Olive Tree Counseling, Inc.
1981 E Palmer-Wasilla Hwy, Suite 220, Wasilla, AK 99654
Phone: (907) 357-6513 | Fax: (907) 357-6514

INSTRUCTIONS

1. Please read the important Notice Regarding Privacy Practices and Client Rights before printing any of your Intake documents. You will have an opportunity to discuss any questions about this notice and all your intake forms at your first appointment.

2. Please thoroughly read, sign, and submit the following required forms to Olive Tree Counseling's office before your first session.
    a. Authorization for Treatment
    b. Agreement Regarding Information for Court
    c. Agreement to Pay for Professional Services
    d. Acknowledgement of Receipt of Notice of Privacy Practices and Client Rights
    e. Acknowledgement of Receipt of Intake Forms
    f. Intake General Information

Thank you,

Holly Hoff, LPC

Derek Sandlin, LPC

Brittney Punt, LCSW

David Banks, LPC

Ken Brewington, LPC

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. REVIEW CAREFULLY AND KEEP FOR YOUR RECORDS.

*Because Olive Tree Counseling, Inc. (aka, OTC) sees clients under 18, all references to "you" include your child as the parent or guardian of the child. A parent or guardian may exercise the rights of the minor or child.

OTC understands that your health information is personal to you, and OTC is committed to protecting your information. This Notice of Privacy Practices and Client Rights (aka, Notice) describes how OTC will use and disclose protected information and data OTC receives or creates related to your health care.

OUR DUTIES

OTC is required by law to maintain the privacy of your health information and to give you this Notice describing our legal duties and privacy practices. OTC is also required to follow the terms of this Notice currently in effect.

USE AND DISCLOSURE OF HEALTH INFORMATION

OTC will not use or disclose your health information without your authorization except in the following situations:

TREATMENT

OTC may use and disclose your health information while providing, coordinating, or managing your health care. Information obtained by a member of your counseling team will be documented in your record and used to determine the course of treatment that should work best for you. OTC may also provide other healthcare providers with the minimum information that will assist them in treating you.

PAYMENT

OTC may use and disclose your medical information to obtain or offer payment for providing your health care. If OTC sends you or your health plan a bill, the information on or accompanying the bill may include information that identifies you, your diagnosis, procedures, or supplies used. OTC may be required to disclose information to your health plan to determine your eligibility for payment for certain benefits. Please note: some insurance companies request detailed information and others request only a diagnosis and office visit codes. It is your responsibility to know what personal information is required by your insurance company.

HEALTH CARE OPERATIONS

OTC may use and disclose health information to deal with certain administrative aspects of your health care and to manage our business more efficiently. OTC's medical staff may use information in your health record to assess the quality of care and outcomes in your case and others like it. This information will be used to improve the quality and effectiveness of the healthcare and services OTC provides.

BUSINESS ASSOCIATES

OTC may disclose your health information to its business associates to perform the job OTC has asked these associates to do, such as accounting or legal analysis. However, OTC requires the business associates to take precautions to protect your health information.

NOTIFICATION OF FAMILY

In an emergency, OTC may use or disclose information, your location, or general condition to notify or assist a family member, personal representative, or other person responsible for your care.

Communication With Family

OTC may disclose to a family member, relative, friend—or other person with whom you identify—health information relevant to said individual's involvement in your care.

Court Proceeding

OTC may disclose your health information in response to requests made during judicial and administrative proceedings, court orders, or subpoenas as required by law.

Other Uses

OTC may use and disclose your personal health information for the following purposes:

- Leave messages for patients regarding upcoming appointments or other administrative matters at the contact numbers on file.
- Describe or recommend treatment alternatives to you.
- Provide information about health-related benefits or services that may be of interest.

Rarely, OTC may disclose information for Food and Drug Administration (FDA), public health, reporting abuse, neglect or domestic violence, health oversight, law enforcement, threats to public health or safety, and specialized government functions (military, national security).

Prohibition on Other Uses or Disclosures

OTC will not make any other use or disclosure of your personal health information without your written authorization. Your name and identity will only be disclosed in accordance with AS 08.29.200. Once given, you may revoke the authorization in writing. OTC is unable to reverse any disclosure that has been made previously with your permission.

