Drew Prochniak, MA, LPC, LMHC
2119 NE Halsey St
Portland, OR 97232

P: 503.308.9408
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www.dprochniak.com

CLIENT INFORMATION

DATE: _____ DOB: _____ SSN: _____

NAME: _____ I PREFER TO BE CALLED: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ MOBILE: _____

E-MAIL ADDRESS: _____

MARITAL STATUS: _____

ARE YOU A STUDENT?: ☐ YES ☐ NO ☐ FULL TIME ☐ PART TIME

EMPLOYER: _____

WHO MAY BE THANKED FOR REFERRING YOU: _____

EMERGENCY CONTACT: _____ PHONE: _____

RELATIONSHIP TO CONTACT: _____

INSURANCE/ EAP INFORMATION
A COPY OF YOUR INSURANCE CARD IS A SUITABLE ALTERNATIVE TO COMPLETING THIS SECTION.

NAME OF INSURED: _____ DOB: _____

RELATIONSHIP TO CLIENT: _____

NAME OF EMPLOYER: _____ PHONE: _____

ADDRESS OF EMPLOYER: _____

INSURANCE/ EAP COMPANY: _____ PHONE: _____

ID #/ AUTHORIZATION #: _____ GROUP #: _____

INSURANCE ADDRESS: _____
DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO

Thank you for taking the time to complete this form.

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NAME: _____ DOB: _____

REASON(S) FOR VISIT

Describe your concerns/ reasons for seeking treatment.
Describe any recent changes that may contribute to this concern:
Why do you think you have this issue?
When did you first experience this issue?

PLEASE PROVIDE THE NAMES, AGES AND RELATIONSHIP TO THOSE LIVING WITH YOU:

NAME	AGE	RELATIONSHIP

PLEASE LIST THE NAMES AND AGES OF ANY CHILDREN NOT LIVING WITH YOU:

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Have you ever been psychiatrically hospitalized: ☐ Yes ☐ No
When? Where?

Why?

Have you ever attempted suicide? ☐ Yes ☐ No When?

Do you have current suicide ideation? ☐ Yes ☐ No
Do you have a current plan for suicide? ☐ Yes ☐ No
Do you currently have the means to complete this plan? ☐ Yes ☐ No

Have you ever engaged in self-harm behavior? ☐ Yes ☐ No
When?

How?

Have you been diagnosed with mental health/ psychiatric problems in the past? ☐ Yes ☐ No

PLEASE LIST AND OTHER OUTPATIENT MENTAL HEALTH TREATMENT (E.G. THERAPY, MEDICATION MANAGEMENT BY PCP OR PSYCHIATRIC PROVIDER)

Name/ Place	Approx. Dates	Diagnosis/ Outcome
	-	
	-	
	-	

PLEASE LIST MEDICATIONS YOU ARE CURRENTLY TAKING FOR MENTAL HEALTH REASONS.

Name of Medication	How long have you taken it?	Usefulness/Side Effects/Concerns?

Thank you for taking the time to complete this form.

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HAVE YOU EXPERIENCED PROBLEMS (PAST OR PRESENT) WITH ANY OF THE FOLLOWING?

☐ Alcohol ☐ Drugs ☐ Gambling ☐ Sex/Love Addiction ☐ Food ☐ Loved One's Addictions
☐ Pornography ☐ None ☐ Other:

WHILE YOU WERE GROWING UP, DURING YOUR FIRST 18 YEARS OF LIFE:

Did a parent or other adult in the household **often** swear at you, insult you, put you down, or humiliate you OR act in a way that made you afraid that you might be physically hurt?	☐ Yes	☐ No
Did a parent or other adult in the household often push, grab, slap, or throw something at you OR **ever** hit you so hard that you had marks or were injured?	☐ Yes	☐ No
Did an adult or person at least 5 years older than you **ever** touch or fondle you or have you touch their body in a sexual way OR try to or actually have oral, anal, or vaginal sex with you?	☐ Yes	☐ No
Did you **often** feel that no one in your family loved you or thought you were important or special OR your family didn't look out for each other, feel close to each other, or support each other?	☐ Yes	☐ No
Did you **often** feel that you didn't have enough to eat, had to wear dirty clothes, and had no one to protect you OR your parents were too drunk or high to take care of you or take you to the doctor if you needed it?	☐ Yes	☐ No
Were your parents **ever** separated or divorced?	☐ Yes	☐ No
Was your mother or stepmother: **often** pushed, grabbed, slapped, or had something thrown at her OR **sometimes or often kicked**, bitten, hit with a fist, or hit with something hard? OR **ever** repeatedly hit over at least a few minutes or threatened with a gun or knife?	☐ Yes	☐ No
Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?	☐ Yes	☐ No
Was a household member depressed or mentally ill or did a household member attempt suicide?	☐ Yes	☐ No
Did a household member go to prison?	☐ Yes	☐ No

TOTAL "YES" _____

☐ **I have been exposed to death, threatened death, actual or threatened serious injury or actual or threatened sexual violence in one of the following ways:**

- ☐ Direct Exposure
- ☐ Witnessing the trauma
- ☐ Learning that a relative or close friend was exposed to a trauma
- ☐ Indirect exposure to aversive details of the trauma, usually in the course of professional duties

☐ Excessive anxiety and worry occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).
☐ Difficulty controlling the worry

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MENTAL HEALTH/ PSYCHIATRIC HISTORY

Please mark any symptoms you believe you experience **C**urrently or in the **P**ast.

