Registration Form
KPS

CLIENT'S NAME______________________________ SEX _____ BIRTHDATE __/__/__ AGE _____

ADDRESS____ ZIP _____________

HOME PHONE_______________________________ CELL PHONE______________________________

MARITAL STATUS M__ S __ OTHER ________________________

EMPLOYED BY ____

ADDRESS _________________________________CITY _______________ STATE ____ ZIP _______

INSURANCE SUBSCRIBER'S NAME _____________________________DATE OF BIRTH_________

INSURANCE COMPANY____

ID NUMBER________________________________ GROUP NUMBER__________________________

SECONDARY INSURANCE ____

ID NUMBER _______________________________ GROUP NUMBER __________________________

NAME AND PHONE NUMBER OF EMERGENCY CONTACT PERSON _________________________

____

RELATIONSHIP TO EMERGENCY CONTACT PERSON ____________________________________

WHO REFERRED YOU TO THIS OFFICE?________________________PHONE __________________

WHO IS YOUR PHYSICIAN? ___________________________________ PHONE _________________

REMINDER CALLS:

KPS systematically provides email or phone reminders to all scheduled clients.

Email address ____ Phone _______________________

It is permissible/not permissible to leave a message with your voicemail.

Leave Message __________________________ DO NOT Leave Message _________________________

Signature ____ Date _____________________

Rev. 1-28-16

KPS
311 S. Prospect Ave.
Hartville, OH 44632
330.877.2093

CLIENT'S RIGHTS, RESPONSIBLITIES, AND GRIEVANCE FORM

Client Rights:

1. The right to be treated with consideration and respect for personal dignity, autonomy, and privacy.
2. The right of service in a humane setting, which is the least restrictive feasible, as defined in the treatment.
3. The right to be informed of one's own condition, of proposed or current services, treatment, or therapies, and of the alternatives.
4. The right to consent or refuse any service, treatment, or therapy upon full explanation of the expected consequences of such consent or refusal.
5. The right to a current written, individualized treatment plan that addresses one's own mental health, physical health, social and economic needs and that specifies the provision of appropriate and adequate services, as available, either directly or by referral.
6. The right to activate an informed participation in the establishment, periodic review, and reassessment of the service plan.
7. The right to freedom from unnecessary and excessive medication.
8. The right to freedom from unnecessary restraint or seclusion.
9. The right to participate in any appropriate and available organizational service, regardless of relapse from earlier treatment in that or another service unless there is valid and specific necessity which precludes and/or requires the client's participation in other services. The necessity shall be explained to the client and written in the client's current service plan.
10. The right to be informed of and refuse any unusual or hazardous treatment procedure.
11. The right to be informed about the role of supervised practioners and the right to refuse such care.
12. The right to have the opportunity to consult with independent treatment specialists or legal counsel, at one's own expense.
13. The right to be advised of and to refuse observation by techniques such as one-way vision mirrors, tape-recorders, televisions, movies, or photographs.
14. The right to confidentiality of communications and of all personal identifying information within the limitations and requirements for disclosure of various funding and/or certifying sources, state or federal statutes, unless release of information is specifically authorized by the client or court appointed guardian of the person of an adult client.
15. The right to have access to one's own psychiatric, medical, or other treatment records, unless access to particular identified items of information is specifically restricted for that individual client for clear treatment reasons in the client's treatment plan." Clear treatment reasons" shall be understood to mean only severe emotional damage to the client, such that danger of self-injurious behavior is an imminent risk. The person restricting the information shall explain to the client the factual information about the individual client that necessitates the restriction. The restriction must be renewed annually to retain validity. Any person authorized by the client has unrestricted access to

all information. Clients shall be informed in writing of our policies and procedures for viewing or obtaining copies of personal records.

