

**PATIENT INFORMATION**

Name: \_\_\_\_\_  
(Last) (First) (Middle Initial) (Nickname)

Mailing Address: \_\_\_\_\_  
(Street/PO Box) (Apt./Unit #) (City) (State) (Zip)

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext. #: \_\_\_\_\_ Cell: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Sex:  M  F Birth date: \_\_\_\_\_ Age: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed  Other \_\_\_\_\_

Ethnicity:  American Indian/Alaskan Native  Asian  African/American  Hispanic  White  Hawaiian/Pacific Islander  Other \_\_\_\_\_

**GUARANTOR INFORMATION (Person who is financially responsible)**

Name: \_\_\_\_\_ Birth date: \_\_\_\_\_  
(Last) (First) (Middle Initial)

Mailing Address: \_\_\_\_\_  
(Street/PO Box) (Apt./Unit #) (City) (State) (Zip)

Relationship to Patient:  Spouse  Mother  Father  Sibling  Other (relationship) \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_

**INSURANCE INFORMATION**

**NOTE: Meier Clinics® ONLY files insurance if your provider is contracted with your insurance plan. Complete the following ONLY if we are filing claims for you.**

**Primary** Insurance Co. Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Relationship to Pt:  Self  Spouse  Parent  Other \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Birth date: \_\_\_\_\_ Member ID #: \_\_\_\_\_ Group ID #: \_\_\_\_\_

**Secondary** Insurance Co. Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Relationship to Pt:  Self  Spouse  Parent  Other \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Birth date: \_\_\_\_\_ Member ID #: \_\_\_\_\_ Group ID #: \_\_\_\_\_

**CONSENTS TO RELEASE INFORMATION**

I hereby consent for Meier Clinics to contact my Primary Care Physician or other health care provider as noted below regarding my treatment, as deemed necessary. This consent shall remain in force during my treatment at Meier Clinics and for 90 days following my last visit unless expressly revoked by me in writing.

Physician Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

I hereby consent for Meier Clinics to contact the person(s) below as deemed necessary regarding the information indicated. This consent shall remain in force during my treatment at Meier Clinics and for 90 days following my last visit or after services have been paid in full unless expressly revoked by me in writing.

Name	Relationship	Daytime Phone #	Evening Phone #	OK to leave message	Financial Info.	Medical Info.	Other (Specify)
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

**CONSENT FOR CONTACT VIA E-MAIL**

By providing an e-mail below, I hereby consent to the following: \*Contact by Meier Clinics via e-mail communication at the personal address below as I am 18 years old or older, or the e-mail provided is that of a parent/legal guardian. \*E-mails may be viewed by unintended persons as e-mails are not sent by way of encryption. \*E-mail communication may be seen, received and/or responded to by any Meier Clinics staff in order to facilitate the communication. \*E-mail is not intended for clinical purposes or a replacement to therapy but may be used as a simple adjunct to therapy or for administrative purposes. \*I release and hold harmless Meier Clinics and Meier Clinics staff for any claim(s) I may have, past, present and future, arising from the use of e-mail. \*This consent will remain in force during my treatment at Meier Clinics, until all account activity has been successfully completed, or upon receipt of my written revocation.

E-mail Address: \_\_\_\_\_

**ACKNOWLEDGEMENTS**

By signing below, I acknowledge the following:

- I have been offered the "Notice of Privacy Policies and Clients Rights."
- I have consented to treatment provided by Meier Clinics and its employees or designees (caregivers). I understand Meier Clinics serves as a training ground for mental health professionals and that I may be seen by an intern who will provide care to me under the supervision of a licensed professional. I authorize the services deemed necessary or advisable by my caregivers to address my needs.
- I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the healthcare operations of Meier Clinics. I authorize Meier Clinics to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that Meier Clinics may release objective clinical information related to my diagnosis and treatment that may be requested by my insurance company (if applicable) or its designated agent.
- I authorize and request my insurance plan(if applicable) pay directly to Meier Clinics the amount due for services rendered to the patient, myself, or others covered by the above insurance plan(s). I authorize the release of any medical, mental health, or substance abuse information necessary to process insurance claims for services rendered. I understand this consent is subject to revocation at any time, except where action has already been taken on the basis of this release. Unless revoked earlier, this consent will be null and void six months after the final payment has been received on this account. This consent is subject to state and federal confidentiality regulations.
- I agree to take full responsibility for the entire amount due for any and all services rendered. If the provider is contracted with my insurance company, I will be responsible only for the co-pay, co-insurance, deductible, and non-covered services as determined by the insurance plan. If I do not inform Meier Clinics in a timely manner of any changes to my insurance coverage, I understand that I may need to pay for services in full if payment is denied in part or in full by my insurance carrier. I further understand that I may not be able to schedule appointments if my account becomes delinquent and/or my account is turned over to collections.
- I understand that my patient records are the property of Meier Clinics and shall be treated as confidential; that Meier Clinics will conduct routine patient audits to insure quality record maintenance; that my records will not be released without my written consent or as provided by the laws of the State where I am receiving treatment. I understand that if I choose to have my records or treatment updates provided to a third party, I must request this in writing using Meier Clinics "Authorization for Use and Disclosure of Protected Health Information" form or another acceptable form, with the exception of information I have agreed to release per this Acknowledgement.
- I acknowledge that if I need to cancel or reschedule an appointment I will provide a minimum of one business day's notice. Otherwise, I understand that I am subject to the full charge for the missed appointment and am responsible for payment in full.
- I acknowledge that Meier Clinics is not a 24/7 care facility and that I am responsible for seeking care at my nearest emergency center or through another provider of choice when my Meier Clinics caregiver is not available.
- I certify that all the information I have provided above is true and correct.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guarantor's Signature (if not patient): \_\_\_\_\_ Date: \_\_\_\_\_

Patient/Guardian Name (please print if applicable): \_\_\_\_\_

**PLEASE COMPLETE THIS SECTION ONLY IF APPLICABLE**

**CHILD AND ADOLESCENT CONSENT FOR TREATMENT**

I certify that I am the  father,  mother,  legal guardian and have legal custody of the above named patient. I, hereby, give my authorization and consent for the patient to receive outpatient assessment/treatment from \_\_\_\_\_  
I understand it is the policy of Meier Clinics that the parent/guardian bringing the patient for treatment is responsible for payment at the time services are rendered. I will be responsible for payment of the patient's treatment regardless of any financial arrangement for payment of the patient's medical care, either oral or written, with the patient's other parent or responsible party. I understand that Meier Clinics assumes no responsibility for collecting payment from the other parent or responsible party with whom I may have financial arrangements for the patient's medical care.

Parent/Guardian Name (please print): \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

TO BE COMPLETED ONLY BY STAFF Provider: \_\_\_\_\_ Appt: \_\_\_\_\_ Acct. #: \_\_\_\_\_  
Staff Witness: \_\_\_\_\_ Comments: \_\_\_\_\_

## PHYSICIAN-PATIENT AGREEMENT & TREATMENT CONSENT

**GENERAL:** I ask all new patients to carefully read this 4 page form prior to our first meeting. Please print two copies, one to keep for your future reference and one to bring to your first appointment, noting any questions you may have about any of its terms. After I have answered your questions, a signed copy of this agreement will become a part of your clinic record.

All Meier Clinics® doctors and counselors are Christians. Addressing any spiritual concerns you have can be an important part of your care, or if you prefer, we can focus only on the medical and psychological aspects of your treatment. I do not supervise the work of any of the clinic counselors, but all chart documentation is accessible to me and to your Meier Clinic counselor, and we will communicate with each other as needed. If you are seeing an independent counselor, I will need a release of information so that we can work together for your benefit. Please direct all phone calls to your counselor except as your questions relate to medication issues.

In accordance with Meier Clinics policy, I am not involved in worker's compensation cases, disability evaluations, child custody, or other legal matters. Therefore, you will be referred to another psychiatrist if the need for testimony and/or reports arises.

