

**Evergreen Behavioral Health
Adult Client Information Form**

Please provide the following information about yourself. This information will help me to better understand your needs and concerns, and develop an appropriate treatment plan. If there are any items you are uncomfortable answering, leave them blank and we can discuss them further during our session.

Client Identification and Contact Information

Client Name: _____ Date of Birth: _____ Age: _____ Sex: _____
Home Street Address: _____
City: _____ State: _____ Zip: _____
OK to send mail? Yes No

Phone Numbers

Home Phone: _____
Cell/Mobile Phone: _____
Work Phone: _____

OK to leave message?

Yes No
 Yes No
 Yes No

Emergency Contact Information

Name: _____ Relationship to Above Client: _____
Home Street Address: _____

City: _____ State: _____ Zip: _____ OK to leave message?
Home Phone: _____ Yes No
Cell/Mobile Phone: _____ Yes No

Work Information

Employer: _____
Position: _____ How long have you been with this employer? _____

Work-related Injury Information

Date of Injury: _____ Nature of Injury: _____
Worker's Compensation (LNI) Caseworker: _____ Caseworker Phone: _____
LNI Claim Number: _____

Referral Information

Who referred you to EBH? _____ Phone: _____
Address: _____
May I contact this person to thank them for the referral? Yes No

Primary Concern

Please describe briefly the main reason you are seeking therapy:

What would you like to get out of coming to therapy? _____

Symptoms: (Please check all of the issues that you are experiencing currently (or in the past several months):

- | | | |
|--|--|---|
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Anxiety/Worry |
| <input type="checkbox"/> Medical/Health Problems | <input type="checkbox"/> Social discomfort | <input type="checkbox"/> Eating problems |
| <input type="checkbox"/> Sadness/Depression | <input type="checkbox"/> Perfectionism | <input type="checkbox"/> Problems with pornography |
| <input type="checkbox"/> Loss of Pleasure/Interest | <input type="checkbox"/> Obsessive thoughts | <input type="checkbox"/> Academic problems |
| <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Compulsive behavior | <input type="checkbox"/> Relationship problems |
| <input type="checkbox"/> Guilt/Shame | <input type="checkbox"/> Aggression/Fights | <input type="checkbox"/> Difficulty completing homework |
| <input type="checkbox"/> Thoughts of death/self harm | <input type="checkbox"/> Frequent arguments | <input type="checkbox"/> Alcohol/Drug use |
| <input type="checkbox"/> Thoughts of hurting others | <input type="checkbox"/> Irritability/Anger | <input type="checkbox"/> Legal matters |
| <input type="checkbox"/> Self harm behaviors | <input type="checkbox"/> Flashbacks | <input type="checkbox"/> Work problems |
| <input type="checkbox"/> Recent/Past Trauma | <input type="checkbox"/> Hearing voices | <input type="checkbox"/> Financial problems |
| <input type="checkbox"/> Lack of motivation | <input type="checkbox"/> Seeing things others cannot see | <input type="checkbox"/> Computer addiction |
| <input type="checkbox"/> Crying spells | <input type="checkbox"/> Suspicion/Paranoia | <input type="checkbox"/> Gambling problems |
| <input type="checkbox"/> Loneliness | <input type="checkbox"/> Racing thoughts | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Low self-worth | <input type="checkbox"/> Excessive energy | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Guilt/Shame | <input type="checkbox"/> Wide mood swings | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Chronic fatigue/low energy | <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Withdrawal from others | <input type="checkbox"/> Nightmares | <input type="checkbox"/> _____ |

To the best of your knowledge, when did the current problems begin? _____

Do you have any ideas regarding what may be contributing to these problems? _____

Do you have any history of attempting to harm yourself or others? If yes, please explain: _____

Previous Mental Health Treatment

Have you received previous psychological, psychiatric, drug and alcohol, or counseling/therapy services? Yes No If yes, please describe:

When	From Whom	For What	Results

Have you ever taken medications for psychiatric or emotional problems? Yes No

If yes, please describe:

When	From Whom	For What	Results

Family History

	Name	Relationship Quality	Age	Live with?
Mother				
Father				
Siblings				
Spouse				
Children				

Have any of your family members experienced the following?	If yes, who?
ADD/ADHD	
Anxiety	
Depression	
Manic Depression/ Bipolar	
Schizophrenia	
Substance Abuse	
Suicide	

Have you experienced any of the following:

- | | | |
|---|--|---|
| <input type="checkbox"/> Violence in the home | <input type="checkbox"/> Homelessness | <input type="checkbox"/> Physical/Sexual Abuse |
| <input type="checkbox"/> Parent substance abuse | <input type="checkbox"/> Financial problems | <input type="checkbox"/> Emotional Abuse |
| <input type="checkbox"/> Parent death/illness | <input type="checkbox"/> Multiple family moves | <input type="checkbox"/> Parents permanently separated/divorced |
| <input type="checkbox"/> Personal Divorce | <input type="checkbox"/> Neglect | <input type="checkbox"/> Loss of a loved one |

