Pamela S. Lawson MA, LMFT
Pearland Counseling Center
2217 N Park Ave
Pearland, TX 77581
Phone: 281-997-8400 Fax: 281-997-8408
www.pearlandcounselingcenter.com

Thank you for choosing me as your counselor. I look forward to being a part of your journey and hope that as we work together you will find the healing and happiness you are looking for.

This document is designed to inform you of my background and to ensure you understand our professional relationship. I have been trained and have experience working with children, young adults, adults, couples, and families.

Goals of Therapy: The goals of therapy vary depending on the problems presented and your level of desire and commitment to change. As therapy is a collaborative process, you and your counselor will discuss your problems and establish goals together. It is important to note that success in counseling calls for a very active effort on your part. In order for your goals to be most successfully achieved, you will work to reach your goals with my assistance both during our sessions and at home.

Length of Counseling: Each session is 45-50 minutes long. The number of sessions completed will be determined by the problems presented, goals, and progress made. You and your Counselor will decide as you progress how often you should attend counseling. Termination of counseling may happen at any time and may be ended by you or your Counselor.

Risks and Benefits of Counseling: The risks or potential side effects of participating in counseling may include increased levels of stress and anxiety, relationship disruption, and emotional reactivity as sensitive areas are explored. Another risk is that counseling may not resolve your problem or concern. Your therapist will assess progress on a session by session basis. Ongoing lack of progress may be reason for referral.

The benefits of counseling may include improved functioning in your personal and professional relationships, improved communication skills, and a reduction in the symptoms which led you to seek therapy in the first place.

Dependent Clients: If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will require that person to provide legal paperwork stating that this person has this authority and can act for you before we take any action. If a parent or guardian of a child under 18 request services, we need permission to counsel that child. The parent or legal guardian will be asked to sign a form that gives the Counselor permission. It is important that the child trust the Counselor. A parent or legal guardian has the right and responsibility to question and understand the nature and progress of the counseling and the Counselor must use her clinical discretion as to what is appropriate disclosure. While the Counselor may not tell you specific information your child provides, the Counselor will discuss your child's participation and progress in treatment.

Appointments and Messages: Appointments and messages are primarily conveyed via the administrative staff at the Pearland Counseling Center. They can be reached at (281) 997-8400 and are available Monday through Thursday from 9am to 7pm, and Friday from 9am to 5pm. Messages may be left 24 hours a day, seven days a week. Calls are recorded by a confidential voice mail system and are returned as soon as possible. To facilitate this, the caller needs to leave a daytime/evening phone, or cell number along with current concerns. Please call 911 in case of an emergency.

All counseling services are by appointment only. The length of the counseling session is usually **45-50 minutes,** or what is known as a clinical hour. Because an appointment is reserved for you, it is required that you let us know **by 1:00 pm the day prior to your appointment** if you must cancel your appointment.

*** **You are financially responsible for the session missed unless you have given the proper notice.**

*****No show or No call is a fee of $50.00**

Fees: Fees for services are based on time approved session length determined by the insurance carrier. You are responsible for all charges that are not paid by your insurance company.

My cash rate fee for a 45-50 minute psychotherapy session is $60.00 with longer sessions pro-rated accordingly. This fee is not covered by insurance. (Rate subject to increase with notice of changes). In addition to weekly appointments, I charge $30 for other professional services such as telephone conversations lasting more than 15 minutes, consulting with other professionals, and time spent performing any other service you may request of me.

In the event there are three sessions cancelled late or not shown up to, all future scheduled appointments will be cancelled. The no show or late cancellation fee must be paid before the next scheduled session. This fee is not covered by insurance.
Payment is expected before each session at the time it is held, unless we agree otherwise. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, future scheduled sessions will be cancelled until payment is received.

If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. You will also be responsible for my legal representation's fees. I charge $600.00 per hour for my involvement at any legal proceedings. If I go to court to testify, you agree to pay 24 hours in advance either $2,400 for half a day: 8:00AM-12:00PM or $4,000 for an entire day. If the duration of my professional involvement continues after six months, my fees are subject to increase by 20%. This fee is not covered by insurance.

