example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)

- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. On your request, I will discuss with you the details of the request process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychotherapist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will inform you in a written letter sent by mail to the address we have on file for you.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact Dr. Maribeth Sadie, 262-782-2090

If you believe that your privacy rights have been violated and wish to file a complaint with my office, you may send your written complaint to Dr. Maribeth Sadie, Trillium Care Group, LLC., 2363 S. 102nd Street, Ste 301, West Allis, WI 53227

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on January 1, 2004

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by written letter.

Ψ

Please sign an acknowledgement indicating that you have received this Notice. See your therapist or receptionist. Thank you.

WISCONSIN HIPAA NOTICE

Notice of Psychotherapists' Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Trillium Care Group, LLC.
2363 S. 102nd Street, Suite 301
West Allis, WI 53227
262-782-2090

WISCONSIN HIPAA NOTICE

Notice of Psychotherapist's Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information (PHI)*, for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- *"PHI"* refers to information in your health record that could identify you.
- *"Treatment, Payment and Health Care Operations"*
  - *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychotherapist.
  - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within my clinic, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my clinic, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If I have reasonable cause to suspect that a child seen in the course of my professional duties has been abused or neglected, or have reason to believe that a child seen in the course of my professional duties has been threatened with abuse or neglect, and that abuse or neglect of the child will occur, I must report this to the relevant county department, child welfare agency, police, or sheriff's department.
- **Adult and Domestic Abuse:** If I believe that an elder person has been abused, or neglected, I may report such information to the relevant county department or state official of the long-term care ombudsman.
- **Health Oversight:** If the Wisconsin Department of Regulation and Licensing requests that I release records to them in order for the Psychology Examining Board to investigate a complaint, I must comply with such a request.
- **Judicial or administrative proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law and I will not release the information without written authorization from you or your personal or legally-appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance, if this is the case.
- **Serious Threat to Health or Safety:** If I have reason to believe, exercising my professional care and skill, that you may cause harm to yourself or another, I must warn the third party and/or take steps to protect you, which may include instituting commitment proceedings.
- **Worker's Compensation:** If you file a worker's compensation claim, I may be required to release records relevant to that claim to your employer or its insurer and may be required to testify.

IV. Patient's Rights and Psychotherapist's Duties

Patient's Rights:

- *Right to Request Restrictions* You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For

Therapist: _____ **Trillium Care Group, LLC.**
Diagnosis: _____ **West Allis**

CLIENT INFORMATION SHEET- ***CONFIDENTIAL***

Date: _____ **Referral Source/Name:** _____

Client Name: _____
(Last) **(First)** **(Middle Initial)**

Address: _____ **City:** _____ **State:** ___ **Zip:** _____

Home Phone: _____ **Wk #:** _____ **Cell #:** _____

Email address _____

Marital Status: _____ **Sex:** ____ **Soc Sec#** _____ **DOB** _____ **Age:** _____

EmployerName/Address: _____

Is this a worker's comp claim? _____ **If so, list the date of injury:** _____

EMERGENCY CONTACT: _____ **Home Phone:** _____

Work Phone: _____ **Cell:** _____

Person Financially Responsible/**Insurance holder**: _____ Birth date _____

Relationship to client _____ Employer _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Cell: _____ Work Phone: _____

Please provide INSURANCE CARD (s)

Dependent Children:

Names Birth date Names Birth date

_____

_____

_____

Primary Care Physician's Name: _____

Address: _____

State: _____ Zip: _____ Phone: _____

over

PATIENT ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION

I acknowledge that I have received a copy of the patient bill of rights and the informed consent for treatment form. I hereby agree to treatment and understand that if I have questions, I will contact my therapist or the clinic staff.

I hereby authorize any insurance carrier to make payment directly to Trillium Care Group, LLC. of any benefits otherwise payable to me for services provided by any member of Trillium Care Group, LLC. professional staff. I understand that I am financially responsible for all charges whether or not paid by my insurance company (s).

I authorize Trillium Care Group, LLC. to release to my insurance company (s) any information from my record which may be necessary to determine benefits payable under my policy. This information may include, but is not limited to diagnosis, treatment procedure and/or photocopies of all or part of my record.