Confidentiality and Privacy

Confidentiality at OTC is maintained according to the AAMFT Code of Ethics, State Professional Counseling regulations and HIPAA regulations. OTC cannot guarantee that your data will be kept private where disclosing information is required by law. There are limits and exceptions to confidentiality. Understand what can and cannot be kept private:

1. When you or another person is in physical danger, OTC is required by law to report it. OTC will reveal the minimum information necessary to protect you or other individuals.
2. If OTC has reason to believe you are threatening harm to another person, OTC is required by law to protect said person. OTC is required to inform said person and the police, or have you hospitalized.
3. If you threaten or act in a way likely to harm yourself, OTC may have you hospitalized or call family to protect you. If such a situation does occur, OTC will attempt to fully discuss the situation with you before acting unless there is an exceptional reason not to.
4. In an emergency where your life or health is in danger, and OTC cannot get your consent, OTC may give another professional minimum information to protect your life. OTC will attempt to get permission first and discuss the situation as soon as possible.
5. If OTC suspects you are abusing a child, elderly person, or disabled person, the law requires OTC to file a report with a state agency. Abuse includes neglect, physically assault, or sexually molest another

person. OTC does not have any legal power to investigate the situation. Discuss legal aspects in detail before you disclose anything to OTC. Consider speaking with a lawyer.

Other considerations regarding confidentiality and treatment:

- OTC may consult with a qualified individual about your treatment without providing your name. Likewise, when OTC is unavailable, another therapist may have access to client records at the client's request. Your information will remain protected under HIPAA guidelines.
- OTC is required to keep records and notes of your treatment. If you have specific or unusual concerns, please speak with your own attorney—OTC does not give legal advice.
- OTC sees people individually, as couples, or as families. OTC will keep information confidential except for the previously listed situations. However, if others need the information for your continued progression in therapy, OTC may encourage and work with you to disclose relevant information.

Records Requests for Minors

While parents have the legal right to receive information their children share in therapy, for the mental wellbeing of the child, OTC encourages parents to not request this data. OTC may encourage and assist children in sharing information, but OTC will not share data unless necessary to protect the life and wellbeing of an individual. OTC does not believe it is in a child's best interest to release therapeutic records in most cases. OTC's code of ethics prohibits harm to clients; therefore, OTC will not willingly release records unless required by law. Clients do not feel safe when information is passed on to family or if information disclosed in therapy is used in court proceedings. Therefore, OTC reserves the right to review or reject any request for records where compliance is not lawfully required.

Other Records Requests

OTC does not release marriage and family therapeutic records to spouses without both spouses' written consent. Only your own individual records are available for you to request. However, it is not in the best interest of an individual to obtain therapeutic records—any request for records with which OTC is legally obligated to comply will include a written statement declaring that you were informed as such.

Individual Privacy Rights

Clients have the right to confidentiality of client health information. As a client, you have the right to:

1. Request restrictions on the health information OTC may use and disclose for treatment, payment, and health care operations. OTC is not required to agree to these requests. To request restrictions, please send a written statement to the address listed at the end of this document.
2. Receive confidential communications of health information about you in a certain manner or at a certain location. For instance, you may request that OTC only contact you at work or by mail. To make such a request, you must write the address listed at the end of this document stating how or where you wish to be contacted.
3. Inspect or copy your health information in paper or electronic form. You must submit your request in writing to the address listed at the end of this document. If you request a copy of your health information, OTC will charge a fee for the cost of copying, mailing, and other supplies. OTC reserves the right to deny

your request to inspect or copy your health information. However, you may request that the denial be reviewed by a separate licensed professional. OTC will comply with the outcome of their review.

4. Amend health information. If the health information that OTC has on record is incorrect or incomplete, you may ask to amend the information. To request an amendment, you must write to the address at the end of this document with the reason to support your request. OTC may deny your request to amend your health information if it is not in writing or a reason to support your request is not provided. OTC may also deny your request if:
    a. The information was not created by OTC, unless the person that created the information is no longer available to make the amendment.
    b. The information is not part of the health information kept on record by or for OTC.
    c. It is not part of the information you are permitted to inspect or copy.
    d. It is accurate and complete.
5. To receive an accounting of disclosures of your health information. You must submit a request in writing to the address listed at the end of this document. Not all health information is subject to this request. Your request must state a time no longer than 6 years and may not include dates before April 14, 2003, and how you would like to receive the report (paper or electronically).
6. There is no charge for your first accounting request. For additional accountings, OTC may charge you the cost of providing this service. OTC will notify you of this cost, and you may choose to withdraw or modify your request before any charges are made.
7. To receive a paper copy of this Notice upon request—even if you have agreed to receive the Notice electronically—you must submit a request for a paper Notice in writing to the address listed at the end of this Notice.

