding confidentiality, payment, missed appointments, matters relating to insurance, and if applicable, preauthorization and utilization reviews.

Some important issues regarding confidentiality need to be understood as we begin our work together. In general, the confidentiality of all communications between a client and Compass Professional Services LLC is protected by law, and a representative of Compass Professional Services LLC can only release information about services to others with a client's written permission. The client has been provided the opportunity to review and/or obtain a copy of the privacy policy as it relates to rights covered by HIPAA.

In addition, there are some circumstances when a representative of Compass Professional Services LLC is required to breach confidentiality without a client's permission. This occurs if a representative of Compass Professional Services LLC suspects the neglect or abuse of a minor

or a dependent adult, in which case, the representative of Compass Professional Services LLC must file a report with the appropriate state agency. If, in his/her professional judgment, a representative of Compass Professional Services LLC believes that a client is threatening serious harm to another, s/he is required to take protective action, which may include notifying the police, warning the intended victim, or seeking the client's hospitalization. If a client threatens to harm him/herself, a representative of Compass Professional Services LLC may be required to seek hospitalization.

The clear intent of these requirements is that Compass Professional Services LLC has both a legal and ethical responsibility to take action to protect endangered individuals from harm when his/her professional judgment indicates that such danger exists. Fortunately, these situations rarely arise in our practice.

There are other matters concerning confidentiality. The therapist may occasionally find it helpful or necessary to consult about a case with another professional in our group. In these consultations, we make every effort to avoid revealing the identity of the client. The consultant is, of course, also legally bound to maintain confidentiality. If we feel that it would be helpful to refer you to another professional for consultation, then, of course, with your authorization, we will discuss your case with him/her.

I/we have completed the above to the best of my/our ability. I/we fully understand the importance and terms of this relationship and the circumstances in which the confidential communications may need to be breached. I/We therefore consent to the professional services of Compass Professional Services LLC.

_____	____/____/____
Client Signature	Date
_____	____/____/____
Client/Partner Signature	Date
_____	____/____/____
Parent/Legal Guardian Signature <i>mandatory if client is a minor</i>	Date
_____	____/____/____
Therapist/Representative of Compass Professional Services LLC	Date