I, _____, understand that Trillium Care Group is a collaborative clinic and as such, my therapist may seek consultation with other Trillium psychotherapists regarding my treatment, progress, etc.

Confidentiality will be strictly maintained under the guidelines of professional ethics and the procedures defined by my insurance program.

_____

Patient/Guardian Signature

_____

Witness Signature

_____

Therapist Signature

_____

Date

ATIENT RIGHTS

hen you receive services for ental health, alcoholism, drug use or developmental disability, an inpatient or outpatient, you ve certain rights under Wisconsin lministrative Code (HSS 94). me of these rights may be stricted or denied for treatment or curity reasons. If any of your ghts are denied, you must be formed of these reasons for doing . You may ask to talk to staff out limitations of your rights.

ie facility providing the services ist post copies of the patient ghts in a place where everyone n easily see them. You should so keep this copy.

ERSONAL RIGHTS:

You must be treated with dignity and respect, free of any verbal or physical abuse.
You have the right to have staff make fair and reasonable decisions about your treatment and care.
You can decide whether you want to participate in religious services.
You cannot be made to work except for personal housekeeping chores. If you agree to do work, you must be paid.
You can make your own decisions about things like getting married, voting, and writing a will.
You cannot be treated differently because of your race, national origin, sex, age, religion, disability or sexual origination.
Your surroundings must be kept safe and clean.

TREATMENT AND RELATED RIGHTS:

- You must be provided prompt and adequate treatment,
- rehabilitation and educational services appropriate for you.
- You must be allowed to participate in the planning of your treatment and care.
- You must be informed of your treatment and care, including alternatives and possible side effects of medications.
- No treatment or medication may be given to you without your consent, unless it is needed in an emergency to prevent serious physical harm to you or others, or a court orders it. [If you have a guardian, however, your guardian can consent to treatment and medications on your behalf.]
- You must not be given unnecessary or excessive medication.
- You cannot be subject to electro-convulsive therapy or any drastic treatment measures such as experimental research without your written informed consent.
- You must be informed of any costs of your care and treatment that you or your relatives may have to pay.
- You must be treated in the least restrictive manner and setting necessary to safety and appropriately meet your needs.

COMMUNICATION AND PRIVACY RIGHTS:

- You may call or write public officials or your lawyer or advocate.
- You may not be filmed or taped unless you agree to it.
- You may use your own money as you choose, within some limits.

RECORD PRIVACY AND ACCESS LAWS:

- Your treatment information must be kept private (confidential).
- Your records cannot be released without your consent, unless the law specifically allows for it.
- You can ask to see your records. You must be shown any records about health or medications. Staff may limit how much you can see of the rest of your records while you are receiving services. You must be informed of the reasons for any such limits. You can challenge those reasons in the grievance process. After discharge you can see your entire records if you ask to do so.
- If you believe something in your records is wrong, you can challenge its accuracy. If staff will not change the part of your record you have challenged, you can put your own version in the record.

RIGHT OF ACCESS TO COURTS:

- You may sue someone for damages or other court relief if they violate any of your rights.

NOTICE TO ALL CHEMCIAL DEPENDENCY PATIENTS:

The confidentially of alcohol and drug abuse patient records maintained by this program is protected by Federal Law and Regulations.
Generally, the program may not say to a person outside the program that a patient attends the program or disclose any information identifying a patient as an alcohol or drug abuser UNLESS:

1. The patient consents in writing; or
2. The disclosure is allowed by a court order; or
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research audit or program evaluation.

The confidentiality of communication between patients and staff and all information recorded in the patient file shall be the responsibility of all staff (in accordance with 42 CFR Part II, and Section 51.30 Wisconsin Statutes.)

Violation of federal Law and Regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal Regulations.

Federal Laws and Regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime.

Federal Laws and Regulations do not protect any information about suspected child abuse or neglect from being reported under State Law to State or Local authorities.