All requests to restrict use of your health information for treatment, payment, and health care operations, to inspect and copy health information, to amend your health information, or to receive an accounting of disclosures of health information must be made in writing to the contact person listed at the end of this Notice.

OTHER CLIENT RIGHTS

As a client, you have the right to:

1. Be treated with respect regarding psychosocial, spiritual, and cultural variables that influence perceptions.
2. Have a safe environment, free from discrimination of race, color, religion, gender, sex, handicap, national origin, or political standing. OTC treats individuals with respect and recognizes basic human rights.
3. Receive information about therapist qualifications, including license, education, training experience, membership in professional groups, special areas of practice, and limits of practice.
4. Have written information about fees, methods of payment, insurance coverage, and number of sessions the therapist thinks will be needed, and cancellation policies.
5. Have informed consent to procedures, benefits and risks, and alternative options for your care.
6. Privacy and confidentiality of your assessment and records, with exceptions noted in this document.
7. Refuse audio or video recordings of sessions.
8. Ask the therapist to inform you of your progress.
9. Report any illegal or immoral behavior by a therapist.

PROPER AND IMPROPER THERAPIST CONDUCT

A therapist should never use threatening or coercing behavior as part of your treatment plan. If you feel threatened by your therapist, confront it immediately and contact OTC's office at (908) 357-6513.
It is normal for clients to develop positive feelings or affection toward a therapist giving clients support and care. However, these feelings may take negative forms of sexual attraction. Sexual contact with your therapist is prohibited and is harmful to the client and therapist. Sexual contact is against the professional code of conduct for all professional groups of mental health workers (i.e., psychologists, psychiatrists, licensed counselors, and marriage and family counselors). You are encouraged to contact OTC's office for more information on any of OTC's therapists or to file a complaint.

NO GUARANTEED OUTCOME

OTC strives to help clients reach the goals they desire. However, therapy does not guarantee success. OTC will do its best to help you or will refer you to someone who can. Consequences not considered ideal, such as divorce, are a possibility. OTC will do its best to encourage the best possible outcomes with the least discomfort. If therapy seems ineffective, OTC will explore alternative therapy or resources for you.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint at (907) 357-6513 or to the address listed below. For severe violations, submit a complaint to the Secretary of the Department of Health and Human Services. OTC will not retaliate against you for filing a complaint.

CONTACT PERSON

The following OTC's contact person for all written questions, requests, or further information related to the privacy of your health information:

Holly Hoff
1981 E. Palmer-Wasilla Hwy. Suite 220
Wasilla, AK 99654 Attn: Privacy Officer
Office: (907) 357-6513 | Fax: (907) 357-6514

CHANGES TO THIS NOTICE

OTC reserves the right to change its privacy practices and apply revisions to previous health information. Any revision to our privacy practices will be described in a revised Notice that will be posted prominently in our facility.

Effective date: Jan. 2025. Reviewed and revised: September 2023.

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PATIENT CONSENT TO ELECTRONIC COMMUNICATIONS

Any use of electronic communication must be pre-approved by Olive Tree Counseling, Inc. (aka, OTC), in agreement with the client, documented in writing, and kept in the client's records.

Full Name: _____

Email: _____

Fax: _____

*If I (the client) authorize email and other online communications, I understand that:

1. Email can be misdirected to or intercepted and disclosed by unintended third parties and, therefore, may not be a confidential medium of communication.
2. Patients who have concerns should consider using another mode of communication.
3. Patients understand and agree that email transmission is being used for the convenience of the patients. OTC does not require the use of email nor guarantee the confidentiality and/or the security of email transmission.
4. Patients, notably those patients who have multi-user email accounts, are responsible for maintaining the confidentiality and security of their own email accounts. OTC is not responsible for information breaches on the end of patients' personal email accounts.
5. Regardless of whether the patient wishes to communicate with OTC via email, it is recommended that patients provide a working and up-to-date email address. Protected information will not be discussed via email without first being authorized by the patient.

*Do you (the client) wish to communicate with OTC via email, text, fax, or online services?

☐ Yes, I authorize EMAIL via the address: _____

☐ Yes, I authorize TEXTING via the phone #: _____
↪ ☐ Sign me up for TEXT appointment reminders

☐ Yes, I authorize FAX via the following #: _____

☐ No, I do NOT authorize online communications with OTC.

