

Today's Date: _____ Referred by: _____

Name: _____

Address: Last First MI Maiden Name

Street City State Zip E-Mail Address

Telephone: work. home pager cellular

Birth Date: _____ Age: _____ Gender: _____ SS#: _____ Living Situation/Dates: _____

married, single, other arrangement

Previous Marriage(s): _____ Education /Training: _____

dates/length/name of spouse(s) years/degrees/institutions/dates

Military Service/Dates: _____ Religion : _____ / _____

branch/dates childhood present

Employer: _____ How Long? _____ Occupation: _____

Employer's Address: _____

Street City State Zip

Emergency Contact: _____ Relationship: _____ Phone: _____

INSURANCE INFORMATION

(Please give us your insurance information even if you are here on an Employee Assistance Plan)

If your insurance company requires prior authorization, have you obtained it? Yes _____ No _____ Not Required _____

authorization code

Insurance Company: _____ Phone: _____

Address: _____

Street City State Zip

Policy Holder: _____ Birth Date: _____ Relationship to Client: _____

Employer: _____ Group Number: _____ ID Number: _____

Secondary Insurance: _____ Phone: _____

Address: _____

Street City State Zip

ID Number: _____ Group Number: _____

PATIENT OR AUTHORIZED PERSON'S SIGNATURE (Required): I authorize the release of any medical or other information necessary to process a claim. I authorize payment of medical benefits to the provider of services. I accept responsibility for paying any amount not covered by insurance.

Signed: _____ Date: _____

For Office Use Only

Dx: DSM-IV: _____ Ins. card to billing _____ Face sheet to billing _____

Special Instructions: _____ Number of visits authorized _____

Presenting Problems

Describe the problem(s) that brought you here today:

Symptoms Check any symptoms that you are having/or have had recently:

- Feeling hopeless
- Feeling of extreme happiness
- Lack of enjoyment of usual activities
- Feeling keyed up/on edge
- Fear of situations where escape is difficult
- Not getting along with friends/family
- Change in sleeping habits
- Paranoid thoughts
- Indecisiveness
- Increased use of alcohol/drugs
- Thoughts about hurting yourself
- Thoughts about hurting others
- Problems with anger
- Physical complaints of pain
- Memory problems
- Lack of energy
- Change in appetite
- Weight changes
- Exaggerated startle response
- Shortness of breath
- Frequent urination
- Sweating/clammy hands
- Gender issues
- Extreme sadness
- Feeling stressed
- Easily irritated
- Feeling guilty
- Feeling fearful
- Perfectionism
- Trouble performing your job
- Procrastination
- Mind going blank
- Avoiding things
- Thoughts about killing yourself
- Thoughts about killing others
- Intrusive thoughts
- Chest pain
- Trouble concentrating
- Numbness
- Stomach or bowel problems
- Chronic weakness
- Trembling/twitching
- Heart symptoms
- Trouble swallowing
- Change in sexual function
- Depression
- Self-esteem problem
- Excessive worry
- Feeling nervous or anxious
- Sudden feelings of panic
- Obsessions or compulsions
- Self-starvation
- Reckless behavior
- Hearing voices
- Crying spells
- Suicide attempts
- Acting violently
- Poor interpersonal skills
- Chronic pain
- Low energy
- Dry mouth
- Change in eating habits
- Nerve problems
- Muscle tension/aches
- Hot flashes
- Dizziness
- Change in sexual interest

Goals for Therapy

What are your goals for treatment?	How would you measure improvement?
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

MEDICAL INFORMATION

What medical health problems do you have? (Please explain)

Do you have any allergies (e.g. to prescription meds, over-the-counter meds, other things)? Yes No

What are you allergic to and what kind of reaction do you have?

Have you seen a doctor within the past year? Yes No

Name of Doctor	Phone	Diagnosis	Purpose of Visit	Outcome

Are you taking any medication (Prescription, over-the-counter or herbal remedy)? Yes No

Medication	Purpose	Dosage	Start Date	Prescribed By

SUBSTANCE USE HISTORY

Have you ever used tobacco in any form? Yes No

(Please describe the history and current pattern of your tobacco use.)

Have you ever used alcohol? Yes No

(Please describe the history and current pattern of your alcohol use.)

Have you ever used caffeine (any form, including cola drinks)? Yes No

(Please describe the history and current pattern of your caffeine use.)

Have you ever used illegal drugs of any kind? Yes No

(Please describe the history and current pattern of your drug use including which drugs.)

