**Tammy M. Beran, Ph.D. Licensed Clinical Psychologist**

401 E. Kilbourn Avenue, Suite 402 **Bridging Science & Spirit**

Milwaukee, WI 53207

p: 414-207-4466 e: drtammyberan@gmail.com

**Welcome**

The following pages contain forms for you to review and complete prior to your initial appointment (if you don't have access to a printer, please review the forms, and I'll have printed forms available for you at your appointment).

* 1. **Disclosure Statement/Consent Form**: It is quite lengthy but contains important information, so I ask that you look it over carefully before our appointment and sign the last page.
	2. **HIPAA Notice of Privacy Practices**: Please read and sign the last page.
	3. **Supplemental Screening Questions & Personal History**: These are typical areas I ask about during an intake. These questions will allow me to get to know you more quickly so that we can jumpstart our work together.

**Directions**

**My office is located at: 401 E. Kilbourn Avenue, Milwaukee, WI 53207.**

This location is at the ***intersection of Milwaukee and Kilbourn***. The bottom floor of the building houses Associated Bank and the outside of the office building is black with “Associate Bank” written on the outside in green. I am located on the 4th floor in a suite labeled “Milwaukee Area Psychological Services”.

**Parking:** There is a free parking lot adjacent to the building that offers a limited number of spots for building customers. In the rare event that all spots in the parking lot are taken, there are numerous metered parking spots directly in front of the building on Milwaukee Avenue, as well as metered angle parking spots on Kilbourn Avenue.

**Finding the suite:** The entrance to the building is located on Milwaukee. You will enter a white foyer that leads to a double elevator bank. Take the elevator to the 4th floor and turn left. My suite will be on the right, after the bathrooms, and marked “Milwaukee Area Psychological Services”. **If you arrive after 6pm**, you may need to call me so that I can let you into the building or up the elevator as they sometimes lock after 6pm.

**Please be aware** that we do not have any support staff in the waiting area. Make yourself comfortable when you arrive, and I’ll come out to greet you when your appointment begins.

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**Psychotherapy Disclosure Statement**

Please read the following information carefully, and let me know if you have any questions. At the end of the form, you are asked to sign indicating your consent to treatment.

I am an independent practitioner solely responsible for the care of my clients. Therapy is a relationship that works in part because of clearly defined rights and responsibilities held by each person. This frame helps to create the safety to take risks and the support to become empowered to change. As a client in psychotherapy, you have certain rights that are important for you to know about because this is your therapy, the goal of which is your own wellbeing. There are also certain limitations to those rights that you should be aware of. As a therapist, I have corresponding responsibilities to you.

**My Responsibilities to You as Your Therapist**

**I. Confidentiality**

With the exception of certain specific exceptions described below, you have the absolute right to the confidentiality of your therapy. I cannot and will not tell anyone else what you have told me, or even that you are in therapy with me without your prior written permission. Under the provisions of the Health Care Information Act of 1992, I may legally speak to another health care provider or a member of your family about you without your prior consent, but I will not do so unless the situation is an emergency. I will always act to protect your privacy even if you do release me in writing to share information about you. You may direct me to share information with whomever you chose, and you can change your mind and revoke that permission at any time.

1. Consultation. There may be times when I may consult with a colleague (e.g., a fellow licensed psychologist) or another professional, (e.g., an attorney) about issues raised in your therapy. These consultations are always conducted with your best interests in mind. Your confidentiality is still protected during my consultation with the professional consulted. During a professional consultation, I will not give any identifying information about you. The consultant will also be legally (and most often ethically) bound to keep all information confidential as well.
2. Out-of-Session Contact. Please note that because of my commitment to maintain your privacy, if we coincidentally meet outside the therapy room I will not initiate interaction of my own volition, but you are welcome to do so if you choose. My behavior will not be a personal reaction to you but a way to maintain the confidentiality of our relationship.
3. Legal exceptions to your right to confidentiality. Please note that I would inform you of any time when I think I will have to put these into effect.
	1. If I have good reason to believe that you will harm another person, I must attempt to inform that person and warn them of your intentions. I must also contact the police and ask them to protect your intended victim.
	2. If I have good reason to believe that you are abusing or neglecting a child or vulnerable adult, or if you give me information about someone else who is doing this, I must inform Child or Adult Protective Services within 48 hours.
	3. If I believe that you are in imminent danger of harming yourself, I may legally break confidentiality and call the police or the county crisis team. I am not obligated to do this, and would explore all other options with you before I took this step. If at that point you were unwilling to take steps to guarantee your safety, I would call the crisis team.
4. Mobile Phone Communication. Please note that if we communicate via my mobile phone by voice or text, your phone number will be stored in the phone’s memory for a period of time and therefore if my mobile phone is lost or stolen, it is theoretically possible that your contact information might be accessed. Note that my mobile phone is itself password protected providing one line of defense against such a breach.
5. Email Communication. If you elect to communicate with me by email, please be aware that email is not completely confidential. All emails are retained in the logs of your and/or my internet service provider. While under normal circumstances no one looks at these logs, they are, in theory, available to be read by the system administrator(s) of the internet service provider. Any email I receive from you, and any responses that I send to you, will be considered part of your treatment record.
	1. Please be aware that I regularly access email communications via my password-protected mobile phone. It is theoretically possible that if my mobile phone is lost or stolen and the password is somehow circumvented our email communications could be accessed.