*I (the client) acknowledge, read, understood, and agreed to OTC's PATIENT CONSENT TO ELECTRONIC COMMUNICATIONS policy. I understand the benefits and risks associated with online communication and consent to the conditions as indicated herein. I agree to adhere to the policies set forth above, as well as any other instructions or guidelines that OTC may impose for using electronic communications.

(Signature required regardless of opt-in/opt-out online communications status)

Client's Signature: _____ Date: _____

TELEHEALTH CONSENT

I (the client) understand that this consent form must be filled in its entirety regardless of whether I wish to receive telehealth treatment. OTC is not liable for any claims and/or damages arising from the optional use of telehealth services. Telehealth services are entirely voluntary and will not influence the quality of care the client will receive from OTC, or condition treatment or payment on the optional use of telehealth services.

Alaska Telehealth/Telemedicine Definition, Alaska policy and regulations telemedicine references; Senate Bill 74 defines telehealth/telemedicine as the practice of health care delivery, evaluation, diagnosis, consultation, or treatment using the transfer of health care data through audio, visual, or data communications, performed over two or more locations between providers who are physically separated from the recipient or from each other, or between a provider and a recipient who are physically separated from each other.

*As a client receiving behavioral health services through online technologies, I (the client) understand that:

1. The interactive technologies used in tele-behavioral health incorporate network and software security protocols to protect the confidentiality of client information transmitted via any electronic channel. These protocols include measures to safeguard data and protect against intentional or unintentional corruption.
2. This service is provided by technology and may not involve direct, face-to-face communication. There are benefits and limitations to this service, such as the following:
    a. Electronic systems used will incorporate network and software security protocols to protect the privacy and security of health information and imaging data and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption. These services rely on technology, which allows for greater convenience.
    b. There are risks in transmitting information over technology that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties.
    c. In emergencies, disruption of services, or for routine or administrative reasons, it may be necessary to communicate by other means, i.e., through the cell phone number provided by the client.
    d. In the event of disruption of services, the client must attempt to re-establish service at least twice before attempts to communicate via cell phone.
3. The client will need access to, and familiarity with, the appropriate technology in order to participate in the service provided.
4. The exchange of information will not be direct, and any paperwork exchanged will likely be provided through electronic means or through postal delivery.
5. During my (client) tele-behavioral health consultation, details of my medical history and personal health information may be discussed with myself or other behavioral health care professionals using interactive video, audio, or another telecommunications technology.
6. If a need for direct, in-person services arises, it is my responsibility to contact my practitioner or practitioners in my area, such as another provider in my behavioral practitioner’s office, or secure an

appointment with my primary care physician if my behavioral practitioner is unavailable. I understand that an opening may not be immediately available in other offices.

7. My practitioner and I will regularly reassess the appropriateness of continuing the online services agreed upon, and we will modify the treatment as needed.
8. While, as a client, it is my responsibility to maintain privacy on my end of communication, I understand that insurance companies, those authorized by me (the client), and those permitted by law may also have access to records or communications.
9. I may decline or discontinue any tele-behavioral health services at any time without jeopardizing my access to future care, services, and benefits.
10. Records of my communications and sessions will be stored in the same, secure manner that face-to-face records are stored.
11. The laws and professional standards that apply to in-person behavioral services also apply to telehealth services. This document does not replace other agreements, contracts, or documentation of informed consent.

*Please list TWO (2) examples of how you (the client) will ensure that telehealth sessions and other online communications will be kept private and directed only to your behavioral health provider or other authorized individuals (example: [1] I will keep my door locked and wear a headset, and [2] I will NOT let friends or family check my email or know my passwords):

I (the client) will ensure privacy by:

1: _____

2: _____

*I (the client) acknowledge that I have thoroughly read, understood, and agreed to OTC's TELEHEALTH CONSENT terms and conditions. I understand the benefits and risks associated with online communications and consent to the conditions as indicated herein. I agree to adhere to the policies set forth above, as well as any other instructions or guidelines that OTC may impose for using electronic communications.

(Signature required regardless of opt-in/opt-out online communications status)

Printed name of Client	Signature of Client	Date

Signature of parent or guardian if applicable	Relationship to client (if necessary)	Date

____Holly Hoff, LPC ___Brittney Punt, LCSW ____Derek Sandlin, LPC ____David Banks, LPC ____Ken Brewington, LPC

Printed name of Staff	Signature of Staff	Date

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS

By signing below, I acknowledge that I have received Olive Tree Counseling, Inc.'s NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS, and I understand and have had an opportunity to ask questions about the Notice, rights, therapist conduct, and other information in the Notice.