16. The right to be informed in advance of the reason(s) for discontinuance of service provision, and to be involved in planning consequences of the event.
17. The right to receive an explanation of the reason for denial of service.
18. The right not to be discriminated against in the provision of service on the basis of religion, race, color, creed, sex, national origin, age, lifestyle, physical or mental handicap, or developmental disability.
19. The right to know the cost of service.
20. The right to be fully informed of all rights.
21. The right to exercise any and all rights without the reprisal in any form, including continued uncompromized access to service.
22. The right to file a grievance.
23. The right to have oral and written instructions for filing a grievance.

PROTECTION OF CLIENT RIGHTS

1. Each client shall receive a written statement of Client Rights during the intake procedure. Staff will explain any and all aspects of Client Rights.
2. Clients will sign the Permission to Treatment form, which includes a signature indicating receipt of the Client Rights and Notice of Privacy Practices.
3. Staff will assist with filing a grievance if requested.

Patient Responsibilities:

1. To become informed about your insurance plan including benefits available.
2. To be engaged in your own journey of health and wellness. Your therapist is only half the therapy relationship.
3. To keep all scheduled appointments. **There will be a $50 charge for cancelled appointments, unless 24 hours notice is given.**
4. To follow all medically appropriate physician orders and prescriptions
5. To treat all personnel with courtesy and respect.
6. To provide complete health status information for accurate diagnosis and appropriate treatment.
7. To notify us as in case you receive Emergency care within twenty-four (24) hours, or as soon as possible.

CLIENT GRIEVANCE PROCEDURE

All complaints will be addressed to Margot Kessler Ph.D. Any client at Kessler Psychological Services who has a concern, complaint, or grievance should contact Dr. Kessler at 330-877-2093, or file a written complaint addressed to:
Margot Kessler Ph.D.
311 S. Prospect Ave.
Hartville, OH 44632

KPS

Thank you for choosing Kessler Psychological Services, LLC as your provider. We are committed to providing you with quality and affordable mental health care. Our practice financial policy is as follows:

1. **Insurance.** We participate in several managed care plans. If you are insured by a plan that we do not participate with, payment in full is required at each visit. If you are unable to provide Kessler Psychological Services, LLC with an up-to-date insurance card, payment in full for each visit will be required until we can verify your coverage. Contact your managed care plan directly for any questions regarding your coverage. By signing this form you authorize Kessler Psychological Services, LLC to release the necessary information in order to complete and process your insurance claims.

2. **Claims Submission.** We will submit a claim to your managed care plan if you provide a current insurance card at each visit. Please note that the insurance coverage is between you and your insurance carrier; **we will file the claim for you, but the balance is your responsibility if your plan does not pay after 30 days**. We do not offer third party billing; the patient or the patient's responsible party is responsible for handling all third party billing.

3. **Non-covered Services.** I understand that some and perhaps all of the services I receive may not be covered by my insurance company or not considered reasonable or necessary by Medicare or other insurers. I agree to pay for any services which have been determined by my insurance plan to be "non-covered". Payment in full is generally due at each visit or immediately after you receive your first Kessler Psychological Services, LLC statement from us.

4. **Copays and Deductibles.** You are required to pay for your visit at the time of service if you have not yet met your annual deductible. If you have met your deductible, but we do not know your contracted rate yet, a minimum of $20.00 is due at time of service. We will provide you with a receipt. Copays are always due at the time of service. This arrangement is part of your contract with your insurance company. The exception would be if your plan does not require copay for the visit.

5. **Updates.** Our staff will ask you to verify billing information prior to your first visit and as needed thereafter. Current information is essential in order for us to contact you regarding your treatment and for obtaining timely payment from your insurance company.

6. **Knowing Your Plan.** Patients should know the requirements of their individual current plans. Your plan may change annually and you should always know what your plan intends to pay for services and your financial responsibility. The billing department at Kessler Psychological Services, LLC does pre-certify your visits as a courtesy.

