

PLEASE TYPE OR PRINT CLEARLY SO WE HAVE ALL THE CORRECT INFORMATION

PATIENT'S NAME (Last, First, Middle Initial)			PATIENT'S DATE OF BIRTH MM/DD/YYYY		
PATIENT'S ADDRESS (No., Street)			PATIENT'S RELATIONSHIP TO INSURED <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____		
CITY	STATE	ZIP CODE	PATIENT'S S.S.#		
TELEPHONE NUMBERS (Including Area Code)			PATIENT STATUS		
Home: _____	<input type="checkbox"/> Contact me here		<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Other _____		
Work: _____	<input type="checkbox"/> Contact me here		Employment Status: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed		
Cell: _____	<input type="checkbox"/> Contact me here		Student: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-time		
PRIMARY CARE PHYSICIAN			EMERGENCY CONTACT		
PCP ADDRESS (No., Street)			RELATIONSHIP		
CITY	STATE	ZIP CODE	EMERGENCY CONTACT'S PHONE		
PCP PHONE	FAX		REFERRED BY:		

RESPONSIBLE POLICY HOLDER INFORMATION - ALL BOXES "MUST" BE COMPLETED

INSURANCE ID #	S.S.#	GROUP POLICY #			
NAME (Last, First, Middle Initial)		DATE OF BIRTH (MM/DD/YYYY)			
ADDRESS (No., Street)		EMPLOYER OR SCHOOL NAME			
CITY	STATE	ZIP CODE	INSURANCE PLAN NAME OR PROGRAM		
TELEPHONE NUMBERS (Including Area Code)		IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO (If yes, What Plan?)			
Home: _____	<input type="checkbox"/> Contact me here				
Work: _____	<input type="checkbox"/> Contact me here				
Cell: _____	<input type="checkbox"/> Contact me here				

PAYMENT, FEES, & CONSENT FOR TREATMENT

If, as a client of SURPRISE BEHAVIORAL HEALTH, you are using your insurance benefits, you are obligated to pay any deductible and copay at the time of service. The amount of deductible and copay is determined by your individual benefit plan. While we can assist you in filing insurance claims, you are responsible for any amounts that your insurance company health benefit plan does not cover. While we will attempt to verify your benefits, it is ultimately your responsibility to know what your health plan will and will not cover. Feel free to discuss insurance coverage with this office. There is a \$25.00 charge on all returned checks. Returned checks and charges must be paid with cash, certified check or money order prior to receiving additional services. Delinquent accounts may be referred for collection and interest may be added to balances over 60 days. I also understand that if I do not show for my appointment or if I cancel my appointment with less than 24-hour notice, I will be charged the full amount of the self-pay rate for that appointment. A client's confidentiality is important and is legally protected. There are, however, circumstances that impose limitations on a client's right or ability to maintain a privileged communication. We are legally bound to report suspected child or elder abuse or neglect and are obligated to take steps to inform others if there is reason to believe that a client is in danger to themselves or others. Confidentiality may also be waived as a result of a court order, legal proceeding, referral to a licensing authority, or other statutory requirement. When a clinician is out of town, another professional will cover crisis calls and that professional may be advised of issues that might arise regarding your case. If a health benefit plan is expected to pay for some portion of the cost of services, it must be mutually understood and accepted that this office may furnish diagnostic, financial and clinical information to that insurance company, and/or medical review organization in order to obtain reimbursement. If you are currently on Short or Long Term Disability, it must be mutually understood and accepted that this office may furnish diagnostic and clinical information to your Disability Medical Review Organization if requested either in writing or by telephone. There are additional charges for providing written reports. Your case may be subject to a Peer Case File Review in order to insure the highest quality of care. In the event group counseling services are provided, it is further acknowledged that the therapist or practice cannot be held responsible for a breach of confidentiality on the part of a group member.

I hereby assign payment of insurance health benefits for treatments for myself, spouse or child to SURPRISE BEHAVIORAL HEALTH/Ruth J. Gruen, LMFT. It is mutually understood, however, that I am financially responsible to SURPRISE BEHAVIORAL HEALTH/Ruth J. Gruen, LMFT for any charges not paid by my insurance company or third party payor.

