Notice of Privacy Practices (Brief Version)

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

My commitment to your privacy

My practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. I am also required by law to keep your information private. These laws are complicated, but I must give you this important information. This is a shorter version of the attached, full, legally required notice of privacy practices. Please talk to the privacy officer (see the end of this form) about any questions or problems.

How I use and disclose your protected health information with your consent

I will use the information I collect about you mainly to provide you with **treatment**, to arrange **payment** for your services, and for some other business activities that are called, in the law, **health care operations.** After you have read this notice, I will ask you to sign a **consent form** to let me use and share your information in these ways. If you do not consent and sign this form, I cannot treat you. If I want to use or send, share, or release your information for other purposes, I will discuss this with you and ask you to sign an authorization form to allow this.

Disclosing your health information without your consent

There are some times when the laws require us to use or share your information. For example:

1. When there is a serious threat to your or another's health and safety or to the public. I will only share information with persons who are able to help prevent or reduce the threat.
2. When I are required to do so by lawsuits and other legal or court proceedings.
3. If a law enforcement official requires me to do so.
4. For workers' compensation and similar benefit programs.

There are some other rare situations. They are described in the longer version of our notice of privacy practices.

Discolosing your health information for purposes of billing and payment

I may use your information to bill you, your insurance, or others, so I can be paid for the treatments I provide to you. I may contact your insurance company to find out exactly what your insurance covers. I may have to tell them about your diagnoses, what treatments you have received, and the changes I expect in your conditions. I will need to tell them about when we met, your progress, and other similar things.

There are obligations and responsibilities when you choose to use your insurance to pay for services. Use of insurance to pay for services requires that this provider release confidential information/PHI in order to secure payment for services. If

this provider is an in-network provider with your insurance company, she is contractually obligated to provide your insurance company with whatever information they request from your medical records at this office. Your insurance company (as the payer of your services) reserves the right to review, audit, or request any information concerning your services and records at this office. Your insurance company may request information even after you are no longer actively receiving services at this office.

Your rights regarding your health information

1. You can ask us to communicate with you in a particular way or at a certain place that is more private for you. For example, you can ask us to call you at home, and not at work, to schedule or cancel an appointment. I will try my best to do as you ask.

2. You can ask me to limit what I tell people involved in your care or the payment for your care, such as family members and friends.

3. You have the right to look at the health information I have about you, such as your medical and billing records. You can get a copy of these records, but I may charge you for it. Contact our privacy officer to arrange how to see your records. See below.

4. If you believe that the information in your records is incorrect or missing something important, you can ask me to make additions to your records to correct the situation. You have to make this request in writing and send it to the privacy officer. You must also tell me the reasons you want to make the changes.

5. You have the right to a copy of this notice. If I change this notice, I will post the new version in our waiting area, and you can always get a copy of it from the privacy officer.

6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with the privacy officer and with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care I provide to you in any way. Also, you may have other rights that are granted to you by the laws of our state, and these may be the same as or different from the rights described above. I will be happy to discuss these situations with you now or as they arise. If you have any questions or problems about this notice or our health information privacy policies, please contact the privacy officer, who is Rachel R. Domingue and can be reached by phone at 337-534-4083.
The effective date of this notice is October 1, 2012.

Rachel R. Domingue
Licensed Professional Counselor

Adult Client Information Form

Today's date: _____

A. Identification
Your Full Name: _____ Nicknames: _____

Biological Sex: ❑ Male ❑ Female Age: _____ Date of birth: _____ Social Security #: _____

Physical Home address: _____

Apt.: _____ OR Lot: _____ City: _____ State: _____ Zip: _____

Mailing address: ❑Same as physical home address *If not, please write below:

_____City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____

Which phone number(s) do I have permission to call? ❑Home only ❑Cell only ❑Both home and cell

B. Referral: Who gave you my name to call?

❑ Insurance list/website ❑ My PCP/Psychiatrist/Other Provider _____

❑ Online search/found my website ❑ Other: _____

May I have your permission to thank this person for the referral? ❑ Yes ❑ No

C. Demographic Information/Identities
Ethnicity/national origin: _____ Race: _____ or other similar way you identify yourself and consider important: _____

Gender identity: ❑ Male ❑ Female ❑ Transgender

Sexual orientation: ❑ Heterosexual ❑ Gay ❑ Lesbian ❑Bisexual

Current religious affiliation: ❑ Catholic ❑ Baptist ❑ Pentecostal ❑ Methodist ❑ Lutheran ❑ Anglican

❑ Presbyterian ❑ Non-denominational Christian ❑ Jewish ❑ Islamic ❑ Buddhist ❑ Hindu Other: _____