7. **Missed Appointments.** We will charge $50.00 for missed appointments, as that appointment time could have been given to another patient that needed to be seen. This is not billable to your insurance. If you call 24 hours prior to appointment, you will not be billed. For Monday appointments please leave a voice mail on Sunday, it is time stamped.

8. **Forms of Payment.** We accept Cash, Check, Money Order, Visa, Mastercard, and Discover.

9. **Non-sufficient Funds Checks.** You will be charged a $40.00 processing fee for NSF checks presented to the practice.

10. **Additional Information.** We do charge for copying medical records and form completion.

If you have any billing questions, please call 330.877.2093.

I have read and understand the financial policy and agree to abide by its guidelines.

_______________________________	_______________
Printed Name of Patient	Patient's Date of Birth
_______________________________	_______________
Signature of Patient or Responsible Party	Date

KPS

NOTICE OF PRIVACY PRACTICES

To all clients:

The Health Insurance Portability and Accountability Act, commonly known as HIPAA, requires us to notify you of how your personal health information is used for your medical and health care, and for business and administrative functions. It requires that your information be kept confidential, and that we have your permission to use that information for any activities outside of the therapy sessions.

We are committed to keeping your personal information confidential. With your written permission, we may use and disclose your information for the purposes of treatment, payment and billing, and for various administrative operations. However, we will only release the smallest amount of information necessary for the purpose needed, and not any additional information. We may disclose this information in writing, orally, by electronic facsimile, or by mail to others.

We may use your personal health information to inform and consult with your physician or other therapist, confer with and refer to other health care providers, gather data, bill and obtain payment for services from your insurance company and for other similar purposes. There are some situations where we must, by law, provide your personal health information to others, such as abuse or neglect, law enforcement, judicial and administrative proceedings, health oversight activities, emergency situations, and those required by state or federal law, or as required by the Secretary of Health and Human Services.

The HIPAA requirements give you certain “rights” as well, including the right NOT to allow us to use this information. You may restrict to whom the information is released if it is not to someone or to an organization involved in your health care. You have the right to have access to your own records, the right to request changes in the information if you feel it is in error, the right to know to whom the information is released, and the right to file a complaint if you feel your information was used inappropriately.

We ask for your signed permission to use your personal information and for your acknowledgement that you have received this notification. Please sign below and retain a copy of this notice for your records. A copy will be placed in your record. Thank you for your cooperation.

If you believe your privacy rights have been violated, you have the right to file a complaint with the Secretary of the Department of Health and Human Services, 200 Independence Ave., S.W. Room 509F, HHH building, Washington, D.C. 20201.

The following paragraph will be included in any emails, letters, or facsimiles we may transmit.

This message and any included attachments are intended only for the addressee. The information contained in this message is confidential, private and may constitute proprietary or non-public information under federal or state laws. Unauthorized forwarding, printing, copying, distribution, or use of such information is strictly prohibited and may be unlawful. If you are not the addressee, please promptly delete or destroy this message and notify sender of the delivery error by email, letter, or facsimile.

RECEIPT OF NOTICE OF PRIVACY PRACTICES:

NAME: ____

BIRTHDATE: ____

My signature documents that I have received the “Notice of Privacy Practices” from this office and that I agree with its contents.

______________________________ ______________________________

Signature Date

KPS

OUTPATIENT SERVICES CONTRACT

WELCOME TO KESSLER PSYCHOLOGICAL SERVICES. This document contains important information about our professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy is a process that is difficult to describe. Therapy depends on the personalities of the therapist and patient, and the particular problems you bring forward. There are many different methods we may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during the sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. There are no guarantees to the outcome of your experience. Changes do come about as a result of therapy but they may not be exactly what your anticipated.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, your therapist will be able to offer you some first impressions of what your work will include and a treatment plan will follow. You should evaluate this information and decide if you feel comfortable working with us. Therapy involves a large commitment of time, money, and energy, so you should be very comfortable with the therapist and the approach. If you have questions about our procedures, please feel free to discuss them as they present themselves. If you find that you are not well matched with your therapist, we will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS

We normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if your therapist is the best person to provide the services you need in order to meet your treatment goals. Once psychotherapy has begun, we usually schedule one 50-minute session (one appointment hour of 50 minutes duration) per week at a time we agree on, although some sessions may be longer, more frequent, or less frequent. Once an appointment hour is scheduled, **you will be expected to pay a $50 cancellation fee unless you provide 24 hours advance notice** (unless we both agree that you were unable to attend due to circumstances beyond your control).