For a copy of clinical records, there is an administrative fee of $25.00 for the first twenty pages and 50¢ for each page thereafter along with a reasonable fee for the cost of mailing, shipping, or delivery.

Professional Records: The laws and standards of my profession require that we keep treatment records. You are entitled to receive a copy of your records or a summary of your sessions. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, it is recommended that we review them together to discuss the contents. Clients will be charged an appropriate fee for any professional time spent in responding to information requests. Should this practice close for business, all records will be maintained for the legally required time (5 years following last session; 5 years after a minor client's 18th birthday) by the owner, Pamela S. Lawson MA, LMFT

Records Request: We make every effort to keep your mental health records secure per HIPAA (Health Insurance Portability and Accountability Act) and the Texas Health and Safety Code regulations.

To request a copy of your (the clients) mental health records:

1) Request a copy of your mental health records/documents in writing. If you mail your request, address the request to your therapist at 2217 N. Park Avenue, Pearland, TX 77581. Please contact Pearland Counseling Center to inquire about information to add in your written request. Please print and sign your name on the request.
2) Please be aware your request for a copy of your records or a copy of documents from your records can be denied.
3) Your therapist has up to 15 days after receipt of your request to provide the requested documents or provide a denial of the request.
4) There may be a fee charged for the requested mental health records/documents.

Confidentiality and Client's Right: Clients are assured that confidentiality is protected by ethical practice and the laws of the State of Texas. There are few exceptions to confidentiality that are legally mandated. In general terms they include: a requirement to notify relevant others if a client has any intentions to harm another person or themselves, and a requirement to report any incidence of suspected child and/ or elder abuse or neglect, to file insurance or work with a managed care company, information regarding your treatment, diagnosis, prognosis and the specific issue for which you have come to treatment are available to the insurance or managed care company. We make every effort to release only the minimum information about you that is necessary for the purpose requested. Once this information is turned over to the insurance, managed care company, or requesting entity, the Counselor has no control over how the information is to be used.*

Limits of Confidentiality:
Communication between a client and a counselor is confidential to the extent of the law. However, there are certain situations that require only that you provide written, advance consent for the release of information concerning what you say in a counseling session. Your signature on this Agreement provides consent for the following activities:

- Consultation with other health and mental health professionals about your case. During a consultation, I make every effort to avoid revealing the identity of my client. The other professionals are also legally bound to keep the information discussed confidential. I will tell you about these consultations if I feel it is important to our work together.
- Processing by administrative staff. In most cases, I need to share protected information with these individuals for administrative purposes, such as scheduling and/or billing.
- Disclosure required by insurance companies that includes a DSM-5 diagnosis.
- **Serious danger to yourself or others. If a client seriously threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection. If I determine that there is a probability of imminent physical injury to the client or others, or there is a probability of immediate mental or emotional injury to the client, I have the right to notify medical or law enforcement and the person(s) the client intends to harm.**
- If a client files a complaint or lawsuit against me, I will disclose relevant information regarding that client in order to defend myself.
- I do not accept friend requests from current or former clients on my psychotherapy related profiles or social networking sites due to the fact that these sites can compromise clients' confidentiality and privacy. For the same reason, I request that clients do not communicate with me via any interactive or social networking websites.
- If I see your child or teenager (minor) for therapy, I may not disclose to you (parent or guardian) and may not make psychotherapy notes/medical records available to you if I think it is in the best interest for the child or teenager.

Disclosure will not be affected by this Agreement in the following situations:

- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and therapy, such information is protected by law. I cannot provide any information without your written authorization, or a court order.

In certain situations I am legally obligated to take action, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a client's therapy. If such a case should arise, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary. Such a situation would be:

- If I have cause to believe a child under the age of 18 has been or may be abused or neglected (including physical injury, substantial threat of harm, mental or emotional injury or any kind of sexual contact or conduct), or that a child is a victim of a sexual offense the law requires that I make a report to the appropriate governmental agency. Once such a report is filed, I may be required to provide additional information.
- If I have cause to believe that an elderly or disabled person is in a state of abuse, neglect or exploitation, the law requires that I make a report to the appropriate governmental agency. Once such a report is filed, I may be required to provide additional information.