**II. Record-keeping**

1. Legally, I must keep records from our sessions. I typically record that you have been here, your symptoms and/or diagnosis, what symptoms were addressed in session, a short summary of the content of the session, and any changes to our treatment plan. If you would prefer that I keep more minimal records of your care, please let me know and we can discuss my keeping only the minimal amount of information necessary.
2. Under the provisions of the Health Care Information Act of 1992, you have the right to a copy of your file at any time, giving me the chance to print it out from my computer. You have the right to request that I correct any errors in your file. You have the right to request that I make a copy of your file available to any other health care provider at your written request. I maintain your records in a secure location that cannot be accessed by anyone else (except in the event of my unanticipated extended absence or death - see section “Coverage” for further details).
3. Please note that in the event that I receive a court-ordered subpoena for your record, I will immediately notify you to give you an opportunity to invoke legal privilege or get a protective order. These are actions you would need to pursue with your own legal counsel.

**III. Diagnosis**

If a third party such as an insurance company is paying for part of your bill, I am normally required to give a diagnosis to that third party. Diagnoses are technical terms that describe the nature of your problems and something about whether they are short-term or long-term problems. All of the diagnoses come from a book titled the DSM-V; I have a copy in my office and will be glad to show it to you. You are welcome to ask me any questions you have about your diagnosis.

**IV. Remote Therapy**

In some unique situations such as when you are away on a trip or unable to make it to the office due to injury or inclement weather, we may consider relying on remote therapy (i.e., therapy via phone, Skype, or other mode of electronic transmission). Although this may change in the future, at present most heath insurances will not reimburse for remote therapy so any expenses incurred will likely become your direct responsibility. It is my ethical responsibility to indicate on invoices any services that were offered remotely. Ethical guidelines in this area are still evolving, but it is useful to highlight a few issues inherent to remote therapy:

1. Phone lines, Skype, and other forms of electronic transmission are less secure and may not be HIPAA compliant.
2. Sessions that rely on technology are vulnerable to that technology malfunctioning. If we are unable to connect or our connection is dropped I will do my best to conduct our session via phone or to reschedule.
3. If frequent or lengthy travel, or a permanent move would require us to conduct most of our sessions remotely it is my ethical and legal responsibility to carefully consider the risks and benefits of continuing our therapy versus transferring you to the care of a provider in your local area. In such a case we would discuss together the potential limitations to effectiveness of therapy, financial burden, availability of local emergency contacts, and any relevant state-licensing issues.

**V. Other Rights**

You have the right to ask questions about anything that happens in therapy. I'm always willing to discuss how and why I've decided to do what I'm doing, and to look at alternatives that might work better. You can feel free to ask me to try something that you think will be helpful. You can ask me about my training for working with your concerns, and can request that I refer you to someone else if you decide I'm not the right therapist for you. You are free to leave therapy at any time.

# My Training and Approach to Therapy

**I. Training**

I am a Licensed Clinical Psychologist with a PhD in clinical psychology and a minor in health psychology. I completed my graduate training in the doctoral program in clinical psychology at the University of California, Los Angeles (UCLA), which is accredited by the American Psychological Association (APA). During my education, I received advanced training in behavioral and cognitive therapies, theories, and research. As part of this training, I provided psychotherapy at the UCLA Psychology Clinic, UCLA Student Psychological Services, and the Simms/Mann UCLA Center for Integrative Oncology. As the capstone to my doctoral clinical training, I completed a one-year APA-accredited internship in clinical psychology at the Los Angeles Ambulatory Care Center Veterans Administration (LAACC VA) in Downtown Los Angeles.

**II. Therapy Modalities**

My approach to psychotherapy is fundamentally **interpersonal, spiritual, and behavioral**.

