

Welcome, and I am looking forward to seeing you for your first session. In order to be clear about our expectations of each other, I have compiled the following practice policies. Please look them over and let me know if you have any questions or comments about them.

Practice Policies

1. All sessions are 45-50 minutes. Please come on time. Due to the scheduling of others' appointments, I am usually unable to extend past the usual end time. Your full fee will be due even if you are late.
2. However, if I am running late, I will either prorate your session fee (if possible, given your payment situation) or extend the time.
3. Fees or copayments are due at the time of the appointment. You may make out a check beforehand if you want to save time during the session.
4. Insurance issues: if you expect another payer (e.g. insurance, Medicare) to be paying for part of your session, it is your responsibility to ensure that you are covered by that payer. You will be charged if the other payer does not pay your bill as you expected.
5. I check my messages at least once each day. I will attempt to return any message you leave for me within 24 hours of getting it. Routine messages left on Saturday or Sunday will be returned on Monday. I am not available by phone after 7 pm or before 9 am.
6. If you are having an emergency and I am not available at that time, you may call a hotline. If it may be a life-threatening emergency, do not call me first. Instead, call 911 or go to your nearest hospital emergency room.
7. There will be a charge for lengthy phone consultations.
8. If any of these policies do not work for you, please let me know; I will attempt to refer you to someone who may be able to meet your needs better.

If you would like to contact me by e-mail:

1. Please feel free to communicate with me by e-mail. My e-mail address is jan@drwiller.com. I typically check my e-mail every 1-4 days, so if your matter needs more timely attention, please call instead.
2. Do not e-mail me in an emergency. Call instead.
3. I will do the best I can to assure your confidentiality through e-mail, but due to viruses, hackers, etc, no e-mail correspondence can be guaranteed to be confidential. So do not send any information that you would consider to be sensitive information through e-mail.

My signature below shows that I understand and agree to comply with the above practice policies.

Signature of client

Date

Printed name

Please give me a copy and keep a copy of this handout for your reference.

CHECKLIST OF CONCERNS

Name: _____ Date: _____

Please mark any items that apply to you. Feel free to add other concerns at the bottom.

I have no problem or concern bringing me here

PROBLEM AREAS--CAREER, SCHOOL

- Career concerns, goals, and choices
- Unemployment
- Job stress
- School problems
- Learning problems
- Work performance issues such as procrastination,
- Work life balance issues, e.g. workaholism/overworking
- Difficulty maintaining employment

PROBLEM AREAS--RELATIONSHIPS

- Communication problems
- Dating issues
- Detachment or estrangement from others
- Divorce, separation
- Friendships
- Infidelity, affairs
- Interpersonal conflicts
- Parenting issues
- Sexual issues with partner
- Social problems
- Physical fights with relationship partner
- Physical fights with others
- Relationship conflict
- Relationship problems
- Withdrawal, isolating

PROBLEM AREAS--LIFE EVENTS

- Childhood issues (your own childhood)
- Financial or money troubles, debt, impulsive spending, low income
- Grieving, mourning, deaths, losses
- Legal matters, charges, suits
- Other (Please specify: _____)

PROBLEM AREAS--PHYSICAL WELL-BEING

- Headaches, neck or back pain (Please specify: _____)
- Health, illness, medical concerns, physical problems
- Menstrual problems, PMS
- Pains, chronic (Please specify: _____)
- Sexual functioning problem (e.g. erectile dysfunction, painful intercourse)

PROBLEM AREAS--SELF

- Identity issues
- Sexual identity issues
- Suicidal ideas
- Thoughts that life may not be worth living
- Self-esteem problems

EMOTIONAL CONCERNS

- Alert for danger, even in safe locations
- Anger, hostility
- Distressing memories of the past
- Suspiciousness
- Anxiety, nervousness
- Aggitated
- Fear of leaving my home
- Fear of specific locations, such as elevators or planes (Please specify: _____)
- Fear of specific situations, such as heights or snakes (Please specify: _____)
- Fear of social situations
- Fear of abandonment
- Obsessive thoughts
- Panic or anxiety attacks
- Feeling hyper or wound up
- Phobias (Please specify: _____)
- Shyness
- Tension—can't relax
- Attention, concentration, are poor
- Confusion
- Distractibility
- Memory problems
- Loneliness
- Depression, low mood, sadness, crying
- More depressed in the morning, with mood better later in the day
- More depressed in the winter, mood better in the summer
- Emptiness feelings
- Failure feelings
- Fatigue, tiredness, low energy
- Guilt
- Inferiority feelings
- Motivation problems
- Oversensitivity to rejection
- Oversensitivity to criticism
- Lack of interest in my usual activities
- Hopelessness
- Mood swings
- Overly high energy level for my age
- Perfectionism
- Sexual drive—lack of
- Feeling that others are out to get me
- Feeling that others are watching me
- Hearing voices