Printed name of Client	Signature of Client	Date

Signature of parent or guardian if applicable	Relationship to client (if necessary)	Date

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

____Holly Hoff, LPC ___Brittney Punt, LCSW ____Derek Sandlin, LPC ____David Banks, LPC ____Ken Brewington, LPC

Signature of therapist	Date

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Acknowledgement of Receipt of Intake Forms

I, _____, acknowledge I have read (or have had read to me) and been offered copies of my Intake Forms, which include:

1. Notice of Privacy Practices & Client Rights
2. Patient Consent to Electronic Communications
3. Fees for Professional & Administrative Services
4. Authorization for Treatment
5. Court & Disclosure Statements

My signature below shows that I understand and agree with the above statements.

Printed name of Client	Signature of Client	Date

Signature of parent or guardian if applicable	Relationship to client (if necessary)	Date

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

____Holly Hoff, LPC ___Brittney Punt, LCSW ____Derek Sandlin, LPC ____David Banks, LPC ____Ken Brewington, LPC

Signature of therapist	Date

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Authorization for Treatment

I acknowledge that I have received, read (or have had read to me), and understand the information provided to me about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in the treatment with the therapist indicated below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist. I am aware that I may stop my treatment at OTC at any time. However, I will still be responsible for paying for the services I have already received. I understand that it is my responsibility to deal with the consequences of discontinuing treatment, i.e., in the event of court-ordered treatments.

I agree that I am responsible for services fees provided by OTC and that my insurance company may make payments on my account. I agree to pay for services up until the time I end the relationship. I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, OTC will stop my treatment.

In the event of an emergency (e.g. I become sick while on the premises, pass out or fall, become suicidal) I hereby give permission to OTC to contact and provide information about the emergency and where I am to the following individual:
_____(Name) at phone number _____
or _____

My signature below shows that I understand and agree with the above statements.

Printed name of Client	Signature of Client	Date

Signature of parent or guardian if applicable	Relationship to client (if necessary)	Date

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

____Holly Hoff, LPC ___Brittney Punt, LCSW ____Derek Sandlin, LPC ____David Banks, LPC ____Ken Brewington, LPC

Signature of therapist	Date

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September 1, 2022 Fee Schedule

Olive Tree Counseling, Inc. Fees

Initial Assessment	$350.00	No Call No Show	Service cost
Individual session 55 min	$200.00	Art Therapy	$200.00
Family session 55min	$200.00	Play Therapy	$200.00
Brief session 45 min	$160.00		

Olive Tree Counseling, Inc. Administrative / Court Fee Schedule:

Copies per page	$ .50
Summary of Care Reports	$ 100.00
Court appearances are hourly (Point to point)	$ 2000.00

I agree that I am responsible for fees of service provided by OTC. My insurance company may make payments on my account; however, under HIPAA guidelines, I understand that other persons—be it friend, spouse, or family—may not make payments on my behalf without necessary authorization in a RELEASE OF INFORMATION. I also understand that OTC reserves the right to change the Fee Schedule and Terms of Payment at any time, and I will be provided with the new Fee Schedule and Terms at the next applicable visit. I am aware that I may stop my treatment any time but will still be responsible for paying for services I have already received. Should I not comply with my responsibility to pay for services, OTC reserves the right to provide my demographic data and financial information to a collection agency.

Insurance Information

I understand that OTC will bill my primary insurance as a courtesy. I understand my insurance will be provided with personal information regarding services received at OTC. I have been informed and understand that OTC does not bill secondary insurance companies. However, I may request OTC to provide claim forms for me submit to secondary insurances myself. I understand that I will be responsible for fees not covered by my primary insurance. I request OTC to bill my insurance company for services I receive.

No Call No Show

I understand it is my responsibility to cancel an appointment at least 24 hours (1 day) before the time of the appointment. If I do not cancel in advance and do not show up, I will be charged for that appointment.

I, _____(Name), acknowledge that I received a copy, thoroughly read, and understand the Fee Schedule of OTC, and agree to comply with the terms listed above.