My **interpersonal** focus is based on the idea that we can learn a great deal about how you function outside of therapy by examining the relationship between us (you and me). This approach emphasizes that the bond formed between us over time will be a major vehicle in your healing and transformation. Using this approach we will work together to notice the ways in which the problems you are having in daily life are occurring in some form in the therapy session and/or in our relationship, too: noticing and working with them in this safe situation can be a powerful and transformative experience.

My **spiritual** orientation is based on the belief that beyond your mind and body exists a larger *Self*. Some might call this Self the “Soul” or “Higher Self”. It is my belief that each of us has the potential to reach higher states of connection with our Higher Selves and, simultaneously, others. The deep listening that occurs during therapy can help you access your deepest Self and in the process, to live a more authentic, meaningful, and purpose-filled life. My work in this area uses prayer, compassion, silence, meditation, and mindfulness.

The **behavioral** approach I use is termed Cognitive Behavior Therapy, or CBT. CBT describes an interrelated set of therapies all based on the idea that our cognitions (the thoughts in our minds) and our behaviors (the actions we take in the world) are intricately related to our emotional experience, including the emotional distress that we experience. In this approach, I will encourage you to become more aware of the dominant thoughts in your life, where these thoughts originated, and whether they are helpful and accurate. With time, this awareness increases your psychological flexibility, giving you a broader perspective and wider range of choices within your life.

**III. Emotional Risks**

Therapy inherently involves emotional risk-taking. Approaching feelings or thoughts that you have tried not to think about for a long time may be painful. Making changes in your beliefs or behaviors can be scary, and sometimes disruptive to the relationships you already have. You may find your relationship with me to be a source of strong feelings. It is important that you consider carefully whether these risks are worth the benefits to you of changing. Most people who take these risks find that therapy is helpful.

**IV. Completion/Termination of Treatment**

1. You normally will be the one who decides therapy will end. Ideally, you and I will have been talking for a number of weeks about your readiness to end therapy and create a meaningful goodbye in our relationship. Though you are of course free to terminate therapy at any time, **I request that you let me know at least 2-3 sessions in advance if you wish to end therapy (for any reason)**. This gives us time to process anything that has come up in our relationship, summarize and celebrate your progress, and say goodbye to one another.
2. There are three cases in which you may not get to decide when therapy ends:
	1. If we have contracted for a specific short-term piece of work, we will finish therapy at the end of that contract.
	2. If I am not, in my judgment, able to help you, because of the kind of problem you have or because my training and skills are in my judgment not appropriate, I will inform you of this fact and refer you to another therapist who may meet your needs.
	3. If you assault, threaten, or harass me, the office, or my family, I reserve the right to terminate you immediately from treatment. If I terminate you from therapy, I will offer you referrals to other sources of care, but cannot guarantee that they will accept you for therapy.

**V. Coverage**

1. Vacations & planned absences. I am away from the office approximately 5-6 times a year for conferences and personal vacations. I will tell you well in advance of any lengthy absences, and give you contact information for sources of support available to you during my absence.
2. Between-session availability. I am typically able to return pertinent phone calls or emails within 48 hours. However, I am not accessible for 24-hr emergency or crisis calls. If you have a pressing matter that does not require immediate attention, please call me and I will return your call as quickly as possible. If you are experiencing an emergency and you believe that you cannot keep yourself safe, please call 911, or go to the nearest hospital emergency room for assistance.
3. Unplanned and/or extended absences: In the event of a health-related extended absence or my untimely death, your therapy records will be transferred to my colleague Leslie Skaistis, Psy.D. (414-269-8660) who will also be available to arrange for referrals to appropriate providers in my absence.

# VI. What to Expect from Our Relationship

1. The most fulfilled people are in touch with themselves and are able to be interpersonally effective. They are able to speak and act compassionately on their truths and gifts, and are able to fully give and receive love. The therapeutic relationship we develop will focus on bringing forth your best self. In order to do that, you must first be in touch with yourself at a core level (e.g., needs, feelings, longings, fears, values, dreams, missions). You will have the opportunity to learn how to express yourself fully, to grieve losses, to develop mindfulness, and to create better relationships. All aspects of your experience will be addressed, including mind, body, feelings, and spirit. I will be challenging you to be more open, vulnerable, aware and present. There is an optimal level of risk-taking in any situation, however, and it’s important that you and I monitor how much outside your comfort zone it is best for you to be at any given time.
2. It will be important for us to focus on our attention on issues (positive or negative) or difficulties that come up with me which also come up with other people in your life. When one feels the power in expressing one's thoughts, feelings, and desires in an authentic, caring and assertive way, one has a greater sense of mastery in life. Our therapeutic relationship will be an ideal place for you to practice being powerful.
3. I consider the space that you enter with me in therapy to be sacred—I am privileged to be embarking on a journey of exploration and growth with you, and I will hold all that you share with reverence and with care. I will be a genuine person in the room with you, and my main guiding principle is to do what is in your best interest.

