Trinity Behavioral Health
Robert W. Young, Ph.D.
Licensed Psychologist PY 6915
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CONSENT TO EVALUATION & TREATMENT

This form is used to acquire informed consent to receive psychological services (i.e. evaluation and treatment). By signing this form I understand I am hereby giving my consent to participate in the evaluation process and any prescribed psychological treatment services (e.g. psychotherapy and biofeedback) as needed. I also acknowledge that I am receiving these services under my own free will and that I understand I can withdraw my consent and discontinue my participation at any time.

Therapy can help a person to gain new understanding about his or her problems and to learn new ways of coping with and solving those problems, such as anxiety, anger, depression, parenting or relationship concerns. Therapy can help a person to develop new skills and to change behavior patterns. Therapy can contribute to improved ability to cope with stress and difficult situations and can increase understanding of self and others.

I acknowledge that Dr. Young has advised me that while there are potential benefits to therapy, there is no guarantee of success and that there are potential risks. I have been advised that during therapy emotions and memories may be stimulated which can evoke strong feelings and that changes in awareness may alter my self-perceptions and ways of relating to others. I have been advised that the process of personal change can be quite varied and individual. I understand that it is important that I mention promptly any concerns or questions to Dr. Young that I may have at any time during the process of therapy.

I have been advised by Dr. Young that all communications with me and all records relating to the provision of psychological services to me are confidential and may not be disclosed without my written consent. I also am aware, and by signing this form give my consent for Dr. Young to release copies of any evaluation reports and treatment notes as needed to third party payers (i.e. insurance carriers) in order to be reimbursed for providing psychological services. I also have been advised by Dr. Young the law places certain limits on the confidential nature of the psychological services provided to me. I have been advised that these limits on confidentiality may arise if Dr. Young perceives that there is risk of harm in situations such as the following: 1) if I present an imminent danger to myself or others the law requires that steps be taken to prevent such harm; 2) if a child is in need of protection a report must be filed with the appropriate agency or authority; 3) if a vulnerable adult is abused or neglected a report may be filed with the appropriate government agency; 4) or if a court orders the disclosure of records

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As a courtesy to each patient, this office will file your insurance for you for reimbursement. In order to accomplish this, you as the patient agree to allow this office to release any personal identifying information (e.g. social security number, address etc.) necessary to the insurance carrier in order to facilitate payment. You also recognize that unless you are covered under a worker's compensation claim, any information provided from this office in order to facilitate billing and reimbursement will not include treatment records (e.g. progress notes or reports). If you are covered under a workers' compensation claim, then treatment records must be forwarded along with each reimbursement claim pursuant to federal and state law.

It also is understood and agreed that should it be necessary for this office to hire an attorney or collection agency to collect the account, the patient agrees to pay fees and all costs of collection. The patient also agrees to and understands that any account sent to collections will necessitate the release of personal identifying information, such as social security number, address etc, in order to facilitate the collection process.

I acknowledge that I have had the opportunity to carefully read this document and to ask, and have answered, any questions or concerns I have about it or arising from it. I further acknowledge that I have read and understood the information contained in this document and that it records my consent and I am aware I can receive a copy of it upon request.

Signed:

Patient Name: ______________________________

Patient Signature: ______________________________ Date: ________________________

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PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY AND SIGN:

Cancellation / No-Show Policy:

When a patient makes a late appointment cancellation, it is impossible for our office to schedule another patient in that time slot, resulting in a loss of revenue. Because of this, it is necessary to assess a **$100 fee** for any cancellations not completed within 24-hours of the scheduled appointment. All **no-show appointments** are automatically assessed the **$100 fee**. There are no exceptions to the no-show policy. No-show appointments will always be assessed the $100 no-show fee.

Credit Card / Debit Card Processing

When you use a credit card or debit card the charge will be under Trinity Behavioral Health. Additionally, there will be a 4% additional fee added to the amount due to cover the fee for processing the credit card charge.

Financial Responsibility

Due to high cost of health care, payment is due at time of service. As a courtesy to each patient, your insurance company will be billed directly. Should your insurance company deny or make only a partial payment, the patient WILL be responsible for the balance due. Please also note, it is understood and agreed that should it be necessary to hire an attorney or collection agency to collect on a patient's account, the patient agrees to pays all fees and costs of collection, to include those of an attorney if one is necessary.

