

**INITIAL VISIT
- Registration -**

Today's Date: _____

CONFIDENTIAL INFORMATION

Name:		Birth Date:	Age:	<i>Please give additional information on last page as needed.</i>
Street Address:				
City/State:			Zip	
Home Phone	Best time to call:	Are voice-messages OK? Y / N	Cell (or Work) Phone	Are (non-encrypted) TEXT messages OK? Y / N
Name of Emergency Contact:		Phone number: ()	Relationship to you?	
By whom were you referred?		Reason for referral?		
Employer or School Name:		Job Title / Degree:	Total Years of Education:	
Current Physician & Date of Last Exam:		Permission for Dr. Swan to inform PC/Physician that we are working together? (This is simply courteous and potentially helpful.) Y / N		
Current Medication/dose/frequency:		(List on last page if needed)		Current Medical Problems/other Professionals:
Name & Reason to see Previous Therapist(s):		Name and Reason of Hospital(s) for Psychological Needs?		

THIRD PARTY PAYOR INFORMATION

Insurance Company:	Subscriber:
Phone:	ID # of Subscriber:
Dr. Swan has my permission to bill my insurance company. I understand that the fees for therapy are my responsibility. I will continue to pay the entire fee until my insurance company starts contributing payments.	
Signature: _____	Date: _____

**CONSENT to TREATMENT &
ACCEPTANCE of FINANCIAL RESPONSIBILITY**

I read the treatment conditions and office policies outlined in the Psychotherapist-Patient Agreement (07/23) including the limits of Confidentiality, the lack of Emergency Services, Phases of treatment, and Frequency of sessions. Understanding that I may ask clarifying questions at any time I agree to begin a professional psychotherapy relationship with Dr. Swan. I have the right to end the therapy at any time and I will inform Dr. Swan of my termination thoughts early enough that we can plan the months of the ending process and consider the meaning of this ending.

Signature: _____ Date: _____

I understand that the fee for 40 - 55 minute sessions is \$170 / \$210 and after my standing-appointments have been established I agree to pay for appointments that I miss.

Signature: _____ Date: _____

I understand that privacy is difficult to assure when it comes to electronic communications. Nevertheless, I agree to brief use of Phone, Text, and Email messages on non-encrypted platforms for scheduling and billing purposes. The Notice of Privacy Practices is available if I am interested in how my protected health information can be used.

Signature: _____ Date: _____

TRAUMA HISTORY: Please indicate if you or a family member has experienced any of the following:

RELATIONSHIP HISTORY

	(Age or Date of Death)	(Health)	(Yourself)	(Family of Origin)
Natural Mother:	_____	_____	_____	neglect _____
Natural Father:	_____	_____	_____	depression _____
Step - Mother:	_____	_____	_____	severe mental illness _____
Step- Father:	_____	_____	_____	anxiety/panic attacks _____
Siblings:	_____	_____	_____	suicide or attempts _____
_____	_____	_____	_____	sexual abuse _____
_____	_____	_____	_____	physical abuse _____
_____	_____	_____	_____	alcohol/drug abuse _____
_____	_____	_____	_____	violence _____
_____	_____	_____	_____	imprisonment _____
_____	_____	_____	_____	death / illness _____
_____	_____	_____	_____	teenage pregnancy _____
_____	_____	_____	_____	separation/divorce _____
_____	_____	_____	_____	multiple family moves _____

CURRENT RELATIONSHIP STATUS:

Spouse / Significant Other: _____

Children:

Feel free to add comments on a separate page.

PREVIOUS RELATIONSHIPS

Name:	First Met:	Results:
_____	_____	_____

SYMPTOM LIST:

1) Please indicate (•) which symptoms you experienced in the (Past) & (Recently)
 2) Then rate the distress level of all RECENT symptoms according to the following scale: 1 = "Not Concerned" 2 = "Moderate Distress" 3 = "Severe Distress"

