Client Name:_____ Date Completed: _____
Client Age:_____

Reason for Seeking Treatment: _____

_____

_____

_____

Rate Intensity of Presenting Problem: 1 2 3 4 5 6 7 8 9 10

During the past TWO WEEKS, how much or how often have you been bothered by the following problems?

	None	**Slight** Rare	**Mild** Several Days	**Moderate** More than half the Days	**Severe** Nearly every Day
Little interest or pleasure in doing things?	0	1	2	3	4
Feeling down, depressed, or hopeless?	0	1	2	3	4
Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4
Sleeping less than usual, but still having a lot of energy?	0	1	2	3	4
Starting lots more projects than usual or Doing more risky things than usual?	0	1	2	3	4
Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4
Feeling panic or being frightened?	0	1	2	3	4
Avoiding situations that make you anxious?	0	1	2	3	4
Unexplained aches and pains (e.g., head, back, joints, abdomen, legs?)	0	1	2	3	4
Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4
Thoughts of actually hurting yourself?	0	1	2	3	4
Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4

Client Name: _____

Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4
Problems with sleep that affected your sleep quality overall?	0	1	2	3	4
Problems with memory (e.g., learning new information) or with location (e.g,. finding your way home)?	0	1	2	3	4
Unpleasant thoughts, urges, or images that repeatedly entered your mind?	0	1	2	3	4
Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4
Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4
Not knowing who you really are or what you want out of life?	0	1	2	3	4
Not feeling close to other people or enjoying your relationship with others?	0	1	2	3	4
Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4
Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4

Prior Therapy: ___ ___ With Whom: _____
_____
Dates: _____
Diagnoses: _____

Psychiatric Hospitalization: ___ ___ Where? _____
When? _____
How Long? _____

Current Medications: Name	Dosage	Date Begun	Prescribed By
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medical Conditions:	Yes	No	Explanation:
Hepatitis:	___	___	_____
Thyroid Disease:	___	___	_____
HIV/AIDS:	___	___	_____
Diabetes:	___	___	_____
Heart Disease:	___	___	_____
Gastrointestinal:	___	___	_____
Seizures:	___	___	_____
Migraines:	___	___	_____
Cancer:	___	___	_____
Drug Allergies:	___	___	List: _____
			_____
Other Medical Conditions:	___	___	_____
Hospitalizations:	___	___	Reason: _____
			_____
			When? _____

Family History:

Have members of your family ever had any of the following problems? Include parents, grandparents, uncles, aunts, brothers, sisters, and children.

Depression:	___	___	_____
Anxiety:	___	___	_____
Manic Depression/Bipolar	___	___	_____
Suicide Attempt:	___	___	_____
Completed Suicide:	___	___	_____
Learning Disability:	___	___	_____
Schizophrenia:	___	___	_____
Alcohol Abuse:	___	___	_____
Drug Abuse:	___	___	_____

CONSENT FOR TREATMENT
AND
RECEIPT OF NOTICE OF PRIVACY PRACTICES

This form is an agreement between you, _____, and Joy D. Bennett, LISW. The word "you" also may mean your child or dependent. If you are not the client, write the client's name here: _____.

When I examine, diagnose, treat, or refer you, I will be collecting what the law calls Protected Health Information about you. I use this information to decide on what treatment is best for you and to provide treatment to you. I may also share this information with others who provide treatment to you or need to arrange payment for your treatment or for other business functions.

By signing this form you are agreeing to let me use your information and send it to others who are responsible for your treatment, payment for services, or for administrative functions. The Notice of Privacy Practices explains in more detail your rights and how I can use and share information. Please read this Notice before you sign this Consent form.

If you do not sign this Consent form agreeing to what is in the Notice of Privacy Practices I cannot treat you.

In the future I may change how I use and share your information and so may change the Notice of Privacy Practices. If I do change it, you can ask me for a copy and I will give one to you.

If you are concerned about some of your information, you have the right to ask me to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell me what you want in writing. Although I will try to respect your wishes, I am not required to agree to these limitations. However, if I do agree, I promise to comply with your wish.

After you have signed this Consent form, you have the right to revoke it by writing a letter telling me you no longer consent. If consent is revoked, treatment will be terminated. I may already have used or shared some of your information, and that cannot be changed.

Signing this form also acknowledges that you received a copy of the Notice of Privacy Practices.

If you fail to notify me of a cancellation without 24 hours notice, you will be CHARGED.

_____ _____
Signature of client or guardian Date

_____ _____
Print name of client or guardian Relationship to the client