Thank you for your understanding.

Robert W. Young, Ph.D.

____________________ ____________________

Patient Signature Date

Biographical Information Form—Adult

Instructions: To assist us in helping you, please fill out this form as fully and openly as possible. All private information is held in strictest confidence within legal limits. If certain questions do not apply to you, leave them blank.

Personal History

1) Name: ______________________ 2) Age: _____ 3) Gender: __ M ___ F

4) Address: ______________ City: __________ State: ____ Zip: _______

5) Today's date: ________ 6) Date of birth: _____ 7) Years of education: ________

8) Occupation: ________ 9) Home phone: _______ 10) Business phone: ________

11) Present marital status:

___ 1) never married
___ 2) engaged to be married
___ 3) married now for first time
___ 4) married now after first time
___ 5) separated
___ 6) divorced and not remarried
___ 7) widowed and not remarried
___ 8) other (specify) ______________

12) If married, are you living with your spouse at present? ______ Yes _______ No

13) If married, years married to present spouse: ______________________________

Therapy History

14) Are you receiving Therapy services at present? _____ Yes _______ No

If Yes, please briefly describe: ______________________________________

____

15) Have you received Therapy in the past? _____ Yes ______ No

If Yes, please briefly describe: ______________________________________

____

16) What is (are) your main reason(s) for this visit? ____________________________

____

____

17) How long has this problem persisted (from #21)? ____________________________

____

____

18) Under what conditions do your problems usually get worse? ____________________

____

____

19) Under what conditions are your problems usually improved? ____________________

____

____

20) How did you hear about this clinic, or who referred you? ______________________

____

____

21) Name and address of your primary physician:

Physician's name: ______________________________

Address: ______________________________________

22) List any major illnesses and/or operations you have had: ______________________

____

____

23) List any physical concerns you are having at present (e.g., high blood pressure, headaches, dizziness, etc.): ______________________________

____

____

24) List any other physical concerns you are having at present: ______________________

____

____

25) When was your most recent complete physical exam? ______________________

Results of physical exam: ______________________________

____

26) On average how many hours of sleep do you get daily? ______________________

27) Do you have trouble falling asleep at night? __ Yes ______________________ No

If Yes, describe: ______________________________________

____

28) Have you gained/lost over ten pounds in the past year? ____ Yes ___ No, ____ gained _ lost

If Yes, was the gain/loss on purpose? _____ Yes ______________________ No

29) Describe your appetite (during the past week):

___ poor appetite ___ average appetite ___ large appetite

30) What medications (and dosages) are you taking at present, and for what purpose?

Medication	Purpose
______________	______________________
______________	______________________
______________	______________________
______________	______________________

31) What is your present religious affiliation?

___ 1) Catholic

___ 2) Jewish

___ 3) Protestant (specify denomination if any) ______________________

___ 4) None, but I believe in God

___ 5) Atheist or agnostic

___ 6) Other (please specify) ______________________________

32) How important is religious commitment to you?

Unimportant			Average Importance			Extremely important
1	2	3	4	5	6	7

33) Do you desire to have your religious beliefs and values incorporated into the Therapy process?
____ Yes ___ No ___ Not sure (If Yes, please explain): ____________________
____

34) Mother's age: ____________ If deceased, how old were you when she died? __________
35) Father's age: ____________ If deceased, how old were you when he died? __________
36) If your parents separated or divorced, how old were you then? ____________________
37) Number of brother(s) ____ Their ages: __ ___ ___ ___ ___ ___
38) Number of sister(s) _____ Their ages: __ ___ ___ ___ ___ ___
39) I was child number _____ in a family of ______ children.
40) Were you adopted or raised with parents other than your natural parents? ____ Yes ____ No
41) Briefly describe your relationship with your brothers and/or sisters: ____________________
____
____

42) Which of the following best describes the family in which you grew up?

Warm and accepting				Average				Hostile and fighting
1	2	3	4	5	6	7	8	9

43) Which of the following best describes the way in which your family raised you?