C	P		C	P		C	P	
☐	☐	Depressed/ sad mood	☐	☐	Muscle Tension	☐	☐	Relationship Problems
☐	☐	Reduced Interest in Activities	☐	☐	Excessive Worry	☐	☐	Parenting Problems
☐	☐	Appetite/ weight change	☐	☐	Panic Symptoms	☐	☐	Grief
☐	☐	Frequent tearfulness/ crying	☐	☐	Boredom	☐	☐	Excessive Social Discomfort
☐	☐	Low Self Esteem	☐	☐	Distractibility	☐	☐	Obsessions
☐	☐	Low Motivation	☐	☐	Impulsivity	☐	☐	Compulsions
☐	☐	Social Isolation	☐	☐	Hyperactivity	☐	☐	Hypervigilance
☐	☐	Hopelessness	☐	☐	Racing Thoughts	☐	☐	Avoid Triggering Reminders
☐	☐	Seasonal Mood Changes	☐	☐	Excessive Energy	☐	☐	Poor Concentration
☐	☐	Loneliness	☐	☐	Flashbacks	☐	☐	Restlessness
☐	☐	Guilt/ Shame	☐	☐	Nightmares	☐	☐	Indecisiveness
☐	☐	Changes to Sleep	☐	☐	Easily Startled	☐	☐	Irritability
☐	☐	Low Energy/ Fatigue	☐	☐	Anger Outbursts	☐	☐	Anxiety
☐	☐	Frequent Thoughts of Death	☐	☐	Excessive Fears	☐	☐	Other
☐	☐	Other	☐	☐	Other	☐	☐	Other
☐	☐	Other	☐	☐	Other	☐	☐	Other

Please describe any further concerns/issues not addressed elsewhere in this questionnaire.

Please describe outcomes you would like from this visit/treatment from this provider.

What are your strengths to assist you in meeting the desired outcomes mentioned above?

Thank you for taking the time to complete this form.

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INFORMED CONSENT

NAME: _____ DOB: _____

After reading each section of this document thoroughly, please initial your understanding. It is the responsibility of the client to understand the information included below.
If you have any questions or clarification is needed, please discuss with your therapist.

Confidentiality
All information disclosed in sessions and the written records pertaining to said sessions are confidential and may not be revealed to anyone without your consent except for when disclosure is Required by Law:

- When there is a reasonable suspicion of child, dependent or elder abuse or neglect,
- When a client presents an imminent danger to themselves, to others, to property, is gravely disabled,
- When client's family members communicate to the therapist that the client presents a imminent danger to self or others.
- In a legal proceeding by or against you. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by your therapist,
- In couples and family therapy, confidentiality and privilege do not apply between the couple or among family members unless otherwise agreed upon.

Your therapist will not release records to any outside party unless authorized to do so by all adult family members who were part of the treatment. In all these situations your therapist will use their clinical judgment when revealing such information. **Initial _____**

Emergencies
If there is an emergency during your work in therapy where your therapist becomes concerned about your personal safety, the possibility of you injuring yourself or someone else, or about you receiving proper psychological care, they will do whatever they can, within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose your therapist may also contact the person whose name you have provided on the biographical sheet.
Initial _____

Health Insurance & Confidentiality of Records
Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process claims. If you instruct your therapist, only the minimum necessary information will be communicated to the carrier. Your therapist has no control or knowledge over what insurance companies do with the information submitted or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy or to future capacity to obtain health or life insurance or even a job. The risk stems from the fact that mental health information is likely to be entered into insurance companies computers and is likely to be reported to the National Medical Data Bank. Accessibility to companies computers or to the National Medical Data Bank database is always in question as computers are inherently vulnerable to break-ins and unauthorized access. Medical data has also been reported to be legally accessed by law enforcement and other agencies, which also puts you in a vulnerable position. **Initial _____**

E-Mails, Cell Phones, Computers and Faxes
It is very important to be aware that computers, e-mail, cell phone and fax communication can be relatively easily accessed by unauthorized people and, can compromise the privacy and confidentiality of such communication. Your therapist's e-mails are not encrypted, their computers, however, are equipped with a firewall, a virus protection and a password. Please notify your therapist if you decide to avoid or limit, in any way, the use of any or all communication devices, such as e-mail, cell phone or fax. Please do not use e-mail or faxes for emergencies. Texting is not an available means of communication. **Initial _____**

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Litigation Limitation
Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you (client) nor your attorney, nor anyone else acting on your behalf will call on your therapist to testify in your or at any other proceeding. Additionally, therapy records will not be released without prior agreement between your therapist and you. **Initial_____**