**APPOINTMENTS AND FEES:** After your first visit, I will need to see you within 1-4 weeks to review your progress. Thereafter, follow-up appointment frequency will be individualized. Office visits are required for my ongoing assessment of your clinical status and treatment needs. I ask that you make every effort to arrange for childcare during appointments. Cell phones should be turned off or adjusted to silent mode prior to appointments to prevent interruptions. My office hours are on Tuesdays, Thursdays, and Saturdays.

Follow-up appointments are 20 minutes in length and cost \$100 for private pay patients and for those for whom I am not an in-network insurance provider. In-network copays/co-insurance vary, so confirm this with your insurance company in advance. It is your responsibility to make alternate payment arrangements with me in advance if you are unable to pay the full fee or your in-network copay/co-insurance at the time of each appointment.

Please be careful to keep track of all your appointments. The clinic generally provides courtesy reminder calls, but do not depend upon receiving such a call. In accordance with clinic policy, you will be charged \$25 for appointments cancelled without 24 hours notice and \$50 for missed appointments. These fees apply whether you have or have not received an appointment reminder call. You will be fully responsible for these fees, as insurance companies will not pay them. To make, change, or cancel an appointment, call the clinic and dial "0" during regular business hours. The clinic does not have a receptionist on Saturdays; so to cancel a Saturday appointment after 5pm the day before, leave a message on my voicemail. I appreciate as much notice of appointment changes as possible, as I do not schedule more than one person per appointment time. Multiple missed appointments may result in the need to terminate our doctor-patient relationship. To be fair to patients who arrive on time, I may not be able to meet with you if you are late for your appointment.

**PHONE CALLS AND EMERGENCIES:** If needs arise that cannot wait until your next appointment, leave a detailed message on my voice mail. I retrieve messages at 2pm on Tuesdays through Saturdays. Messages left after 2pm on Saturdays will be responded to on the following Tuesday.

If you do not get a response in a timely manner, I have not received your message, so please call again. If another doctor is on call for me, my voice mail will tell you how to contact him or her. You will be charged \$31-93 for the time required if frequent phone calls and/or calls of greater than 5 minutes duration are necessary between appointments. Insurance companies do not pay for phone consultations, so these fees will be your responsibility.

If you need to speak with me emergently, you can reach me during business hours by asking the clinic staff to page me, or by calling the answering service at 972-216-6102 after business hours. Emergency pages are to be restricted to needs that cannot wait until the next business day. If you do not get a call back from me in a timely manner; if you can not wait up to an hour for me to respond; or if you are in danger of harming yourself, harming someone else, or being harmed by someone, go to the nearest hospital emergency room or call 911.

Successful treatment requires that you attend all scheduled sessions and express your ideas and emotions honestly and openly using verbal communication only. Threats or acts of physical harm to me, others, or clinic property will result in immediate termination of treatment and notification of the proper authorities.

It is important that I always have your current address, home and work phone numbers. I also need you to designate an emergency contact person:

Name: \_\_\_\_\_

Phone: \_\_\_\_\_ (cell phone preferable)

Relationship to you: \_\_\_\_\_

**MEDICATION TREATMENT:** In order to provide the best quality care, treatment is not conducted over the phone. Medication changes and dosage adjustments require an office visit. I will always prescribe enough medication to last until you are to come for a follow-up appointment. If for any reason you run out of medicine, do not have your pharmacy call for a refill. Rather, leave me a message with your name and phone number, your pharmacy phone number, needed medication and current dosage, and the date of your next appointment. Refill requests are processed only on Tuesday, Thursday and Saturday mornings. A \$20 fee will be charged for refill calls to your pharmacy, so please make every effort to schedule appointments before you will run out of medicine. Insurance companies do not pay refill fees, so this cost will be your responsibility. Lost or stolen prescriptions for a controlled medication cannot be replaced or refilled early.

**CONFIDENTIALITY:** Doctor-patient confidentiality is limited under the following circumstances:

1. Insurance companies require dates of service and diagnosis code information to pay for services rendered, and they frequently request additional patient information to satisfy their prior authorization requirements for services and for certain medications to which they limit access.
2. If a legal action is filed in which your mental health is at issue and I am asked or ordered to testify.
3. If malpractice is alleged.
4. If I become aware of abuse or neglect of a child, elder or disabled person, I am obligated to report it to the appropriate authorities.
5. If I determine you are an imminent danger to yourself or others, I must contact a family member and/or the police in an effort to provide for your/others' safety.
6. I cannot respond to any phone calls or correspondence from family members or friends unless I have a signed consent from you.