Transfer Plan for Incapacitation or Death

In the unlikely event that I am unable to provide ongoing services Gale Grant-LeRoy, MS, LPC-S, NCC will provide those services or will refer you to the appropriate resource. Gale Grant-LeRoy may be contacted at Pearland Counseling Center located at 2217 N. Park Avenue, Pearland, Texas 77581 or via phone at 281-997-8400. Her role as custodian includes:

- Access information. I will provide the custodian location(s), keys, passwords, access codes and other information necessary or a protocol to obtain this information in order to execute the transfer plan.
- Notify you of my inability to practice. The custodian will send a letter to you notifying you of my inability to practice. The custodian will offer to provide ongoing counseling services (if clinically appropriate) or provide referrals to the most appropriate service provider.
- Possession of clinical records. The custodian will take possession/responsibility of the clinical records and inform you on procedures to access your clinical records.
- Requests for information. The custodian will respond to a request for information in concert with state laws, HIPAA guidelines and code of ethics.
- Maintaining and destruction of clinical records. The custodian will maintain clinical records (post treatment) for 5 years or 5 years past age of majority for minors.

I affirm that prior to becoming a client I was given sufficient information to understand the nature of counseling and maintaining respectable boundaries during the treatment process. I have had all my questions answered fully. I agree to play an active role in this process. I further understand that no guarantees have been made to me as to the results of the counseling process.

You should consider this information along with your own opinions of whether you feel comfortable working with me because counseling involves a commitment of time, money and energy. Feel free to discuss any questions you have about my procedures whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

If your intention in seeking counseling services is for legal purposes, a referral will be given to seek assistance from another professional counselor that has experience and/or is an expert in testifying in court.

Complaint Process:

An individual who wishes to file a complaint against a Licensed Professional Counselor may write to:

Complaints Management and Investigative Section
P.O. Box 141369
Austin, Texas 78714-1369
1-800-942-5540

*Please see "Notice of Privacy Practices" brief version for additional information located in your introduction packet. A long version of the Notice of Privacy Practices is available upon request and is also posted in the waiting room.

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Upon complete review of all documents in this packet, pages 1-13, your therapist will provide an Acknowledgement and Consent form to be signed by you (the client) and your therapist during the initial sessions.

I (the client) understand that pages 1-13 (Excluding Signature Page 5) of this packet are available to me anytime online at www.pearlandcounselingcenter.com or by request. This request can be made in person at Pearland Counseling Center, 2217 North Park Avenue, Pearland, Texas 77581.

I (the client) understand that my signature is required on the Acknowledgement and Consent form before services can be provided. I (the client) understand that **if I choose NOT to sign the Acknowledgement and Consent form counseling services will not be provided.**

IMPORTANT: It is required the Acknowledgement and consent for is signed by you (the client) and witnessed prior to the start of counseling services.

CLIENT REGISTRATION PAGE

TODAY'S DATE: _____

Patient Name: _____ DOB: __ __ - __ __ - __ __ __ __ Age: ____ Gender: ____

Marital Status: **SINGLE MARRIED DIVORCED WIDOWED** SS#: __ __ __ - __ __ - __ __ __ __ DL#: __ __ __ __ __ __ __ __

Address: _____ APT#: _____

City: _____ State: _____ Zip: _____

Home: __ __ __ - __ __ __ - __ __ __ __ Work: __ __ __ - __ __ __ - __ __ __ __ Cell: __ __ __ - __ __ __ - __ __ __ __

May we contact your home #? _____ May we contact your work #? _____ May we contact your cell #? _____

May we leave a message? Y N May we leave a message? Y N May we leave a message? Y N

E-Mail Address: _____

Employer: _____ Occupation: _____

Emergency Contact

Name: _____ Relationship: _____

Home: __ __ __ - __ __ __ - __ __ __ __ Work: __ __ __ - __ __ __ - __ __ __ __ Cell: __ __ __ - __ __ __ - __ __ __ __