Involvement: ❑ None ❑ Some/irregular ❑ Active

How important are spiritual concerns in your life? _____

Which (if any) church, synagogue, temple, or place of worship are you involved with? _____

What is the primary language you speak? _____

Do you need any translation or interpreter services? ❑ Yes ❑ No

D. Your medical care: From whom or where do you get your medical care (your primary care doctor/PCP)?
Clinic/doctor's name: _____ Phone: _____

Address: _____

Do I have permission to share information with this provider/physician? ❑ Yes ❑ No

E. Emergency information

If some kind of emergency arises and I cannot reach you directly, or I need to reach someone close to you, whom should I call?
Name: _____ Phone: _____ Relationship: _____

Address: _____

F. Your education and training

Please check off your highest level of education:
❑ High school diploma/GED ❑ Workforce Training Certification/Associate degree ❑ Bachelor's degree
❑Master's degree ❑ PhD/MD Describe: _____

If you do NOT have a high school diploma or GED, what was the last grade you completed? _____

Did you have to repeat any grades while in elementary, middle, or high school? ❑ Yes ❑ No

Did you have an IEP or special accommodations? ❑ Yes ❑ No

Did you receive special education services? ❑ Yes ❑ No

Were you diagnosed with a learning disability? ❑ Yes ❑ No

Did you skip any grades while in elementary, middle, or high school? ❑ Yes ❑ No

Were you in the gifted/talented program? ❑ Yes ❑ No

G. Employment/Military Service

❑ I am unemployed at this time. ❑ I do not work outside of the home by choice.

Employer: _____ Address: _____

Work phone: _____ or other means of communication _____

Do I have permission to call you at work and leave a message? ❑ Yes ❑ No

On a scale of 1 to 10, how satisfied are you at your current job? _____

Is your work a part of the reason why you are seeking services? ❑ Yes ❑ No
If yes, please explain_____

_____

Are you considering a change in career? ❑ Yes ❑ No

Are you recently unemployed? ❑ Yes ❑ No

Are you currently seeking employment/rejoining the work force? ❑ Yes ❑ No

Are you currently serving in the military? ❑ Yes ❑ No If yes, which branch?_____

Are you retired or discharged? ❑ Yes ❑ No Years served: From _____ to _____

H. Family-of-origin history

Relative	Name	Current age (or age at death)	Illnesses (or cause of death, if deceased)
Father (Bio. or Adoptive?)			
Mother (Bio. or Adoptive?)			
Brothers			
Sisters			
Stepparents			

Were you adopted? ❑ Yes ❑ No If yes, how old were you? _____

Were you ever a ward of the state? ❑ Yes ❑ No

❑Your parents were never married.

❑Your parents were married and are still married.

❑Your parents were married, but divorced when you were _____ years old.

Describe custody/living arrangements if your biological parents were never married OR if they divorced:

_____

_____

Any family history (e.g. parents, siblings, grandparents, aunt/uncle) of? ❑ Yes ❑ No

If yes, please check off all that apply and provide details below:

❑Depression ❑Anxiety ❑Bipolar Disorder ❑Schizophrenia ❑Autism ❑Alcohol/Substance issues

❑Other: _____

Please provide details: _____

_____

_____

I. Developmental history

Did your biological mother take medication, use alcohol, drugs, or tobacco while pregnant with you? ❑ Yes ❑ No

If yes, please provide details: _____

Any complications with the pregnancy or your birth? (check all that apply)

☐ None ☐ Diabetes ☐ Premature Birth ☐ High Blood Pressure ☐ Cesarean Section
☐ Poor Nutrition ☐ Breech Birth ☐ Poor Emotional Health ☐ Toxemia ☐Jaundice
☐ Mother's Loss of Consciousness ☐ Special medical help at birth: _____

Do you achieve all physical developmental milestones (holding head up, rolling over, crawling, walking, etc) on time?

❑ Yes ❑ No If no, please provide details: _____

_____

Client Name: _____ DOB: _____ MR#_____

Were you ever diagnosed with any speech/language disorder? ❑ Yes ❑ No If yes, check all that apply:

☐ Difficulty pronouncing certain sounds ☐ Stuttering ☐ Lisping ☐ Delayed speech ☐ Selective mutism

☐ Expressive language disorder ☐ Receptive language disorder

☐ Other: _____

Have you been diagnosed with an intellectual disability? ❑ Yes ❑ No

Have you been diagnosed with a vision or hearing disability or impairment? ❑ Yes ❑ No
If yes, please provide details: _____