**VII. Ethical Standards and Disclosures**

1. I will use my best knowledge and skills to help you and will adhere to the ethical standards of the American Psychological Association. In your best interests, the APA puts limits on the relationship between a therapist and a client, and I will abide by these.
2. I am not trained in the fields of law, medicine, finance, or any other profession. I am not able to give you good advice from these other professional viewpoints.
3. In your best interests, and following APA standards, I can only be your therapist. I cannot have any other role in your life. I cannot, now or ever, be a close friend or socialize with any of my clients. I cannot be a therapist to someone who is already a friend. I can never have a sexual or romantic relationship with any client during, or after, the course of therapy. I cannot have a business relationship with any of my clients, other than the therapy relationship.
4. If you ever become involved in a divorce or custody dispute, please understand that I will not provide evaluations or expert testimony in court. You should hire a different mental health professional for any evaluations or testimony you require. This position is based on two reasons: (1) My statements will be seen as biased in your favor because we have a therapy relationship; and (2) the testimony might affect our therapy relationship, and I must put this relationship first.

**Your Responsibilities and Rights as a Therapy Client**

**I. Scheduling, Attendance and 24-hour Cancellation Policy**

1. You are responsible for coming to your session on time and at the time we have scheduled. Sessions last for approximately 50 minutes. If you are late, we will end on time and not run over into the next person's session.
2. If you miss a session without canceling, or cancel with less than **24 hours (1 day) notice**, you must pay the full fee for that session at our next regularly scheduled meeting (missed appointments are not covered by insurance).

**II. Fees & Payment**

1. You are responsible for paying for sessions at the end of each session in their entirety. My fee is $150 per hour, which is the typical rate of a Licensed Clinical Psychologist in the Milwaukee. However, I understand that this rate is not financially feasible for all individuals and desire that high quality mental health care be accessible to all individuals regardless of financial situation. Therefore, I offer a small number of reduced fee slots. If you request a reduced fee and I cannot accommodate you, I will do my best to provide you with appropriate referrals.
2. I am not a contracted provider with any insurance company. Some reasons for this choice are to keep decisions about treatment between clients and myself, the ability to keep client records more confidential, and to avoid lengthy disputes about coverage and delays in payment. However, your insurance company may cover some of my services on an “out-of-network” basis. Each insurance company is different in this regard and specific questions should be directed to your insurance company. I can provide a receipt of service to your insurance company, which may be reimbursed at the “out-of-network” rate. Please speak to me if you are interested in this option.
3. If letters/reports need to be provided to an outside source (such as a lawyer, the court system, an insurance company, etc.), you will be charged for this service at our contracted hourly rate.
4. Emergency phone calls of less than ten minutes are normally free. However, if we spend more than 15 minutes in a week on the phone, or if I spend more than 15 minutes reading or responding to electronic messages from you during a given week I will bill you on a prorated basis for that time.
5. My fees go up $10.00 every two years, on the odd year. If a fee raise is approaching I will remind you of this well in advance.
6. I do not allow clients to run a bill with me. Any overdue bills will be charged 1.5% per month interest. If you eventually refuse to pay your debt, I reserve the right to give your name and the amount due to a collection agency.

**III. Questions, Suggestions, and Complaints**

If you have questions or suggestions about our work, or if you're unhappy with what's happening in therapy, I urge you to talk to me about it in session. This is an essential feedback loop in our relationship, which I depend on to make the experience meet your needs. I will take your feedback seriously, and with care and respect.

**Client Consent to Psychotherapy**

I have read this statement, had sufficient time to be sure that I considered it carefully, asked any questions that I needed to, and understand it. I agree to pay the agreed amount per session. I understand my rights and responsibilities as a client, and my therapist's responsibilities to me. I agree to undertake therapy with Tammy M. Beran, Ph.D. I know I can end therapy at any time I wish and that I can refuse any requests or suggestions made by Dr. Beran.

