Griffin Therapy Center

EMPOWERMENT FOR HEALING

Psychiatric Intake

By filling out the following in its' entirety prior to your appointment, you are freeing up your time to discuss your psychiatric needs. Please take a moment to fill in all the information below.

Patient Name_____ Date of Birth _____ Gender_____

Address _____ City _____ Zip _____

Have you ever been to Griffin Therapy Center before? _____

Cell _____ Okay to send text reminders? _____

Email_____ Okay to send email? _____

Parent Name (if patient is a minor) _____

Cell _____ Okay to send text reminders? _____ Occupation _____

About Us

Thank you for choosing Griffin Therapy Center. We're a dedicated private practice counseling agency providing out-patient mental health care. We believe successful growth and healing begins with a collaborative relationship between client and clinicians. We will work together to navigate your concerns and determine how your thoughts affect both your feelings and behavior. From this understanding you can feel empowerment to choose new direction and healing.

Psychiatric care can hold great benefits such as: improved understanding of yourself and others, progress toward defined goals and objectives, greater moods and behavior management, improved self-esteem and self-assertion, relationship enhancement, and an improved capacity for independence. Potential risks of counseling include a lack of progress, upsetting insight, and feelings of distress.

We DO NOT provide emergency and/or crisis services. For all crises and/or emergencies, please 911 or visit your nearest emergency room. You can additionally call the Crisis Help Line at 972-233-2233 or the Teen Help Line at 972-233-8336.

What are your primary reasons for seeking psychiatric consultation at this time? _____

_____

When did these symptoms begin? _____

Did something occur to precipitate symptoms? _____

Have there been symptom free periods? _____

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Medical History

Current Medications

Name of Medication	Doseage	Reason for Rx	Prescriber	Helpfullness/ Side Effects

Do you smoke cigarettes? Yes/No If yes, how much _____

Do you drink alcohol? Yes/No If yes, how much _____

Other drugs? Yes/No If yes, which and how much _____

Psychiatric History

When did treatment first begin? _____

Previous Psychiatrists? _____

Have you (your child) ever been psychiatrically hospitalized? If yes, when, where, and for what reason? _____

Have you (your child) ever thought of or attempted to complete suicide? If yes, when, how, and under what circumstances? _____

Have you (your child) ever hurt oneself in any way? For example, cutting or burning self. If yes, when, how, and under what circumstances? _____

Past Medications

Name of Medication	Doseage	Reason for Rx	Prescriber	Helpfullness/ Side Effects

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Family History

Complete below for anyone currently living in the home

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List any immediate family members not living in the home

_____	_____	_____
_____	_____	_____

Are you or have you ever been married _____

Do you have any children _____

Occupation/Student _____

Level of Education _____

Have you experienced or are you currently experiencing emotional, physical or sexual abuse _____

Have you experienced or are you currently experiencing legal problems _____

Family Psychiatric History

Have any family members had any of the following? Circle and indicate which family member.

Depression _____	ADHD/ADD _____
Mania/Bipolar Disorder _____	Learning Disability _____
Suicidal thoughts/urges/behaviors _____	Coordination problems _____
Anxiety _____	Mental Retardation _____
Panic _____	Autism spectrum _____
Obsessions/compulsions _____	Sleep disorder _____
Rituals _____	Drug use _____
Movement Disorders_____	Alcohol use _____
Tics _____	Psychosis _____
Unusual noises/vocalizations _____	Legal problems _____
Eating disorder _____	Psychiatric hospitalizations _____

Other _____

Medical History

Please circle any that the patient has had an include dates as best you can

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Head injury/loss of consciousness
Seizures/convulsions
Other neurological problems
Ear, nose or throat problems
Dental problems
Asthma
Chest problems
Urinary or bladder/wetting

Heart problems
Rheumatic fever/strep infections
Liver/kidney problems
Skin problems
Joint/Limb problems
Hearing/vision problems
Growth/endocrine problems
Childhood measles/mumps

Provide information about significant medical issues on the FATHER'S side: _____

_____

Provide information about significant medical issues on the MOTHER'S side: _____

_____

Prenatal History

Was the pregnancy healthy? Yes/No Problems _____
Were medications used during the pregnancy? Yes/No
If yes, what kind? _____ How often? _____
Were drugs and/or alcohol used during the pregnancy? Yes/No
If yes, what kind? _____ How often? _____
Did the mother smoke during the pregnancy? Yes/No If yes, how often? _____
Was the pregnancy full term? Yes/No
Was the delivery normal? Yes/No If no, problems _____
Any feeding problems? _____ Gained weight well? _____
Any problems in the first week? _____
First month? _____
First year? _____

