Kathryn G White, PhD

CLIENT INFORMATION - ADULT

Date: ____________________

Name: First__________________________M________________________Last__________________________

Prefer to be called: __________________________ Date of birth: ____________________

Address:____________________________________City/ST:___________________________Zip:__________

Phone: Cell:___________________________Ok to leave message? voice_________text _____________

Other:______________________________________Ok to leave message? __________________________

Email Address:__________________________________________Referred by:_________________________

Employer or School:_______________________________

Profession/Title/or area of study:______________________________

Marital status (circle): Never married, married, cohabitating, divorced, widowed, separated

Gender/Pronoun: ____________/______________ Administrative/legal sex: _______________

Partner's name, if applicable: _________________________________________________________

Person to notify in case of emergency: ___________________________________

Phone #____________________________________Relationship to you: ___________________________

(OPTIONAL) How you describe yourself Ethnicity? ____________________________________________

Covid era forms: I have read and agreed to the informed consent documents:

In office ❑ Yes Teletherapy ❑ Yes

Household members:

| Name | Age | Gender | Relationship |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Payment Information

Self Pay ❑ Yes Insurance ❑ Yes

if so Insurance Company__________________________ (or attach photo/scan of ID card)

Policyholder's Name and DOB _______________________________________________________

Policyholder's employer ____________________________________________________________

Insurance ID# _____________________________ Group_____________________

Co-pay ______________

Guardian or other responsible party ____________________________________________

Rev 3.20

Patient Name: ____________________________________________________

## Therapy goals

What is the main reason you're seeking therapy now?

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

Does this seem to you to be situational, or is it similar to problems you've had in the past?

___________________________________________________________________________

What symptoms do you most want to see improve?

___________________________________________________________________________

___________________________________________________________________________

What do you hope to gain from psychotherapy overall?

___________________________________________________________________________

___________________________________________________________________________

Knowing that therapy involves different styles, overall what are you looking for in your therapy? You might say "not at all," "a little," "some," "very much," or whatever describes it for you.

___Something practical, involving advice, suggestion, and techniques
___A quiet therapist who allows me to express my thoughts and emotions
___Just help getting through this immediate situation or decision
___Exploring emotions I'm not so aware of
___Discovering my unconscious or implicit dynamics
___Lifelong patterns that I need to see and understand
___Acceptance of my spiritual perspective
___An active therapist who engages me in discussion
___Understanding family dynamics
___Anything else?_____________________________________________________

Patient Name: ____________________________________________________

## Current Problems and Symptoms

Please indicate the degree to which the following items are a problem to you in the past month by placing the appropriate number next to the problem.

1 – No Difficulty    2 – Mild Difficulty    3 – Great Difficulty    4 – Overwhelmed

_____ Job _____ School _____ Alcohol _____ Partner/Relationship

_____ Financial _____ Family _____ Drug Use _____ Sexual Activity

(Rate each problem 1 a little — 4 a lot and CIRCLE all words in parenthesis that pertain to you)

_____ Anxiety (Worry, fear, scared feelings, excessive guilt, anxiety attacks)

_____ Depression (unhappiness, hopelessness, lack of motivation, loss of enjoyment)

_____ Suicidal Thoughts (wishing you weren't alive, thoughts about suicide, suicide plan)

_____ Thinking (concentration, confusion, memory, intrusive, racing or obsessive thoughts)

_____ Attention (distractible, losing things, forgetting to do things, getting lost in your head)

_____ Hyperactivity (restless, talk too much or too fast, fidgety, always active)

_____ Confusion (problems knowing what's real, mind playing tricks, too suspicious or jealous)

_____ Physical Stress Symptoms (pain, headaches, fatigue, stomach aches, poor sleep, nightmares)

_____ Self Control (uncontrolled anger, overpowering sexual desires, addictive behavior)

_____ Emotions (change quickly, hard to control, control too much)

_____ Relationships with others (friend, co-worker, partner, family member)

## Legal Issues

Are you currently involved with or do you plan to become involved in any legal or other proceedings (ex. laws suits or workers compensation suits) for which you would plan to use documentation of your psychotherapy? ❑ No ❑ Yes

Explain:

______________________________________________________________________

______________________________________________________________________

Patient Name: ______________________________________________

## Health and Treatment History

Psychiatrist, APRN or other current Mental Health Providers:

______________________________________________

______________________________________________

Primary Care Physician: ______________________________________________

Other physicians Involved in ongoing or chronic care:

______________________________________________

______________________________________________

______________________________________________

Current medications: (please include dose if known and prescribing doctor)

______________________________________________

______________________________________________

______________________________________________

Medical conditions that you or your doctor believe may be related to stress or cause you psychological distress:

______________________________________________

______________________________________________

Other significant health conditions or surgery:

______________________________________________

______________________________________________

Past Mental Health or Chemical Dependency Hospitalization or Intensive Outpatient Treatment

| Year | type | where | how long | was it helpful? |
|---|---|---|---|---|
| | | | | |
| | | | | |

Prior outpatient treatment including psychotherapy and medication:

| Year | type | provider | how long | was it helpful? |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

Patient Name: ____________________________________________________

______________________________________________________________________

Have you ever done any type of psychological testing or assessment? ❑ No ❑ Yes

If yes, when and for what purpose?____________________________________

## Personal History

The following questions are important to providing appropriate therapy, but they are not required to begin therapy. If you would prefer to discuss later, you may write that.