Have you been diagnosed with any of the following developmental disorders?
☐ Autism spectrum disorder ☐ Cerebral palsy ☐ Fetal Alcohol Syndrome ☐ Muscular Dystrophy

☐ Tourette Syndrome ☐ Spina bifida ☐ Attention-Deficit/Hyperactivity Disorder (ADHD)

☐ Other: _____

J. Sexual/Reproductive Health and History

Are you currently being treated for any STDs (sexually transmitted diseases)? ❑ Yes ❑ No

If yes, please specify: _____

Are you currently sexually active? ❑ Yes ❑ No

If yes, are you taking any precautions to prevent STDs or pregnancy? ❑ Yes ❑ No

The following questions are for female clients ONLY

Are you currently pregnant? ❑ Yes ❑ No Or planning to become pregnant? ❑ Yes ❑ No

Have you ever been pregnant? ❑ Yes ❑ No If yes, any complications?_____

Have you ever had a miscarriage or stillbirth? ❑ Yes ❑ No

Have you ever been diagnosed with postpartum depression/anxiety/psychosis? ❑ Yes ❑ No

K. Relationship history

Marital relationships

	Spouse's name	Date of marriage	Your age at marriage	Spouse's age at marriage	Status * (M, S, D, W)	Is spouse remarried?
First						
Second						
Third						

* M=married, S=separated, D=divorced, W-widowed

Significant nonmarital relationships

Describe any significant nonmarital relationships that you think are relevant: _____

_____

_____

Present relationships

1. How do you get along with your present spouse or partner? _____

_____

_____

2. How do you get along with your children? _____

_____

_____

3. Friendships.

How many close friends do you currently have? _____

Do you tend to feel equal to your friends? ❑ Yes ❑ No

Do you find your friendships are based on respect and mutual giving and receiving? ❑ Yes ❑ No

L. Children

Please list all of your children from oldest to youngest. Indicate those from a previous marriage or relationship with "P" in the second to last column. Indicate whether the child is biological (B), adopted (A), or a step-child (S) in the last column.

Name	Date of Birth	Age	Gender (M or F)	Grade	B, A, or S

M. Household

List all people living in your household. Please list yourself first.

Name	Date of Birth	Age	Gender (M or F)	Shared Custody/ Visitation?

Please describe custody and visitation agreements for those children who spend time at other households.

_____

_____

_____

_____

N. Chief concern

Please describe the main difficulty that has brought you to see me: _____

_____

_____

_____

_____

_____

O. Behavioral Health History

1. Have you ever received counseling services before? ❑ Yes ❑ No
If yes, please provide details (provider?, what for?, when? outcome?): _____

_____

_____

_____

2. Have you ever received drug/alcohol treatment before? ❑ Yes ❑ No

If yes, please provide details(provider?, what for?, when? outcome?): _____

_____

_____

_____

3. Have you ever taken medications for psychiatric or emotional problems? ❑ Yes ❑ No
If yes, please provide details (provider?, what for?, when? outcome?): _____

_____

_____

_____

4. Have you ever been hospitalized for psychiatric reasons? ❑ Yes ❑ No
If yes, please provide details (provider?, what for?, when? outcome?): _____

_____

_____

_____

Client Name: _____ DOB: _____ MR#_____

P. Medical History

Please list any and all medical conditions that you have been diagnosed/treated for (e.g hypothyroidism, sleep apnea, acid reflux, diabetes, stroke/heart attack, any chronic disease, any genetic conditions, any disabilities, allegies/adverse reactions to any medications).

_____

_____

_____

_____

_____

List ALL medications (physical and psychiatric, as well as supplements, vitamins, etc) that you are currently taking.

Name of medication	Dosage	Frequency (daily, as needed)

Q. Chemical use

1. How many cups of regular coffee do you drink each day? _____ How many cups of tea each day? ____

How many sodas/pop with caffeine (Coke, Pepsi, Mountain Dew, Dr. Pepper, Orange Crush, etc.) each day? ____

How many "energy drinks" each day? ____ How often do you use No Doz or similar caffeine pills? _____

2. How much tobacco do you smoke or chew each week? _____

Alcohol and Other Substance Use:

❑I do NOT currently use any alcohol.

❑I currently drink alcohol (wine, beer, liquor). ❑I have a history of alcohol use, but do not use currently.

1. How much beer, wine, or hard liquor do you consume each week, on the average? _____

2. Have you ever felt the need to cut down on your drinking? ❑ Yes ❑ No

3. Have you ever felt annoyed by criticism of your drinking? ❑ Yes ❑ No

4. Have you ever felt bad or guilty about your drinking? ❑ Yes ❑ No

5. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? ❑ Yes ❑ No

6. Are there times when you drink to unconsciousness, or run out of money as a result of drinking? ❑ Yes ❑ No

Client Name: _____ DOB: _____ MR#_____

❑I do NOT currently use any substances.