Developmental History

Describe yourself/child as an infant:
1. active / active but calm / passive / other: _____
2. cuddly / irritable / withdrawn / other: _____
3. cried easily and frequently / reasonable amount / seldom /
4. soothed easily / difficult to soothe / average
5. response to changes: severe / moderate / mild

6. response to being held (describe): _____
7. reaction to strangers: friendly / indifferent / fearful
Describe current eating habits: _____ Problems: _____
Describe current sleeping habits: _____ Problems: _____
Developmental Milestones **(only mark if significantly early or late)**

Motor:	Language:	Adaptive:
Rolled front/back (4 mo) _____	Smiling (4-6 wks) _____	Mouthing (3 mo) _____
Sit with support (6 mo) _____	Cooing (3 mo) _____	Transfers Objects (6 mo) _____
Sit alone (9-10 mo) _____	Babbling (6 mo) _____	Picks up raisin (11-12 mo) _____
Pull to stand (10 mo) _____	Jargon (10-14 mo) _____	Scribble (15 mo) _____
Walks alone (10-18 mo) _____	Follows 1-step order (15 mo) ____	Drinks from cup (10 mo) _____
Running (15-24 mo) _____	2 word combo (22 mo) _____	Uses spoon (12-15 mo) _____
Tricycle (3 yrs) _____	3 word sentence (3 yrs) _____	Bladder trained _____
Bicycle (5-7 yrs) _____	Speech problems _____	Bowel trained _____

School

Repeated Grade? Yes/No If yes, which? _____
Special resource classes? _____
Other special services? (Speech/OT/PT) _____
IEP? Yes/No 504 Plan? Yes/No Academic grades received? _____
Academic evaluations performed?
Date _____ Type _____ Reasons _____
Results _____
Date _____ Type _____ Reasons _____
Results _____
Relationships with teachers? _____ With peers? _____
Ability to work independently? good / average / poor
Organize self? good / average / poor
Attendance? good / average / poor
Have you (your child ever had truancy proceedings? Yes/No
Have you (your child) had any legal proceedings? Yes/No
If yes, explain _____
Describe you (your child's activities, interests, hobbies, skills, strengths:
_____
_____

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Problematic Behavior Checklist

	Past	Occasionally	Often	Very Often
Short attention span				
Impulsivity (act before thinking)				
Won't follow rules/directions				
Irritable, poor frustration tolerance				
Easily riled up				
Picks on others				
Feels picked on				
Teases others unmercifully				
Deliberately tries to annoy people				
Easily angered, bad temper				
Frequent accidents				
Gets out of control				
Gets violent and aggressive				
Cruel to animals				
Fire setting				
Steals				
Cries easily				
Gets giddy and silly				
Tiredness/listlessness				
Lack of interest in activities				
Isolates self from others				
Sadness				
Poor appetite				
Problems getting to sleep				
Early morning awakening				
Self-injurious behavior/abusive behaviors				
Excessive sleeplessness				
Weight gain/loss				
Worries a lot				
Fear of the dark				
Other specific fears (heights, etc)				
Catastrophic fears				
Reluctance to go to school				
Repeated unwanted thoughts				
Compulsive behaviors				
Rituals (has to repeat the same action)				
Hair pulling				
Excessive concerns				
Body preoccupation				

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Limits of Confidentiality

The relationship between you and your therapist will be based on trust, rapport and common effort of you achieving your therapeutic goals. For this to occur, your therapist must maintain professional boundaries and follow the regulations of licensure. Your relationship is limited to a professional one, and will not include any components of a social relationship. Contact with your counselor will be limited to communication directly related to your counseling process. If you see your counselor in public, we will continue to protect your confidentiality by not acknowledging you in that setting.

In the event that your therapist becomes incapacitated or dies, your records and treatment coordination responsibilities will transfer to the agency of Griffin Therapy Center.

The law protects the relationship between a client and a psychotherapist or psychiatrist, meaning information cannot be disclosed without parent or guardian written permission. Exclusions include:

- I must break confidentiality if a client is threatening serious bodily harm to another person/s, in order to notify the police and to inform the intended victim.
- I am required by law to immediately report any suspected child or elder abuse to the appropriate authority.
- If a client intends to harm him or herself, I will make every effort to enlist their cooperation to ensure client safety. If he or she does not cooperate, I will take further measures without permission that are provided to me by law in order to ensure safety.