Is there anything else you would like me to know about your family background at this time? _____

Substance Abuse

Do you currently consume alcohol? Yes No

If yes, how much and how often: _____

Do you currently use non-prescribed drugs or street drugs? Yes No

If yes, how much and how often: _____

Have you ever experienced problems with the law, relationships, or work/school functioning due to your drug use? Yes No

Have you ever had any arrests for any reason? Yes No

Strengths, Interests, and Social Support

Please describe your social support network:

- | | | |
|------------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Family | <input type="checkbox"/> Community Group: _____ | <input type="checkbox"/> Friends |
| <input type="checkbox"/> Neighbors | <input type="checkbox"/> Religious/Spiritual Group: _____ | <input type="checkbox"/> Other: _____ |

Would you like your religious/spiritual beliefs to be incorporated into therapy? Yes No

Please describe any special skills, talents, hobbies or strengths: _____

Medical Information

Have you experienced any of the following:

	Past	Present	Details
Chronic Pain	<input type="checkbox"/>	<input type="checkbox"/>	
Chronic Headaches	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	
Hearing Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Vision Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Sleep Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	
Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	
Head Injury/Loss of Consciousness	<input type="checkbox"/>	<input type="checkbox"/>	
Broken Bones	<input type="checkbox"/>	<input type="checkbox"/>	
Other Serious Injury	<input type="checkbox"/>	<input type="checkbox"/>	
Hospitalization	<input type="checkbox"/>	<input type="checkbox"/>	
Serious Illness/Fevers	<input type="checkbox"/>	<input type="checkbox"/>	
Other (Please Describe)	<input type="checkbox"/>	<input type="checkbox"/>	
Other (Please Describe)	<input type="checkbox"/>	<input type="checkbox"/>	
Other (Please Describe)	<input type="checkbox"/>	<input type="checkbox"/>	
Other (Please Describe)	<input type="checkbox"/>	<input type="checkbox"/>	

Please list any current medications or over the counter drugs you are taking:

Medication	Reason for Taking	Who is it prescribed by?	How long have you been taking this medication?

Primary Care Physician

Doctor's Name: _____ Phone: _____
 Clinic Name: _____ Fax: _____
 Address: _____

Evergreen Behavioral Health
2621 NE 134th Street, Ste. 340
Vancouver, Washington 98686

Billing Information Form

Client Information

Patient name: _____ Date of Birth: _____ Age: _____
Social Security Number: _____

Payer Information

Name: _____ Date of Birth: _____
Social Security Number: _____ Relationship to Client: _____

Payment Plan

I agree that payments or co-pays for services are due at the time of service and the responsibility for payment is mine. Denial of payment by an insurance carrier or other third party does not waive my responsibility to pay. Please initial the preferred option.

_____ Charge my credit card for each session or co-payment at the time of service.

_____ I intend to pay in full for the session or co-payment at the time of services are rendered with check/cash. My credit card will be charged for any payments 30 days or more in arrears.

In addition, bill my insurance carrier or third-party.

_____ I elect to have an insurance carrier or other third party billed on my behalf. I authorize that any balance outstanding 90 days after billing will be charged to my credit card.

Finally, I understand that no show or late cancelled sessions (less than 24 hours notice) will be \$50 fee.

_____ I authorize that the fee for any late cancelled/no show sessions will be charged to my credit card.

Credit Card Information *REQUIRED*

I authorize Evergreen Behavioral Health to charge this account for services according to the payment plan agreed above:

Card Type: Visa/MC/Discover (circle one) **Card Number:**

Expiration Date: (Mo. Yr.) _____ **3-digit CID:** _____ (on back of card)

Name of card holder:

Signature of card holder:

Address of card holder:

Signature of client:

*****PLEASE WAIT TO SIGN UNTIL REVIEWED WITH PSYCHOLOGIST*****

Our Agreement

I, the client, understand I have the right not to sign this form. My signature below indicates that I have read and discussed this agreement; it does not indicate that I am waiving any of my rights. I understand I can choose to discuss my concerns with you, the therapist, before I start formal therapy. I also understand that any of the points mentioned above can be discussed and may be open to change. If at any time during the treatment I have questions about any of the subjects discussed in this document, I can talk to you about them, and you will do your best to answer them. I understand that after therapy begins I have the right to withdraw my consent to therapy at any time, for any reason. However, I will make every effort to discuss my concerns about my progress with you before ending therapy.

I have read, or have had read to me, the issues and points in this document and in the Notice of Privacy Practices document. I have discussed those points I did not understand, and have had my questions, if any, fully answered. I agree to act according to the points covered in this document. I hereby agree to enter into therapy with this therapist (or to have the client enter into therapy) as shown by my signature here.