**MEDICAL CARE:** I advise all patients to have a complete physical examination with appropriate laboratory tests to rule out medical causes and/or contributors to psychological symptoms. Provide me with a copy of the results from your doctor to ensure coordination of care. If you do not follow this recommendation, you take on the liability for any disability or deterioration in physical or mental health incurred as a result. In order to provide appropriate treatment, I must be the only physician prescribing your psychiatric medications, including sleep aids. I may request a release of information to communicate with your other doctor(s) to optimize your care.

**MEDICATION USE PRECAUTIONS:** I may recommend psychiatric medication for you in an effort to improve your mental health. You always have the option of deciding not to take or continue prescribed medications, but it is always prudent to talk with the prescriber before discontinuing medication to ensure a medication is stopped in a safe manner.

All medications have the potential to cause good effects and side effects, some of which can be very serious, therefore, regular follow-up and monitoring is necessary. Always read all of the medication precaution information you receive from your pharmacy and contact me with any questions or concerns. Any medication can impair thinking or reaction time until your body gets accustomed to it. Therefore, do not operate hazardous machinery, including automobiles, or do anything potentially dangerous until you are certain any newly prescribed medication(s) does not affect your abilities.

Notify me and all your other doctors of any and all changes in prescribed and over-the-counter medicines. Keep in mind that "herbal/natural" does not always mean safe or good. Some over-the-counter products and medications acquired via the Internet should not be taken with the medications I prescribe due to the possibility of dangerous interactions. Two examples are St. John's Wort, which is dangerous to take along with antidepressant medication, and Kava, which has been associated with liver failure. For your safety, it is your responsibility to talk with me about any prescription, over-the-counter, or internet-acquired substances you are considering adding to the medications I prescribe for you.

Store all medications I prescribe at room temperature and away from heat and light. Contact me if you experience any unanticipated medication effects including a skin rash as that indicates a medication allergy. I advise you not to consume alcohol, including beer, or take illicit drugs while taking medication as this will prevent optimal benefit and the combination can be physically dangerous.

If you or someone else takes more than the recommended dose of a medicine, contact poison control, call 911, or go to an emergency room. Do not allow others to take your medicine and do not take medications prescribed for someone else. Keep all medications out of the reach of children and impaired adults. If you miss a dose, do not take two doses at the same time; instead resume your regular medication schedule. I recommend the use of a weekly pillbox to avoid accidentally taking more or less than prescribed.

**WOMEN:** Notify me of any intent to become pregnant as some medications should be discontinued prior to conception. Waiting to stop medication until you discover you are pregnant exposes your baby to medication during the critical first few weeks of organ development and can lead to birth defects. Whenever possible, psychiatric medications should not be used at any time during pregnancy or while breastfeeding. Contact me within 24 hours if you discover you have become pregnant while taking medication. The effectiveness of birth control pills can be altered by certain medications, so be sure to discuss with me any intent to start, stop, or change birth control methods.

**REFERRALS:** I do not provide inpatient or day hospital care. If at any time you should need that form of treatment, you would be transferred to the care of another psychiatrist for the duration of your hospital stay, and I may not be able to resume your care upon discharge. As your treating psychiatrist, it is my duty to seek your best interest; therefore, I can not also serve as a consultant or witness in any legal matters. I will refer you to another psychiatrist for an objective evaluation if at any time legal reports or testimony is needed. If there is some aspect of your care we are unable to agree upon, I will need to

refer you to another psychiatrist to continue your care. Please do not refer any of your family members or friends to me without discussing this directly with me in advance.