Client's Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client's Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(if client is under age 18)

Therapist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Tammy M. Beran, Ph.D.,

 Licensed Clinical Psychologist: License #: WI 3360-57

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**NOTICE OF PRIVACY PRACTICES**

The privacy of your health information is important to me. I will maintain the privacy of your health information and I will not disclose your information to others unless you tell me to do so, or unless the law authorizes or requires me to do so.

A federal law commonly known as HIPAA requires that I take additional steps to keep you informed about how I may use information that is gathered in order to provide health care services to you. As part of this process, I am required to provide you with the attached Notice of Privacy Practices and to request that you sign the attached written acknowledgment that you received a copy of the notice. The notice describes how I may use and disclose your protected health information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. This notice also describes your rights regarding health information I maintain about you and a brief description of how you may exercise these rights.

Please let me know if you have any questions about this notice.

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**NOTICE OF PRIVACY PRACTICES**

**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 and ask if you have any questions**

I am required by federal and state law to maintain the privacy of your health information. I am also required to give you this notice about my privacy practices, legal obligations, and your rights concerning your health information (**“Protected Health Information” or “PHI”**). I must follow the privacy practices that are described in this notice (which may be amended from time to time).

For more information about my privacy practices, or for additional copies of this notice, please contact me. See also Section II G of this notice.

**I.** **uses and disclosures of protected health information (phi)**

 **A. Permissible Uses and Disclosures Without Your Written Authorization**

I may use and disclose PHI without your written authorization, excluding Psychotherapy Notes as described in Section II, for certain purposes as described below. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures that are permissible under federal and state law. You have a right to object to any of these disclosures.

1. **Treatment:** I may use and disclose PHI in order to provide treatment to you. For example, I may use PHI to diagnose and provide counseling service to you. In addition, I may disclose PHI to other health care providers involved in your treatment.
2. **Payment:**  I may use and disclose PHI so that services you receive are appropriately billed to, and payment is collected from, your health plan. For example, I may disclose PHI to permit your health plan to take certain actions before it approves or pays for treatment services.
3. **Health Care Operations:** I may use and disclose PHI in connection with our health care operations, including quality improvement activities, training programs, accreditation, certification, licensing or credentialing activities.
4. **Required or Permitted by Law:** I may use and disclose PHI when I am required or permitted to do so by law. For example, I may disclose PHI to appropriate authorities if I reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. In addition I may disclose PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. Other disclosures permitted or required by law include the following: disclosures for public health activities; health oversight activities including disclosures to state or federal agencies authorized to access PHI; disclosures to judicial and law enforcement officials in response to a court order or other lawful process; disclosures for research when approved by an institutional review board; and disclosures to military or national security agencies, coroners, medical examiners, and correctional institutions or otherwise as authorized by law.

**B. Uses and Disclosures Requiring Your Written Authorization**

1. **Psychotherapy Notes:**  Notes I have recorded documenting the contents of a therapy session with you will be used only by me and will not otherwise be used or disclosed without your written authorization.
2. **Marketing Communications:** I will not use your health information for marketing communications without your written authorization.
3. **Other Uses and Disclosures:** Uses and disclosures other than those described in Section I.A. above will only be made with your written authorization. For example, you will need to sign an authorization form before I can send PHI to your life insurance company, to a school, or to your attorney. You may revoke any such authorization at any time.

**II. your individual rights**

1. **Right to Inspect and Copy.** You may request access to your medical record and billing records maintained by me. All requests for access must be made in writing. Under limited circumstances, I may deny access to your records. I may charge a fee for the costs of copying and sending you any records requested. If you are a parent or legal guardian of a minor, please note that certain portions of the minor’s medical record will not be accessible to you, such as records related to mental health, drug treatment, or family planning services.
2. **Right to Alternative Communications.** You may request, and I will accommodate, any reasonable written request for you to receive PHI by alternative means of communication or at alternative locations.
3. **Right to Request Restrictions.** You have the right to request a restriction on PHI used for disclosure for treatment, payment, or health care operations. You must request any such restriction in writing addressed to me. I am not required to agree to any such restriction you may request.
4. **Right to Accounting of Disclosures.** Upon written request, you may obtain an accounting of certain disclosures of PHI made by me after December, 2015. This right applies to disclosures for purposes other than treatment, payment, or health care operations, excludes disclosures otherwise authorized by you, and is subject to other restrictions and limitations.
5. **Right to Request Amendment.** You have the right to request that I amend your health information. Your request must be in writing, and it must explain why the information should be amended. I may deny your request under certain circumstances.
6. **Right to Obtain Notice.** You have the right to obtain a paper copy of this notice by submitting a request to me at any time.
7. **Questions and Complaints.** If you desire further information about your privacy rights, or are concerned that I have violated your privacy rights, please contact Dr. Beran, who is the privacy officer for her individual practice, immediately. You may also file complaints with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **I will not retaliate against you for filing a complaint.**

**III. effective date and changes to this notice**

1. Effective Date. This Notice is effective on October, 1st, 2015.
2. Changes to this Notice. I may change the terms of this notice at any time. If I change this notice, I may make the new notice terms effective for all PHI that I maintain, including any information created or received prior to issuing the new notice. If I change this notice, I will post the revised notice in the waiting area of my office. You may also obtain any revised notice by contacting me.