PROFESSIONAL FEES

Our fee for the initial visit is $160 and our hourly fee for subsequent visits is $120. In addition to weekly appointments, we charge this amount for other professional services you may need, though we will break down the hourly cost if the work takes less than one hour. Other services include report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of us. If you become involved in legal proceedings that require our participation, you will be expected to pay for professional time even if we

INSURANCE REIMBURSEMENT

You should be aware that most insurance companies require you to authorize us to provide them with a **clinical diagnosis**. Sometimes we have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report we submit, if you request it.

CONTACT BETWEEN SESSIONS

If you are difficult to reach, please inform us of alternative times and ways to reach you, (phone#/email). If you are unable to reach us and feel that you can't wait for us to return your call, contact your family physician **or go to the nearest emergency room** and ask for the psychologist (psychiatrist) on call. If your therapist will be unavailable for an extended time, we will provide you with the name of a colleague to contact, if necessary in his/her absence. We are often not available by telephone. During office hours, therapists are usually with clients. Our telephone is answered by our clerical staff. We monitor our messages frequently and will make every effort to return your call that day.

PROFESSIONAL RECORDS

The laws and standards of this profession require that we keep treatment records. You are entitled to receive a copy of the records unless we believe that seeing them would be emotionally damaging, in which case we will be happy to send them to a mental health professional of your choice. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. We recommend that you review them in your therapist's presence so that we can discuss the contents. Patients will be charged an appropriate fee for any time spent in preparing information requests.

MINORS

If you are under eighteen years of age, please be aware that the law may provide your parents/caretakers the right to examine your treatment records. It is our policy to request an agreement from parents that they agree to give up access to your records. If they agree, we will provide them only with general information about our work together, unless we feel there is a high risk that you will harm yourself or someone else. In this case, we will notify them of this concern. We will also provide parents with a summary of your treatment when it is complete. Before giving parents any information, we will discuss the matter with you, if possible, and do our best to handle any objections you may have with what we are prepared to discuss.

CONFIDENTIALITY

In general, the privacy of all communications between a patient and a psychologist is protected by law, and we can only release information about our work to others with your **written permission**. But there are a few exceptions.

In most legal proceedings, you have the right to prevent us 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 our testimony if he/she determines that the issues demand it.

There are some situations in which we are legally obligated to take action to protect others from harm, even if we have to reveal some information about a patient's treatment. For example, if we believe that a child, elderly or disabled person is being abused, we must file a report with the appropriate state agency.

If we believe that a patient is threatening serious bodily harm to another, we are required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, we may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.   These situations occur only rarely. If a similar situation occurs, we will make every effort to fully discuss it with you before taking any action.

If we believe that you are at risk of killing yourself, our only treatment goal is going to be to keep you safe and alive. We will do whatever we need to do to protect you, including notifying and involving members of your family. If this is unacceptable to you, then we will need to refer you elsewhere.

We may occasionally find it helpful to consult other professionals about a case. During a consultation, we make every effort to avoid revealing the identity of our patients. The consultant is also legally bound to keep the information confidential. If you don't object, we will not tell you about these consultations unless we feel that it is important to our work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. We will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and we are not attorneys.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

____
Client

____
Witness

____
Date

How Did You Hear About Us?
Please check the appropriate box.