Clinic Rules and Regulations
The patient is responsible for following clinic rules and regulations affecting patient care and conduct. Any information that patients learn about other patient's families is confidential, and may not be discussed with anyone, except during treatment groups or activities with authorized personnel.

Respect and Consideration
The patient is responsible for being considerate of the rights of other patients and clinic personnel and for assisting in the control of noise.

The patient is responsible for being respectful of the clinic. Patients will be held financially responsible for any property that is destroyed.

GRIEVANCE RESOLOUTION PROCESS:

- If you feel your rights have been violated, you may file a grievance.
- You cannot be threatened or penalized in any way for filing a grievance.
- The service provider or facility must inform you of your rights and how to use the grievance process.
- You may, at the end of the grievance process or any time during it, choose to take the matter to court.

Contact your Client Rights Specialist, whose name is shown below, to file a grievance or to learn more about the specific grievance process used by the agency from which you are receiving services.

YOUR CLIENT RIGHTS SPECIALIST IS:

Maribeth Sadie
NAME

262-782-2090
TELEPHONE

Client Signature

Date

Witness

Date

Trillium Care Group, LLC.

FINANCIAL POLICY AND AGREEMENT

Welcome to Trillium Care Group, LLC. Thank you for choosing us as your health care provider. We look forward to providing you quality treatment and professional service. Please understand that payment of your bill is considered a vital part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to your treatment. Please let us know if you have any questions or concerns.

Regarding Insurance and Managed Care

We may accept assignment of insurance benefits. If you are covered by insurance we will bill your insurance company if you provide us with your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event that we do accept assignment of benefits, we will give you credit for the amount covered by insurance. If your insurance company has not paid your account in full within 60 days, the balance will automatically be transferred to you. Please be aware that the cost of the services provided will become your responsibility if covered in part or not at all by your insurance company. **In addition, you are expected to pay the difference between the amount covered and amount owed each time you come for an appointment.** All co-pays and deductibles are due at the time of treatment. If you are a subscriber to a managed care policy, it is your responsibility to ensure that the first session is authorized by your insurance company. We also request that you understand the requirements of your insurance carrier and inform us of what procedures we must comply with to ensure payment. **While our therapists may be members of several managed care networks, it is your responsibility to ensure that your therapist is a provider for your individual policy.**

Monthly Statements

All monthly statements are due in full upon receipt unless prior arrangements have been made with your therapist. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

If your account is overdue (unpaid) and there is no written agreement on a payment plan, (therapist) can use legal or other means (courts, collection agencies, etc.) to obtain payment.

Missed Appointments

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of **$ 125.00 per session.** Insurance carriers will not pay for missed or cancelled appointments. Please help us serve you better by keeping scheduled appointments.

Fee Agreement

The agreed upon fee for professional services is:

$ _____ for initial session and $ _____ per 40-45-minute sessions.

I agree to pay a minimum of $ _____ toward the professional fees at each session. This includes any co-payment or deductible of which I am aware.

Telephone conversations, site visits, report writing and reading, consultation with other professionals, longer sessions, travel time, etc. will be charged at the same rate, unless indicated and agreed in writing upon otherwise. Please notify therapist if any problems arise during the course of therapy regarding your ability to make timely payments.

I have read the financial policy. I understand and agree to this policy. I also hereby authorize my insurance benefits to be paid directly to Trillium Care Group, LLC. and acknowledge that I am financially responsible for any unpaid balance.

Signature of Patient or Responsible Party **Date**

TRILLIUM CARE GROUP

INFORMED CONSENT FOR TREATMENT

I want you to be aware of your rights as a client and ask for your informed consent to receive treatment. Please be aware of my practice regarding confidentiality of your health information. Your rights as a patient are shown below. My privacy practices are shown in a separate document provided to you.

(A) The benefits of being a recipient of services may include, but are not limited to, being better able to meet your personal needs: improved communication skills, clearer thought process, and more stable mood.

(B) Services provided may include psychiatric assessment, case management, group, individual, family, and couples therapy. If medication is a part of your treatment program, the purpose of the medications will be discussed with you by your psychiatrist.