**AGREEMENT:** Your signature below indicates that you have carefully read, understand, and accept all the terms of this treatment consent and agreement. You are hereby giving your consent for appropriate medical treatment by Dr. Trulson following ongoing discussions of the risks and benefits of all prescribed medications and other treatments. Keep your copy of this agreement for future reference. This agreement is in addition to the general Meier Clinics Patient Information and Consent to Treatment signed by all new clinic patients.

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Print your name

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Date

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Signature

Name \_\_\_\_\_ Date \_\_\_\_\_ ID # \_\_\_\_\_

## P S Y C H I A T R I C M E D I C I N E S

ANTI-DEPRESSANTS	MOOD STABILIZERS	ANTI-ANXIETY	Major Tranquilizers	ADHD	SLEEP	PAIN
Anafranil	Carbatrol	Ativan (Lorazepam)	Abilify	Adderall	Ambien	Amerge
Aplenzin	Celontin	Buspar	Clozaril	Clonidine	Ambien CR	Anaprox
Brintellix	Depakote	Klonopin (Clonazepam)	Fanapt	Concerta	Dalmane	Axert
Celexa	Dilantin	Librium	Geodon	Cylert	Doxepin	Butalbital
Cymbalta	Felbatol	Moban	Haldol	Daytrana	Lunesta	Codeine
Desyrel	Gabitril	Neurontin	Invega	Dexadrine	Restoril	Darvocet
Effexor	Keppra	Restoril	Latuda	Focalin	Rozerem	Esgic
Elavil	Lamictal	Serax	Loxitane	Intuniv	Silenor	Fiorcet
Emsam	Lithium	Tranxene	Mellaril	Metadate	Sonata	Frova
Fetzima	Lyrica	Valium (Diazepam)	Navane	Methylin	Trazadone	Hydrocodone
Lexapro	Myosline	Vistaril	Prolixin	Nuvigil		Imitrex
Luvox	Phenobarbital	Xanax	Risperdal	Provigil		Lorcet
Nardil	Tegretol		Saphris	Ritalin		Lortab
Norpramin	Topamax		Seroquel	Strattera		Midrin
Pamelor	Trileptal		Stelazine	Tenex		Norco
Parnate	Zarontin		Thorazine	Vyvanse		Percocet
Paxil	Zonegran		Trilafon			Phrenilin
Pristiq			Zyprexa			Stadol
Prozac						Ultracet
Remeron				<b>ALCOHOL/DRUG CRAVINGS</b>		Ultram
Serzone						Vicodin
Sinequan				Campral		Zomig
Viibryd				Naltrexone		Zydone
Vivacti		<b>PSUEDOBULBAR AFFECT(PBA)</b>		Neurontin		
Wellbutrin		Nuedexta		Suboxone		
Zoloft						

Place a check mark next to any medications you think you may have taken in the past even if it was for a very short time. Then, off to the side please write a one to two word description or phrase describing your experience with the medicine (e.g. "good" "bad" "great" "made me dizzy" "made me sleepy" etc.). Knowing how you responded on certain medication in the past will help us in your treatment.

**MEDICATIONS:** *Please list medications you are currently taking (psychiatric or other)*

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*List any Medications you are allergic to:*

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Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Employment Status: \_\_\_\_\_

Date Symptoms Began: \_\_\_\_\_ Date Symptoms Worsened: \_\_\_\_\_

What is your goal for seeking Counseling at this time in your life? \_\_\_\_\_

\_\_\_\_\_

**SYMPTOM CHECKLIST**

- Depressed or Sad Mood
- Irritability/Short tempered
- Lack of Motivation/Drive
- Poor Concentration
- Can't sleep well
- Appetite/weight changes
- Loss of pleasure in activities
- Diminished self-esteem
- Hopeless/Helpless
- Decreased Energy/fatigue
- Excessive guilt or worry
- Crying Spells
- Decreased sex drive
- Intense fear of being fat

- Spending sprees
- Special Abilities
- Increased self-esteem
- Decreased need for sleep
- Lots of great ideas to get out
- Racing thoughts/can't keep up
- Increased energy/hyperactive
- Increased Sex Drive
- Making lots of plans/schemes
- Rapid speech
- Nonstop talking/can't interrupt
- Day-to-Day mood swings

