PATIENT REGISTRATION

PLEASE FILL OUT ALL INFORMATION AS COMPLETELY AS POSSIBLE

Patient Name:_____

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

Sex: M F Age:_____ **DOB:**_____

Marital Status: Single___ Married___ Divorced___ Widowed___ Other_____

Home Phone:_____ **Work Phone:**_____

Cellular Phone:_____ **Pager:**_____

e-mail:_____

Please answer the following questions.

Are you having thoughts of suicide? Yes No
Have you ever attempted suicide? Yes No
Have you ever harmed yourself? Yes No
Have you ever harmed anyone else? Yes No
Are you addicted to Alcohol or Drugs? Yes No
Are you using any illegal drugs? Yes No
Are you on any prescription drugs (antidepressants, etc.)? Yes No
Are you on any herbal medications? Yes No
Have you had a period of prolonged depression that was not responsive to a combination of medication and counseling? Yes No
Have you had a history of having frequent or acute emergencies requiring more than two counseling sessions per week, after hours help or weekend help? Yes No
Have you ever been convicted of any crimes, incarcerated or broken laws other than minor traffic violations? Yes No
Have you ever had a disorder that caused you to lose touch with reality (psychosis, schizophrenia, acute manic phase of bi-polar disorder, etc.)? Yes No
Have you sought psychotherapy/counseling in the past? Yes No
If so, how long were you in treatment?_____ **Was it helpful? Yes No ?**
Have you ever been hospitalized for psychiatric issues? Yes No
Is anyone else requiring or pressuring you to be in therapy? Yes No
Do you believe that it is possible for you to get better? Yes No ?

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Psychotherapist

Therapy Agreement

CANCELLATION POLICY:

- **I agree that if I must change a scheduled session, that I will contact the office at least 24 business hours in advance.**
- **Since the time has been reserved for me, I agree to pay the regular fee for unkept appointments which are not canceled 24 business hours in advance.**
- **This fee will not apply in the case of illness or emergency situations.**
- **However, I understand that if as many as two appointments are canceled due to illness or emergencies with less than 24 hours notice that I agree to pay the regular fee for any further cancellations or rescheduled appointments with less than 24 business hours notice.**

LENGTH OF APPOINTMENTS:

I understand that appointments begin on the hour and end 45 to 50 minutes after the hour regardless of what time I arrive for the appointment.

PAYMENT:

I understand that payment is due at the time of service and that cash, checks, Visa or MasterCard are acceptable forms of payment.

I agree to these terms and conditions.

_____ _____

Signature **Date**

375 MUNICIPAL DR., SUITE 230, RICHARDSON, TEXAS 75080 (972) 997 -9955

Therapy Information Form

Name:_____ Date:_____

What issues / problems are causing you to seek counseling?

_____
_____
_____
_____
_____
_____

How long have these been a concern? _____

How have these effected your life? (work, personal life, family, happiness, etc.)

_____
_____
_____
_____
_____

List the friends or family that live close by and briefly describe your relationship with them.

_____
_____
_____
_____
_____
_____
_____
_____

Describe your relationship with the person that you feel the closest to: _____

_____
_____
_____
_____

Are you dissatisfied with any part of this relationship? Yes_____ No _____

Comments: _____

_____

Education: _____

Occupation: _____

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Do you have any traumatic memories? Yes_____ No _____ If so, please list them and the age that you were when the event happened:

_____
_____
_____
_____
_____
_____

Are you able to remember your childhood? Yes _____ No _____

How would you describe your childhood?

_____
_____

Are there any specific blocks of time that you can not remember? Yes _____ No _____
Comments: _____

Do you have difficulty controlling your anger? Yes _____ No _____ Describe below:

_____

Do you experience any panic, anxiety, phobias or frequent worry? Yes _____ No _____
Describe: _____

_____

Are you feeling depressed? Yes _____ No _____ If yes, for how long? _____
Describe your history regarding depression: _____

_____
_____
_____

Do you find yourself repeating any actions compulsively? (even though you don't want to)
Yes _____ No _____ Describe:_____

_____

Do you have any obsessive thoughts that you just can't keep from thinking? Yes____ No____
Explain: _____

_____

List the things that have been the most stressful during the last two years: _____

_____
_____
_____
_____

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Have you experienced any unwanted weight gain, weight loss or loss of appetite recently?
Yes _____ No _____ Describe:_____

Do you smoke? Yes _____ No _____ How long?_____

Do you drink alcohol? Yes _____ No _____ Type? _____
How often? _____ How much? _____

Do you use illegal drugs? Yes _____ No _____ Frequency? _____

Do you have a history of drug or alcohol abuse? Yes _____ No _____ Explain: _____
_____