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**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

By my signature below I, , acknowledge that I received a copy of the Notice of Privacy Practices for Tammy M. Beran, Ph.D.

Signature of client (or personal representative) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of legal guardian (if client is under 18) Date

If this acknowledgment is signed by a personal representative on behalf of the client, complete the following:

Personal Representative’s Name:

Relationship to Client:

**For Office Use Only**

I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

* Individual refused to sign
* Communications barriers prohibited obtaining the acknowledgement
* An emergency situation prevented us from obtaining acknowledgement
* Other (Please Specify)

This form will be retained in your medical record.

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**Screening Questions & Personal History**

Your responses to the following questions will help me better understand you and your situation. This will facilitate the best possible treatment. Please answer all questions as completely as you are comfortable with.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred phone number: \_\_\_work \_\_\_cell \_\_\_home

It is okay for Dr. Beran to leave a message/voicemail at my preferred phone number? (circle one)

**Yes No**

It is okay for Dr. Beran to leave a message at my preferred email address? (circle one)

**Yes No**

I have contact/communication concerns (circle one) **Yes No**

 If yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency contact phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please fill in the blanks listed below, or circle “prefer not to answer”.

Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or prefer not to answer

Sexual orientation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or prefer not to answer

Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or prefer not to answer

Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or prefer not to answer

Other aspects of your identity that are important to you (please list): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Check here if you are experiencing any of the following problems:

 \_\_\_ Pain \_\_\_ Drug Abuse \_\_\_ Eating/Appetite \_\_\_ Marital/Relationship

 \_\_\_ Depression \_\_\_ Alcohol Abuse \_\_\_ Ill Health \_\_\_ Family

 \_\_\_ Unstable Mood \_\_\_ Stress Management \_\_\_ Sexual \_\_\_ Employment

 \_\_\_ Suicidal Thoughts \_\_\_ Anxiety/Worry \_\_\_ Financial \_\_\_ Body image

 \_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

People often understand their problems in their own way, which may be similar to or different from how doctors describe the problem. How would you describe the issue that brings you to therapy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did the problem(s) begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How has it changed over time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please describe ***as specifically as possible*** what you would like to work toward in therapy.

**PSYCHOLOGICAL HISTORY**

Have you ever been in counseling or psychotherapy before? \_\_\_\_\_Y \_\_\_\_\_N

 If YES, when, and where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you ever taken medication for anxiety, depression, sleep, or other emotional conditions: \_\_\_\_Y \_\_\_\_\_N

 If YES, what and when: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you had any past hospitalizations for emotional problems? \_\_\_\_\_Y \_\_\_\_\_N

 If YES, when, and where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you ever intentionally hurt yourself or made a suicide attempt? \_\_\_\_\_Y \_\_\_\_\_N

 If YES, please explain how and when: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please read each statement and indicate how much the statement applied to you *over the past two weeks*. There are no right or wrong answers. Do not spend too much time on any one statement.

|  |  |
| --- | --- |
| **Statement** | **Your Response** |
|  | **Not at all** | **Several days** | **More than half the days** | **Nearly every day** |
| Feeling nervous, anxious or on edge  |  |  |  |  |
| Not being able to stop or control worrying  |  |  |  |  |
| Worrying too much about different things  |  |  |  |  |
| Trouble relaxing  |  |  |  |  |
| Being so restless that it is hard to sit still  |  |  |  |  |
| Becoming easily annoyed or irritable  |  |  |  |  |
| Feeling afraid as if something awful might happen  |  |  |  |  |

Over the last two weeks, how often have you been bothered by any of the following problems?