BEHAVIORAL ISSUES

- I drink alcohol more than 2 nights per week
- At least one day a week, I have 4 drinks or more (if female) or 5 drinks or more (if male)
- I have used an illegal drug in the last month
- I smoke at least one cigarette per week
- At least once a week, I drink more than 2 cups of coffee, OR more than 4 colas or cups of tea

- I have had a DUI (When? _____)
- I have been charged with a crime in the past (other than parking, speeding or DUI)
- Aggressive or violent thoughts or behaviors
- Arguing
- Compulsive behaviors (Please specify: _____)
- Repetitive behaviors (e.g handwashing, checking doors, checking stove)
- Cutting or otherwise injuring self
- Other self-harm in past (Describe: _____)
- Decision making problems, indecision, mixed feelings, putting off decisions
- Disorganization
- Gambling
- Irritability
- Impulsiveness
- Irresponsibility
- Judgment problems, risk taking
- Self-neglect, poor self-care
- Suicide attempt in past (When? _____)
- Temper problems, self-control, low frustration tolerance

EATING/WEIGHT ISSUES

- Lack of appetite
- Weight loss (How much? _____ Over what time? _____)
- Overeating
- Weight gain (How much? _____ Over what time? _____)
- Vomiting
- Taking laxatives, enemas or diuretics to lose weight
- Binging on food
- Diet issues
- Fear of becoming fat

SLEEP ISSUES

- Sleeping too much
- Insomnia
- Difficulty going back to sleep upon awakening during night
- Too much worrying or thinking keeps me from getting to sleep
- Waking at least 2 hours too early in the morning
- Feeling extremely restless or squirmy prior to bedtime
- I have taken a sleeping pill or drank alcohol to sleep at least once in the past month
- Nightmares or upsetting dreams
- Suddenly falling asleep in inappropriate locations
- Snoring
- Grinding teeth during sleep
- Stopping breathing briefly during sleep (noticed by you OR partner)
- Sleepwalking

ANY OTHER CONCERNS OR ISSUES:

WHICH CONCERN DO YOU MOST WANT HELP WITH?

CLIENT INFORMATION FORM

TODAY'S DATE _____

GENERAL INFORMATION

Your full name (Last, First, Middle Initial) _____

Date of birth _____ Age _____ Social Security # _____

Address _____ Apt # _____

City _____ State _____ Zip Code _____

I need to send mail to clients occasionally. If you have any problems with this, please let me know. If this is ok, please initial here: _____

Home/evening phone _____ Cell phone _____

Calls will be discreet, but please indicate any restrictions _____

e-mail address _____

I need to send e-mail to clients occasionally. If you have any problems with this, please let me know. If this is ok, please initial here: _____

Does anyone live in your home with you? What is (are) the relationship(s) to you?

How were you referred to my office? _____

Who may we thank for referring you? _____

MEDICAL CARE*

Physician _____ Phone _____

Address _____

**At your request, I would be happy to give your primary care physician a very brief summary of your mental health diagnosis and status. Many people like their primary care physician to be updated on all of their health care. If you would like me to assist you in this way, please sign a Release of Information form and supply your physician's name.*

EMPLOYER

Name of Employer _____ Work phone _____

Calls will be discreet, but please indicate any restrictions _____

YOUR CURRENT CONCERNS

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

PSYCHOTROPIC MEDICATIONS

_____ I do not take psychotropic medications

Psychiatrist _____ Phone _____

Address _____

If you enter treatment with me for psychological problems, I strongly recommend that treatment be coordinated between your psychiatrist and me. Do you have any problems with this? ___ No ___ Yes

EDUCATION AND TRAINING

Did you graduate from HIGH SCHOOL? ___ Yes ___ No

Year of graduation _____

COLLEGE OR VOCATIONAL SCHOOL Attendance and Degrees/Certificates:

From	To	School	Degree Program	Did you graduate?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

EMPLOYMENT AND MILITARY ENLISTMENT for the last 2 years

Dates		Name of military or employers	Job title or duties	Reason for leaving
From	To			
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

HISTORY OF EVENTS

Please indicate any of the following events that may have occurred to you in the past:

- ___ My parents/caretakers punished me physically as a child or teenager
- ___ My parents/caretakers were verbally harsh and critical of me as a child or teenager
- ___ My parents/caretakers did not provide appropriate supervision, food, shelter or other protection.
- ___ My parents/caretakers were unaware of my difficulties when I was a child or teenager.
- ___ I experienced inappropriate sexual contact as a child or teenager
- ___ I experienced sexual harassment as an adult
- ___ I experienced other upsetting sexual experience(s) as an adult
- ___ As an adult, I experienced a physical injury intentionally caused by another adult.
- ___ I experienced any other upsetting experience(s) as noted below:

PRESENT RELATIONSHIP

___ I do not have a partner at present
 How would you characterize your relationship with your partner? _____

USE OF CAFFEINE, ALCOHOL, TOBACCO AND STREET DRUGS

How much coffee, cola, tea, or other sources of caffeine do you consume each day?

- 1. Have you ever felt the need to cut down on your drinking? ___ No ___ Yes
- 2. Have you ever felt annoyed by criticism of your drinking? ___ No ___ Yes
- 3. Have you ever felt guilty about your drinking? ___ No ___ Yes
- 4. Have you ever taken a morning "eye-opener"? ___ No ___ Yes
- 5. How much beer, wine, or hard liquor do you consume each week, on the average?

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

7. Which street drugs have you used in the last 3 years?

LEGAL ISSUES

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

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

3. Are you required by a court, the police, or a probation/parole officer to have this appointment?
 ___ No ___ Yes If yes, please explain

4. Have you had any contacts with the police, courts, and jails/prisons regarding a crime that you were charged with? No Yes
5. Are there any other legal involvements I should know about? No Yes
- If yes, pls describe:
-

MEDICAL HISTORY

1. Please list all CURRENT MEDICAL PROBLEMS that you have. Be sure to include chronic conditions such as asthma, seizure disorder, arthritis, diabetes and so on

2. Please rate your current level of PHYSICAL PAIN on a scale of 0-10, with 0 being no pain and 10 being the worse pain you have ever had _____
 Rate the most severe pain you have had in the past month _____
 Why were you experiencing pain? _____

3. List all MEDICATIONS, HERBAL SUPPLEMENTS, VITAMINS, AND OVER-THE-COUNTER DRUGS you have taken in the last month.

Medication/drug	Dose (how much?)	Taken for	Prescribed by
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

HEALTH HABITS

1. What kinds of physical exercise do you get?

2. How many times per week do you typically exercise for 20 minutes or more? _____
3. Do you try to restrict your eating in any way? How? Why?

4. What is your average number of hours of sleep per night? _____

CONTACT PERSON IN CASE OF EMERGENCY

Name: _____

Address: _____

Phone: _____ Relationship to you: _____

INFORMATION CHECKLIST

Please review the following list of treatments you may have had in the past. Please put a check next to any that apply to you and indicate the dates, to the best of your recollection.

				Dates:
Inpatient psychiatric hospitalization	___ No	___ Yes		_____
Intensive outpatient treatment (e.g. at least 2-3 days per week)	___ No	___ Yes		_____
Psychotherapy	___ No	___ Yes		_____
Outpatient Substance Abuse counseling	___ No	___ Yes		_____
Attending AA/NA/CA meetings	___ No	___ Yes		_____
Taking medication for emotional difficulty	___ No	___ Yes		_____
Taking medication for sleep	___ No	___ Yes		_____

NOTE: PLEASE FILL OUT A RELEASE OF INFORMATION FORM FOR ANY MENTAL HEALTH PRACTITIONER OR PROGRAM YOU HAVE BEEN TREATED BY DURING THE LAST 2 YEARS. ALSO, PLEASE FILL OUT A FORM FOR ANY PHYSICIAN WHO HAS GIVEN YOU PSYCHOTROPIC MEDICATIONS WITHIN THE LAST 2 YEARS.

CANCELLATION AND NO-SHOW POLICY

PLEASE READ CAREFULLY!

If you need to cancel, please call at least 48 hours ahead.

Cancellation fees are as follows:

- 48 hours or more: No fee
- Less than 48 hours: \$100 fee
- If you do not show up for your appointment and do not call, there is a \$100 fee as well.

SPECIAL CIRCUMSTANCES

- **If you have a crisis and can't attend your appointment, call me and we will talk about it.**

My signature below shows that I understand and agree to comply with the cancellation policy.

Signature of client

Date

Printed name

Please turn this page in and keep a copy of this page for your reference.