Signature of Client (or person acting for client)

Date

Printed Name

I, the therapist, have discussed the issues above with the client and provided a copy for their records.

Signature of Therapist

Date

*****PLEASE WAIT TO SIGN UNTIL REVIEWED WITH PSYCHOLOGIST*****

Evergreen Behavioral Health
2621 NE 134th Street, Ste. 340
Vancouver, Washington 98686

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Your signature below acknowledges that:

- You have had an opportunity to review and ask questions about my Notice of Privacy Practices, and have been offered a paper copy.
- You agree that protected health information (PHI) may be used and disclosed by Evergreen Behavioral Health to conduct treatment, payment, and health care operations as described in the Notice of Privacy Practices.

Printed client name

Client date of birth

Client signature (if client is age 14 or older)

Date

Printed name of parent/legal guardian

Relationship to the client

Parent/legal guardian signature (if client is a minor)

Date

Evergreen Behavioral Health
2621 NE 134th Street, Suite 340
Vancouver, Washington 98686

Participation in Research

In the future Evergreen Behavioral Health hopes to be able to pursue research and publish the outcomes from therapeutic interventions. In such an event, your name or other identifying information would be removed from any data. The data would include scores on tests of symptom severity and possible medical diagnosis. There would be no way to link you with the data. Your therapy will not be impacted by your decision to have your data included in such research. If you are willing to have your data as part of this research please sign and date below.

I consent to have the aforementioned data included in research.

I decline to have the aforementioned data included in research.

Client Name (Print)

DOB

Client Signature

Date

Parent/Legal Guardian Signature (if applicable)

Date

Evergreen Behavioral Health

2621 NE 134th St. #340

Vancouver, WA 98686

P: 360-450-0140

F: 877-343-0535

Authorization to Use and Disclose Protected Health Information

Client Name: _____ DOB: ___/___/___

With my signature below, I authorize _____ and Evergreen Behavioral Health to:
 OBTAIN information from _____ DISCLOSE information to _____

Contact Person: _____ Organization: _____
Address: _____ Telephone: _____
City, State, Zip: _____ Fax: _____

Information to be used/disclosed consists of mental healthcare information, including:
 Assessment/Evaluation Treatment Plan Notes Coordination of care information
 Other _____

The purpose for the disclosure/communication:
 Coordination of care Other: _____

I understand that additional laws about mental health, HIV/AIDS, genetic, and alcohol/drug treatment information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space.

- Initial: _____ Mental health information
- Initial: _____ Drug/alcohol diagnosis, treatment, or referral information
- Initial: _____ HIV/AIDS information
- Initial: _____ Genetic testing information

Other information

I understand that I am not required to sign this authorization. If I refuse to sign this, it will not prevent me from getting mental health or drug/alcohol treatment at Evergreen Behavioral Health (EBH). The only exception is if the services I am seeking are only for providing health information to someone else and this authorization is needed to make the disclosure.

I may revoke this authorization in writing at any time. If I revoke this authorization, the information described may no longer be used or disclosed for the reasons described here. If EBH has already used or disclosed information, that cannot be undone. To revoke this authorization, I can request the form from my provider and return the completed form to them.

I understand that the information used or disclosed as a result of this authorization may be subject to re-disclosure and no longer protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS, mental health information, genetic testing information, and drug/alcohol diagnosis, treatment, or referral information.

Unless revoked, this authorization expires 60 days after the completion of treatment or: _____

Signature

I have read this authorization and understand it.

Client signature: _____ Date: _____

Parent/Guardian/Representative: _____ Date: _____

If Personal Representative, Print Name: _____

Relationship to client: Parent Legal guardian Power of Attorney/Healthcare Other

PTSD CheckList – Civilian Version (PCL-C)

Client's Name: _____

Instruction to patient: Below is a list of problems and complaints that veterans sometimes have in response to stressful life experiences. Please read each one carefully, put an "X" in the box to indicate how much you have been bothered by that problem *in the last month*.