Allowed me to be very independent				Average				Attempted to control me
1	2	3	4	5	6	7	8	9

44) Employment History (list each job you have held over past 10 years with dates to best of your ability):

Job Title	Date Began	Date Ended

Thoughts and Behaviors

45) Please check how often the following thoughts occur to you:

1) Life is hopeless.	___ Never ___ Rarely ___ Sometimes ___ Frequently
2) I am lonely.	___ Never ___ Rarely ___ Sometimes ___ Frequently
3) No one cares about me.	___ Never ___ Rarely ___ Sometimes ___ Frequently
4) I am a failure.	___ Never ___ Rarely ___ Sometimes ___ Frequently
5) Most people don't like me.	___ Never ___ Rarely ___ Sometimes ___ Frequently
6) I want to die.	___ Never ___ Rarely ___ Sometimes ___ Frequently
7) I want to hurt someone.	___ Never ___ Rarely ___ Sometimes ___ Frequently
8) I am so stupid.	___ Never ___ Rarely ___ Sometimes ___ Frequently
9) I am going crazy.	___ Never ___ Rarely ___ Sometimes ___ Frequently
10) I can't concentrate.	___ Never ___ Rarely ___ Sometimes ___ Frequently
11) I am so depressed.	___ Never ___ Rarely ___ Sometimes ___ Frequently
12) God is disappointed in me.	___ Never ___ Rarely ___ Sometimes ___ Frequently
13) I can't be forgiven.	___ Never ___ Rarely ___ Sometimes ___ Frequently
14) Why am I so different?	___ Never ___ Rarely ___ Sometimes ___ Frequently
15) I can't do anything right.	___ Never ___ Rarely ___ Sometimes ___ Frequently
16) People hear my thoughts.	___ Never ___ Rarely ___ Sometimes ___ Frequently
17) I have no emotions.	___ Never ___ Rarely ___ Sometimes ___ Frequently
18) Someone is watching me.	___ Never ___ Rarely ___ Sometimes ___ Frequently
19) I hear voices in my head.	___ Never ___ Rarely ___ Sometimes ___ Frequently
20) I am out of control.	___ Never ___ Rarely ___ Sometimes ___ Frequently

Please comment (e.g., examples, frequency, duration, effects on you) about each of the above thought that occur frequently or are a concern to you. Use the back of this sheet is necessary.

____

____

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Symptoms

46) Check the behaviors and symptoms that occur to you more often than you would like them to take place:

____ aggression	____ fatigue	____ sexual difficulties
____ alcohol dependence	____ hallucinations	____ sick often
____ anger	____ heart palpitations	____ sleeping problems
____ antisocial behavior	____ high blood pressure	____ speech problems
____ anxiety	____ hopelessness	____ suicidal thoughts
____ avoiding people	____ impulsivity	____ thoughts disorganized
____ chest pain	____ irritability	____ trembling
____ depression	____ judgment errors	____ withdrawing
____ disorientation	____ loneliness	____ worrying
____ distractibility	____ memory impairment	____ other (specify)
____ dizziness	____ mood shifts	________________
____ drug dependence	____ panic attacks	________________
____ eating disorder	____ phobias/fears	________________
____ elevated mood	____ recurring thoughts	________________

Please give examples of how each of the symptoms you checked impairs your ability to function (e.g., socially, emotionally, occupationally, physically). Use the back of this sheet if necessary.

____

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47) List your main difficulties at home: ____

____

____

____

____

____

48) List your behaviors you would like to change: ______________________________________

____

____

____

____

____

49) Additional information you believe would be helpful: ______________________________

____

____

____

____

____

BDI-II

Date:

Name: ______ Marital Status: ______ Age: ______ Sex: ______

Occupation: ______ Education: ______

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the one statement in each group that best describes the way you have been feeling during the past two weeks, including today. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

1. Sadness

0 I do not feel sad.
1 I feel sad much of the time.
2 I am sad all the time.
3 I am so sad or unhappy that I can't stand it.

2. Pessimism

0 I am not discouraged about my future.
1 I feel more discouraged about my future than I used to be.
2 I do not expect things to work out for me.
3 I feel my future is hopeless and will only get worse.

3. Past Failure

0 I do not feel like a failure.
1 I have failed more than I should have.
2 As I look back, I see a lot of failures.
3 I feel I am a total failure as a person.