Suicide attempts: Have you ever attempted suicide? ❑ No ❑ Yes
If yes, how many times, when:

______________________________________________________________________

______________________________________________________________________

Do you think about suicide currently?_❑ No ❑ Yes

Self harm: Have you intentionally hurt yourself in another way? ❑ No ❑ Yes

If yes, in what way? __________________________________________________

Is it a current problem? ❑ No ❑ Yes When was the last time? ______________________

## Trauma History

Have you experienced significant trauma in your life ❑ No ❑ Yes – multiple or significantly in the past ❑ Yes – recent. Optional: If yes, and you'd like to describe in general here:

______________________________________________________________________

______________________________________________________________________

## Family Psychiatric History

❑ No ❑ Yes – Optional: If yes, and you'd like to describe in general here:

______________________________________________________________________

______________________________________________________________________

Patient Name: ______________________________________________________

## Any Unique Social, Family or Personal History

Optional: If yes, and you'd like to describe in general here:

______________________________________________________________________________

______________________________________________________________________________

## Alcohol and Drug Use

Smoking, Drinking, Drug-use:
Do you smoke (anything)? Or use tobacco in any other form? ❑ No ❑ Yes If yes, what?

_________________________________________________

How much? ___________________________ Frequency? ___________________

Do you drink alcohol? ❑ No ❑ Yes If yes, what? How much, how often?

Do you currently use any recreational drugs (anything)? ❑ Yes ❑ No

If yes, what? _______________________________________________________

How much? ___________________________ Frequency? ___________________

How much caffeine do you consume a day?

___________________________________________________________________

## Eating and Nutrition

Are your diet or eating habits unusual in any way? ❑ Yes ❑ No
If yes, how?

______________________________________________________________________________

______________________________________________________________________________

## Sleep Habits

Are you having any problems with your sleep? ❑ Yes ❑ No

______________________________________________________________________________

______________________________________________________________________________

Nightmares or frequent bad dreams? ❑ Yes ❑ No

How much time in bed do you spend in a typical night? ______________________

Patient Name: ____________________________________________

## Physical Exercise

What kind and how much physical exercise do you get?

______________________________________________________________

______________________________________________________________

## Spiritual Life

If your religious or spiritual life is important to you, it may also be part of understanding you.

______________________________________________________________

______________________________________________________________

## Strengths and Goals

Are there strengths you think you have that you think would be helpful if developed more?

______________________________________________________________

______________________________________________________________

Times, people, activities you really enjoy and have been helpful or healing to you?

______________________________________________________________

______________________________________________________________

Anything particularly important and meaningful that has gotten you through hard times ?

______________________________________________________________

______________________________________________________________

Patient Name: ____________________________________________________

## Signature Pages

Documents detailing office and payment policy, HIPPA Patient Notification of Privacy Rights are available online for reading, downloading, or printing at www.kathryngwhite.com or you can ask Dr White for a paper copy.

## Payment/Insurance Agreements & Authorization

I accept responsibility for payment of charges for services rendered to me. If I choose to use insurance I authorize Dr White to bill my insurance provider for psychological services rendered on my behalf. If Dr White is an out of network provider to my plan, I am personally responsible for the payment of all charges not covered. If she is in my network, I'm responsible for my plan's deductible and co-payment.

I understand that, as a courtesy, Dr White or her representative will file insurance claims for the services provided, including out of network plans. However, this does not release me of my responsibility for payment of the charges for services.

I further understand and agree that a collection agency and/or the courts may be used in the event of a delinquent payment, and I realize that such action could require that the doctor release to the collection agency, attorneys, and/or the courts, information which identifies the parties involved, gives the patient diagnoses, and describes the dates and nature of the charges, as well as all other information contained on any claim filed.

If I am using insurance, I understand that securing benefits under my insurance plan will require that the Dr White provide the plan management with confidential patient information, including diagnosis and the dates and type of service rendered. Further, I understand that for utilization review and other claims review purposes, it may sometimes be necessary for the doctor to provide the plan management with additional information concerning case history, presenting problems, treatment plans, prognosis, and medical record. I fully and freely consent to the release of any and all such patient information as is necessary for the processing and review of health care claims made on my behalf. This consent shall remain in effect until all claims have been fully processed and all review procedures completed.

Signature_____________________________________________

I understand that my insurance company will not reimburse for missed appointments and agree that I will be charged for and required to **pay for missed appointments not cancelled at least 24 hours in advance**

Signature_____________________________________________

Patient Name: ____________________________________________________

## Self Pay Agreement

Only for people not using insurance:
For personal reasons I decided to engage Dr. White's services and self-pay for all services rendered, and not to file for insurance reimbursement.

Signature____________________________________________

I understand and agree that I will be charged for and required to **pay for missed appointments not cancelled at least 24 hours in advance.**

Signature____________________________________________

## Informed Consent to Care Your

Psychiatric and psychological care like other things in life offer no absolute guarantee of success and there are limitations to any form of care offered a patient. Since such limitations are always a function of the particular problem in question, I invite you to discuss your treatment plan with me. . Your signature acknowledges that you have seen have seen the document outlining Dr White's office policies and the parameters of care and acknowledges your informed consent for care.

Signature____________________________________________

## Patient Notification of Privacy Rights

The Health Insurance Portability and Accountability Act (HIPAA) provides patient protections related to the electronic transmission of data, the keeping and use of patient records and storage and access to health care records. All health care providers are now required to provide patients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.
By law, I am required to secure your signature indicating you have received this Patient Notification of Privacy Rights Document.

Signature____________________________________________Date__________________