Name: _____ Date: _____
Address: _____ Gender: M___F___ Age: ___
_____ Date of Birth: ___/___/_____
City: _____ State: _____ Zip: _____

SSN: _____/_____/_____

CONTACT TELEPHONE NUMBERS
Please complete relevant information and indicate the number at which you wish to be contacted first.
PHONE NUMBERS **OK** to leave **Primary contact**
Messages? number?
YES NO
HOME: ( ) _____ ___ ___ ___
WORK: ( ) _____ ___ ___ ___
CELL: ( ) _____ ___ ___ ___

RELATIONSHIP STATUS
___ SINGLE ___DIVORCED (___) YRS

___ LIVING WITH SIGNIFICANT OTHER (___) YRS

___MARRIED (___) YRS ___SEPARATED (___) YRS ___WIDOWED (___) YRS

EMPLOYMENT STATUS
Are you employed: ___ Yes ___No
Employer Name: _____

EMERGENCY CONTACT INFORMATION
Name: _____
Address: _____
Phone: ( ) _____ Relationship to you: _____

PRIMARY CARE PHYSICIAN
Current Physician: _____
Physician Address: _____
Physician Phone Number: ( ) _____
Physician Fax Number: ( ) _____
REFERENT INFORMATION
BY WHOM WERE YOU REFERRED? _____
PHONE: ( ) _____ FAX: ( ) _____
PRESENTING PROBLEM: _____

Blake Bazel, Ph.D., Licensed Clinical Psychologist

1677 Wells Road, Suite A

Orange Park, Florida 32073

PSYCHOLOGIST-CLIENT SERVICE AGREEMENT

Welcome to my practice. This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

PSYCHOLOGICAL SERVICES☐ Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I, as your therapist, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

APPOINTMENTS ☐Appointments will ordinarily be 50 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, I ask that you provide me with 48 hours notice. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

PROFESSIONAL FEES ☐The standard fee for the initial intake is

$160.00 and each subsequent session is $135.00. You are responsible for paying at the time of your session unless prior arrangements have been made. Payment can be made by check, cash, or credit card (MasterCard, Visa, American Express, or Discover). Any checks returned to my office are subject to an additional fee to cover the bank fee that I incur.

PROFESSIONAL RECORDS☐ I am required to keep appropriate records of the psychological services that I provide. Your records are maintained in a secure location in the office. I keep records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records I receive from other providers, copies of records I send to others, and your billing records. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted to untrained readers. For this reason, I recommend that you initially review them with me, or have them forwarded to another mental health professional to discuss the contents. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

CONFIDENTIALITY☐

With the exception of certain specific exceptions described below, you have the absolute right to the confidentiality of your therapy. You may direct me to share information with whomever you chose, and you can change your mind and revoke that permission at any time.

II. "Limits of Confidentiality"

1. You are also protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA). This law insures the confidentiality of all electronic transmission of information about you. Whenever I transmit information about you electronically (for example, sending bills or faxing information), it will be done with with special safeguards to insure

confidentiality.

If you elect to communicate with me by email at some point in our work together, please be aware that email is not completely confidential. All emails are retained in the logs of your or my internet service provider. While under normal circumstances no one looks at these logs, they are, in theory, available to be read by the system administrator(s) of the internet service provider. Any email I receive from you, and any responses that I send to you, will be printed out and kept in your treatment record.

2. If I have good reason to believe that you will harm another person, I must attempt to inform that person and warn them of your intentions. I must also contact the police and ask them to protect your intended victim.

3. I would have to contact the appropriate agency, including Child Protective Services and/or the Department of Children and Families, if I have good reason to believe that you or other persons are abusing or neglecting a child or vulnerable adult.

4. I would have to contact the appropriate agency and/or mental health facility if I believe that you are in imminent danger of harming yourself.

5. In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.

CONTACTING ME: If I am not immediately available by telephone, you may leave a message and your call will be returned as soon as possible. If, for any number of unseen reasons, you feel you cannot wait for a return call or if you feel unable to keep yourself safe, 1) contact Community Mental Health Services in your county, 2) go to

your Local Hospital Emergency Room, or 3) call 911 and ask to speak to the mental health worker on call. I will make every attempt to inform you in advance of planned absences, and provide you with the name and phone number of the mental health professional covering my practice.

CONSENT TO PSYCHOTHERAPY☐ Your signature below indicates that you have read the information in this form and agree to its terms.