Name of person responsible for this client: _____ Relationship: _____

INSURANCE INFORMATION

Name of Insured person: _____ Relationship: _____

Insured SS#: __ __ __ - __ __ - __ __ __ __ Insured DOB: __ __ - __ __ - __ __ __ __ Gender: _____

Insured Employer: _____ Employer Phone #: __ __ __ - __ __ __ - __ __ __ __

Name of Insurance: _____ Ins. Phone #: __ __ __ - __ __ __ - __ __ __ __

ID or Policy #: _____ Group #: _____

ADDRESS AND CONTACT INFORMATION OF INSURED PERSON, *IF NOT THE SAME AS CLIENT*

Address: _____ APT#:_____

City: _____ State: _____ Zip: _____

Home: __ __ __ - __ __ __ - __ __ __ __ Work: __ __ __ - __ __ __ - __ __ __ __ Cell: __ __ __ - __ __ __ - __ __ __ __

MEDICAL HISTORY

Reason for seeking Counseling: _____

_____

Other physicians treating you: _____ Phone #: __ __ __ - __ __ __ - __ __ __ __

Other physicians treating you: _____ Phone #: __ __ __ - __ __ __ - __ __ __ __

Other physicians treating you: _____ Phone #: __ __ __ - __ __ __ - __ __ __ __

Current physical problems (describe): _____

_____

Current Medications: _____

_____

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NOTICE OF PRIVACY PRACTICES – BRIEF VERSION

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

Our commitment to your privacy:
Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We also are required by law to keep your information private. These laws are complicated, but we must give you this important information. This pamphlet is a shorter version of the full, legally required NPP which is available upon your request and contains more information regarding your protected health information. Please talk to your Privacy Officer (see the end of this pamphlet) about any questions or problems.

We will use the information about your health which we get from you or from others mainly to provide you with **treatment**, to arrange **payment** for our services, and for some other business activities which are called, in the law, health care **operations.** After you have read this NPP we will ask you to sign a **Consent Form** to let us use and share your information. If you do not consent and sign this form, we cannot treat you.

If we or you want to use or disclose (send, share, release) your information for any other purposes we will discuss this with you and ask you to sign an Authorization form to allow this.

Of course we will keep your health information private but there are some times when the laws require us to use or share it. For example:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share information with a person or organization that is able to help prevent or reduce the threat.

2. Some lawsuits and legal or court proceedings.

3. If a law enforcement official requires to do so.

4. For Workers Compensation and similar benefit programs.

There are some other situations like these but which don't happen very often. They are described in the longer version of the NPP.

Your rights regarding your health information

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place which is more private for you. For example, you can ask us to call you at home and not at work to schedule or cancel an appointment. We will try our best to do as you ask.

2. You have the right to ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends. While we don't have to agree to your request, if we do agree, we will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you.

3. You have the right to look at the health information we have about you such as your medical and billing records. You can even get a copy of these records but we may charge you. We will provide one accounting a year for free, but will charge a reasonable, cost-based fee if you ask for another within 12 months. Contact your Privacy Officer to arrange how to see your records. See below.

4. If you believe the information in your records is incorrect or missing important information, you can ask us to make some kinds of changes (called amending) to your health information. You have to make this request in writing and send it to your Privacy Officer. You must tell us the reasons you want to make the changes.

5. You have the right to a copy of this notice. If we change this NPP we will post the new version in our waiting area and you can always get a copy of the NPP from your Privacy Officer.

6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with your Privacy Officer Pamela S. Lawson MA, LMFT at 2217 North Park Avenue, Pearland, TX 77581. All complaints to our Privacy Officer must be in writing. You can also file a complaint with the Secretary of the Department of Health and Human Services Office for Civil Rights at 200 Independence Ave., S.W. Washington, D.C. 20201, or by calling 1-877-696-6775 or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. Filing a complaint will not change the health care we provide to you in any way.

If you have any questions regarding this notice or our health information privacy policies, please contact your Privacy Officer who is Pamela S. Lawson MA, LMFT, and can be reached by phone at 281-997-8400.

Designated Privacy and Security Officer for this Practice

Pamela S. Lawson MA, LMFT is the designated Security Officer for this practice.

Pamela S. Lawson MA, LMFT is the designated Privacy Officer for this practice.

