DONALD W SWAN, PsyD **LICENSED PSYCHOLOGIST**

SwanPsychological.com
Oregon License 1308

4900 SW GRIFFITH DR, Suite 161
BEAVERTON, OR 97005
(503) 641-4546

INITIAL VISIT
- Registration -

Today's Date:

CONFIDENTIAL INFORMATION

Name:	Birth Date:	Age:	***Please give additional information on separate pages as needed.***
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 or 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 Medications, dose & frequency:	Current Medical Problems? Name any other Professionals involved:		
Name & Reason to see Previous Therapist(s):	Name and Reason of Hospital(s) used 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 and I will continue to pay the entire fee until my insurance company starts making payments.

Signature: Date:

CONSENT to TREATMENT & ACCEPTANCE of FINANCIAL RESPONSIBILITY

I read the treatment conditions and office policies outlined in the Psychotherapist-Patient Agreement (02/21) 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 $160 / $200 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: _____

RELATIONSHIP HISTORY

	(Age or Date of Death)	(Health)
Natural Mother:		
Natural Father:		
Step - Mother:		
Step- Father:		
Siblings:		

CURRENT RELATIONSHIP STATUS: _____

Spouse / Significant Other:

_____ _____ _____

Children:

_____ _____ _____
_____ _____ _____
_____ _____ _____

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

(Yourself)		(Family of Origin)
_____	neglect	_____
_____	depression	_____
_____	severe mental illness	_____
_____	anxiety/panic attacks	_____
_____	suicide or attempts	_____
_____	sexual abuse	_____
_____	physical abuse	_____
_____	alcohol/drug abuse	_____
_____	violence	_____
_____	imprisonment	_____
_____	death / illness	_____
_____	teenage pregnancy	_____
_____	separation/divorce	_____
_____	multiple family moves	_____

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	o	o __	Lack/Excess of Energy	o	o __	Easily Fatigued	o	o __
Slowed Thinking	o	o __	Guilt Feelings	o	o __	Socially Withdrawn	o	o __
Racing Thoughts	o	o __	Thoughts of Death	o	o __	Low Self-esteem	o	o __
No Loving Feelings	o	o __	Hopeless Feelings	o	o __	Cannot Enjoy Life	o	o __
Too Much/Little Sleep	o	o __	Suicide Attempts	o	o __	Difficulty with Decisions	o	o __
Memory Problems	o	o __	Unwanted Thoughts	o	o __	Unsure of Reality	o	o __
Difficulty Staying Asleep	o	o __	Difficulty Concentrating	o	o __	Unsure of Identity	o	o __
Drinking Problems	o	o __	Depressed Feelings	o	o __	Unusual Experiences	o	o __
Fears	o	o __	Irritable	o	o __	Physical Violence	o	o __
Angry Outbursts	o	o __	Restless/Keyed Up	o	o __	Poor Appetite	o	o __
Nightmares	o	o __	Buying Sprees	o	o __	Lost Pleasure in old joys	o	o __
Sexual Indiscretions	o	o __	High Risk Activities	o	o __	Out of Control Behavior	o	o __
Disturbing Memories	o	o __	Anxious Feelings	o	o __	Unusual Sweating	o	o __
Shortness of Breath	o	o __	Relive Past Events	o	o __	Often on Guard	o	o __
Startle Easily	o	o __	Clammy Hands	o	o __	Overly Confident	o	o __
Frequent Arguments	o	o __	Racing/Pounding Heart	o	o __	Sexual Difficulties	o	o __
Confusion	o	o __	Hearing Voices	o	o __	Eating Disorders	o	o __
Addictions	o	o __	Out of Control Behavior	o	o __	OTHER _____		__
Losing Track of Time	o	o __	Work Problems	o	o __	Feeling Undeserving	o	o __
Feeling Lonely	o	o __	Rejected	o	o __	Dismissed	o	o __
Feeling Blamed	o	o __	Accusing Others	o	o __	Inadequate	o	o __
Insecure	o	o __	Shame	o	o __	Unimportant	o	o __

Headaches	o o __	Pregnancy	o o __	Impaired Vision/Hearing	o o __	Vomiting	o o __
Seizures	o o __	Abortion	o o __	Chest Pain	o o __	Muscle Spasms	o o __
Alcohol/Drug Use	o o __	Dizzy Spells	o o __	Hypertension	o o __	Numbness	o o __
Weight Gain/Loss	o o __	Fainting/Blackouts	o o __	Stomach Discomfort	o o __	Compulsive Diet	o o __

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 self or another person? __ YES __ NO

PLEASE DESCRIBE WHY YOU ARE HERE TODAY: (List additional information on separate pages as needed.)

- Optional Page -

Trauma: Please comment on any of the above checked items (including your age when the trauma occurred and the details of the traumatic 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?