Your Printed Name	Your Signature	Date
Stella Adebusoye	Counselor's Signature	Date

In Case of Emergency

Below is the person that can be contacted in order to prevent harm or in case of emergency.

Name	Phone Number	Relationship

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Policies and Payment

Your Psychiatric Nurse Practitioner: Stella Adebusoye
Full Rate: $200 Intake, $100 Follow-Up

Griffin Therapy Center requires 24-hour notice for all cancellations and rescheduling. If you do not provide 24 hours notice you will be billed $200/100 for the full cost of the counseling session. Insurance does not cover cancellations or missed appointments. Additionally, if insurance is filed and fails to pay, you will be responsible for all counseling fees.

A $25 late fee is assessed for fees not paid at the time of service. Overdue accounts will be charged for any collection fee plus a $70.00 processing fee.

For appointments, cancellations, or to reschedule please call Griffin Therapy Center at 940-765-6487 or email at appointments@griffintherapycenter.com. Phone messages will be returned with 24 hours.

I agree to the billing terms set forth above, and agree to the confidential storage of my card on file for the future use of billing and automatic drafting of payments for late-cancellation and no-show fees.

Name as it Appears on Card: _____

Card #: _____

Expiration Date:_____3-Digit Code:_____Billing Zip Code: _____

_____ _____ _____Your
Printed Name Your Signature Date

Insurance Company:_____ Member ID: _____

Group Number: _____

Policy Holder's Name:_____ Your Relation to Policy Holder: _____

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HIPAA

HIPAA (Health Insurance Portability and Accountability Act)

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

Notice of Client Rights

• You have the right to receive full information from your counselor about his or her professional knowledge, skills, preparation, experience, and credentials.
• You have the right to be informed about the options available for treatment interventions and the effectiveness of the recommended treatment.
• You have the right to have explained to you how a therapy technique works as well as given an explanation for its intended purpose before it is employed.
• You have the right to refuse a particular therapy technique or method.
• You have the right to request restrictions on certain uses and disclosures of your counseling records. However, your counselor is not required to agree to a restriction you request.
• You have the right to request and receive confidential communications from your counselor by alternative means and at alternative locations. For example, if you don't want coworkers to know you are seeing a therapist, you can direct your counselor to telephone you only at home.
• You have the right to inspect and/or obtain a copy of your, or your minor child's, counseling record for as long as the record is maintained. Your counselor may deny your request.
• You have the right to request an amendment of your or your minor child's counseling record for as long as the record is maintained. Your counselor may deny your request.
• You generally have the right to receive an accounting of disclosures from your or your minor child's counseling record, for which you have neither provided consent nor authorization.
Such disclosures are described under the section: "Limits of Confidentiality" above.
• You have the right to complain should you believe your privacy rights have been violated. In such cases first discuss the concern with your counselor to seek a satisfactory resolution, which may include a referral. If you are not satisfied with the outcome, you may file a written complaint to the Texas Department of Human Services (DHS) to further assist in resolving the matter:

Complaints Management and Investigative Section
P.O. Box 141369 Austin, Texas 78714-1369
Or call 1-800-942-5540 to request the appropriate form or obtain more information.

Your Printed Name	Your Signature	Date
Stella Adebusoye	Nurse's Signature	Date

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Notice of Privacy Practices

• Your counselor has been and will always be totally committed to maintaining clients' confidentiality. He or she will only release information about your counseling records in accordance with federal and state laws and ethics of the counseling profession. This notice describes your counselor's policies related to the use and disclosure of your counseling records. Uses and disclosure of your counseling records for the purposes of providing services, providing treatment services, collecting payment, and conducting counseling operations are necessary activities for quality care. State and federal laws allow your counselor to use and disclose information from your counseling records for these purposes.
• Treatment—your counselor may need to use or disclose information from your counseling records to provide, manage, or coordinate your treatment or related services, which could include consultations with medical or mental health professionals and potential referral sources.
• Payment—your counselor may need to disclose information from your counseling records that is needed to verify insurance coverage and/or benefits with your insurance carrier, to process your claims as well as information needed for billing and collection purposes.
• Counseling Operations—your counselor may need to use information about you to review his treatment procedures and business activity. This may involve supplying a government agency with statistical data. In such cases your name and personal information will not be divulged.
• Other uses or disclosure of your information that does not require your authorization or consent—these disclosures are described under the section: "Limits of Confidentiality" above

My signature below indicates I have been given a notice of this document for my personal keeping. In addition I have online access to the above HIPAA information at www.griffintherapycenter.com

Your Printed Name	Your Signature	Date
Stella Adebusoye	Nurse's Signature	Date