4. Loss of Pleasure

0 I get as much pleasure as I ever did from the things I enjoy.
1 I don't enjoy things as much as I used to.
2 I get very little pleasure from the things I used to enjoy.
3 I can't get any pleasure from the things I used to enjoy.

5. Guilty Feelings

0 I don't feel particularly guilty.
1 I feel guilty over many things I have done or should have done.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.

6. Punishment Feelings

0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.

7. Self-Dislike

0 I feel the same about myself as ever.
1 I have lost confidence in myself.
2 I am disappointed in myself.
3 I dislike myself.

8. Self-Criticalness

0 I don't criticize or blame myself more than usual.
1 I am more critical of myself than I used to be.
2 I criticize myself for all of my faults.
3 I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes

0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

10. Crying

0 I don't cry anymore than I used to.
1 I cry more than I used to.
2 I cry over every little thing.
3 I feel like crying, but I can't.

_____ Subtotal Page 1

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11. Agitation

0 I am no more restless or wound up than usual.
1 I feel more restless or wound up than usual.
2 I am so restless or agitated that it's hard to stay still.
3 I am so restless or agitated that I have to keep moving or doing something.

12. Loss of Interest

0 I have not lost interest in other people or activities.
1 I am less interested in other people or things than before.
2 I have lost most of my interest in other people or things.
3 It's hard to get interested in anything.

13. Indecisiveness

0 I make decisions about as well as ever.
1 I find it more difficult to make decisions than usual.
2 I have much greater difficulty in making decisions than I used to.
3 I have trouble making any decisions.

14. Worthlessness

0 I do not feel I am worthless.
1 I don't consider myself as worthwhile and useful as I used to.
2 I feel more worthless as compared to other people.
3 I feel utterly worthless.

15. Loss of Energy

0 I have as much energy as ever.
1 I have less energy than I used to have.
2 I don't have enough energy to do very much.
3 I don't have enough energy to do anything.

16. Changes in Sleeping Pattern

0 I have not experienced any change in my sleeping pattern.
1a I sleep somewhat more than usual.
1b I sleep somewhat less than usual.
2a I sleep a lot more than usual.
2b I sleep a lot less than usual.
3a I sleep most of the day.
3b I wake up 1–2 hours early and can't get back to sleep.

17. Irritability

0 I am no more irritable than usual.
1 I am more irritable than usual.
2 I am much more irritable than usual.
3 I am irritable all the time.

18. Changes in Appetite

0 I have not experienced any change in my appetite.
1a My appetite is somewhat less than usual.
1b My appetite is somewhat greater than usual.
2a My appetite is much less than before.
2b My appetite is much greater than usual.
3a I have no appetite at all.
3b I crave food all the time.

19. Concentration Difficulty

0 I can concentrate as well as ever.
1 I can't concentrate as well as usual.
2 It's hard to keep my mind on anything for very long.
3 I find I can't concentrate on anything.

20. Tiredness or Fatigue

0 I am no more tired or fatigued than usual.
1 I get more tired or fatigued more easily than usual.
2 I am too tired or fatigued to do a lot of the things I used to do.
3 I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex

0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.

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_______ Subtotal Page 2

_______ Subtotal Page 1

NAME ______________________ **DATE** ______________________

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by each symptom during the PAST WEEK, INCLUDING TODAY, by placing an X in the corresponding space in the column next to each symptom.

Symptom	NOT AT ALL	MILDLY (It did not bother me much)	Moderately (It was very unpleasant- but I could Stand it)	SEVERELY (I could Barely Stand it)
1. Numbness or tingling.	1.			
2. Feeling hot.	2.			
3. Wobbliness in legs.	3.			
4. Unable to relax.	4.			
5. Fear of the worst happening.	5.			
6. Dizzy or lightheaded.	6.			
7. Heart pounding or racing.	7.			
8. Unsteady.	8.			
9. Terrified.	9.			
10. Nervous.	10.			
11. Feelings of choking.	11.			
12. Hands trembling.	12.			
13. Shaky.	13.			
14. Fear of losing control.	14.			
15. Difficulty breathing.	15.			
16. Fear of dying.	16			
17. Scared.	17.			
18. Indigestion or discomfort in abdomen	18.			
19. Faint.	19.			
20. Face flushed.	20.			
21. Sweating (not due to heat).	21.			

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