Printed name of Client	Signature of Client	Date
Signature of parent or guardian if applicable	Relationship to client (if necessary)	Date

_____Jody Rossing ____Holly Hoff, LPC _____Brittney Punt, LCSW _____Derek Sandlin, LPC ____David Banks, LPC ____Ken Brewington, LPC

Printed name of Staff	Signature of Staff	Date

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AGREEMENT REGARDING INFORMATION FOR COURT:
Minors, Couples, Families

OTC does not make recommendations to the court concerning divorce, custody, or parenting issues—the court appoints professionals to conduct such evaluations, and you may request an evaluation through your attorney if necessary. The purpose of the following agreement is to avoid harming the clinical relationship between clients, including couples, children, and families, and their therapist. Therefore, OTC will notify and discuss with all clients and couples with children of the following:

I (the client) acknowledge and understand the following agreement (please initial):

_____ I understand that the information the therapist gains from working with me, my family, and/or my child
(initial) is confidential, and that OTC will not release this information without my written authorization.

_____ I agree to not request any information from OTC for **any** court-related reason whatsoever, including but
(initial) not limited to divorce or custody issues.

_____ OTC may share a minor's relevant information to a parent or legal guardian with the minor's written
(initial) permission. However, I agree that this information will not be used in court except in necessary cases, such as abuse.

_____ I understand that it is not the role of a therapist to make recommendations to the judge or to express
(initial) opinions concerning divorce or custody issues.

My signature below shows that I understand and agree with the above statements.

Printed name of Client	Signature of Client	Date

Signature of parent or guardian if applicable	Relationship to client (if necessary)	Date

____Holly Hoff, LPC ___Brittney Punt, LCSW ____Derek Sandlin, LPC ____David Banks, LPC ____Ken Brewington, LPC

Signature of therapist	Date

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INTAKE: GENERAL INFORMATION

A. Date:_____

B. Your Name: _____ Date of Birth: _____ Age: _____ Soc Sec#_____

Spouse's Name: _____ Date of Birth: _____Age: _____Soc Sec#_____

Home Address: _____ City, State, Zip: _____

Mailing Address: _____

Home Phone: _____ Cell Ph: _____ Email address: _____

Current Employer: _____ Work Phone: _____

Insurance Carrier_____Group #_____ID# _____

Primary Language: _____

Your Education, Training, or Military experience: _____

Minors:

Child's Name: _____Date of Birth: _____Age: _____Soc Sec#_____

Name of Child's Biological Parent if different than above: _____

Biological Parent Date of Birth: _____ Biological Parent Social Security # _____

Home Address: _____

Mailing Address: _____Phone:_____

C. Referral Information

Name: _____ Relationship_____Phone: _____

How did this person explain OTC might be of service? _____

D. Chief Concern

Please describe the primary difficulty that has prompted you to seek help:

_____

_____

D. Your two most important goals _____

_____

E. Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before?

NO_____ YES_____ if yes, Please indicate:

When/Dates	From Whom?	For What?	With What Results?
_____	_____	_____	_____
_____	_____	_____	_____

F. Have you ever taken medications for psychiatric or emotional problems? No____ Yes_____

Medication Name	Prescribed by whom?	For What?	With What Results?
_____	_____	_____	_____
_____	_____	_____	_____

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Name: _____ Date: _____

Please mark all of the items below that apply. Write in any clarifying remarks

☐ Anger, Rage_____

☐ Anxiety, nervousness, worry _____

_____

_____ I feel restlessness or keyed up on edge frequently _____ I have feelings of irritability

_____ I am easily fatigued _____ I have muscle tension

_____ I have difficulty concentrating or my mind going blank _____ I experience sleep disturbance

_____ I fear or avoid social situations

I have experienced these feelings for _____6mo _____1year _____2 years _____since childhood

☐ Attention, concentration, distractibility

☐ Career concerns, goals, and choices

☐ Codependence

☐ Confusion

☐ Custody of children

☐ Decision making, indecision, mixed feelings, putting off decisions

☐ Delusions (false ideas)

☐ Depression _____

_____I feel sad most of the day, nearly every day _____I feel low energy or fatigue

_____I have a poor appetite, or I overeat _____I experience feelings of low self esteem

_____I have trouble sleeping or I sleep a lot _____I experience feelings of hopelessness

_____I have poor concentration or difficulty making decisions _____I have had a significant weight loss or gain

_____I have feelings of committing suicide _____I feel like dying

I have experienced these feelings for _____6mo _____1yr _____years _____since childhood

☐ Eating problems – Overeating, under eating, no appetite (see also "Weight and diet issues")

☐ I have used diuretics, laxatives, or induced vomiting ☐ I have been diagnosed with an eating disorder

☐ I have difficulty maintaining my body weight ☐ I eat food for comfort when I am upset or lonely