- Suspiciousness/Paranoia
- Hallucinations (see/hear things)
- Unusual facial expressions
- Strange posture/gestures
- Disorganized thoughts
- Confusion
- Bizarre Behaviors
- Unusual or unwanted thoughts
- Constantly washes hands

- Anxiety about everything
- Intense episodes of fear
- Fear of Going crazy/losing control
- Chills/Hot flashes
- Abdominal distress/nausea
- Chest discomfort/choking
- Dizziness
- Numbness/tingling
- Feeling jumpy/on edge/easily startled
- Constantly Alert/Vigilant
- Nightmares/reliving trauma
- Avoiding of stressors/stimulus
- Heart racing/palpitations
- Sweating
- Trembling
- Shortness of Breath
- "Lump in Throat"/can't swallow
- Intense anxiety, fear, or panic
- Unable to leave home
- Counts things constantly
- Impaired intellect/thinking
- Language/speech difficulties
- Impulsive/poor judgment
- Unusual sleep pattern
- Disorganized/Confused
- Poor Memory

**SUBSTANCE ABUSE**

- Amphetamines/Stimulants
- Cocaine/Crack
- Marijuana/Cannabis
- Alcohol
- Sedative/Hypnotics
- Opiates/Narcotic pain pills/Heroin

- Suicidal thoughts?  Yes  No
- passing thoughts/no intent
- persistent thoughts
- current plans/definite intent
- recent attempt
- past attempts
- Pulling hair out
- Anger/Emotional outburst
- Binge Eating/Purgine
- Uncontrolled Gambling
- Stealing or Lying
- Ritualized behaviors/obsessions
- Attention/concentration issues
- Impulsive/can't wait turn
- Hyperactive/restless
- Can't perform at work/school
- Aggressive/Assaultive
- Self-mutilation/Self-harm
- Sleeping all the time
- Staring spells
- Chronic Pain
- Self induced vomiting
- Constant agitation
- Intense fear of ejection/
- Legal Troubles
- Unexplained body complaints

Personal Past Psychiatric History:  Counseling  Psychiatrist  Hospitalization  Suicidal Attempts

Past or Current Medical Issues (thyroid/high blood pressure/etc): \_\_\_\_\_

\_\_\_\_\_

Please List your top 3 symptoms: \_\_\_\_\_



# PSYCHOSOCIAL ASSESSMENT

Age 16 and Above

Name: \_

Record# \_

Age: \_

Sex: \_

Clinician: \_

**DIRECTIONS: Please answer the following questions as fully as possible.**

**Problem Assessment**

Present Problem/Stressors: *Please check all that apply:*

- Marital issues       Health issues       Job issues       Financial issues
- Parent/child issues     Issues of past (guilt, abuse, neglect, family of origin issues, etc.)
- Other \_

Symptoms: *Please check all that apply:*

- Change in sleep pattern       Depressed mood       Mood swings
- Decreased energy       Decreased interest or pleasure       Anger problems
- Decreased concentration       Change in appetite       Thoughts of death
- Decreased motivation       Anxiety/Worry/Panic
- Other \_

**Suicidal/Homicidal Ideation**

Have you attempted to commit suicide or homicide in the past?  yes     no

If yes, how? \_

Is there a history of suicide in your nuclear and/or extended family?  yes     no

Have you ever inflicted burns or wounds on yourself?  yes     no

Are you presently suicidal or homicidal?  yes     no

Are there any other risk-taking behaviors that you engage in?  yes     no

If yes, please explain \_

What event(s) in the recent past has prompted you to seek counseling? \_

\_\_\_\_\_

Describe additional problems you are experiencing. \_\_\_\_\_

\_\_\_\_\_

When did these problems develop? \_\_\_\_\_

\_\_\_\_\_

Check any recent losses you have experienced.

- Family       Health       Disruption of lifestyle       Job       Significant other
- Other \_

List your strengths and weaknesses.

Strengths	Weaknesses

**Psychiatric History**

Have you ever had any previous outpatient counseling?  yes  no If yes, please complete information below.