_____☐

Signature of Patient Date

_____☐

Printed Name of Patient Date

_____

Blake Bazel, Ph.D., Licensed Clinical Psychologist Date

Blake Bazel, Ph.D., Licensed Clinical Psychologist

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_____☐

Signature of Patient Date

_____☐

Printed Name of Patient Date

_____

Blake Bazel, Ph.D., Licensed Clinical Psychologist Date

Release of Information (to Insurance)

Client

Name: _____

Address: _____

Phone number: _____

I authorize **Dr. Blake Bazel, Ph.D.** and all business partners to release billing information which may include client name, date and type of services, diagnoses codes, substance abuse information and/or treatment plans to my insurance company/ies for the purpose of collecting insurance benefits or for authorization of additional sessions.

Information to be shared:

Billing

I understand that my records are protected under State and Federal confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time, except to the extent that action has already been taken. This consent expires automatically one year from the date signed.

Signature

Client: _____ Date: _____

Witness: _____ Date: _____

Revocation

I revoke my previous authorization for Dr. Blake Bazel, Ph.D. and all business partners to release billing information for the purpose of collecting insurance benefits or for authorization of additional sessions.

Client: _____ Date: _____

Witness: _____ Date: _____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ **DATE:** _____

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual				
9. Thoughts that you would be better off dead, or of hurting yourself in some way				
add columns:		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.) **TOTAL:**

10. If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- **Not difficult at all** _____
- **Somewhat difficult** _____
- **Very difficult** _____
- **Extremely difficult** _____

ZT242043

FORM n1293 (January 2010)

Name. _____ Date: _____

PRESENTING PROBLEMS AND CONCERNS

Describe the problem that brought you here today: _____

_____

Please check all of the behaviors and symptoms that you consider problematic:

- ☐ Distractibility
- ☐ Hyperactivity
- ☐ Impulsivity
- ☐ Boredom
- ☐ Poor memory/confusion
- ☐ Seasonal mood changes
- ☐ Sadness/depression
- ☐ Loss of pleasure/interest
- ☐ Hopelessness
- ☐ Thoughts of death
- ☐ Self-harm behaviors
- ☐ Crying spells
- ☐ Loneliness
- ☐ Low self worth
- ☐ Guilt/shame
- ☐ Fatigue
- ☐ Other: _____
- ☐ Change in appetite
- ☐ Lack of motivation
- ☐ Withdrawal from people
- ☐ Anxiety/worry
- ☐ Panic attacks
- ☐ Fear away from home
- ☐ Social discomfort
- ☐ Obsessive thoughts
- ☐ Compulsive behavior
- ☐ Aggression/fights
- ☐ Frequent arguments
- ☐ Irritability/anger
- ☐ Homicidal thoughts
- ☐ Flashbacks
- ☐ Hearing voices
- ☐ Visual hallucinations
- ☐ Suspicion/paranoia
- ☐ Racing thoughts
- ☐ Excessive energy
- ☐ Wide mood swings
- ☐ Sleep problems
- ☐ Nightmares
- ☐ Eating problems
- ☐ Gambling problems
- ☐ Computer addiction
- ☐ Problems with pornography
- ☐ Parenting problems
- ☐ Sexual problems
- ☐ Relationship problems
- ☐ Work/school problems
- ☐ Alcohol/drug use
- ☐ Recurring, disturbing memories

Are your problems affecting any of the following?

- ☐ Handling everyday tasks
- ☐ Work/School
- ☐ Recreational activities
- ☐ Self esteem
- ☐ Housing
- ☐ Sexual activity
- ☐ Relationships
- ☐ Legal matters
- ☐ Health
- ☐ Hygiene
- ☐ Finances

☐ Yes ☐ No Have you ever had thoughts, made statements, or attempted to hurt yourself? If yes, please describe: _____

☐ Yes ☐ No Have you ever had thoughts, made statements, or attempted to hurt someone else? If yes, please describe: _____

☐ Yes ☐ No Have you recently been physically hurt or threatened by someone else? If yes, please describe: _____

Name: _____

FAMILY AND DEVELOPMENTAL HISTORY

Relationship	Name	Age	Quality of Relationship
Mother			
Father			
Stepmother			
Stepfather			
Siblings			
Spouse/partner			
Children			

