**Barbara Price Roth, LCPC, LLC**

***Licensed Clinical Professional Counselor***

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Welcome to my practice. In order to assist me in providing you with quality services, inform you fully and facilitate insurance reimbursement, please complete this form, read the attached *Patient Rights and Responsibilities*, and sign where indicated. Thank you.

Today’s Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_

Gender [male] [female] [other] Marital Status [single] [married] [divorced] [separated]

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mailing Address**:

Street \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ZIP \_\_\_\_\_\_\_\_\_

Preferred Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-Mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Persons in primary household**: Name & age, also include P/T family and pets

**Losses or family changes within past 2 years**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**History of Trauma – victim of physical / emotional / neglect/ environmental/ other**

**What is the main reason you are seeking treatment?**

**When did the problem start and what did you notice?**

**What would you most like to accomplish in treatment?**

**Other concerns?**

**Please check ALL that apply to you at this present time:**

**Increased Crying**

**Nightmares**

**Poor Concentration**

**Easily Startled**

**Phobias**

**Irritability**

**Anger**

**Hallucinations**

**Chest Discomfort**

**Feelings of Guilt**

**Dizziness**

**Suspicions**

**Excessive Sweating**

**Hypervigilance** (excessive attention

to things around me)

**Lack of Motivation**

**Fear of Social Performance**

**Avoidance of Places, People or things**

**Sad Mood**

**Poor Sleep**

**Sad Affect**

**Racing Thoughts**

**Low Energy**

**Anxiety in Public Places**

**Impulsiveness**

**Loss of interest in things once enjoyed**

**Memory Problems**

**Abused Physically, emotionally or sexually**

**Restlessness**

**Obsessions/Compulsions** (constant checking, washing or worries)

**Weight Changes**

**Decreased Self Esteem**

**Stomach Problems**

**Rapid Heartbeat**

**Intense Fear**

**Behavior Problems**

 explain:

**Legal Problems**

 explain:

**Sexual Issues**

explain:

**Eating Problems**

 explain:

**Wellness Information (Adult/Adolescent)**

**Have you participated in regular exercise/sports/recreation (about 3 times/week) to keep fit? \_\_\_\_**

**Have you been dieting to lose weight? \_\_\_\_ Amt. of weight gain or loss in the past 3 months\_\_\_\_**

**Please list other Wellness activities, hobbies or pursuits that you enjoy ?**

Spiritual or Religious Preference –

Strengths & Personal Assets –

Educational Background (HS, College, post college, Trade): Challenges & Achievements -

Current Career/Employment - & other relevant career interests or transitions at work:

**Drug/Alcohol Use**

**Do you smoke or chew tobacco? \_\_\_\_\_\_\_ If so, how often ?**

**Have you smoked or chewed tobacco in the past? \_\_\_\_\_\_\_\_ If so, how often ?**

**Do you use Marijuana? \_\_\_\_\_\_ If so, how often?**

**Do you use prescribed Marijuana? \_\_\_\_\_\_\_\_**

**How often in the past month did you drink alcohol? (please circle) A) I do not drink at all B) about 1x/month C) 2-3 times/month D) 2-3x/week E) once a day or more**

**In the past month have you ever felt you ought to cut down on your drinking or drug use? \_\_\_\_\_\_**

**In the past month have you ever felt annoyed by people criticizing your drinking or drug use? \_\_\_\_**

**In the past month have you felt bad or guilty about your drinking or drug use? \_\_\_\_\_**

**In the past month, how many days were you able to work but had to *cut back* on how much you got done because of your physical or mental health? (*answer only if employed*) \_\_\_\_\_\_days**

**In the past month, how many days were you *unable to work* because of your physical or mental health? (*answer only if employed*) \_\_\_\_\_\_\_days**

**Suicide Risk Assessment**

**Have you ever had thoughts of harming yourself?** [yes] [no]

**If YES, please answer the questions below. If NO, please skip this section.**

**Do you currently want to harm yourself?** [yes] [no]

**How often do you have these thoughts?**

**When is the last time you remember having these thoughts?**

**Have you devised a plan on how you would harm self?** [yes] [no]

**Is there anything that would prevent you from harming yourself?** [yes] [no]

 If yes, please explain:

**Medical Information**

Your Primary Care Provider \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Location & Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Permission to communicate with this person is (please initial): Authorized\_\_\_\_ Withheld \_\_\_\_

Medical conditions or concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In the past 6 mo., how many times did you visit a medical provider? None\_\_ 1\_\_\_ 2-4\_\_ 5+\_\_\_

Please list client’s OTC & Prescription medications and supplements

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

Other current Medical Providers or Behavioral Health Supports: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Previous Behavioral Health or Psychiatric History: therapist names and dates \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Hospitalization for Assessment, Treatment or ER visits for any reason or Subs. Abuse (dates)

Date:\_\_\_\_\_\_\_\_\_Reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Where:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If none then: \_\_\_\_\_\_ [initial] I have had no previous psychiatric or psychological treatment

**Family history** **of Depression/ Anxiety or Other Psychiatric Condition** – relationship to client:

**Personal & family history** related to: Social- home, friends, work, neighborhood; Legal

problems, Educational or Health challenges not already mentioned:

**Are firearms in the home?** [yes] [No] If so, how many & what type:

*I affirm that the above information is correct and complete and that I have read and understand the attached* ***Patient Rights and Responsibilities****. I understand that I am responsible for sessions canceled with less than 24 hours notice and for any portion of my bill not covered by insurance for any reason. I have been advised that psychotherapy carries both risks and benefits and my signature below constitutes my informed consent to share confidential information with my insurance company or other third party payer and any outside billing representative.*

*Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Parent (if client is under 18) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*