All privacy and security questions, requests, and concerns should be directed to me, Pamela S. Lawson MA, LMFT and I will be responsible for handling them.

Acknowledgement of Receipt of Notice of Privacy Practice

I, _____, have read and understand this document. I recognize that I have the opportunity now and in the future to discuss any question I may have with my counselor. I agree to the practices and policies delineated herein and have received a copy of this Office's Notice of Privacy Practices.

Print Name: _____

Signature: _____ Date: _____

It is your right to refuse to sign this document.

For Office Use Only:

The reason that a standard acknowledgment (such as the above) of the receipt of the Notice of Privacy Practices was not obtained:

_____ Patient refused to sign.

_____ Communication barriers prohibited obtaining the acknowledgement.

_____ An emergency situation prevented this office from obtaining it.

_____ Others: _____

POLICY FOR NO SHOW/LATE CANCEL AND OUTSTANDING BALANCE DUE

We are very committed to serving our clients and strive to accommodate all of our clients by making appointments available as soon as possible.

When an appointment is reserved for you, we require that the appointment be cancelled by **1:00 pm the day prior to the appointment.** We understand that emergencies happen, and we will be happy to work with you in those situations. If you have any questions, please feel free to speak with our office manager.

****

I understand that I will be responsible for a **missed appointment fee of $50.00** and that my credit card will be charged if I am unable to provide the proper notice that I will not keep my scheduled appointment. Note: This policy may also apply to sessions provided by Employee Assistance Programs (EAP).

I also understand that I will be responsible for any outstanding balance for services rendered and that my credit card will be charged to pay for the outstanding balance.

If you choose to provide your flexible spending account information, an additional credit or debit card number is required as the situation may occur that your flex account holds insufficient funds or its balance has become depleted.

We accept the following debit/credit cards: Visa, Discover, American Express and MasterCard.

FOR FLEX CARD:

Name As Appears On Card: _____

Credit Card Number: ___ ___ ___ ___ - ___ ___ ___ ___ - ___ ___ ___ ___ - ___ ___ ___ ___

Expiration Date: _____

FOR CREDIT/DEBIT CARD:

Name As Appears On Card: _____

Credit Card Number: ___ ___ ___ ___ - ___ ___ ___ ___ - ___ ___ ___ ___ - ___ ___ ___ ___

Expiration Date: _____

I have read, understand and agree to the Policy above and give my permission for my card to be charged if a violation occurs.

Print Name: _____

Signature: _____ Date: _____

I _____ (CREDIT CARD HOLDER NAME) understand that by providing my Credit Card information I am consenting to being financially responsible for _____ (CLIENT NAME) regarding any violation of the Policy stated above.

Print Name: _____

Signature: _____ Date: _____

You may revoke this consent at any point, by submitting a request in writing which MUST include:
Date of request, client's name, your name, signature, copy of your current Driver's License, and an explanation of the information to be removed. If you are mailing your request, please keep in mind there could be charges to your card until your request is received by our office.

OFFICE USE ONLY: DATE OF REVOKE REQUEST: _____ DATE REQUEST REC'D (EFF. DATE OF REVOKE): _____

Email and Texting Consent

HIPAA regulations and my professional Code of Ethics both require that I keep your Protected Health Information private and secure, and indeed I want to do so. Email is a very convenient way to handle administrative issues like scheduling or receipt requests, but email is not 100% secure. Some of the potential risks you might encounter if we email include:

- Misdelivery of email to an incorrectly typed address.
- Email accounts can be 'hacked,' giving a 3rd party access to email content and addresses.
- Email providers (i.e., Gmail, Comcast, and Yahoo) keep a copy of each email on their servers, where it might be accessible to employees, etc.

For these reasons, I will not use email to discuss clinical issues (i.e., the important things we talk about in session.)

If you are comfortable doing so, I am happy to use email to handle small administrative matters like scheduling and billing. This will only be utilized if the Office Staff is unavailable to assist you with these matters.

The Office Staff will handle all scheduling, billing and other office matters by phone only. Email and text will not be used as a form of communication. If this policy changes, you will be notified at the time of change and be provided with an updated consent to review and sign.

