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| Joann carter, LCSWjoanncarter.lcsw@gmail.com(702)430-4633  |  | | --- | | 2850 W Horizon Ridge PKWysuite 200henderson NV 890522340 Paseo del prado d307las vegas NV 89102 | |  | |  | | --- | | new client registration Date:  Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Emergency Contact Name/phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  I authorize treatment of the named client. I assign and authorize payment of medical benefits directly to Joann Carter, LCSW and its representatives. To cancel an appointment, the named patient must notify Joann Carter, LCSW at least 24 hours prior to scheduled appointment time, or else I will be responsible for a $75 cancellation fee. If the named patient fails to attend an appointment, I will be responsible for paying a $75 missed appointment fee. I have read, understand, agree to the described disclosure, financial policy and various releases and guarantee.  Client and/or Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Acknowledgement of Participation in Treatment Plan Development  I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, acknowledge that I participated in the development of the treatment plan for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (name of client). I was given the opportunity to discuss treatment goals and to ask questions about services that will be provided by Joann Carter, LCSW. **Initial\_\_\_\_\_\_**  Consent to use Unencrypted Email or Text  Computer email, texts and e-fax communication, can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. These forms of communication are vulnerable to such unauthorized access due to the fact that servers or communication companies may have unlimited and direct access to all emails, texts and e-faxes that go through them. It is always possible that e-faxes, texts and emails can be sent to erroneously to the wrong address and computers. Please note that emails, faxes and texts are all a part of your clinical record. Also, be aware that phone messages are transcribed and sent to unencrypted email. Please notify Joann Carter, LCSW in any way of limitations to text, e-fax or email. If you communicate confidential or private information via these forms of communication named above, it will be assumed that you have evaluated the risk that such communication may ne intercepted, and your desire to communicate on such matters will be honored. Do not use texts, email, voice mail or faxes for emergencies, it is advised that you call 911. **Initial\_\_\_\_\_**  Professional Fees  Cash pay per session: $130/50 minute session  Other services you may need: $100/hour  Other billable services can include letters to other professionals, telephone conversations lasting longer that 5 minutes, attendance at meetings with other professionals authorized by you, preparation of treatment summaries, completion of disability forms.  If you become involved in legal proceedings that require therapist participation, you will be charged for the professional time even if the therapist is called to testify by another party. The charge is $150/hour for preparation, travel, and attendance. **Initial\_\_\_\_\_**  \*\*\*If a custody arrangement is in place, therapist requires a copy and signature by designated/appropriate caregiver/parent. **Initial\_\_\_** | |

Limits of Confidentiality

Psychotherapy is confidential, with the below stated expectations.

Duty to Warn: Therapists are mandated by law to disclose pertinent information discussed in therapy if the client has an intent or plan to harm another person. We are required to inform the intended victim and notify legal authorities.

Suicide/Self-harm: Depression is a common emotion expressed in therapy, but if the client is feeling hopeless enough to imply or disclose a plan for suicide; steps need to be taken to ensure safety. This could be, but is not limited to calling the authorities or your stated emergency contact.

Animal abuse: I will report animal abuse, including but not limited to cases of neglect and hoarding.

Vulnerable adults and children: Mental health professionals are required by law to report stated or suspected abuse of a child or vulnerable adult to the appropriate social service agencies and/or legal authorities.

Prenatal exposure to controlled substances: in keeping with protecting vulnerable populations, mental health providers are required to report admitted use of controlled substances during pregnancy that are potentially harmful to the fetus.

Parents/Guardianship: Parents or legal guardians have the right to access a minors health information.

Insurance: A superbill will be provided at the request of the client to submit to their private insurance company for reimbursement. If the insurance company contacts Joann Carter, LCSW I give her permission to disclose needed information. Initial\_\_\_\_\_

I have read and understand the above stated limitations to confidentiality. I accept the subsequent ramifications should there be a need to act on one of the above stated exceptions. Other than the noted exceptions, if there is a reason to disclose my protected information I understand that I will be provided a Release of Information form.

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH RECORD (Also known as Protected Health Information)

PATIENT NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address (Mailing) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize Joann Carter, LLC to use or disclose information from my mental health record, which may include information about psychiatric diagnosis and treatment and substance abuse issues to: Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FAX \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dates of Treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Information to be released (Please describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Purpose of Disclosure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. I understand that, unless withdrawn, this authorization will expire 180 days from the date of signature. A photocopy of this form will be considered as valid as the original. 2. I understand that I may revoke this authorization at any time by notifying the Department of Mental Health & Counseling at the address indicated above, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it. 3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information and mental health information. 4. I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment. 5. My health care and payment for my health care at Yale Health Center will not be affected if I do not sign this form. 6. I understand that I can request a copy of this form after I sign it. 7. I understand that in compliance with CT general statute, I will pay a fee of $0.65 per page.