Place	Length of Time	Date(s)

Have you ever been admitted to the hospital for mental health or addiction issues?  yes  no

Place: \_\_\_\_\_ Dates: \_\_\_\_\_

Name of current doctor and/or therapist: \_\_\_\_\_

Have you ever received a psychiatric diagnosis?  yes  no If yes, please explain. \_\_\_\_\_

Do you feel medications you have been on, past or present, have been effective?  yes  no

Please explain: \_\_\_\_\_

List all medications you have taken *in the past* for anxiety, depression, and/or sleep. \_\_\_\_\_

**Medical Information**

How would you describe your current condition of health? \_\_\_\_\_

Do you have any disabilities and/or disorders?  yes  no If yes, explain. \_\_\_\_\_

Explain any special adjustments needed for the disability or disorder: \_\_\_\_\_

Are you currently on any medication?  yes  no If yes, please complete the information below.

Name of Medication	Dosage/Frequency	Prescribing Physician

Are you allergic to any medications or have you ever had an adverse reaction to medication?  yes  no

If yes, please list: \_\_\_\_\_

Has it been more than a year since your last physical exam, including blood tests?  yes  no

Have you ever had an abortion?  yes  no Males: Has a child of yours ever been aborted?  yes  no

Do you have allergies?  yes  no If yes, explain. \_\_\_\_\_

List any previous health problems, operative procedures, and medical hospitalizations.

Problem	Dates	Treatment

**Substance Use History**

Describe your current usage, or usage within the past year (includes alcohol, any illegal drugs, caffeine and tobacco).

Substance	Amount	Frequency	Age of 1 <sup>st</sup> Use	Age regular use started	Last use

Have you experienced a recent increase in the use of alcohol and/or other substances?  yes  no  
 Do you, your family, or your friends see your current usage as a problem?  yes  no If yes, when did it become problematic? \_  
 Please describe any previous experience with drugs or alcohol. \_  
 Describe any significant family history of substance abuse. \_

**Nutrition**

Do you feel you have balanced, healthy eating patterns?  yes  no  
 Do you have a lot of concerns about your weight and shape?  yes  no  
 Do you often eat out of depression, boredom, anger?  yes  no  
 Do you ever binge eat or fear losing control of your eating?  yes  no  
 Do you ever self-induce vomiting?  yes  no  
 How do you feel about eating with others in a group? \_  
 Do you use laxatives, diuretics (water pills), or diet medications to control your weight?  yes  no  
 Do you or others believe you exercise excessively?  yes  no

**Legal History** Please explain all that apply.

Charges as a minor: \_  
 Charges presently: \_  
 Arrests (How many): \_  
 Incarcerations (How many): \_  
 Parole: \_  
 Convictions (How many): \_  
 Probation: \_  
 Bankruptcy: \_  
 Civil Suits: \_  
 Child Custody Problems: \_

**Developmental History**

List members of your family of origin and comment on how you got along with each one.

Name	Relationship	Comment

What was your birth order? I was the \_ of \_ children. Who primarily raised you? \_  
 How would you describe your childhood?  Traumatic  Painful  Uneventful  Good  Happy  
 What were you like as a child (include friends, school, hobbies, and personality)? \_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Did you have any unusual or traumatic experiences as a child?

Date	Age	Event

Have you ever been the recipient of unwanted sexual acts?  yes  no  
 If yes, please explain: \_  
 Have you ever been the victim of abuse, neglect, or violence?  yes  no  
 If yes, please explain: \_

Have you ever been the perpetrator of abuse, neglect, or violence towards another person?  yes  no  
If yes, please explain: \_

What is your sexual orientation?  Heterosexual  Homosexual  Bisexual

**Living Arrangements**

Satisfactory?  Unsatisfactory?

Where do you currently live? \_ How long there? \_

With whom are you living? \_

Describe your current relationships with family members. \_

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**Social Relationships/Support System**

Who can you count on for support? *Check as many as apply.*

- Parents Spouse Siblings Extended Family Employer Church Pastor Co-worker  
Neighbor(s) Close Friend Self-help Group Community Services Therapist Medical Doctor

List close friends, outside of family, if any. \_

What are your hobbies or leisure activities? \_

**Marital History (if applicable)**

When were you married? \_ Name and age of spouse. \_

Previous marriage(s)?  yes  no If yes, date of divorce(s). \_

How many children from above marriage(s)? \_

What is your perception of your current marriage (include communication patterns, problems, sexual relations).