❑I currently use substances. ❑I have a history of substance use, but do not use currently.

1. Have you EVER used any illegal substances/drugs? ❑ Yes ❑ No If yes, check all that apply:

❑ Marijuana ❑ Heroin ❑ Cocaine ❑ Amphetamines/Meth ❑ Opioids ❑ LSD/Ecstasy

❑ Inhalants ("huffing" glue, gasoline, or paint thinner) ❑ Any medication that was NOT prescribed to you

Please provide details about your use of these drugs/substances, such as amounts, how often you used them, and last date of use: _____

_____

_____

Are you currently attending, or have you ever attended, Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) meetings? ❑ Yes ❑ No

R. Trauma/Abuse history:

PLEASE BE AWARE OF LIMITS OF CONFIDENTIALITY BEFORE COMPLETING THIS SECTION. DUE TO MANDATORY REPORTING LAWS, I AM REQUIRED TO REPORT SUSPICIONS OR KNOWLEDGE OF ABUSE OF CHILDREN, THE ELDERLY, AND VULNERABLE ADULTS. IF THIS IS A SENSITIVE TOPIC FOR YOU. YOU ARE WELCOME TO SKIP THIS SECTION AND ASK TO DISCUSS IT WITH ME WHILE IN A COUNSELING SESSION.

❑ Childhood physical abuse ❑ Childhood verbal/emotional abuse ❑ Childhood sexual abuse

❑ Childhood neglect (e.g. lack of basic necessities, lack of supervision, abandonment)

❑ Witnessed domestic violence as a child

❑ Domestic violence in your own past relationships ❑ Currently experiencing domestic violence

❑ Witnessed a traumatic or violent death ❑ Traumatic combat experiences

❑ Other: _____

❑ I do NOT have any history of trauma/abuse.

❑ I am NOT currently experiencing any trauma/abuse.

Have you ever perpetrated abuse against someone else (physical, verbal/emotional, sexual, neglect)? ❑ Yes ❑ No

S. Legal history

1. Are you presently suing anyone or thinking of suing anyone? ❑ Yes ❑ No If yes, please explain: _____

_____

Your current attorney's name: _____ Phone: _____

2. Is your reason for coming to see me related to an accident or injury? ❑ Yes ❑ No If yes, please explain:

_____

3. Are you required by a court, the police, or a probation/parole officer to have this appointment? ❑ Yes ❑ No

If yes, please explain: _____

_____

4. List all the contacts with the police, courts, and jails/prisons you have had. Include all open charges and pending ones. Under "Jurisdiction," write in a letter: F = federal, S = state, Co = county, Ci = city.
Under "Sentence," write in the time and the type of sentence you served or have to serve (AR = accelerated or alternate resolution, CS = commu-nity service, F = fine, I = incarceration, Pr = probation, Pa = parole, O = other, R = restitution).

Date	Charge(s)	Jurisdiction (F,S,C,Ci)	Sentence (AR, I, Pr, Pa)	Probation/parole officer's name	Your attorney's name

❑ I do NOT have any history of contact with the police, court, or jail/prison.

6. Are there any other legal involvements I should know about? _____

_____

T. Grief and Loss

Please list all of your loved ones who have died.

Name	Relationship	Date of death	Cause of death	Birthday	Anniversary (if you were married)

Have you recently moved into a retirement community or nursing home? ❑ Yes ❑ No

Have you ever become disabled? ❑ Yes ❑ No Please explain:_____

_____

Have you recently moved? ❑ Yes ❑ No If yes, Within the same state? ❑ From another state? ❑

When? What were the circumstances/reason for the move?:_____

_____

U. Current Needs

Check all that apply:

❑ Transportation ❑ Food ❑ Housing ❑ Financial Assistance ❑ Employment ❑ Education/Career

❑ Translation or Interpreter services ❑ Other: _____

V. Community Resources that you are currently using:

Check all that apply:

❑ Medical Transportation ❑ Public transportation ❑ Housing assistance/Section 8 ❑ SNAP (food stamps)

❑ Food pantry ❑ LA Workforce Commission ❑ Childcare assistance ❑ Social Security benefits

❑ Supplemental Security Income benefits (SSI) ❑ Translation or Interpreter services ❑ GED program

❑ Student loans/grants ❑ Health Insurance assistance (Medicaid, Medicare, marketplace policy)

