Autism Counseling and Behavior Consultation, Inc.

Adult Aged Client Information

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information. Please fill out this form and bring it to your first session.

Date ___________________

Name ____
(Last) (First) (Middle Initial)

Address ____
(Street and Number)

____
(City) (State) (Zip)

____
(Date of Birth) (Social Security #)

Home Phone ________________________________ May we leave a message? ___ Yes ___ No

Work Phone ________________________________ May we leave a message? ___ Yes ___ No

Cell Phone ________________________________ May we leave a message? ___ Yes ___ No

Email ____

Please note: Email correspondence is not considered to be a confidential medium of communication. Providing your email address will be considered implied consent for our office to contact you about appointments and billing issues.

Emergency Contact

Name ____ Phone __________________________________

Are you your own legal guardian? ___Yes ___ No

Is another person currently an active part of supporting you financially? (i.e. providing money regularly, paying bills, providing housing) ___ Yes ___ No

If Yes, who:

___ Spouse ___ Parent ___ The State

___ Romantic Partner ___ Legal Guardian ___ Other ______________________

Name____

List the names and ages of all people living in your residence (not including yourself):

Name	**Relationship to You**	**Date of Birth**	**Age**	**Level of Education**	**Occupation**

Father's Name ____________________________________ City/State Currently Living ________________________________

Mother's Name ____________________________________ City/State Currently Living ________________________________

Are your parents married? ___ Yes ___ No Number of Siblings ______________________

If No, but they were once married, how old were you when they divorced? ______________________

What is your relationship like with your parents now?

	Above Average	Average	Poor	Deceased
Mother	______	______	______	______
Father	______	______	______	______

Do you have children or dependents? ___ Yes ___ No

Name	**Date of Birth**	**Age**	**Level of Education**	**Relation (biological, adopted, step . . .)**

Marital Status (check one)

___ Married ___ Single ___ Married but Living Apart

If you are currently married or in a romantic relationship:

How long? ______________________

On a scale of 1-10, how would you rate your relationship? ______________________
(1 being very dissatisfied and 10 being very satisfied)

Spouse's Name	**Date of Birth**	**Level of Education**	**Occupation**

___ Divorced

____ Number of Times Divorced

If you have children, check custodial status

___ Joint Custody ___ Sole Custody

___ Mother ____ Father Does your child have visitation with non-custodial parent? ___ Yes ___ No

___ Other (explain) ______________________

Education

Level of Education Completed

___ High School	___ Associate's Degree	___ Master's Degree
___ Some College	___ Bachelor's Degree	___ Doctorial Degree

In High School, did you:

Receive any special education services? ___ Yes ___ No

Have an IEP (Individualized Education Plan)? ___ Yes ___ No

Have social problems (i.e. isolated or difficulty getting along with peers)? ___ Yes ___ No

Have significant disciplinary action/s (i.e. suspensions, expulsions at school)? ___ Yes ___ No

Have teachers who expressed concern about your success at school? ___ Yes ___ No

Did you graduate with a diploma? ___ Yes ___ No

Did you graduate with a certificate of completion? ___ Yes ___ No

Mental Health Concerns and History

Please briefly list your symptoms/behaviors of concern:

___

___

What is your primary goal for this appointment?

___

Have you had any previous treatment for mental health symptoms? ___ Yes ___ No

Have you ever been given a mental health diagnosis (i.e. ADHD, Depression, Autism)? ___ Yes ___ No

If Yes:

Diagnosis: ___ Made by: ___ Date: ___

If No, what diagnosis do you suspect? ___

Are you currently experiencing overwhelming sadness, grief or depression? ___ Yes ___ No

If Yes, for how long? ___

Are you currently experiencing anxiety, panic attacks or have any phobias? ___ Yes ___ No

If Yes, when did you start experiencing this? ___

Are you currently experiencing any chronic pain? ___ Yes ___ No

If Yes, please describe: ___

Are you currently experiencing difficulties with anger management? ___ Yes ___ No

If Yes, when did you start experiencing them? ___

List all outpatient clinics, mental health centers or therapists that you have visited for the treatment of mental health symptoms within the past two years:

Clinic /Center/Therapist	Reason for Visits	Date of First Visit	Estimated # of Visits

Have you ever had inpatient or residential treatment for mental health symptoms? ___ Yes ___ No

If Yes, list below:

Facility	Reason for Hospitalization	Dates of Stay	Length of Stay

* **Potential stress history** (check all that apply):

___ Divorce (family of origin)
___ Domestic Violence (family of origin)
___ Separation, Divorce or Marital problems
___ Serious Illness in the Family
___ Loss of employment
___ Moved from one home to another
___ Arrest/Conviction of family members
___ Exposure to firearms
___ Death in the family
___ Financial Hardship
___ Other (please list)______________
___ Other (please list)______________

* Have you ever been in a natural disaster? ___ Yes ___ No

* Have you ever had legal problems? ___ Yes ___ No

If Yes, please briefly describe: ____

* Are there any biological family members who have had any of the following?