PATIENT OR PARENT (if client is a minor) _____ Date: _____

I do hereby seek and consent to take part in treatment at SURPRISE BEHAVIORAL HEALTH. I understand that developing a treatment plan with the 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 the therapist. I am aware that I may stop my treatment with the therapist at any time. I understand that I will still be responsible for the payment of any and all services I have already received at the time of termination. I understand that I may lose other services or may have to deal with other problems should I terminate treatment early. (For example, if my treatment has been court ordered, I will have to answer to the court.) I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. Failure to do so will result in my being charged that appointment.

I HAVE REVIEWED THE INFORMATION ON THIS PAGE AND ACCEPT THESE UNDERSTANDINGS, AND AGREE TO PARTICIPATE IN TREATMENT.

PATIENT OR PARENT (if client is a minor) _____ Date: _____

PATIENT'S NAME: _____ AGE: _____ DATE: _____

Where were you born? _____ How long in Phoenix? _____ From where? _____
List all of your siblings including their ages from youngest to oldest (including yourself): _____

Are you parents deceased? Mother Father If deceased, your age at his/her death: Mother _____ Father _____
Give a brief description of your Mother's personalty and how she treated you: _____

Give a brief description of your Father's personality and how he treated you: _____

If you were raised by anyone other than your biological parents, please identify who they were and describe how they treated you: _____

Give an impression of your childhood home environment: including what kind of relationship existed between the parents, between parents and children and between children: _____

Conditions that may have applied to you during childhood: Bedwetting Nail biting Stuttering Sleepwalking Physical abuse
 Emotional abuse Sexual abuse PLEASE EXPLAIN: _____

Serious Illness/Disease? Accidents/Surgeries? (duirng childhood): _____

Highest level of education Complete? Grade School Jr. High High School College Graduate School Degree _____
Academic Performance in: Grade School _____ Jr. High _____ High School _____ College _____ Graduate School _____

Your Occupation: _____ How long? _____ Are you satisfied with it? _____ Does it meet your financial needs? _____

Are you married? YES NO If married, how long? _____ Have you ever been divorced? _____ If so, how many times? _____
Date(s) married: _____ Date(s) divorced: _____

Please explain causes of divorces: _____

Do you have children from either present or past marriages? If so, plese indicate present or past, names, ages and with whom they live: _____

Indicate which of the following behaviors, practices, or habits is true for you by marking the appropriate boxes:

	NEVER	RARELY	OFTEN	VERY OFTEN		NEVER	RARELY	OFTEN	VERY OFTEN
Birth-Control Pills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use Painkillers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Take Diet Pills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Take Sedatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use Marijuana	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Take Stimulants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anger Outbursts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use Narcotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Take Vacations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gambling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Go to Concerts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smoke Cigarettes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Play Sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chew Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Attend Sporting Events	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drink Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ALCOHOL AND SUBSTANCE USE/ABUSE					
Type	Use in Last 30 Days	Amount Used	Day of Last Use	# of Years Used	Age of First Use

Past hospitalization or treatment for addictions? (If yes, explain) _____

Past hospitalization for psychological problems? (If yes, explain) _____

Do you have any prior history of counseling for mental health, alcohol or drugs, marriage or family, other (be specific): _____

Have you or anyone in your family ever attempted suicide? (Explain) _____

Have you ever been arrested, including DUI's/DV? (Explain) _____

Is your present sex life satisfactory? Yes No If no, please explain _____

Describe any unpleasant memories related to sexual experiences (include forced or traumatic sexual incidents): _____

Describe any sexual inhibitions or problems that you might have at this time: _____