If you are not comfortable with these risks, we can handle administrative issues via phone calls.

I do not text clients appointment confirmations.

Please indicate your preference about email below and sign. **(CIRCLE ONE OF THE OPTIONS BELOW)**

I DO or DO NOT consent to use email for administrative matters.

If given, consent will expire 2 years after our last appointment. This means that I will not initiate contact via email, although you are always still welcome to email me, and I can reply briefly if you do.

Print Name: _____

Signature: _____ Date: _____

SOCIAL MEDIA

Social media is used for personal use only and should not be used in professional relationships. In order to respect the boundaries of both the clients and the staff, including maintaining confidentiality, there can be no affiliation on these websites.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Client's Initials: _____ Parent/Guardian Initials (If client is under 18 years old): _____ _____

INSURANCE – ASSIGNMENT AND RELEASE

I the undersigned certify that I (and/or my dependents) have insurance coverage with

_____ and that I assign directly to Pamela S. Lawson MA, LMFT all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize Pamela S. Lawson MA, LMFT to release any information necessary to secure payment of benefits. I authorize this signature on all insurance submissions.

Client's Initials: _____ Parent/Guardian Initials (If client is under 18 years old): _____ _____

POLICY FOR PROVIDING NEW INSURANCE INFORMATION

Our clients are very important to us and our main goal is make their time here as pleasant and smooth as possible. It is pertinent that we receive any updated information prior to your scheduled appointment so that we are able to avoid any discrepancies with your insurance coverage.

If/when you acquire new insurance, we require a **48 HOUR NOTICE prior to your scheduled appointment**. If you do not provide your updated insurance information within the 48 hour timeframe you will be subject to a fee. The fee will be based on the contracted rate of your insurance company.

Client's Initials: _____ Parent/Guardian Initials (If client is under 18 years old): _____ _____

Print Name: _____

Signature: _____ Date: _____

MINORS:

Child's Printed Name_____

Child's Signature_____ Date_____

Parent's Printed Names_____

Parent's Signatures_____ Date_____

Parent's Printed Names_____

Parent's Signatures_____ Date_____

SELF-ASSESSMENT Name: _____ Date: _____

What is happening in your life which resulted in this appointment? _____

_____

What would you like to see accomplished in therapy? _____

_____

CHIEF COMPLAINT (CHECK ALL THAT APPLY TO YOU):

__ Depression
__ Low Energy
__ Low self-esteem
__ Poor concentration
__ Hopelessness
__ Worthlessness
__ Guilt
__ Sleep disturbance (more/less)
__ Appetite disturbance (more/less)
__Thoughts of hurting yourself
__ Thoughts of hurting someone
__ Isolation/social withdrawal
__Sadness/loss
__Stress
__ Anxiety/panic
__ Heart pounding/racing
__ Chest pain
__ Trembling/shaking
__ Sweating
__ Chills/hot flashes
__ Tingling/numbness
__ Fear of dying
__ Fear of going crazy
__ Nausea
__ Phobias
__ Obsessions/compulsive behaviors
__ Thoughts racing
__ Can't hold onto an idea
__ Easily agitate
__ Excessive behaviors (spending, gambling)
__ Delusions/hallucinations
__ Not thinking clearly/confusion

__ Feeling that you are not real
__ Feeling that things around you are not real
__ Lose track of time
__ Unpleasant thought won't go away
__ Anger/frustration
__ Easily agitated/annoyed
__ Defies rules
__ Blames others
__ Argues
__ Excessive use of prescription medications
__ Blackouts
__ Physical abuse issues
__ Sexual abuse issues
__ Spousal abuse issues
__ Other problems/symptoms:
_____
_____

Number of marriages _____ Number of years married _____

Number of children ___ Ages and Gender _____ _____ _____

Number of step-children ___ Ages and Gender _____ _____ _____

Do you use alcohol? _____ If yes, how much per week? _____

_____

_____

_____

Previous outpatient therapy? ____ No ____ Yes, with _____

What was accomplished? _____

_____

Previous hospitalization? ____ No ____ Yes, Number of hospitalizations _____ ECT? _____

_____