|  |  |
| --- | --- |
| **Statement** | **Your Response** |
|  | **Not at all** | **Several days** | **More than half the days** | **Nearly** **every day** |
| Little interest or pleasure in doing things |  |  |  |  |
| Feeling down, depressed, or hopeless |  |  |  |  |
| Trouble falling asleep, staying asleep, or sleeping too much |  |  |  |  |
| Feeling tired or having little energy |  |  |  |  |
| Poor appetite or overeating |  |  |  |  |
| Feeling bad about yourself – or that you are a failure or have let yourself or your family down |  |  |  |  |
| Trouble concentrating on things, such as reading the newspaper or watching television |  |  |  |  |
| Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual |  |  |  |  |
| Thoughts that you would be better off dead, or of hurting yourself |  |  |  |  |

**MEDICAL HISTORY**

Check if you are currently experiencing or have ever experienced the following medical issues:

 \_\_Chronic Pain \_\_ Anemia \_\_ Allergies

 \_\_Heart (trouble, disease, surgery) \_\_ Thyroid problem \_\_ Sinus problems

 \_\_Chest pain or angina pectoris \_\_ Kidney or bladder problems \_\_ Weight change

 \_\_Abnormal blood pressure \_\_ Liver Disease \_\_ Eating problems

 \_\_ Fainting Spells \_\_ Hepatitis- type A B C \_\_ Ulcers/Abdominal pain

 \_\_ Epilepsy (Seizure Disorder) \_\_ Jaundice/rashes/sores \_\_ Venereal disease

 \_\_ Neurological disorders \_\_ Frequent or severe headaches \_\_ HIV positive/AIDS/ARC

 \_\_ Memory Loss \_\_ Hemophilia blood disease \_\_ Broken Bones

 \_\_ Stroke \_\_ Cancer/Tumors \_\_ Hearing problems

 \_\_ Arthritis/Rheumatism \_\_ Emphysema \_\_ Vision problems

 \_\_ Head Injury \_\_ Pregnancies not carried to term \_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you checked any of the above medical items, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any allergies or reactions to medications? \_\_\_Y \_\_\_N

 If YES, what medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking any prescribed medications? \_\_\_Y\_\_\_N

Who is your primary care physician? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Medication | Dose and Frequency | Reason for Medication | Physician |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Please indicate any homeopathic or alternative forms of medicine you are currently using: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY**

Please list Parents, Siblings, Spouse/Partner, Children and Significant Relatives/Others:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name (First, Last) | Relationship | Age | School/Occupation | City of Residence |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
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|  |  |  |  |  |

Current Relationship Status:

\_\_\_Single \_\_\_Long-term relationship \_\_\_Married \_\_\_Re-Married \_\_\_Divorced \_\_\_Separated \_\_\_Widowed

Who currently lives in your household? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you having problems with your children? \_\_\_Y \_\_\_N \_\_\_No children

 If YES, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family-of-Origin History:**

**Please describe the following about the relationships in your family of origin:**

Who raised you?

\_\_\_Two Parents \_\_\_Mother alone \_\_\_Mother w/ partner \_\_\_ Father alone \_\_Father w/ partner \_\_\_Other

Your parents’ relationship with each other:

Your relationship with each parent and with other adults present:

Your parents’ physical health problems, chemical use, and mental or emotional difficulties:

Your relationship with your brothers and sisters (if any), in the past and present:

**Significant Friendships**

Your important friends, past and present:

|  |  |  |
| --- | --- | --- |
| Name | Good parts of relationship  | Bad parts of relationship |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Significant Romantic Relationships**

Your important partners, (i.e., spouses, lovers, boyfriends, girlfriends) past and present:

|  |  |  |
| --- | --- | --- |
| Name | Good parts of relationship  | Bad parts of relationship |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**SOCIAL HISTORY**

How do you relate to others? Check all that apply:

\_\_\_ I seem to focus heavily on my interests \_\_\_ I am bothered by sounds, textures, smells that other people are not

\_\_\_ Have many close friends \_\_\_ Have several close friends \_\_\_ Have few close friends

\_\_\_ Have no close friends \_\_\_ Make friends easily \_\_\_ Am a leader

\_\_\_ Am a follower \_\_\_ Fight with others \_\_\_ Prefer to be alone

\_\_\_ Interact well with family members \_\_\_ Difficulty with siblings \_\_\_ Prefers younger friends

\_\_\_ Am teased by others \_\_\_ Feel rejected by peer group

\_\_\_ Have friends who get in trouble \_\_\_ Want friends, but don’t know how to make or keep them

\_\_\_ I have difficulty understanding jokes \_\_\_ I have difficulty understanding people’s feelings

\_\_\_ I stick to the same routine every day \_\_\_ I find change very stressful

If you’ve had trouble getting along with others, how long has this gone on? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Spiritual and/or Religious History**