- Significant medical conditions (i.e. seizures, sudden death)
- Autoimmune disorders (i.e. lupus, multiple sclerosis)
- Psychiatric conditions (i.e. anxiety, depression, schizophrenia, bipolar disorder, obsessive compulsive disorder, ADHD)
- Neurological conditions (i.e. mental retardation, learning problems, language delay, tics, autism, Asperger's, PDD)
- Drug/alcohol problems

If yes please list:

Relationship (father, mother, brother, sister, grandmother, cousin, uncle, etc...)	**Name or Description of Condition** Please include all categories listed above

Please check any of your current symptoms:

___ Addiction
___ Appetite Increased
___ Depressed Mood
___ Excessive Sweating
___ Feelings of Hopelessness
___ Indecisiveness
___ Panic Attacks
___ Compulsions
___ Destruction of Property
___ Fatigue/Tiredness
___ Gambling Excessively
___ Racing Thoughts
___ Inability to enjoy activities
___ Sexual Difficulties
___ Anxiety
___ Constipation
___ Diarrhea
___ Fear
___ Hallucinations
___ Irritability
___ Loneliness
___ Appetite Decreased
___ Mood Swings
___ Feelings of Guilt
___ Impaired Family Relationships
___ Memory Impairment
___ Obsessive Compulsive Symptoms
___ Concentration Impairment

___ Paranoid Thoughts	___ Shakiness/Tremulousness	___ Restlessness	___ Impaired Productivity at work or school
___ Self Harm (cutting, hitting, burning)	___ Shopping-Spending Excessively	___ Anger	___ Overuse or Misuse of Alcohol
___ Impulsivity	___ Sleep, waking too early	___ Dizziness	___ Overuse or Misuse of Recreational Drugs
___ Sleep is not refreshing	___ Sleep, problems falling asleep	___ Tearfulness	___ Pain ______________________________ (describe)
___ Violence towards others	___ Sleep, problems staying asleep	___ Weight Gain	___ Other ______________________________
___ Suicidal thoughts	___ Suicide attempts in the past	___ Weight Loss	___ Other ______________________________

List all **current medication** used for **emotional or behavioral problems** below: (attach additional sheet if necessary)

Medication Name	Dose (how much & how often)	Date Started	Date Stopped	Prescribed By

List all **past medications** used for **emotional** or **behavioral problems** below: (attach additional sheet if necessary)

Medication Name	Dose (how much & how often)	Date Started	Date Stopped	Why Stopped?

Have you ever taken vitamins, nutritional supplements or other non-prescription medications to treat mental health concerns?

___ Yes ___ No

If yes, list any treatments ever taken below: (attach additional sheet if necessary)

Medication Name	Dose (how much & how often)	Date Started	Date Stopped	Why Stopped?

Medical Health History and Concerns

Are you currently being treated for any medical illnesses? ___ Yes ___ No

If Yes, please explain:

____

____

List all **current** medications for **medical illnesses** and doses below**:**

Medication	Prescribed for (i.e. allergy)	Start Date	Dose (how much & how often)	Prescribed by

Please list any pertinent past medical history:

____

____

____

____

____

Please list any past surgeries/operations

____

____

____

____

____

Please indicate if you have had any of the following tests completed in the past:

___ Sleep Study	___ Neuropsychological Testing	___ EEG	___ Testosterone Level
___ Psychological Testing	___ Brain MRO or CT Scan	___ Thyroid Tests	___ Hormone Levels

Please provide any additional information regarding any of the items you marked above:

____

____

____

<u>Client Cultural Information</u>

Do you identify with or follow a specific spiritual/religious tradition? ___ Yes ___ No

If Yes, please list: ____

Is there anything about your spiritual/cultural traditions that we should be aware of that may conflict with services? ___ Yes ___ No

If Yes, please explain:

____

____

What is your primary language? ______________________________ Are other languages spoken in the home? ___ Yes ___ No

If so, which language(s)? ____

General Health and Mental Health Information

How would you rate your current physical health? (please check)

___ Poor ___ Unsatisfactory ___ Satisfactory ___ Good ___ Very Good

Please list any specific health problems you are currently experiencing:

____

How would you rate your current sleeping habits? (please check)

___ Poor ___ Unsatisfactory ___ Satisfactory ___ Good ___ Very Good

How many times per week do you generally exercise? ______________________________________

What types of exercise do you participate in? ____

____

List any difficulties you experience with your appetite or eating patterns:

____

Do you drink alcohol more than once a week? ___ Yes ___ No

How often do you engage in recreational drug use?

