

CONFIDENTIAL CLIENT INFORMATION

Client Name: _____ **Ethnicity:** _____

Primary Issue: _____

Are you currently receiving treatment for an illness, injury or other medical condition? _____

Are you currently taking any prescribed medications? If yes, please list names and use: _____

How often do you drink alcohol? ___ Never ___ Seldom ___ Occasionally ___ Often ___ Daily

How often do you smoke marijuana? ___ Never ___ Seldom ___ Occasionally ___ Often ___ Daily

Other recreational drugs used? _____

Brief Mast

- | | | |
|---|-----|----|
| 1. Do you feel you are a normal drinker? | YES | NO |
| 2. Do friends or relatives think you are a normal drinker? | YES | NO |
| 3. Have you ever attended a meeting of Alcoholics Anonymous (AA)? | YES | NO |
| 4. Have you ever lost friends or girlfriends/boyfriends because of your drinking? | YES | NO |
| 5. Have you ever gotten into trouble because of your drinking? | YES | NO |
| 6. Have you ever neglected your obligations, your family, or your work for two or more days in a row because of your drinking? | YES | NO |
| 7. Have you ever had delirium tremors (DTs), severe shaking, heard voices, or see things that weren't there after heavy drinking? | YES | NO |
| 8. Have you ever blacked out and not known where you are after drinking? | YES | NO |
| 9. Have you ever been in a hospital because of your drinking? | YES | NO |
| 10. Have you ever been arrested for drunk driving or driving after drinking? | YES | NO |

Legal Issues and History: Please tell us if you have any current legal issues (arrests, convictions, civil or criminal lawsuits, and judgements, order of protection, juvenile delinquency or pending or probably legal situations): _____

Are you having suicidal thoughts? Yes or No If yes, Do you have a plan? Yes or No
Have you ever had suicidal thoughts? Yes or No Please explain: _____

Have you ever attempted suicide? Yes or No If yes, how many times? _____
Have you ever been to counseling before? Yes or No If yes, who with? _____

What are your goals for therapy? _____

What do you consider are your strengths? _____

What do you consider are your weaknesses? _____

Have you ever had an abortion or miscarriage? _____

Any recent deaths in your personal world (including pets)? _____

Please circle any of the feelings or issues that you are having from the list below:

- | | | | | |
|--------------|-----------------------|-------------|-----------------|--------------|
| worried | overwhelmed | worthless | lonely | desperate |
| anxious | “don’t care” attitude | lethargic | tired | unstable |
| distracted | lack concentration | sad | sleep a lot | hardly sleep |
| impatient | overly confident | fight a lot | agitated | angry |
| manic | troubled relationship | hyper | racing thoughts | fidgety |
| lying | poor self-esteem | moody | intense | defiant |
| stealing | afraid to be alone | chews nails | overly focused | cutting |
| migraines | stomach issues | dizziness | memory loss | confused |
| unloved | sexual problems | shyhopeless | ashamed | helpless |
| avoid others | don’t like others | other: | _____ | |

Briefly describe what it was like growing up in your home: _____

Any hospitalizations, trauma (including sexual or physical) in your/child’s history? _____

Status (please circle all that apply): MARRIED DIVORCED SINGLE COHABITATING

Current Spouse/Partner: _____ **Their Age:** _____

Occupation: _____ **Years Married/Together:** _____

Children (list name and ages. For child clients please list siblings): _____

With whom do you live with now? _____

Any family history of mental or emotional illness? _____

The above information is true and correct to the best of my knowledge.

Printed Name of Person Completing the Form

Date

Circle relation below:
Self Parent Spouse Other

Signature of Person Completing the Form

Date

Grandparent Significant Other

- **Worker's Compensation:** If you file a worker's compensation claim, I may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

IV. Client's Rights and Psychologist's Duties

Client's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychotherapist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will provide you with a revised notice either at the office or through the mail.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact Kelly S. Zentner, MA, LPC-S, Owner, 210-833-1900. If you believe that your privacy rights have been violated and wish to file a complaint with *me/my* office, you may send your written complaint to or call Kelly S. Zentner, MA, LPC-S, 19115 FM 2252, Ste 15 Garden Ridge, TX 78266, 210-833-1900. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request. You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on October 10, 2017. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by either mail or at the office.