Do you take any prescription medications for psychiatric reasons? Yes _____ No _____
If so, list the Rx, the dosage and what it is for:_____
_____
_____

Do you have any medical problems that adversely effect your mind or emotions?
Yes _____ No _____ Explain: _____
_____

Are you in treatment with anyone else for psychotherapy, counseling, or psychiatry?
Yes _____ No _____ If so, please list by name and phone number:
_____
_____
_____

List the name and phone number of your primary care physician: _____
_____

List other relevant health care providers by name and phone number:
_____
_____

I give Steve B. Reed, LPC, LMSW, LMFT permission to receive information from and provide information to any of my health care team in order to facilitate my treatment.

Print your name: _____

Your signature: _____ Date: _____

Please add any additional information that may be relevant to your treatment: _____
_____
_____
_____

REMAP Trauma List

Instructions: In the spaces below compile a list of incidents that you experienced as traumatic. Name the incident and then rank it on a scale of 0 to 10. Zero represents something that doesn't bother you at all. Ten represents something that bothers you as bad as you can imagine. If you really let yourself think about an event (remember what it looked like, sounded like and felt like) and you feel a lot of emotional intensity, then include it on this list. Of particular interest are those events that you would rank between 7 and 10. These traumatic incidents can then be targeted for treatment.

1. _____ 0————10
2. _____ 0————10
3. _____ 0————10
4. _____ 0————10
5. _____ 0————10
6. _____ 0————10
7. _____ 0————10
8. _____ 0————10
9. _____ 0————10
10. _____ 0————10
11. _____ 0————10
12. _____ 0————10
13. _____ 0————10
14. _____ 0————10
15. _____ 0————10

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GAD-7 developed by Dr. Robert L. Spitzer, Dr. K. Kroenke, (et al.)*

How often during the past 2 weeks have you felt bothered by:

1. Feeling nervous, anxious, or on edge?
   - 0 = not at all
   - 1 = several days
   - 2 = more than half the days
   - 3 = nearly everyday

2. Not being able to stop or control worrying?
   - 0 = not at all
   - 1 = several days
   - 2 = more than half the days
   - 3 = nearly everyday

3. Worrying too much about different things?
   - 0 = not at all
   - 1 = several days
   - 2 = more than half the days
   - 3 = nearly everyday

4. Trouble relaxing?
   - 0 = not at all
   - 1 = several days
   - 2 = more than half the days
   - 3 = nearly everyday

5. Being so restless that it is hard to sit still?
   - 0 = not at all
   - 1 = several days
   - 2 = more than half the days
   - 3 = nearly everyday

6. Becoming easily annoyed or irritable?
   - 0 = not at all
   - 1 = several days
   - 2 = more than half the days
   - 3 = nearly everyday

7. Feeling afraid as if something awful might happen?
   - 0 = not at all
   - 1 = several days
   - 2 = more than half the days
   - 3 = nearly everyday

*Spitzer RL, Kroenke K, Williams JB, et al. A Brief Measure for Assessing Generalized Anxiety Disorder: The GAD-7. [Journal Article] Arch Intern Med 2006 May 22; 166(10) :1092-7.

Scoring:
Add the results for each question.

Scores will be between 0 and 21.

Total Score_____

Scores over 10 indicate generalized anxiety disorder.

The higher the score is then the more severe the problem.

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

__Not difficult at all __Somewhat difficult __Very difficult __Extremely difficult

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ DATE: _____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
		add columns	+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

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Psychiatric Research Unit
WHO Collaborating Centre in Mental Health

WHO (Five) Well-Being Index (1998 version)

Please indicate for each of the five statements which is closest to how you have been feeling over the last two weeks. Notice that higher numbers mean better well-being.

Example: If you have felt cheerful and in good spirits more than half of the time during the last two weeks, put a tick in the box with the number 3 in the upper right corner.

	Over the last two weeks	All of the time	Most of the time	More than half of the time	Less than half of the time	Some of the time	At no time
1	**I have felt cheerful and in good spirits**	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
2	**I have felt calm and relaxed**	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
3	**I have felt active and vigorous**	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
4	**I woke up feeling fresh and rested**	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
5	**My daily life has been filled with things that interest me**	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0

Scoring:

The raw score is calculated by totalling the figures of the five answers. The raw score ranges from 0 to 25, 0 representing worst possible and 25 representing best possible quality of life.

To obtain a percentage score ranging from 0 to 100, the raw score is multiplied by 4. A percentage score of 0 represents worst possible, whereas a score of 100 represents best possible quality of life.