___ Daily ___ Weekly ___ Monthly ___ Infrequently ___ Never

Employment

Are you currently employed? ___ Yes ___ No

If yes, what is your current employment situation?

____

____

Do you enjoy your work? Is there anything stressful about your current work?

____

____

Do you or have you received employment support through Vocational Rehabilitation? ___ Yes ___ No

____

____

If you are not currently employed, have you been employed in the past? ___ Yes ___ No

If Yes, please briefly describe your employment history:

____

____

Other Information

What do you consider to be some of your strengths?

____

____

What do you consider to be some of your weaknesses?

____

____

What would you like to accomplish out of your time in therapy?

____

____

Please let us know how you were referred to our practice:

___ By primary care physician	___ By another physician involved in my care	___ Television/Radio	___ By my insurance company
___ By a friend	___ By a family member	___ Internet/Website	___ Phone Book
___ Other _________________	___ Article in the newspaper or local publication	___ Other ________________	___ Other _________________

Name of Person Referring (optional) ____

Please bring copies of the following information to your first visit if you have them available. We will need to keep these copies for our client files. The information you provide will not be passed on to third parties:

Psych Testing, Doctors Reports and Diagnosis, (Mental Health only), Voc Rehab Reports.

Notice of Privacy Practices
Autism Counseling & Behavior Consultation, Inc.

Effective 4/15/2003

THIS NOTICE DESCRIBES HOW MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. PURPOSE: Autism Counseling and Behavior Consultation, employees, and trainees follow the privacy practices described in this Notice. Autism Counseling and Behavior Consultation keeps your mental health information in records that will be maintained and protected in a confidential manner, as required by law. Please note that in order to provide you with the best possible care and treatment, all professional staff involved in your treatment and employees involved in the health care operations of Autism Counseling and Behavior Consultation may have access to your records.

2. WHAT ARE TREATMENT, PAYMENT and HEALTH CARE OPERATIONS?
Your treatment includes sharing information among mental health care providers who are involved in your treatment. For example, if you are seeing both a physician (psychiatrist) and a psychotherapist, they may share information in the process of coordinating your care. Information will not be shared with other providers without a signed exchange of information form. We may use and disclose your medical information to bill and collect payment for treatment and services provided to you. Treatment records may be reviewed as part of an on-going process directed toward assuring the quality of Autism Counseling and Behavior Consultation operations.

3. HOW WILL AUTISM COUNSELING AND BEHAVIOR CONSULTATION USE MY PROTECTED HEALTH INFORMATION?
Your personal mental health record will be retained by Autism Counseling and Behavior Consultation for approximately seven years after your last clinical contact with the agency. After that time has elapsed, the record will be destroyed or otherwise maintained in a way that protects your privacy.

Until the records are destroyed they may be used, unless you ask for restrictions on a specific use or disclosure, for the following purposes:

- Appointment reminders.
- Notification when an appointment is cancelled or rescheduled.
- Treatment alternatives.
- Research - 1) We may release information about you to researchers preparing to conduct a research project who need to know how many patients have a specific health problems. 2) We may use and disclose medical information about you for research purposes if the research has been subjected to a careful review process conducted by a specially selected and trained committee and received this committee's approval. This process evaluates a proposed research project and its use of medical information, and balances the potential benefit of the research against individual patients' needs for privacy of their medical information. 3) A research project may involve comparing the health and recovery of all patients who received one treatment to those who received another for the same condition. In that situation, you would not be identified or contacted, but your medical information may be used but kept confidential. 4) In other studies, if a provider caring for you believes you may be interested in, or benefit from, a research study, your provider and the committee will approve someone to contact you to see if you are interested in the study. At that time, you would receive more information and you would have the right to authorize continued contact or refuse further contact.
- Workers' Compensation – We may release medical information about you for workers' compensation or similar programs that provide benefits for work-related injuries or illness.
- As may be required by law.
- For public health purposes such as reporting of child or elder abuse or neglect; reporting reactions to medications; infectious disease control; notifying authorities of suspected abuse, neglect, or domestic violence (if you agree or as required by law.)
- Mental health oversight activities, e.g., audits, inspections or investigations of administration and management of Autism Counseling and Behavior Consultation.
- Individuals involved in your care or payment for your care. We may release medical information about you to a friend or family member who is involved in your therapeutic care. In addition, we may disclose medical information about you to another entity assisting in disaster relief efforts so that your family can be notified about your condition, status and location. If you do not want this information shared, please let us know in writing.
- Lawsuits and disputes (We will attempt to provide you advance notice of subpoena before disclosing information from your record.)
- Law enforcement (e.g., in response to a court order or other legal process) to identify or locate an individual being sought by authorities; about victim of a crime under restricted circumstances; about a death that may be the result of criminal conduct; about criminal conduct that occurred in Autism Counseling and Behavior Consultation facilities; when emergency circumstances occur relating to a crime.
- To prevent a serious threat to health or safety.
- To carry out treatment and health care operations functions through medical transcription services.
- To military command authorities if you are a member of the armed forces or a member of a foreign military authority.