Provide information about any unwanted pregnancies and the consequences: _____

Support Systems: Family Friends Church Self-help Groups Other _____

PLEASE MARK ALL THOSE WHICH APPLY TO YOU

- | | | |
|--|--|---|
| <input type="checkbox"/> Sadness/Increased Tearfulness | <input type="checkbox"/> Appetite Change | <input type="checkbox"/> Mood Swings |
| <input type="checkbox"/> Insomnia/Sleeplessness | <input type="checkbox"/> Weight Gain/Loss | <input type="checkbox"/> Easily Fatigued |
| <input type="checkbox"/> Increased Need for Sleep | <input type="checkbox"/> Negative Thinking | <input type="checkbox"/> Unexplained Aches & Pains |
| <input type="checkbox"/> Excessive Sleep | <input type="checkbox"/> Difficulty Concentrating | <input type="checkbox"/> Increased Irritability |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Stomachaches/Digestive Problems | <input type="checkbox"/> Increased Anger Outbursts |
| <input type="checkbox"/> Feeling Unrested Upon Wakening | <input type="checkbox"/> Unresolved Grief Issues | <input type="checkbox"/> Loss of Pleasure in Activities |
| <input type="checkbox"/> Feelings of Helplessness/Hopelessness | <input type="checkbox"/> Decreased Energy | <input type="checkbox"/> Low Self-Esteem |
| <input type="checkbox"/> Excessive Guilt | <input type="checkbox"/> Decreased Motivation | <input type="checkbox"/> Low Frustration Tolerance |
| <input type="checkbox"/> Decreased Sexual Interest | <input type="checkbox"/> Difficulty Making Decisions | <input type="checkbox"/> Increased Withdrawal/Isolation |
| <input type="checkbox"/> Previous History of Depression | | |
| <input type="checkbox"/> Treated | <input type="checkbox"/> Untreated | <input type="checkbox"/> Suicide Ideation (thoughts) |
| | | <input type="checkbox"/> Plan |
| | | <input type="checkbox"/> Attempt (when? _____) |

- Excessive anxiety and worry, occurring more days than not for at least 6 months.
- You are finding it difficult to control the worry
- Feeling restless or keyed up or on edge for at least 6 months
- Easily fatigued for at least 6 months
- Difficulty concentrating or mind going blank for at least 6 months
- Irritability for at least 6 months Muscle tension lasting at least 6 months
- Sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep) for at least 6 months
- The anxiety/worry that you have been feeling for the past 6 months causes significant distress or impairment in
 social occupational or other areas of functioning (please explain): _____

ANXIETY/PANIC ATTACKS with: Heart Palpitations Sweats Shaking Shortness of Breath Chest Pain Nausea
 Dizzy/lightheaded Numbness/Tingling Fear of going out FREQUENCY _____ How long has it been going on? _____

COMPULSIVE BEHAVIORS (cleaning, checking, hand washing, hoarding) OBSESSIONS (repetitive, ruminations)

- | | | |
|---|---|---|
| <input type="checkbox"/> Makes careless mistakes | <input type="checkbox"/> Short Attention Span | <input type="checkbox"/> Does not seem to listen |
| <input type="checkbox"/> Does not follow through on directions | <input type="checkbox"/> Disorganized | <input type="checkbox"/> Avoids sustained mental attention |
| <input type="checkbox"/> Loses things necessary to complete tasks | <input type="checkbox"/> Easily Distracted | <input type="checkbox"/> Often forgetful of daily activities |
| <input type="checkbox"/> Fidgets | <input type="checkbox"/> Feeling restless | <input type="checkbox"/> Difficulty with quiet leisure activities |
| <input type="checkbox"/> Often "on the go" | <input type="checkbox"/> Talks Excessively | <input type="checkbox"/> Blurts out answers |
| <input type="checkbox"/> Difficulty awaiting turn | <input type="checkbox"/> Interrupts | <input type="checkbox"/> Many projects at once |
| <input type="checkbox"/> Procrastinates | <input type="checkbox"/> Easily bored | <input type="checkbox"/> Does not complete projects |
| <input type="checkbox"/> Impulsive Behaviors | <input type="checkbox"/> Engages in Dangerous Behaviors | |

STRESSORS: Money Housing Family Conflict Work Grief & Loss Illness Transitions Other

Do you have any prior history of counseling for Mental Health, alcohol or drug use/abuse, marriage or family issues, other? If so, give dates, provider, types of interventions and responses: _____

What have been the major stressors in your life over the past 1-5 years? (BE SPECIFIC/GIVE DETAILS) _____

What has brought you in today and why NOW? (BE SPECIFIC/GIVE DETAILS) _____

What are your major strengths? _____
 What spiritual or religious issues are important to you? How does your culture influence you? _____

CLIENT SIGNATURE: _____ DATE: _____