Records and Your Right to Review Them
Both the law and the standards of our practices require that appropriate treatment records be kept. As a client, you have the right to review or receive a summary of your records. A written request is required to access your records. After this request is received, you will receive a summary of your records within 30 days. There are times, however, when your therapist may request to withhold these documents such as limited legal or emergency circumstances or when they believe that releasing such information might be harmful in any way. In such a case they may provide the records to an appropriate and legitimate professional of your choice. Taking the above-mentioned circumstances in consideration, if appropriate, upon your request your therapist will release information to any agency/person you specify. **Initial _____**

Mediation & Arbitration
All disputes arising out of, or in relation to these services shall first be referred to mediation, before, and as a pre-condition to the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement of your therapist and you, the client. The cost of such mediation, if any, shall be split equally, unless otherwise agreed upon. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement shall be submitted to and settled by binding arbitration in accordance with the rules of the American Arbitration Association which are in effect at the time the demand for arbitration is filed.

In the event that your account is overdue (unpaid) and there is no agreement on a payment plan, your therapist can use legal means (court, collection agency, etc.) to obtain payment. The prevailing party in arbitration or collection proceeding shall be entitled to recover a reasonable sum for attorneys fees, time lost as a result of arbitration, process fees and other fees associated with arbitration. In the case of arbitration the arbitrator will determine that sum. **Initial _____**

Consultation
Your therapist consults regularly with other professionals regarding clients; however, clients identity remains completely anonymous, and confidentiality is fully maintained. **Initial _____**

Termination
Your therapist has a responsibility to determine whether or not they can be helpful to you, and will not accept clients whose therapeutic needs they cannot meet. In such a case you will be given a number of referrals. If at any point during your treatment your therapist assesses that they are not effective in helping you reach your therapeutic goals, they are obligated to discuss it with you and, if appropriate, to terminate treatment. If you request it and authorize it in writing, they will talk to the therapist of your choice in order to help with the transition. If at any time you want another professional opinion or wish to consult with another therapist, your current therapist will assist you in finding someone qualified, and with your written consent and will provide them with the essential information needed. You have the right to terminate therapy at any time. If it is your wish to terminate therapy, a "termination session" is requested between you and your therapist. If you choose to terminate services, your therapist will offer to provide you with names of other qualified professionals whose services you might prefer. **Initial _____**

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Payments & Insurance Reimbursement

Telephone conversations, site visits, report writing, consultation with other professionals, reading records, longer sessions, travel time, etc. will be charged at the same rate, unless indicated and agreed upon otherwise. Please notify your therapist if any problems arise during the course of therapy regarding your ability to make timely payments. Clients who carry insurance should remember that professional services are rendered and charged to the client and not to the insurance company. **Not all issues/ conditions/ problems dealt with in therapy are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage. If your account is overdue (unpaid) and there is no written agreement on a payment plan, your therapist can use legal or other means (courts, collection agencies, etc.) to obtain payment.** Should you elect to pay by check, you are responsible to ensure that sufficient funds are available to cover the expense. Should a check be returned as unpayable due to insufficient funds, or any other reason, you are responsible for any fee charged to the account by the banking institution as well as the cost of the initial service. In addition, a $25.00 fee will be charged on all returned checks. **Initial _____**

Telephone & Emergency Procedures

If you need to contact your therapist between sessions, please leave a message on their private line and your call will be returned within two business days. Messages are checked during business hours only. If an emergency situation arises, indicate it clearly in your message, and if you are dealing with an emergency needing immediate assistance and cannot reach your therapist, call 911. Do not use e-mail, faxes or texts for emergencies. Texting is not an available means of communication. **Initial _____**

Cancellation/ Missed Appointments

Since the scheduling of an appointment involves the reservation of time specifically for you, **a minimum of 24 hours notice is required for re-scheduling or canceling an appointment**. Unless an agreement is reached and is in writing:

- **$50.00 fee will be charged for sessions missed without such notification.**
- **$120.00 fee will be charged for a missed session without prior cancellation.**
- **Clients utilizing EAP benefits will be assessed one session for a no-show.**

Cancellation/ missed appointment charges are not covered by insurance companies and will need to be paid for out-of-pocket.

Initial _____

Copayments are due at the time of service. Failure to pay co-payment at time of service may result in additional charges. **Initial _____**

Client and/or Guarantor assume responsibility for all charges resulting from treatment provided. Most insurance carriers are billed in exception of prompt payment. Responsibility for unpaid balances is that of the Client and/or Guarantor. Payment for services is due within 15 days of receipt of statement, unless financial arrangements are made in advance. **Initial _____**

I understand it is my responsibility to understand the terms, deductibles and conditions of my insurance plan. **Initial _____**

Accounts sent to collections are subject to an increase in charges equal to the cost of the collection fee. **Initial _____**

Your signature indicates you have read, agree to and understand the above information.

_____ _____
Client Date

_____ _____
Parent or Guardian (If client is under the age of 18) Date

Thank you for taking the time to complete this form.