❑ Other: _____

Client Name: _____ DOB: _____ MR#_____

W. Strengths/Hobbies/Leisure Activities

❑ Educated ❑ Common Sense/Practical knowledge ❑ Artistic ❑ Creative ❑ Musical

❑ Verbal/Written Communication skills ❑ Insightful/Psychologically minded ❑ Athletic ❑ Humor

❑ Physically healthy ❑ Empathetic/Compassionate ❑ Assertive ❑ Confident ❑ Brave/Courageous

❑ Hard-working ❑ Self-disciplined/Self-control ❑ Honest ❑ Optimistic/Hopeful ❑ Forgiving

❑ Flexible/Open-minded ❑ Persistent ❑ Curious ❑ Patient ❑ Modest/Humble ❑ Imaginative

❑ Adventurous/Willing to try new things ❑ Logical thinking/Analytical ❑ Love of learning ❑ Ambitious

❑ Motivated/Proactive/Self-starter ❑ Generous ❑ Helpful ❑ Resilient ❑ Cooperative/Good in groups

❑ Loyal/Dedicated ❑ Observant ❑ Organized/Orderly/Neat ❑ Trustworthy ❑ Planning ahead

❑ Problem-solving ❑ Faith/Spirituality ❑ Committed to fairness/justice ❑ Leadership

❑ Has hobbies/interests ❑ Has a good support network of family/friends ❑ Meaningful and gainful employment

❑ Other: _____

X. Other

Is there anything else that is important for me as your therapist to know about, and that you have not written about on any of these forms? If yes, please tell me about it here or on another sheet of paper: _____

_____

_____

Client Name: _____ DOB: _____ MR#_____

Adult Checklist of Presenting Concerns

Please mark all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked.

❑ Abuse Perpetrator – physical/sexual/emotional abuse or neglect (of children or elderly persons or partner/spouse), cruelty to animals

❑ Abuse Victim – physical, sexual, emotional (either during childhood or in current adult relationship); domestic violence

❑ Aggression, verbal threats, intimidation, throwing things, physical acts of violence

❑ Alcohol/substance use

❑ Anger, hostility, arguing, irritability

❑ Anxiety, nervousness, tension

❑ Attention, concentration, distractibility

❑ Career concerns, goals, and choices

❑ Childhood issues (your own childhood)

❑ Decision making, indecision, mixed feelings, putting off decisions

❑ Delusions (false ideas/beliefs)

❑ Depression, low mood, sadness, crying

❑ Divorce, separation

❑ Eating problems (overeating, undereating, appetite, binging, purging)

❑ Emptiness

❑ Fatigue, tiredness, low energy

❑ Fears, phobias _____

❑ Financial or money troubles (debt, impulsive spending, low income)

❑ Friendships

❑ Gambling

❑ Grieving, mourning, deaths, losses

❑ Guilt

❑ Hallucinations (hearing or seeing things that are not there)

❑ Health - illness, medical concerns, physical problems, chronic pain, disability, weight and diet issues

❑ Impulsiveness, loss of control, outbursts, speaking or acting without thinking first

❑ Judgment problems, risk taking

❑ Legal matters, charges, suits

❑ Loneliness

❑ Memory problems, Confusion

❑ Mood swings

❑ Motivation (lack of drive)

❑ Obsessions, compulsions (thoughts or actions that repeat themselves)

❑ Oversensitivity to rejection

❑ Panic or anxiety attacks

❑ Parenting (child management/discipline, single parenthood, co-parenting, custody of children)

❑ Perfectionism

❑ Pessimism

❑ Romantic relationship problems (conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments, disagreements over household responsibilities)

❑ School/Educational difficulties

❑ Self-esteem, inferiority feelings

❑ Self-neglect, poor self-care

❑ Sexual issues (dysfunctions, conflicts, desire differences)

❑ Shyness, oversensitivity to criticism

❑ Sleep problems – too much, too little, insomnia, nightmares

❑ Social anxiety (uncomfortable in groups, difficulty meeting or interacting with new people, fear of being judged negatively, difficulty speaking in front of a group)

❑ Spiritual issues (religious identity questioning, moral/ethical questions)

❑ Stress, relaxation, stress management, tension

❑ Suspiciousness, distrust, difficulty trusting others

❑ Suicidal thoughts or self-harm behavior

❑ Temper problems, low frustration tolerance

❑ Thought disorganization and confusion

❑ Trauma (reliving past traumatic memories, avoidance of triggers)

❑ Withdrawal from others, isolating

❑ Work problems - unemployment/underemployment, workaholism/overworking, can't keep a job, dissatisfaction, conflict with co-workers/supervisors)

❑ Other concerns or issues: _____