*If you desire, I will do my best to incorporate your spiritual/religious beliefs into session. I do not want to assume anything about your belief system, and will rely on you to educate me about it. I invite you to share as much about your beliefs and spiritual/religious goals as you feel comfortable.*

Spiritual or religious beliefs/values of your family of origin:

Are you interested in incorporating your spiritual/religious values into your treatment? **Y/N**

*If No, feel free to skip remainder of this section.*

Current spiritual or religious beliefs/values that are important to you (if none, write N/A):

Please describe briefly the spiritual or religious language and/or figures that are most comfortable for you: (e.g., “God”, “Allah” “Spirit”, “Universe”, “Jesus”, “Buddha”, “Source”, “Brahman”, “Dharma”, “Animism”)

Are you interested in the use of prayer within your therapy sessions? **Y/N**

**Abuse History:**

 \_\_ I was not abused/neglected in any way.

\_\_ I was abused/neglected.

 If you were abused or neglected, please complete the following chart. If a column does not apply to you, please write n/a.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Type of Abuse 🡪 | **Physical Abuse** (e.g., beatings) | **Sexual Abuse**(e.g., touching, molesting, fondling, intercourse) | **Neglect**(e.g., failure to feed, shelter, or protect you) | **Emotional Abuse** (e.g., humiliation) |
| Your age (or age range) at the time? |  |  |  |  |
| Abused By Whom? |  |  |  |  |
| Effects on you? |  |  |  |  |
| Whom did you tell? |  |  |  |  |
| Consequences of telling |  |  |  |  |

**Trauma History:**

Please briefly describe any significant traumatic experiences that aren’t included in the previous chart (e.g., physical or sexual assault, domestic violence, combat trauma, threats against you or your family, brushes with death, intense physical pain, etc.):

**Chemical Use**

Have you ever felt the need to cut down on your drinking? [ ] Yes [ ] No

Have you ever felt annoyed by criticism of your drinking? [ ] Yes [ ] No

Have you ever felt guilty about your drinking? [ ] Yes [ ] No

Have you ever taken a morning "eye-opener"? [ ] Yes [ ] No

Which drugs (not medications prescribed for you) have you used in the last 10 years?

Please provide details about your use of these drugs or other chemicals, such as amounts, how often you used them, their effects, and so forth:

At any time in your life, have you been concerned about your drug use or received treatment for it? If yes, please describe.

**EDUCATIONAL AND VOCATIONAL HISTORY**

Highest grade completed? \_\_\_ GED completed? \_\_Y \_\_N How did you do academically in school? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How was your conduct throughout school? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If attended college, what is your degree and /or status? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently employed? \_\_\_ Y \_\_\_ N

Have you ever been terminated from a job? \_\_\_Y \_\_\_N

 If YES, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you have any language or reading difficulties? \_\_\_Y \_\_\_N

 If YES, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Legal History**

Are you presently suing anyone or thinking of suing anyone?

[ ] No

[ ] Yes. Please explain:

List all the contacts with the police, courts, and jails/prisons you have had. Include all open charges and pending ones.

Are you currently, or do you expect to be, involved in any court proceedings for which you might request a custody/parenting evaluation, disability evaluation, or other forensic report?

[ ] No

[ ] Yes. Please explain:

**Other**

Is there anything else that is important for me as your therapist to know about, and that you have not written about on any of these forms? If yes, please tell me about it here or on another sheet of paper:

**Life Events Chart:**

Summarizing the main aspects of your life history will save us time in therapy. Please reflect on your life from birth to present in terms of the highlights, challenges, celebrations, relationships, enduring circumstances, turning points, accomplishments, losses, adventures, and the peaks and valleys that have shaped who you are as a person. Then fill in the Life Events Chart. A simplified example is provided on the next page to help you understand the process – please include more detail in your own chart!

Increasingly Positive Experiences

**EXAMPLE LIFE EVENTS CHART**

**Life Events Chart**

Increasingly Negative Experiences

**Present**

Age 42: Divorcing, custody issues

Age 39: found out about K’s affair

Age 9: Parent’s divorced

Age 33: Marriage proposal

Age 34: Married K.

Age 37: First daughter born

Age 23: Relationship with N., ended , I was heartbroken

Age 21: Began relationship w N. – my first love

Age 18: graduated with honors

Age 4: Little sister was born

Age 9-15: Mom depressed, withdrawn

**Birth**

Increasingly Positive Experiences

**YOUR LIFE EVENTS CHART**

**Life Events Chart**

**Birth**

Increasingly Negative Experiences

**Present**