Client-Therapist Agreement

Confidentiality:

All information you share with me remains confidential with the following exceptions. Oregon law stipulates that if I believe you are a physical danger to yourself or others or that there is physical abuse of a child or an elderly person I must report it to the proper authorities. Also, your insurance company has the right to request information to determine your eligibility to receive insurance benefits.

If I believe it would be helpful to exchange information with another professional, your physician for example, I will discuss this with you. If you agree, you will need to sign an authorization for this to occur and I will then place a call to that person.

Fee Schedule:

My standard fee for a 50-minute session is \$120. The initial session on insurance is considered an assessment and is \$180. Longer or shorter sessions are charged proportionately. I also charge at the same rate for significant amounts of time spent on phone calls or contacting other professionals, family members, etc. Travel time to home or hospital visits and report preparation time is charged at 50% of the usual rate.

Additional fees are as follows: (None of these fees can be paid for through your insurance benefit.)

- After hours (any session that begins before 8:40 AM or after 4:30 PM & on weekends) 10% extra.
- Cancellation (with more than 48 hours notice) 20% of what the fee would have been for a kept appointment.
- Late cancellation (with less than 48 hours notice) 40% of what the fee would have been for a kept appointment.
- Failed appointment (no shows) 60% of what the fee would have been for a kept appointment.
- Make-up appointments. The cancellation, late cancellation, and failed appointment fees may be reduced by one half if you reschedule the missed appointment within the same time frame.
- Group. My standard fee for group therapy is \$60 per session and sessions run about 2 hour. Because there is no way to refill your space in group, you will be charged \$40 for all sessions missed, regardless of the reason or amount of advanced notice.

Please pay all fees at the beginning of each session. Client who are not on insurance and pay in full each time will receive a 10% discount. If you believe that your insurance will pay for part of your therapy you need only pay your deductibles and copays instead of the full fee for the session. Bank fees for returned checks will be billed to you. If you have more than one returned check you will be required to pay in cash or money order at the beginning of each session.

Urgencies and Emergencies:

If it is important that you reach me on an urgent matter, please call my office number, 503 228-7574. If I do not answer, your call will be sent directly to my voice mail. If you leave a message on my voice mail I will automatically be paged and I will respond as soon as possible. I also carry a cellular phone for this purpose. Of course, if your matter is an emergency, dial 911.

Termination:

You have the right to either terminate therapy or request referral to another therapist at any time. If you are considering either possibility, it is important that you discuss that decision in the therapy session. Since therapy is a cooperative and often emotional venture, please raise any such thoughts that you have so that we can consider them together. Also, if you find yourself reacting to me in any way it is enormously helpful to discuss this in the session.

I have read and understand the above information. I understand that if for any reason my insurance company does not pay any portion of my bill it will be my responsibility to pay it and I will do so in a timely manner and not more than 60 days from notification by the insurance company of nonpayment. I recognize that these policies are subject to change without notice. I have received a copy of this document and I agree to abide by the terms set forth herein:

Client's Signature: _____ Date: _____

(This form must be read, signed, and dated in order to receive treatment.)

Health Care Coordination Form

Because of my commitment to improving my clients' overall health and because physical and mental health profoundly affect one another, I encourage the notification of significant health care providers that therapy is taking place. This form serves to allow me to exchange information and ideas with a provider in order to maximize the quality of care for the client.

Health Care Professional:

Name: _____ Clinic Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

Patient/Client:

Name: _____ DOB: _____ SS#: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____
work. home pager/cellular

Presenting Problems:

- Alcohol
- Depression
- Anxiety
- Drugs
- Job/School
- Legal
- Marital/couple
- Family/parenting
- Financial
- Trauma history
- Stepfamily issues
- Other: _____

Current Psychotropic Medications:

Medication	Purpose	Dosage	Start Date	Prescribed By

Release of Information:

I understand that this form serves as notification to my medical provider that I am currently in therapy. I hereby give permission for my health care provider and my therapist, John C Flanagan, LCSW to exchange any information that in their judgment will enhance my overall health and well being.

Signature: _____ Date: _____
(Please note that failure to sign this authorization will not prevent you from receiving therapy.)

Treatment Information:

Outpatient care is being delivered and the treatment plan includes the following modalities:
 Individual therapy Couples Therapy Family Therapy Group Therapy Frequency: _____

Dx: _____ Date of First Session: _____

Therapist's comments: _____

Therapist's Signature: _____ Date: _____

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Client's copy. Please keep this copy to refer to when you have questions!