(C) The risks of receiving services may include feelings of anxiety, depression, frustration, loneliness, helplessness or other intense emotions when you discuss life problems or experience with your treatment providers. Certain medications may have common side effects that will be discussed with you at the time that you see the psychiatrist for a medication evaluation. It is your right, unless under court order, to decide whether or not you want to take any medication.

(D) If you disengage from services or elect not to participate, it is possible your problems may not be addressed or may become worse than they are at the present time.

(E) The treatment staff may suggest alternate treatment modes and will make referrals to other services when appropriate or necessary.

(F) You may be discharged from treatment for failure to follow through with treatment recommendations, failure to show up for appointments or abuse of medication.

(G) Services never involve sexual contact between therapist and client; this is unethical and against the law.

(H) This informed consent will be in effect no longer than fifteen months from the time that consent is given.

(I) You have a right to withdraw this informed consent, in writing, at any time.

DENIAL OF PATIENT RIGHTS

Your rights may only be denied in certain circumstances such as:

(1) When there is a danger to life or health of the client or potential harm to others.
(2) Suspected cases of child abuse or neglect (s.48.98)
(3) A lawful order of the court to which you must comply.

By my signature below, I attest that my rights as a patient have been explained to me and I give my consent for treatment. I have also received a copy of the Rights and the Grievance Procedure, and a copy of the Notice of Privacy Practices. My signature below also confirms that I have received the Notice of Privacy Practices under HIPAA and I have been provided an opportunity to review it.

_____ _____
Client/ Guardian Signature* Date

_____ _____
Client's Name (Please Print) Date of Birth

_____ _____
Witness Date

*If client does not sign, please document reason: _____

_____

Communication by Email, Text Message, and other non-secure means

It may become useful during the course of treatment to communicate by email, text message (e.g., "SMS") or other electronic methods of communication. Be informed that **these methods**, in their typical form, **are not confidential means of communication.** If you use these methods to communicate with your Trillium therapist, there is a reasonable chance that a third party may be able to intercept and eavesdrop on those messages.

The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages
- Your employer, if you use your work email to communicate with your Trillium therapist
- Third parties on the internet such as server administrators and others who monitor internet traffic

Consent for Transmission of Protected Health Information by non-secure means

I consent to allow my Trillium therapist to use unsecured email and mobile phone text messaging to transmit to me the following protected health information:

- Information related to the scheduling of meetings or other appointments
- Information related to billing and payment

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that **I am not required to sign this agreement in order to receive treatment.** I also understand that I may terminate this consent at any time.

_____ _____

Client Signature Date

NAME TRILLIUM CARE GROUP

_____

HEALTH HISTORY QUESTIONNAIRE

1. Please list all current medications you are taking for either physical or emotional difficulties.

_____

_____

2. Allergy (Medications):

_____

3. Current Medical/ Emotional Conditions (Please check)

____Anxiety	____Diabetes	____Sleep Disturbance
____Allergies	____Epilepsy/Seizure Disorder	____Stomach Problems
____Asthma	____Frequent Constipation	____Skin Problems
____Arthritis	____Frequent Headaches	____Sexually Transmitted Diseases
____Back Trouble	____Fatigue	____Vision Problems
____High Blood Pressure	____Hay Fever	____Weight Loss
____Cancer	____Heart Problems	____Smoker / Amount per day__
____Depression	____Irritable Bowels	____Other _____

Is there any family history of the above conditions? _____

4. Medical Doctor: _____ Last Physical Examination: _____

Are you currently being treated? _____ Problem: _____

Date Last Seen: _____

5. Have you ever previously been seen for outpatient therapy?
(Please list previous therapists and reasons seen.)

_____

_____

Have you been previously hospitalized for emotional difficulties?
(Please list hospitals and approximate dates.)

_____

Have you previously been treated for chemical dependency?
(Please list hospitals and approximate dates.)

_____

6. Do any family members have chemical dependency, alcoholism or emotional problems?
List:

_____

7. Do you use sedatives, alcohol, tobacco, laxative, caffeine_____

List type and amounts per day: _____

8. Are you having problems in your sexual relationship?

_____

Trillium Client Intake Form

Last Name: _____ **First Name:** _____

Date of Birth: _____ **Date of Assessment:** _____

Circle the number that best describes problems you have in the following areas.