	(Past)	(Recent)		(Past)	(Recent)		(Past)	(Recent)
Mood Swings	<input type="radio"/>	<input type="radio"/>	Lack/Excess of Energy	<input type="radio"/>	<input type="radio"/>	Easily Fatigued	<input type="radio"/>	<input type="radio"/>
Slowed Thinking	<input type="radio"/>	<input type="radio"/>	Guilt Feelings	<input type="radio"/>	<input type="radio"/>	Socially Withdrawn	<input type="radio"/>	<input type="radio"/>
Racing Thoughts	<input type="radio"/>	<input type="radio"/>	Thoughts of Death	<input type="radio"/>	<input type="radio"/>	Low Self-esteem	<input type="radio"/>	<input type="radio"/>
No Loving Feelings	<input type="radio"/>	<input type="radio"/>	Hopeless Feelings	<input type="radio"/>	<input type="radio"/>	Cannot Enjoy Life	<input type="radio"/>	<input type="radio"/>
Too Much/Little Sleep	<input type="radio"/>	<input type="radio"/>	Suicide Attempts	<input type="radio"/>	<input type="radio"/>	Difficulty with Decisions	<input type="radio"/>	<input type="radio"/>
Memory Problems	<input type="radio"/>	<input type="radio"/>	Unwanted Thoughts	<input type="radio"/>	<input type="radio"/>	Unsure of Reality	<input type="radio"/>	<input type="radio"/>
Difficulty Staying Asleep	<input type="radio"/>	<input type="radio"/>	Difficulty Concentrating	<input type="radio"/>	<input type="radio"/>	Unsure of Identity	<input type="radio"/>	<input type="radio"/>
Drinking Problems	<input type="radio"/>	<input type="radio"/>	Depressed Feelings	<input type="radio"/>	<input type="radio"/>	Unusual Experiences	<input type="radio"/>	<input type="radio"/>
Fears	<input type="radio"/>	<input type="radio"/>	Irritable	<input type="radio"/>	<input type="radio"/>	Physical Violence	<input type="radio"/>	<input type="radio"/>
Angry Outbursts	<input type="radio"/>	<input type="radio"/>	Restless/Keyed Up	<input type="radio"/>	<input type="radio"/>	Poor Appetite	<input type="radio"/>	<input type="radio"/>
Nightmares	<input type="radio"/>	<input type="radio"/>	Buying Sprees	<input type="radio"/>	<input type="radio"/>	Lost Pleasure in old joys	<input type="radio"/>	<input type="radio"/>
Sexual Indiscretions	<input type="radio"/>	<input type="radio"/>	High Risk Activities	<input type="radio"/>	<input type="radio"/>	Out of Control Behavior	<input type="radio"/>	<input type="radio"/>
Disturbing Memories	<input type="radio"/>	<input type="radio"/>	Anxious Feelings	<input type="radio"/>	<input type="radio"/>	Unusual Sweating	<input type="radio"/>	<input type="radio"/>
Shortness of Breath	<input type="radio"/>	<input type="radio"/>	Relive Past Events	<input type="radio"/>	<input type="radio"/>	Often on Guard	<input type="radio"/>	<input type="radio"/>
Startle Easily	<input type="radio"/>	<input type="radio"/>	Clammy Hands	<input type="radio"/>	<input type="radio"/>	Overly Confident	<input type="radio"/>	<input type="radio"/>
Frequent Arguments	<input type="radio"/>	<input type="radio"/>	Racing/Pounding Heart	<input type="radio"/>	<input type="radio"/>	Sexual Difficulties	<input type="radio"/>	<input type="radio"/>
Confusion	<input type="radio"/>	<input type="radio"/>	Hearing Voices	<input type="radio"/>	<input type="radio"/>	Eating Disorders	<input type="radio"/>	<input type="radio"/>
Addictions	<input type="radio"/>	<input type="radio"/>	Out of Control Behavior	<input type="radio"/>	<input type="radio"/>	OTHER _____		
Losing Track of Time	<input type="radio"/>	<input type="radio"/>	Work Problems	<input type="radio"/>	<input type="radio"/>	Feeling Undeserving	<input type="radio"/>	<input type="radio"/>
Feeling Lonely	<input type="radio"/>	<input type="radio"/>	Rejected	<input type="radio"/>	<input type="radio"/>	Dismissed	<input type="radio"/>	<input type="radio"/>
Feeling Blamed	<input type="radio"/>	<input type="radio"/>	Accusing Others	<input type="radio"/>	<input type="radio"/>	Inadequate	<input type="radio"/>	<input type="radio"/>
Insecure	<input type="radio"/>	<input type="radio"/>	Shame	<input type="radio"/>	<input type="radio"/>	Unimportant	<input type="radio"/>	<input type="radio"/>
Headaches	<input type="radio"/>	<input type="radio"/>	Pregnancy	<input type="radio"/>	<input type="radio"/>	Impaired Vision/Hearing	<input type="radio"/>	<input type="radio"/>
Seizures	<input type="radio"/>	<input type="radio"/>	Abortion	<input type="radio"/>	<input type="radio"/>	Chest Pain	<input type="radio"/>	<input type="radio"/>
Alcohol/Drug Use	<input type="radio"/>	<input type="radio"/>	Dizzy Spells	<input type="radio"/>	<input type="radio"/>	Hypertension	<input type="radio"/>	<input type="radio"/>
Weight Gain/Loss	<input type="radio"/>	<input type="radio"/>	Fainting/Blackouts	<input type="radio"/>	<input type="radio"/>	Stomach Discomfort	<input type="radio"/>	<input type="radio"/>
						Compulsive Diet	<input type="radio"/>	<input type="radio"/>

3) Have you ever purposely hurt yourself or someone else? YES NO Please describe on the blank page.
 4) Have you ever had thoughts or made statements of wanting to hurt yourself or another person? YES NO

PLEASE DESCRIBE WHY YOU ARE HERE TODAY:

(List additional information on separate pages as needed.)

- Optional Page -

When you are thriving, what do you like to do?

When you are doing well, what stands out about you?

Trauma: Please comment on any of the items you checked on the previous page (including your age when the trauma occurred and the details of the event):

Is there anything happening NOW in your current living situation or in your family that is especially stressful for you?

How important are spiritual matters to you? Not at all Little Somewhat Very much

If spiritual matters are important to you, are you affiliated with a particular spiritual or religious group? YES NO

Would you like your spiritual/religious beliefs incorporated into the counseling? YES NO

If you answered yes to either of the last two questions, would you like to describe your particular religious group and/or the spiritual practices that are important to you?