Family Mental Health Problems	Who?
Hyperactivity	
Sexually Abused	
Depression	
Manic Depression	
Suicide	
Anxiety	
Panic Attacks	
Obsessive-Compulsive	
Anger/Abusive	
Schizophrenia	
Eating Disorder	
Alcohol Abuse	
Drug Abuse	

☐ Parents legally married or living together
☐ Parents temporarily separated
☐ Parents divorced or permanently separated

☐ Mother remarried: Number of times _____
☐ Father remarried: Number of times _____

Please check if you have experienced any of the following types of trauma or loss:

☐ Emotional abuse
☐ Sexual abuse
☐ Physical abuse
☐ Parent substance abuse
☐ Teen pregnancy
☐ Neglect
☐ Violence in the home
☐ Crime victim
☐ Parent illness
☐ Placed a child for adoption
☐ Lived in a foster home
☐ Multiple family moves
☐ Homelessness
☐ Loss of a loved one
☐ Financial problems

PREVIOUS MENTAL HEALTH TREATMENT

Yes	No	Type of Treatment	When?	Provider/Program	Reason for Treatment
		Outpatient Counseling			
		Medication (mental health)			
		Psychiatric Hospitalization			
		Drug/Alcohol Treatment			
		Self-help/Support Groups			

SUBSTANCE USE HISTORY

Substance Type	Current Use (last 6 months)				Past Use			
	Y	N	Frequency	Amount	Y	N	Frequency	Amount
Tobacco								
Caffeine								
Alcohol								
Marijuana								
Cocaine/crack								
Ecstasy								
Heroin								
Inhalants								
Methamphetamines								
Pain Killers								
PCP/LSD								
Steroids								
Tranquilizers								

☐ Yes ☐ No Have you had withdrawal symptoms when trying to stop using any substances? If yes, please describe: _____

☐ Yes ☐ No Have you ever had problems with work, relationships, health, the law, etc. due to your substance use? If yes, please describe: _____

MEDICAL INFORMATION

Date of last physical exam: _____

Have you experienced any of the following medical conditions during your lifetime?

☐ Allergies	☐ Asthma	☐ Headaches	☐ Stomach aches
☐ Chronic pain	☐ Surgery	☐ Serious accident	☐ Head injury
☐ Dizziness/fainting	☐ Meningitis	☐ Seizures	☐ Vision problems
☐ High fevers	☐ Diabetes	☐ Hearing problems	☐ Miscarriage
☐ Sexually transmitted disease	☐ Abortion	☐ Sleep disorder	☐ Other: _____

Please list any CURRENT health concerns: _____

Current prescription medications: ☐ None

Medication	Dosage	Date First Prescribed	Prescribed By

Current over-the-counter medications (including vitamins, herbal remedies, etc.): _____

Allergies and/or adverse reactions to medications: ☐ None

If yes, please list: _____

INTERPERSONAL/SOCIAL/CULTURAL INFORMATION

Please describe your social support network (check all that apply):
☐ Family ☐ Neighbors ☐ Friends ☐ Students ☐ Co-workers ☐ Support/Self-Help Group
☐ Community Group ☐ Religious/Spiritual Center (which one? _____)

To which cultural or ethnic group do you belong? _____
If you are experiencing any difficulties due to cultural or ethnic issues, please describe: _____

How important are spiritual matters to you? ☐ Not at all ☐ Little ☐ Somewhat ☐ Very much

Please describe your strengths, skills, and talents? _____

Describe any special areas of interest or hobbies (art, books, physical fitness, etc.). _____

MISCELLANEOUS INFORMATION

Employment

Employer: _____ Position: _____
Length of time in this position: _____ Job Duties: _____
Stress level of this position: ☐ Low ☐ Medium ☐ High
Other jobs you have held: _____

Education

☐ Yes ☐ No Are you currently attending school?

☐ High School Graduate? Or ☐ GED? Year _____
☐ Associate's Degree Year _____ Major area of study _____
☐ Undergraduate Degree Year _____ Major area of study _____
☐ Graduate Degree Year _____ Major area of study _____

Military Service

☐ Yes ☐ No Have you been/are you currently in the military? (If no, skip remainder of this section)

Branch _____ Date of Discharge _____ Type of Discharge _____ Rank _____
☐ Yes ☐ No Were you in combat?

Legal

☐ Yes ☐ No Have you ever been convicted of a misdemeanor or felony? If yes, please explain _____

☐ Yes ☐ No Are you currently involved in any divorce or child custody proceedings? If yes, please explain _____