☐ **Self-Referral**	☐ **Current Client**	☐ **Former Client**	☐ **Other Psychologists**
☐ **Primary Care Physician**	☐ **Insurance**	☐ **Court Ordered**	☐ **Health Grades**
☐ **KPS Web site**	☐ **Linked In**	☐ **Psychology Today**	

☐ **Other** ____________________________________

KPS
311 South Prospect Ave.
Hartville, OH 44632
PHONE: 330-877-2093
FAX: 330-877-2104

PERMISSION FOR TREATMENT

I hereby authorize Kessler Psychological Services LLC to provide the following services:

______ Individual Psychotherapy
______ Psychological Testing/Evaluation
______ Family Counseling
______ Other

I understand that mental health services sometimes carry a risk of undesirable side effects. I am aware that I am entitled to an explanation of such side effects. I also understand that only those services listed above will be provided unless I give signed authorization for additional services.

____
Signature of Client or Parent/Legal Guardian

____
Relationship to Client

____
Signature of Witness

____
Date

Client Rights, Responsibilities, and Grievances/Notice of Privacy Practices

I have received a copy of Kessler Psychological Services LLC Client Rights, Responsibilities, and Grievance Procedures and a copy of Notice of Privacy Practices (HIPAA). A member of the staff has offered to explain the policies and procedures to me.

______________________________	______________________________
Signature of Client	Date
______________________________	______________________________
Signature of Staff	Date

Rev. 1-28-16

KPS
Social and Health Background Sheet

DATE ___________________________

NAME ____

ADDRESS ____ ZIP CODE _______

HOME_______________________ CELL_______________________ WORK_______________________

DOB ____________ AGE ______ RACE/ETHNICTY_________________________

CURRENT FAMILY INFORMATION:

NAME	RELATIONSHIP	AGE	SEX	OCCUPATION
________________________	________________	___	___	_____________________
__________________________	________________	___	___	_____________________
__________________________	________________	___	___	_____________________
__________________________	________________	___	___	_____________________
__________________________	________________	___	___	_____________________

DEVELOPMENTAL HISTORY:

PLEASE LIST SIBLINGS, INCLUDING YOURSELF, AND THE BIRTH ORDER IN FAMILY OF ORIGIN:

1. ______________________ 2. ____________________ 3. _______________________

4. ______________________ 5. ___________________ 6. _______________________

PLEASE CHECK ANY OF THE FOLLOWING WHICH WERE PROBLEMS IN THE **FAMILY IN WHICH YOU WERE RAISED:**

____ FREQUENT MOVES ___ ALCOHOL/DRUG ___ DEATH FAMILY MEMBER
____ PARENTS' DIVORCE ___ LEGAL PROBLEMS ___ ABUSE/NEGLECT
____ PARENTS' REMARRIAGE ___ PARENT CONFLICT ___ SEXUAL ABUSE
____ PARENTS SEPARATED ___ PARENT JOB LOSS ___ DOMESTIC VIOLENCE
____ FAMILY ILLNESS ___ FINANCIAL STRESS ___ EMOTIONAL PROBLEMS
____ LOSS OF JOB ___ PERSONAL ILLNESS ___ LEARNING PROBLEMS
OTHER____
____ OTHER ISSUE (WISH TO DISCUSS WITH COUNSELOR IN PERSON)

INFORMATION ABOUT **YOUR DEVELOPMENT UP TO AGE 18**. THIS MAY HELP CLARIFY A PROBLEM YOU MIGHT PRESENTLY BE HAVING. PLEASE CLICK IN THE BOXES FOR THOSE THAT APPLY TO YOU.