- National security and intelligence activities.
- Protection of the President or other authorized persons for foreign heads of state, or to conduct special investigations.
- Alcohol and drug abuse information has special privacy protections. Autism Counseling & Behavior Consultation will not disclose any information identifying an individual as being a client or provide any mental health or medical information relating to a client¹s substance abuse treatment unless: (i) the client consents in writing; (ii) a court order requires disclosure of the information; (iii) medical personnel need the information to meet a medical emergency; (iv) qualified personnel use the information for the purpose of conducting research, management audits, or program evaluation; or (v) it is necessary to report a crime or a threat to commit a crime or to report abuse or neglect as required by law.

4. YOUR AUTHORIZATION IS REQUIRED FOR OTHER DISCLOSURES. Except as described previously, we will not use or disclose information from your record unless you authorize (permit) in writing Autism Counseling and Behavior Consultation to do so. You may revoke your permission in writing, which will be effective only after the date of your written revocation.

5. YOU HAVE RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION.
You have the following rights regarding your health information, provided that you make a written request to invoke the right to Autism Counseling and Behavior Consultation.

- Right to request restriction. You may request limitations on your mental health information we may disclose, but we are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.
- Right to confidential communications. You may request communications in a certain way or at a certain location, but you must specify in writing how or where you wish to be contacted.
- Right to inspect and copy. You have the right to inspect and copy your mental health information regarding decisions about your care; however, psychotherapy notes may not be inspected and copied. We may charge a fee for copying, mailing, and supplies. Under limited circumstances, your request may be denied; you may request review of the denial by another licensed mental health professional chosen by Autism Counseling and Behavior Consultation. Autism Counseling and Behavior Consultation will comply with the outcome of the review.
- Right to request record clarification. If you believe that the information we have about you is incorrect or incomplete you may ask to add clarifying information. Autism Counseling and Behavior Consultation is not required to accept the information that you propose.
- Right to accounting of disclosures. You may request a list of the disclosures of your mental health information that have been made to persons or entities other than for treatment or health care operations in the last six (6) years, but not prior to April 14, 2003.
- Right to a copy of this Notice. You may request a copy of this Notice at any time, even if you have been provided a copy.

6. REQUIREMENTS REGARDING THIS NOTICE. Autism Counseling and Behavior Consultation is required to provide you with this Notice that governs our privacy practices. Autism Counseling and Behavior Consultation may change its policies or procedures in regard to privacy practices. If and when changes occur, the changes will be effective for mental health information we have about you as well as any information we receive in the future. Any time you come in to the Autism Counseling and Behavior Consultation facilities for an appointment, you may ask for and receive a copy of the Privacy Notice that is in effect at the time.

7. COMPLAINTS. If you believe your privacy rights have been violated, you may file a written complaint with Autism Counseling and Behavior Consultation. You will not be penalized or retaliated against in any way for making a complaint.

Contact: Autism Counseling and Behavior Consultation through your treatment site if you:

- have a complaint;
- have any questions about this notice
- wish to request restrictions on uses and disclosure for health care treatment or operations.

Autism Counseling & Behavior Consultation, Inc.

IMPORTANT NOTICE TO CLIENTS

As required by the HIPAA Privacy Regulations, all clients who receive health care services in my office on or after April 14, 2003, must:

- Receive the attached "Notice of Privacy Practices" Form
- Sign the "Acknowledgement" Form below and return it to me for my records.

Please note that the attached Notice is not a consent form that must be read in full and signed before treatment can be provided; rather, the Notice provides my clients with a summary description of (1) how my office will use and disclose medical and billing information for legitimate business purposes, and (2) how my clients can exercise their rights with regard to this medical information. These notices are similar to the ones that the general public received from their banks and other financial institutions last year.

Please sign the acknowledgement form below and return it to me for my records. Thank you very much.

____

Kelly A. Ernsperger, LCSW

ACKNOWLEDGEMENT FORM

I hereby acknowledge that I have received a current copy of the Privacy Notice.

____ Date _________________
Client/Guardian Signature

If signed by Guardian, state relationship to Patient:

____