By signing below, I acknowledge that I have read and understand this Authorization.

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

Signature of Patient Date

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

Parent/Legal Guardian/Authorized Person

Mental Health Intake Form

Please complete all information on this form and bring it to the first visit. It may seem long, but most of the questions require only a check, so it will go quickly. You may need to ask family members about the family history. Thank you!

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are the problem(s) for which you are seeking help? 1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your treatment goals?

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Current Symptoms Checklist: (check once for any symptoms present, twice for major symptoms)

( ) Depressed mood ( ) Racing thoughts ( ) Excessive worry ( ) Unable to enjoy activities

( ) Impulsivity ( ) Anxiety attacks ( ) Sleep pattern disturbance ( ) Increase risky behavior

( ) Avoidance ( ) Loss of interest ( ) Increased libido ( ) Hallucinations ()Concentration/forgetfulness ( ) Decrease need for sleep ( ) Suspiciousness ( ) Change in appetite ( ) Excessive energy ( ) Excessive guilt ( ) Increased irritability ( ) Fatigue ( ) Crying spells

( ) Decreased libido

Suicide Risk Assessment

Have you ever had feelings or thoughts that you didn't want to live? ( ) Yes ( ) No.

Do you currently feel that you don't want to live? ( ) Yes ( ) No

Reviewed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist signature

Notes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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List ALL current prescription medications and how often you take them: (if none, write none) Medication Name Total Daily Dosage Estimated Start Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Current over-the-counter medications or supplements: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current medical problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Past medical problems, nonpsychiatric hospitalization, or surgeries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List ALL current psychiatric prescription medications and how often you take them: (if none, write none) Medication Name Total Daily Dosage Estimated Start Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Psychiatric Hospitalizations ( ) Yes ( ) No

If yes, please list dates and reason for hospitalization:

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

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Substance Use: Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No

If yes, for which substances? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, where were you treated and when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many days per week do you drink any alcohol? \_\_\_\_\_\_\_\_\_\_\_\_

What is the least number of drinks you will drink in a day? \_\_\_\_\_\_\_

What is the most number of drinks you will drink in a day? \_\_\_\_\_\_\_

In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? \_\_\_\_\_\_

Have you ever felt you ought to cut down on your drinking or drug use? ( ) Yes ( ) No

Have people annoyed you by criticizing your drinking or drug use? ( ) Yes ( ) No

Have you ever felt bad or guilty about your drinking or drug use? ( ) Yes ( ) No

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ( ) Yes ( ) No

Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No

Have you used any street drugs in the past 3 months? ( ) Yes ( ) No

If yes, which ones? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Have you ever abused prescription medication? ( ) Yes ( ) No If yes, which ones and for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Circle if you have ever tried the following:

Methamphetamine Cocaine Stimulants (pills) Heroin LSD or Hallucinogens Marijuana Pain killers (not as prescribed) Methadone Tranquilizer/sleeping pills Alcohol Ecstasy Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many caffeinated beverages do you drink a day? \_\_\_\_\_

Tobacco History: How you ever smoked cigarettes? ( ) Yes ( ) No Currently? ( ) Yes ( ) No

How many packs per day on average? \_\_\_\_\_\_\_\_\_\_\_ How many years? \_\_\_\_\_\_\_\_\_

In the past? ( ) Yes ( ) No How many years did you smoke? \_\_\_\_\_\_\_\_ When did you quit? \_\_\_\_

Pipe, cigars, or chewing tobacco: Currently? ( ) Yes ( ) No In the past? ( ) Yes ( ) No What kind? \_\_\_\_\_\_\_\_\_\_ How often per day on average? \_\_\_\_\_\_ How many years? \_\_\_\_\_\_\_\_\_\_\_\_

Trauma History: Do you have a history of being abused emotionally, sexually, physically or by neglect? ( ) Yes ( ) No. Please describe when, where and by whom: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Educational History: Highest Grade Completed? \_\_\_\_\_\_\_\_\_\_

Did you attend college? \_\_\_\_\_\_\_\_ Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Major?

Occupational History: Are you currently:

( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired

What is/was your occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Where do you work? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Have you ever served in the military? \_\_\_\_\_\_\_ If so, what branch and when?

Relationship History and Current Family: Are you currently: ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( )Widowed

How long? \_\_\_\_\_ If not married, are you currently in a relationship? ( ) Yes ( ) No

If yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List everyone who currently lives with you (including children and their ages/gender):

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

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Legal History: Have you ever been arrested? \_\_\_\_\_\_\_

Do you have any pending legal problems? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spiritual Life: Do you belong to a particular religion or spiritual group? ( ) Yes ( ) No

If yes, what is the level of your involvement? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you find your involvement helpful during this time, or does the involvement make things more difficult or stressful for you? ( ) more helpful ( ) stressful

Is there anything else you would like to include in this comprehensive questionnaire that was not asked: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_