____ PREMATURE BIRTH	___ AVOIDING OTHERS	___ BEDWETTING
____ BIRTH DEFECT	___ NERVOUS	___ FIDGETY / RESTLESS
____ HEAD INJURY	___ ABUSE / NEGLECT	___ EATING DISORDERS
____TALKING	___ REFUSING TO TALK	___ BAD DREAMS
____ LEARNING PROBLEMS	___ SPEECH PROBLEMS	___ SLEEPWALKING
____ POOR COORDINATION	___ FREQUENT EAR PROBLEM	___ SCHOOL BEHAVIOR
____ FEELING REJECTED	___ VISUAL DIFFICULTIES	___ FEARFUL LEAVING HOME
____ BEHAVIORAL PROBLEM	___ STRONG WILLED	___ "WORRY WART"
____ LEAVING A LOVED ONE	___ TOILET TRAINING	___ FEW FRIENDS
____ OVERWEIGHT	___ SMALL FOR AGE	___ SHY
____ RAN AWAY FROM HOME	___ FIGHTING	___ PICKED ON
____ REPEATED GRADE	___ READING PROBLEM	___ TROUBLE WITH POLICE

MARITAL/COMMITTED RELATIONSHIP HISTORY:

PLEASE LIST **ALL** MARITAL OR COMMITTED PARTNERS:

DATES OF MARRIAGES	DATES OF DIVORCE/SEPARATIONS	CHILDREN FROM THIS RELATIONSHIP
________________	____________________	________________
________________	____________________	________________
________________	____________________	________________
________________	____________________	________________

IN YOUR **PRESENT** RELATIONSHIP DO YOU

ENJOY GOOD COMMUNICATION WITH EACH OTHER?	____ YES	___ NO
FEEL SATISFIED WITH YOUR SEXUAL RELATIONS?	____ YES	___ NO
SPEND PRIVATE COUPLE TIME WITH EACH OTHER?	____ YES	___ NO
SHARE SIMILAR INTERESTS AND VALUES?	____ YES	___ NO

EDUCATION HISTORY

HIGH SCHOOL: __________________________ COLLEGE: ______________________

DEGREES: ______________________________ CERTIFICATIONS: _______________

MILITARY SERVICE HISTORY:

BRANCH: _________________ DATES OF SERVICE: __________________

PRIOR MENTAL HEALTH HISTORY:

HAVE YOU HAD PRIOR MENTAL HEALTH TREATMENT? ____ YES ___ NO

IF YES:

DATE _________________

WAS THIS PERSON A:

____ PSYCHIATRIST	____PSYCHOLOGIST	____CLINICAL SOCIAL WORKER
____ CLINICAL COUNSELOR	____MINISTER	____OTHER

HAVE YOU EVER BEEN HOSPITALIZED FOR EMOTIONAL PROBLEMS? ___ YES ___NO

NAME OF HOSPITAL ________________________________ DATE _______________

LOCATION ____ HOW LONG? _________

DOCTOR WHO TREATED YOU____

MEDICATONS YOU TOOK____

DO YOU STILL TAKE MEDICATIONS FOR YOUR NERVES? ____ YES ___ NO

ALCOHOL /DRUG HISTORY:

DO YOU HAVE A HISTORY OF ALCOHOL /DRUG ABUSE? ____YES ___ NO

IF YOU ARE USING ALCOLHOL OR DRUGS HAS THIS RESULTED IN:

____ MARITAL PROBLEMS
____ PROBLEMS WITH FAMILY OR FRIENDS
____ PROBLEMS ON THE JOB
____ LEGAL PROBLEMS
____ PHYSICAL PROBLEMS
____ FINANCIAL PROBLEMS
____ MEMORY BLACKOUT
____ PREOCCUPATION WITH ALCOHOL/DRUG
____ LOSS OF CONTROL
____ WITHDRAWAL SYMPTOMS
____ PERIODS OF ABSTINENCE
____ CHARGES OF DUI or DWI

LEGAL HISTORY:

HAVE YOU BEEN IN TROUBLE WITH THE LAW? ____ YES ___ NO

IF YES, PLEASE CHECK THOSE THAT APPLY TO YOU:

____ TROUBLE WITH THE LAW AS A JUVENILE?
____ TROUBLE WITH THE LAW AS AN ADULT?
____ HAVE LEGAL MATTER PENDING?
____ HAVE YOU EVER BEEN IN JAIL?