☐ I am often disturbed by my body's shape or weight ☐ I binge eat

☐ Emptiness

☐ Exercise: How often/What type_____

☐ Envy

☐ Failure

☐ Fatigue, tiredness, low energy

☐ Fears, phobias

☐ Financial or money troubles, debt, impulsive spending, low income

☐ Friendships – None or limited supportive friendships

☐ Forgiveness- I have a difficult time forgiving others

☐ Gambling

☐ Grieving, mourning, deaths, losses, divorce

☐ Guilt

☐ Headaches, other kinds of physical pains_____

☐ Housework/chores - quality, schedules, sharing duties

☐ I pull out my hair and there is noticeable hair loss

☐ I sometimes feel a sense of tension until I pull out my hair and/or I feel a sense of relief after I pull out my hair

☐ Inferiority feelings
☐ Interpersonal conflicts
☐ Impulsiveness, loss of control, outbursts
☐ Irresponsibility
☐ Judgment problems, risk taking
☐ Loneliness
☐ Marital conflict:

_____Distant/coldness	_____Infidelity/Affair	_____Remarriage
_____Disappointments/Discontent	_____Lack of communication	_____Value/Belief System differences
_____Parenting style differences	_____Difference in sexual desire	_____Pornography issues
_____Physical or Emotional Intimacy	_____Emotional Neglect or Abuse	_____Domestic Violence

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☐ Memory problems
☐ Menstrual problems, PMS, menopause
☐ Mood swings
☐ Motivation, laziness
☐ Obsessions/ Compulsions

_____I have recurrent or persistent thoughts	_____I experience images or impulses that are intrusive
_____I feel anxiety	_____I ignore or suppress thoughts, urges, or images
_____I repeat behaviors (i.e. washing hands, checking, ordering)	_____I experience anxiety if I don't repeat behaviors

☐ Oversensitivity to rejection
☐ Panic or anxiety attacks

_____palpitations, pounding of or increased heart rate _____Sweating _____trembling or shaking _____nausea _____fear
_____shortness of breath _____feeling of choking _____chest pain/discomfort _____dizziness _____fear of losing control

☐ Parenting, child management, single parenthood
☐ Perfectionism
☐ Pessimism
☐ Pregnancies: How many_____ Losses_____ Terminations _____ Difficulties _____
☐ Problems associated with prescriptions medications, over-the-counter medications
☐ Procrastination, work, inhibitions, laziness
☐ Relationship problems (with friends, with relatives, or at work)
☐ Self-centeredness
☐ Self-esteem, Self-neglect, poor self-care
☐ Sexual issues, dysfunctions, conflicts, desire differences
☐ Shyness, oversensitivity to criticism
☐ Sleep problems—too much, too little, insomnia, nightmares
☐ Smoking and tobacco use
☐ Sometimes I see or hear things others do not hear or see
☐ Spiritual, religious, moral, ethical issues
☐ Stress, relaxation, stress management, stress disorders, tension
☐ Suspiciousness
☐ Suicidal thoughts: Describe_____
Suicide attempt: Describe_____
Homicidal thoughts or attempts: Describe_____
☐ Temper problems, self-control, low frustration tolerance
☐ Thought disorganization
☐ Threats, violence
☐ Withdrawal, isolating
☐ Work problems, employment, workaholism/overworking, can't keep a job, dissatisfaction, ambition
☐ No one could really love me as I am
☐ I must be right or perfect to be ok

☐ I am basically a bad, unworthy person

☐ Internet use: hours per day do you engage in: gaming _____ surfing_____ YouTube/etc._____ Facebook/etc._____
Other_____

☐ Sex is my most important need or sign of love

☐ My needs are never going to be met if I have to depend on others

☐ I have trouble with authority figures

☐ I dislike taking instructions or having someone tell me what to do

☐ I have in the past or am currently cutting myself

☐ Alcohol or drug use over the past 12 months:

- ☐ Have you gotten into trouble at home, at school or in the community, because of your drinking, using drugs or inhalants?
- ☐ Have you missed school or work because of using alcohol, drugs or inhalants?
- ☐ In the past year have you ever had 6 or more drinks at any one time?
- ☐ Have you done harmful or risky things when you were high?
- ☐ Do you think you might have a problem with your drinking, drug or inhalant use?
- ☐ When using alcohol, drugs or inhalants have you done things without thinking, and wished you had not done them later?
- ☐ Do you miss family activities, after school activities, community events, traditional ceremonies, potlatches, or feasts because of using alcohol, drugs or inhalants?
- ☐ Does anyone close to you worry or complain about your using alcohol, drugs or inhalants?
- ☐ Have you lost a friend or hurt a loved one because of your using alcohol, drugs or inhalants?
- ☐ Do you use alcohol, drugs or inhalants to make you feel normal?
- ☐ Does it make you mad if someone tells you that you drink or use drugs or inhalants too much?
- ☐ Do you feel guilty about your alcohol, drug or inhalant use?