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List names and ages of children. How do you get along with each one?

Name	Age	Comment

**Financial Situation**

Describe briefly your financial situation. \_

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**Religious/Cultural Factors**

What is your religious background? \_

Describe the religious atmosphere in your home (past or present). \_

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Do you currently attend church, synagogue, mosque, or other religious services?  yes  no

What does God seem like to you? \_

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Describe your relationship with God. \_\_\_\_\_

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What do you consider to be the role of God in your recovery? \_\_\_\_\_

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Please list any issues (positive or negative) which are important or may have affected you in regard to religion or ethnic/cultural background. \_

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**Educational History**

What was school like for you? \_

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Highest grade level achieved. \_\_\_\_\_ What type of grades did you make? \_\_\_\_\_

Are you currently in school?  yes  no If yes, what grade level? \_\_\_\_\_

**Work Adjustment History**

Describe your current job/career. \_

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Would you enjoy doing this job on a long-term basis? \_\_\_\_\_

How do you deal with authority figures? \_\_\_\_\_

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Describe your relationship with co-workers. \_\_\_\_\_

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Describe your job performance. \_\_\_\_\_

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Have you ever been fired or laid-off?  yes  no If yes, explain. \_\_\_\_\_

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How many jobs have you held within the previous five years? \_\_\_\_\_

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**Military History**

List branch, dates, and duties.

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**Family**

Would it be beneficial for any member(s) of your family/legal guardian to be involved in your treatment?

yes  no If yes, explain who and why. \_

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May we contact any of the persons you have mentioned above for their input and involvement in your care?

yes Contact Information: \_

no

What is your family/legal guardian's perception of your difficulties? \_

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**Miscellaneous**

Are there any other things that would be helpful for us to know about you? \_

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With your permission, is there anyone else that would be appropriate to contact in regard to your care?

yes Name and phone number. \_

no

How were you referred to Meier Clinics®? \_

Is there anyone that we are legally required to notify in regard to your care?  yes  no

If yes, please give us the necessary information to contact them. \_

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Is there a need for assistive technology in your treatment?  yes  no If yes, what is that need? \_\_\_\_\_

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What would you like to accomplish during your treatment with Meier Clinics®? \_\_\_\_\_

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Client Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Read and Reviewed by \_\_\_\_\_

(Clinician)

Date: \_\_\_\_\_

## Patient Preference Regarding Communication of Health Information

### Who to Contact

I hereby authorize **Meier Clinics** (“Facility”) to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), relative(s), close personal friend(s), and/or others I so designate:

NAME	RELATIONSHIP TO CLIENT	TELEPHONE
NAME	RELATIONSHIP TO CLIENT	TELEPHONE
NAME	RELATIONSHIP TO CLIENT	TELEPHONE
<input type="checkbox"/> I do not wish to disclose any information with anyone.		

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require a specific authorization prior to the disclosure of *any* medical information.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	DATE	TIME

### Authorization to Leave Messages

I hereby authorize Meier Clinics to leave messages regarding any medical/mental health condition, such as lab reports and other test results, medications, and appointment reminders on the phone number(s) provided. This authorization will be in effect indefinitely until I revoke it through a written notice.

AUTHORIZED TELEPHONE NUMBER(S):		
<input type="checkbox"/> HOME <input type="checkbox"/> WORK ( ) - <input type="checkbox"/> MOBILE	<input type="checkbox"/> HOME <input type="checkbox"/> WORK ( ) - <input type="checkbox"/> MOBILE	<input type="checkbox"/> HOME <input type="checkbox"/> WORK ( ) - <input type="checkbox"/> MOBILE

I the undersigned understand that I may revoke this consent in writing, care of the Medical Records Custodian. I have read and understand the above information and give my authorization.

PATIENT – SIGNATURE	DATE	TIME