MEDICAL HISTORY:

DATE OF LAST PHYSICAL EXAMINATION ____

FAMILY DOCTOR ____

PLEASE DESCRIBE YOUR CHIEF MEDICAL / PHYSICAL COMPLAINTS ____________________

____

____

DO YOU HAVE ANY SPECIAL PROBLEMS WITH HEARING, SPEECH, VISION? _______________

PLEASE EXPLAIN____

____

ARE YOU ON ANY MEDICATIONS? ____ YES ____ NO IF YES, PLEASE LIST: _____________

____

PLEASE DESCRIBE ANY SIDE EFFECTS: ____

____

DO YOU HAVE ANY ALLERGIES? ____ YES _____NO IF YES, PLEASE DESCRIBE:_________

____

LIST ANY SERIOUS ILLNESSES, INJURIES, OR SURGERIES:

____

PLEASE CLICK THE BOXES IN THE LEFT HAND COLUMN IF THIS CONDITION EXISTS. IN THE RIGHT COLUMN WRITE: SELF, FATHER, MOTHER, SISTER, BROTHER, AUNT, UNCLE, ETC.

____ ALCOHOLISM ____
____ ALLERGIES ____
____ MENTAL RETARDATION ____
____ OBESITY ____
____ A DEGENERATIVE DISEASE ____
____ MENTAL HEALTH PROBLEMS ____
____ SUICIDE ____
____ CANCER ____
____ DIABETES ____
____ EPILEPSY ____
____ HIGH BLOOD PRESSURE ____
____ HEART TROUBLE ____
____ OTHER ____

MEDICAL CONDITIONS AND SYMPTOMS

NOW / PAST / NEVER

___ ___ ___ ANGER OUTBURSTS
___ ___ ANXIETY
___ ___ ___ ARTHRITIS
___ ___ ___ ASTHMA
___ ___ ___ BACKACHES
___ ___ ___ BARBITURATES
___ ___ ___ BINGEING
___ ___ ___ BROKEN SLEEP
___ ___ ___ CANCER
___ ___ ___ CAN'T WORK UNDER PRESSURE
___ ___ ___ CHEST PAIN
___ ___ ___ CHRONIC PAIN
___ ___ ___ COLOR BLIND
___ ___ ___ CONSTIPATION
___ ___ ___ DEPERSONALIZATION
___ ___ ___ DEPRESSION
__ ___ ___ DIABETES
___ ___ ___ DIFFICULTY GOING TO SLEEP
___ ___ ___ DIFFICULTY STAYING ASLEEP
___ ___ ___ DISTRACTIBILITY
___ ___ ___ DIZZINESS
___ ___ ___ DRUG/ALCOHOL ABUSE
___ ___ ___ DRUG REACTIONS
___ ___ ___ EMOTIONAL UPSETS
___ ___ ___ EPILEPSY
___ ___ ___ EXCESSIVE SWEATING
___ ___ ___ EXHAUSTION
___ ___ ___ FAINTING SPELLS
___ ___ ___ FAST PULSE
___ ___ ___ FATIGUE
___ ___ ___ FOOD CRAVING FOR SWEETS
___ ___ ___ "GOING CRAZY" SENSATIONS
___ ___ ___ HALLUCINATIONS
___ ___ ___ HAND TREMORS
___ ___ ___ HAY FEVER
___ ___ ___ HEADACHES
MORNING ___
EVENING ___
HOW LONG? _________