No.	Response	Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
1.	Repeated, disturbing <i>memories, thoughts, or images</i> of a stressful experience from the past?					
2.	Repeated, disturbing <i>dreams</i> of a stressful experience from the past?					
3.	Suddenly <i>acting or feeling</i> as if a stressful experience <i>were happening</i> again (as if you were reliving it)?					
4.	Feeling <i>very upset</i> when <i>something reminded</i> you of a stressful experience from the past?					
5.	Having <i>physical reactions</i> (e.g., heart pounding, trouble breathing, or sweating) when <i>something reminded</i> you of a stressful experience from the past?					
6.	Avoid <i>thinking about</i> or <i>talking about</i> a stressful experience from the past or avoid <i>having feelings</i> related to it?					
7.	Avoid <i>activities</i> or <i>situations</i> because they <i>remind you</i> of a stressful experience from the past?					
8.	Trouble <i>remembering important parts</i> of a stressful experience from the past?					
9.	Loss of <i>interest in things that you used to enjoy</i> ?					
10.	Feeling <i>distant</i> or <i>cut off</i> from other people?					
11.	Feeling <i>emotionally numb</i> or being unable to have loving feelings for those close to you?					
12.	Feeling as if your <i>future</i> will somehow be <i>cut short</i> ?					
13.	Trouble <i>falling</i> or <i>staying asleep</i> ?					
14.	Feeling <i>irritable</i> or having <i>angry outbursts</i> ?					
15.	Having <i>difficulty concentrating</i> ?					
16.	Being " <i>super alert</i> " or watchful on guard?					
17.	Feeling <i>jumpy</i> or easily startled?					

PCL-M for DSM-IV (11/1/94) Weathers, Litz, Huska, & Keane National Center for PTSD - Behavioral Science Division

This is a Government document in the public domain.

DASS

Name:

Date:

Please read each statement and circle a number 0, 1, 2 or 3 that indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

- 0 Did not apply to me at all
- 1 Applied to me to some degree, or some of the time
- 2 Applied to me to a considerable degree, or a good part of time
- 3 Applied to me very much, or most of the time

1	I found myself getting upset by quite trivial things	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I just couldn't seem to get going	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I had a feeling of shakiness (eg, legs going to give way)	0	1	2	3
8	I found it difficult to relax	0	1	2	3
9	I found myself in situations that made me so anxious I was most relieved when they ended	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting upset rather easily	0	1	2	3
12	I felt that I was using a lot of nervous energy	0	1	2	3
13	I felt sad and depressed	0	1	2	3
14	I found myself getting impatient when I was delayed in any way (eg, elevators, traffic lights, being kept waiting)	0	1	2	3
15	I had a feeling of faintness	0	1	2	3
16	I felt that I had lost interest in just about everything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I perspired noticeably (eg, hands sweaty) in the absence of high temperatures or physical exertion	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life wasn't worthwhile	0	1	2	3

Reminder of rating scale:

- 0 Did not apply to me at all
- 1 Applied to me to some degree, or some of the time
- 2 Applied to me to a considerable degree, or a good part of time
- 3 Applied to me very much, or most of the time

22	I found it hard to wind down	0	1	2	3
23	I had difficulty in swallowing	0	1	2	3
24	I couldn't seem to get any enjoyment out of the things I did	0	1	2	3
25	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3
26	I felt down-hearted and blue	0	1	2	3
27	I found that I was very irritable	0	1	2	3
28	I felt I was close to panic	0	1	2	3
29	I found it hard to calm down after something upset me	0	1	2	3
30	I feared that I would be "thrown" by some trivial but unfamiliar task	0	1	2	3
31	I was unable to become enthusiastic about anything	0	1	2	3
32	I found it difficult to tolerate interruptions to what I was doing	0	1	2	3
33	I was in a state of nervous tension	0	1	2	3
34	I felt I was pretty worthless	0	1	2	3
35	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
36	I felt terrified	0	1	2	3
37	I could see nothing in the future to be hopeful about	0	1	2	3
38	I felt that life was meaningless	0	1	2	3
39	I found myself getting agitated	0	1	2	3
40	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
41	I experienced trembling (eg, in the hands)	0	1	2	3
42	I found it difficult to work up the initiative to do things	0	1	2	3

Reminder of rating scale:

- 0 Did not apply to me at all
- 1 Applied to me to some degree, or some of the time
- 2 Applied to me to a considerable degree, or a good part of time
- 3 Applied to me very much, or most of the time

22	I found it hard to wind down	0	1	2	3
23	I had difficulty in swallowing	0	1	2	3
24	I couldn't seem to get any enjoyment out of the things I did	0	1	2	3
25	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3
26	I felt down-hearted and blue	0	1	2	3
27	I found that I was very irritable	0	1	2	3
28	I felt I was close to panic	0	1	2	3
29	I found it hard to calm down after something upset me	0	1	2	3
30	I feared that I would be "thrown" by some trivial but unfamiliar task	0	1	2	3
31	I was unable to become enthusiastic about anything	0	1	2	3
32	I found it difficult to tolerate interruptions to what I was doing	0	1	2	3
33	I was in a state of nervous tension	0	1	2	3
34	I felt I was pretty worthless	0	1	2	3
35	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
36	I felt terrified	0	1	2	3
37	I could see nothing in the future to be hopeful about	0	1	2	3
38	I felt that life was meaningless	0	1	2	3
39	I found myself getting agitated	0	1	2	3
40	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
41	I experienced trembling (eg, in the hands)	0	1	2	3
42	I found it difficult to work up the initiative to do things	0	1	2	3