	3 = Severe	2 = Moderate	1 = Minimal	0 = None
Depression	3 2 1 0	Financial Problems	3 2 1 0	Excessive Spending 3 2 1 0
Anger	3 2 1 0	Sexual Problems	3 2 1 0	Grief Issues 3 2 1 0
Anxiety	3 2 1 0	Sexual Orientation Issues	3 2 1 0	Marital 3 2 1 0
Withdrawn	3 2 1 0	Alcohol/Drug Use (self)	3 2 1 0	Other Relationships 3 2 1 0
Suicidal Thoughts	3 2 1 0	Alcohol/Drug Use (others)	3 2 1 0	Parenting Problems 3 2 1 0
Suicidal Attempts	3 2 1 0	Gambling	3 2 1 0	Physical Abuse 3 2 1 0
Job Problems	3 2 1 0	Excessive Eating	3 2 1 0	Sexual Abuse 3 2 1 0
Legal Problems	3 2 1 0	Excessive Dieting	3 2 1 0	Domestic Violence 3 2 1 0

How long has problem existed? _____weeks _____months _____years

In the past six months, have you experienced the following? (please check mark)

Physical Reactions:

____Rapid Heart Rate
____Stomach Aches
____Shaking
____Neck or Back Pain
____Dizziness
____Nausea
____Impaired Sleep
____Other _____
____Lightheaded
____Chest pain/Pressure
____Fatigue
____Headaches
____Sweating
____Muscle Tension

Mental Reactions:

____Nightmares
____Suicidal Thoughts
____Paranoia
____Compulsive Behavior
____Flashbacks
____Suicidal Plans
____Delusions
____Phobias
____Intrusive Images
____Homicidal Thoughts
____Hallucinations
____Short-Term Memory
____Homicidal Plans
____Obsessive thoughts
____Long-Term memory

Other _____

Emotional Reactions:

____Fears	____ Feeling Unsafe	____Sadness	_____ Grief
____Mood Swings	____ Anxiety	____Depression	_____Anger
____Irritability	____ Fatigue	____ Guilt	_____Shame
____Blaming (self/others)	____ Difficulty trusting others	____ Emotional Numbness	_____Sensitive
____Isolating	____ Poor Memory	____ Poor Concentration	____Worthlessness
____Lack of Sexual Desire	____Crying Spells	____ Hopelessness	____Lack of Motivation

Other _____

Behavioral Reactions:

____Suicide Attempts	____Agitation	____Loss of Interests	____Easily Distracted
____Confrontational	____Aggressiveness	____Withdrawn	____Procrastination
____Easily Startled	____Overeating	____Under Eating	____Anorexia
____Binging	____Purging	____Bulimia	____Gambling
____Increased Alcohol Use	____Alcohol Dependence	____Other Substance Use	
____Sexually Inactive	____Sexually Overactive		

Other _____

Do you physically harm yourself? How so?

_____

_____

What are your current stressors?

_____

_____

Are you having financial/legal difficulties?

_____

_____

What do you do to cope?

_____

_____

_____

Have you had any significant losses (relatives, friends, jobs, pets, etc.)?

_____

_____

Military History

Branch of Service _____ Dates _____

Combat Experience _____ Dates _____

Combat Trauma _____ Dates _____

Psychiatric Inpatient/Outpatient Treatment _____ Dates _____

Veteran Support Group _____ Dates _____

Educational History

Names of Schools _____ Dates _____

_____

Highest Academic Level _____ Dates _____

Other Job Training _____ Dates _____

_____

Job History

Current Place of Employment _____ How long? _____

Previous Employers _____ Dates _____

_____ Dates _____

What do you do for leisure?

_____

_____

Do you have a regular exercise program? _____

Church/Spiritual Affiliation _____

Any other information that would be helpful for your therapist?

_____

_____

_____

_____ _____

Client **Date**

Reviewed by:

_____ _____

Therapist **Date**