NOW / PAST / NEVER

___ ___ ___ HEARING VOICES
___ ___ ___ HEART MEDICINE
___ ___ ___ HEART PALPITATIONS
___ ___ ___ HORMONES
___ ___ ___ HYPERTENSION
___ ___ ___ ITCHY SKIN
___ ___ ___ INSULIN DEPENDENT
___ ___ ___ LAXATIVES USED
___ ___ ___ LEG CRAMPS
___ ___ ___ LOOSE BOWELS/GAS
___ ___ ___ LOSE TEMPER EASILY
___ ___ ___ MEMORY PROBLEMS
___ ___ ___ MINIMAL SEXUAL DESIRE
___ ___ ___ EARLY MORNING AWAKENING
___ ___ ___ MOODY OFTEN
___ ___ ___ MOIST PALMS
___ ___ ___ MUSCLE TWITCHING
___ ___ ___ NERVE MEDICINE
___ ___ ___ NERVES
___ ___ ___ NERVOUS BREAKDOWN
___ ___ ___ NERVOUSNESS
___ ___ ___ OVEREATING
___ ___ ___ OVERWORKED
___ ___ ___ PAIN MEDICINE
___ ___ ___ PERFECTIONIST
___ ___ ___ POOR APPETITE
___ ___ ___ POOR DIGESTION
___ ___ ___ SHAKING
___ ___ ___ SMOKING
PACKS PER DAY _______
___ ___ ___ STOMACH MEDICINE
___ ___ ___ STOMACH UPSETS
FROM FOOD ________
FROM MEDICINE________
FROM LIQUOR _______
___ ___ ___ SUICIDE ATTEMPT
___ ___ ___ TREATED FOR MENTAL CONDITION
___ ___ ___ WORRIER, FEEL INSECURE

CURRENT SOURCES OF STRESS:

PLEASE LIST YOUR MOST SIGNIFICANT SOURCES OF STRESS OR WORRY:

1. ______________________________

2. ______________________________

WHAT DO YOU HOPE TO ACCOMPLISH WITH THIS COUNSELING EXPERIENCE?

____

____

ENVISION HOW YOUR LIFE WOULD BE DIFFERENT IF YOU COULD MANAGE SOME OF THESE PROBLEMS BETTER.

____

____

____

ADDITIONAL INFORMATION: PLEASE ADD ANY INFORMATION YOU FEEL WHICH MIGHT BE HELPFUL IN ASSISTING IN YOU TREATMENT:

____

____

____

YOUR SIGNATURE BELOW INDICATES YOU UNDERSTOOD THE QUESTIONS AND WERE ABLE TO ASK FOR CLARIFICATION AS NEEDED. THIS INFORMATION IS TRUE TO THE BEST OF YOUR KNOWLEDGE.

______________________	__________	______________	______
CLIENT SIGNATURE	**DATE**	**RECEIVED BY**	**DATE**

KPS

☐ Check here if patient does not have a Primary Care Physician

Client: Please fill out data in boxes only. Remember to sign at "X". Thank you!

Primary Care Physician Name ______________________ Phone Number ______________

Address ____ Fax Number ________________

Dear Dr. ____

Your patient, ____________________________________, DOB: ___________, was seen at our office for outpatient counseling. We hope that the following information will be helpful in coordinating this patient's care.

Date of Initial Consultation ___________________ Date of Next Appointment _____________________

Diagnoses and/or brief description of presenting problem(s) _______________________________________

____

Treatment recommendations ____

Please call if further information would be helpful

Treating Clinician's Printed Name ____

Kessler Psychological Services LLC
311 S. Prospect Ave.
Hartville, OH 44632
Phone 330-877-2093 Fax 330-877-2104

Sincerely,

____
Clinician's Signature

<u>Authorization to Disclose Information</u>

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CRF Part 2 and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This release will automatically expire twelve months from the date signed.

I, _________________________________, hereby authorize _____________________________
(Print Patient's Name (Print Treating Clinician's Name)

Please check:
☐ To release any applicable information **TO** my primary care physician (as listed above)
☐ **NOT** to release information to my primary care physician (as listed above)
☐ To receive the following information **FROM** my primary care physician

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X ____ ________________________________
(Signature of Patient or Guardian) (Date Signed)