Medical: Personal and Family of Origin

Name of Personal Family Physician _____

☐ Do you have any allergies? No Yes if yes, please describe_____

☐ How would you describe your health/medical status? Excellent good fair poor

☐ Please describe any chronic / current medical conditions_____

_____

Please list any medications you are taking for these conditions_____

_____

☐ Please describe any past or present psychiatric, counseling or drug / alcohol treatment you have received

When/Dates	From Whom?	For What?	With What Results?

☐ Please list any psychiatric medications you have taken in past or are currently taking

Medication Name	When/From Whom?	For What?	With What Results?

☐ I am at low medium high risk for HIV

☐ I am at low medium high risk for Hepatitis

☐ I have been diagnosed with TB

☐ I have been treated for TB

☐ I have had a blow to the head that caused me lose consciousness

☐ I have had a blow to the head that caused a concussion

☐ I have received an injury that caused vision and / or hearing loss

☐ Did your father or his parents have any medical or psychological problems? No Yes if yes, please describe

_____

☐ Did your mother or her parents have any medical or psychological problems? No Yes if yes, please describe

_____

Your Children:

Name	Gender	Age	Who do they live with	Describe your relationship with them

Family History:

1. Where were you born and raised? How many siblings do you have?

   _____

2. Which of these words best describes your relationship with your parents as a child?

   Mother: ___Warm ___Loving ___Distant ___Difficult ___Supportive ___Bonded ___Attached ___Chaotic
   Father: ___Warm ___Loving ___Distant ___Difficult ___Supportive ___Bonded ___Attached ___Chaotic

3. Which of these words best describes your relationship with your Siblings?

   Name of sibling: _____ ___Warm ___Loving ___Distant ___Difficult ___Supportive ___Bonded ___Attached ___Chaotic
   Name of sibling: _____ ___Warm ___Loving ___Distant ___Difficult ___Supportive ___Bonded ___Attached ___Chaotic
   Name of sibling: _____ ___Warm ___Loving ___Distant ___Difficult ___Supportive ___Bonded ___Attached ___Chaotic
   Name of sibling: _____ ___Warm ___Loving ___Distant ___Difficult ___Supportive ___Bonded ___Attached ___Chaotic
   Name of sibling: _____ ___Warm ___Loving ___Distant ___Difficult ___Supportive ___Bonded ___Attached ___Chaotic

4. List two positive things your parents taught you when you were growing up: _____
5. List two negative things your parents taught you: _____
6. Did a parent or other adult in the household often … Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt? Who? _____ _____Yes _____No
7. Did a parent or other adult in the household often … Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured? Who? _____ _____Yes _____No
8. Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? or Try to or actually have oral, anal, or vaginal sex with you? Who? _____ _____Yes _____No
9. Did you often feel that… no one in your family loved you or thought you were important or special? Or your family didn't look out for each other, feel close to each other, or support each other? _____Yes _____No
10. Did you often feel that… you didn't have enough to eat, had to wear dirty clothes, had no one to protect you Or your parents were too drunk or high to care for you or take you to the doctor if needed? _____Yes _____No
11. Were your parents ever separated or divorced? How old were you? _____ _____Yes _____No
12. When you were a child were any of your caregivers treated violently, often pushed, grabbed, slapped, had something thrown at them, kicked, bitten, hit with a fist, or hit with something hard; or threatened with a gun or knife? Who? _____ _____Yes _____No
13. Did you live with anyone who was a problem drinker or used street drugs? Who? _____ _____Yes _____No
14. Was a household member depressed or mentally ill or did a household member attempt suicide? Who? _____ _____Yes _____No
15. Did a household member go to prison? Who? _____ _____Yes _____No

Additional Lifetime losses / Adult OR Teen Traumas NOT previously noted.(Briefly describe)

Abandonments _____
Assaults / Violent Events (including date or stranger rape)_____
_____
Betrayals_____
Deaths_____
Separation or Divorces (How many? Briefly describe cause) _____
_____
Threats / Intimidation (Briefly describe)_____

Please comment on any additional information in space below: