**Dr. Yvonne DeMoss, PhD, LPC, MAC**

**4980 S. ALMA SCHOOL RD. A-2 #256**

**303-979-1972**

NAME SEX: M F AGE:

Last First Middle

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Street and Number City Sate Zip Code

HOME/CELL PHONE msg ok BUSINESS PHONE msg ok

EMAIL ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BIRTH DATE \_\_\_/\_\_\_/\_\_\_

[SOC.SEC.NO](http://soc.sec.no/). \_\_\_-\_\_\_-\_\_\_\_ DRIVER’S LICENSE # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYED YES NO OCCUPATION:

EMPLOYER NAME

EMPLOYER PHONE

EMERGENCY CONTACT RELATIONSHIP

ADDRESS OF ABOVE PHONE

**PARTY RESPONSIBLE FOR PAYMENT (including insurance information)**

**IF OTHER THAN CLIE**NT RELATIONSHIP

ADDRESS OF ABOVE PHONE

INSURANCE CARRIER

GROUP/POLICY NO.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AUTHORIZATION #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ANY CURRENT OR PREVIOUS THERAPY** (Please include any year/duration/diagnosis)

**WHAT DO YOU HOPE TO GET FROM THERAPY?** **WHAT YOU WOULD LIKE TO BE DIFFERENT IN YOUR LIFE WHEN YOU ARE DONE WITH THERAPY?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRESENTING PROBLEM:**

What concern has led you to seek therapy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approximately how long have you had your current problem or concern? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How have you been coping with this problem? Has the problem been getting worse over time? \_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where did you learn about my services? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Website [ ]Yes [ ]No Referral [ ]Yes [ ]No

Referral Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May I contact them to thank them? [ ]Yes [ ]No

Other (please list): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently in a relationship that is verbally, emotionally, or physically abusive? [ ] Yes [ ] No

Are you currently concerned for your physical safety? [ ] Yes (If YES why?) [ ] No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In the last **4** weeks, have you experienced any of the following (check those that apply):

[ ] Worry about your health [ ] Trouble falling or staying asleep, or sleeping too much

[ ] Little or no sexual desire or pleasure during sex [ ] Increased stress at work or school

[ ] Difficulties with love ones [ ] Financial issues or loss of job

[ ] Stress of care-taking children, parents, or family members [ ] An upsetting or traumatic event

[ ] Having no one to turn to when you have a problem [ ] Reduced interest or pleasure in doing things

[ ] Thinking or dreaming about a traumatic event in your past [ ] Feeling tired or having little energy

[ ] Feeling down, depressed, or hopeless [ ] Poor appetite or overeating

[ ] Feeling bad or thinking negatively about yourself [ ] Feeling fidgety or restless

[ ] Trouble concentrating on things [ ] Change in Appetite

[ ] Moving or speaking so slowly other people notice [ ] Extreme Anger

[ ] Illness or Disability [ ] Victim of domestic violence

[ ] Loss of a loved one, job, separation [ ] Marital Conflicts

[ ] Anxiety, worry, or stress for several days at time [ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SUICIDE/PSYCHIATRIC RISK ASSESSMENT**:

Have you ever had or do you currently have a desire to kill yourself? ( ) Yes ( ) No

(If YES please answer the following)

When was the last time you had suicidal thoughts? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often do you have these thoughts? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever thought about how you would kill yourself? Explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have access to guns or other types of weapons? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever attempted suicide? If so how and when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there any family history of suicide? Explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever assaulted anyone? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever intentionally set a fire? \_\_\_\_ Yes \_\_\_\_ No How old were you? \_\_\_\_ Where? \_\_\_\_\_\_\_\_\_

Have you ever intentionally hurt or killed an animal other than hunting? \_\_\_\_ Yes \_\_\_\_ No

How old were you? \_\_\_\_ Please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY OF ORIGIN:**

Parents married? \_\_\_\_\_\_ If divorced at what age were you? \_\_\_\_ Whom did you live with? \_\_\_\_\_\_\_\_ What was your relationship with each parent like? Whom were you closest to? Who was the disciplinarian and how were you disciplined? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Siblings: (oldest to youngest, include yourself and step-siblings and ages) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there any family history of emotional, physical, or sexual abuse? If yes, please describe what type of abuse, by whom and indicate if it was reported: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How was anger expressed in your family? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How do you express anger? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who were you closest to growing up? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What was expected of you growing up? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any family history of: (a) alcohol/drug problems (b) compulsive behavior such as gambling (c) suicide (d) depression (e) mental illness/disorder (f) eating disorders etc?

\_\_\_ Dad \_\_\_ Step-parent \_\_\_ Uncle (paternal) \_\_\_ Grandfather (paternal)

\_\_\_ Mom \_\_\_ Step-brother \_\_\_ Aunt (paternal) \_\_\_ Grandmother (paternal)

\_\_\_ Brother \_\_\_ Step-sister \_\_\_ Uncle (maternal) \_\_\_ Grandfather (maternal)

\_\_\_ Sister \_\_\_ Any in-law \_\_\_ Aunt (maternal) \_\_\_ Grandmother (maternal)

**DEVELOPMENTAL HISTORY:**

Did your mother have any illness or complications before delivery? Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did mother abuse alcohol or drugs during pregnancy? \_\_\_Y\_\_\_ N Length of pregnancy: \_\_\_\_\_ Full Term? \_\_\_Y\_\_ N Birth Weight \_\_\_lbs. \_\_\_oz.

Any head injuries? (If so, what and when) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EDUCATIONAL/VOCATIONAL HISTORY:**

Highest level of education completed \_\_\_\_\_\_\_\_\_\_ Is it as far as you would have liked? \_\_\_\_\_\_

Educational goals (if any) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of school you are attending now \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What degree do you hold? High school \_\_\_\_\_\_\_\_ GED \_\_\_\_\_\_ Trade School \_\_\_\_\_\_

2 yr Assoc \_\_\_\_\_\_\_ BA/BS \_\_\_\_\_\_\_ Masters \_\_\_\_\_\_ PhD \_\_\_\_\_

If you had problems with teachers in school what were they?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been suspended or expelled? \_\_\_\_\_\_\_\_ How many times? \_\_\_\_\_\_\_\_\_

Why?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were you ever diagnosed with a learning disability? \_\_\_\_\_ At what age? \_\_\_\_\_\_What? \_\_\_\_\_\_

**MILITARY HISTORY:**

Branch of service \_\_\_\_\_\_\_ Dates \_\_\_\_\_\_ Type of discharge \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RELATIONSHIP/SOCIAL:**

Current relationship status? \_\_\_ Married \_\_\_ Single \_\_\_ Divorced \_\_\_ In committed relationship \_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sexual orientation (check all that apply)

Heterosexual \_\_\_\_ Bisexual \_\_\_\_ Gay \_\_\_\_ Lesbian \_\_\_\_ Transgender \_\_\_\_

Do you have children? \_\_\_ Yes \_\_\_ No \_\_\_ Living at Home? If yes, please list all your children. (Include deceased children)

Name of Child Age List if Child is Biological, Step, Adopted, Foster

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Is there anyone else who lives in your home? Please describe. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Besides family members, approximately how many people can you really count on currently for friendship or emotional support? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are these people you see regularly? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY:**

Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe your current health and list any physical complaints or health concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any medications you are taking at this time:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Medications | Dosage | Frequency | Effectiveness | Physician |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**ALCOHOL/SUBSTANCE USE:**

Date of First Use Yearly/Amt Daily/Amt Weekly/Amt Mthly/Amt Date of last use

Alcohol\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marijuana\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cocaine\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Amphetamine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hallucinogens\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Inhalants\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heroin \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tranquilizers\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pain Kille\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prescription meds \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a DUI?DWAI/DUID? \_\_\_\_\_\_\_ If so, what was the date and circumstances? \_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LEGAL HISTORY:**

Please describe any incidents that resulted in arrest (whether or not convicted) the dates, circumstances and outcome \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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How do you feel about the legal system? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SPIRITUAL RESOURCES:**

Were you raised in any religious/spiritual tradition, if so which one? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How significant a role does spirituality play in your life? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this something that you would like to incorporate in your treatment? Yes\_\_\_\_ No\_\_\_\_\_

This will certify that I have read and understand the above information and will comply with the rules

described herein.

**Patient Signature Date**

**Therapist Signature Date**

**Guardian Signature Date**

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**AUTHORIZATION FOR RELEASE**

I hereby authorize Dr. DeMoss, PhD, LPC, CACIII to release the information described below to

This consent may be revoked at any time by myself and expires at the end of therapy with Dr. DeMoss.

Information/items to be released:

I wish to exclude the release of the following:

The above information is to be released for the following purpose:

**I understand that I may revoke this authorization to release information at any time by giving written notice to Dr. DeMoss. I also understand that any information released prior to my revoking this authorization shall not be a breach of my right to confidentiality except as listed in the Colorado Revised Statute, Section 12-43-218.**

**Patient Signature Date**

**Therapist Signature Date**

**Guardian Signature Date**

**NOTICE TO RECIPIENT:** This information has been disclosed to you from records whose confidentiality is protected by Federal Law (42 CFR, Part 2) which prohibits you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. No responsibility can be accepted by me if it is made available to any other person including the client. Re-disclosure or re-transfer of these records is expressly prohibited and such re-disclosure may subject you to civil liability.

**Dr. Yvonne DeMoss, PhD, LPC, MAC**

**4980 S. ALMA SCHOOL RD. A-2 #256**

**303-979-1972**

**AGREEMENT FOR PAYMENT OF SERVICES**

Between Dr. Yvonne DeMoss, PhD, LPC, CACIII and:

please print name

**FEES & PAYMENTS:**

Payment is requested at the beginning of each session.

I understand the fee for a **fifty** (4**5)** **minute** session is:

$ per individual,

$ per couple,

$ per family, and

$ per group session (intake is $35).

I understand that payment is made in check or money order at each session unless other arrangements have been made in advance.

I understand emergency phone calls carry no charge up to ten (10) minutes however, prolonged calls will be at the same rates as above prorated by the number of minutes.

Sessions are expected to begin and end at the scheduled time. Late arrival on your part will not extend the

scheduled ending time for a session. I am also expected to be on time, and I will make appropriate

compensation if I am late, such as by making up the time, prorating the fee, etc.

I understand I will be charged $25 charge for a returned check and that if there is a second returned check

I will be on a cash only basis of payment thereafter.

**CANCELLATIONS:**

I understand that if I will not be able to make an appointment, I will notify Dr. DeMoss **immediately.**

I understand the **regular fee will be charged for missed or cancelled appointments with less than**

**24-hour notice** (emergencies will be the only exception). Most insurances will not pay for no shows

or late cancellations.

**COLLECTION:**

I understand that I will additionally pay all attorney/collection costs should collection procedures be undertaken after 90-days for non-payment of fees.

**Dr. Yvonne DeMoss, PhD, LPC, MAC**

**4980 S. ALMA SCHOOL RD. A-2 #256**

**303-979-1972**

**INSURANCE COVERAGE:**

Prior to the **beginning** of therapy, **I will** take responsibility to check with my own insurance carrier to verify coverage for:

1) Outpatient psychotherapy/mental health services; and

2) Outpatient substance abuse or alcoholism treatment.

And be responsible for charges should insurance refuse payment for any reason.

This will certify that I have read and understand the above information and will comply with the rules

described herein.

**Patient Signature Date**

**Therapist Signature Date**

**Guardian Signature Date**

**Dr. Yvonne DeMoss, PhD, LPC, MAC**

**4980 S. ALMA SCHOOL RD. A-2 #256**

**303-979-1972**

**PATIENT INFORMATION AND CONSENT**

**Training, Experience and Credentials:**

Bachelor of Science Degree, Kent State University

Master of Arts Psychology Degree, Regis University

Senior Certified Addictions Counselor #4003 Master Addictions Counselor

Member American Mental Health Counselors Association

Board Member 1st Judicial District Juvenile Planning Committee

Doctorate-North Central University

**Grievance Board, CRS 12-43-214 (1) (c):**

The practice of both licensed and unlicensed psychotherapy is regulated by the Department of Regulatory Agencies.

**COLORADO NOTICE FORM OF HIPAA LEGISLATION**

Policies and Practices to Protect the Privacy of Your Health Information

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact me. You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint. Questions or complaints may be addressed to:

**State of Arizona**

**Board of Behavioral Health Examiners**

**3443 North Central Avenue, Suite 1700**

**Phoenix, Arizona 85012**

**602-542-1882 FAX 602-364-0890**

**Psychotherapist’s Duties:**

I am required by law to maintain the privacy of Private Health Information (PHI) and to provide you with a notice of my legal duties and privacy practices with respect to PHI. I reserve the right to change the privacy policies and practices described in this notice.

**Patient’s Rights:**

1. *Right to Request Restrictions*: You have the right to request restrictions on certain uses and disclosures of protected health information regarding you. However, I am not required to agree to a restriction you request.

2. *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations:* You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)

3. *Right to Inspect and Copy:* You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

**Dr. Yvonne DeMoss, PhD, LPC, MAC**

**4980 S. ALMA SCHOOL RD. A-2 #256**

**303-979-1972**

**PATIENT INFORMATION AND CONSENT(cont.)**

4. *Right to Amend:* You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

5. *Right to an Accounting:* You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.

6. *Right to a Paper Copy:* You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

*Psychotherapy Notes* are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

**III.** Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

1. *Child Abuse*: If I have reasonable cause to know or suspect that a child has been subjected to abuse or neglect, I must immediately report this to the appropriate authorities.

2. *Adult and Domestic Abuse*: If I have reasonable cause to believe that an at-risk adult has been mistreated, self-neglected, or financially exploited and is at imminent risk of mistreatment, self-neglect, or financial exploitation, then I must report this belief to the appropriate authorities.

3. *Health Oversight Activities:* If the Grievance Board for Unlicensed Psychotherapists or an authorized professional review committee is reviewing my services, I may disclose PHI to that board or committee.

4. *Judicial and Administrative Proceedings:* If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and I will not release information without your written authorization or a court order. The privileged does not apply when you are being evaluated by a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

5. *Serious Threat to Health or Safety*: If you communicate to me a serious threat of imminent physical violence against a specific person or persons, I have a duty to notify any person or persons specifically threatened, as well as a duty to notify an appropriate law enforcement agency or by taking other appropriate action. If I believe that you are at imminent risk of inflicting serious harm on yourself, I may disclose information necessary to protect you. In either case, I may disclose information in order to initiate hospitalization.

6. *Worker’s Compensation:* I may disclose PHI as authorized by and to the extent necessary to comply with laws relating to worker’s compensation or other similar programs, established by law that provided benefits for work-related injuries or illness without regard to fault.

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**PATIENT INFORMATION AND CONSENT(cont.)**

**Patient Rights and Important Information, CRS 12-43-214 (1) (d):**

A patient is entitled to receive information about methods of therapy; the techniques used; the duration of therapy (if known); and the fee structure. In a professional relationship sexual intimacy is inappropriate and should be reported to the grievance board. A patient may seek a second opinion from another therapist or may terminate at any time. While you may choose to terminate, I ask that you have one final termination session.

A formal assessment will be conducted in order to help me gain an understanding of your current situation; it is possible that you will receive a diagnosis. The purpose of the diagnosis is to help us and other mental health professionals identify the problems you are having and the counseling procedures that may be most helpful in treating those problems.

In some cases, a diagnosis may also be required in order to receive third-party reimbursement for services therapists provide. Certain diagnoses (e.g. partner or parent-relational, academic problems) may not be covered by your insurance plan. It is important that we review several possible limitations of mental health diagnosis. It is your responsibility to contact your insurance company to identify their specific method for storing and sharing confidential information. If you are concerned about this, we can discuss alternative options, including out-of-pocket pay, pro bono services, or referral to other service providers.

If you are involved in any type of litigation, such as a child custody situation your therapy records

including your mental health diagnosis may be subpoenaed by the courts and released during court

proceedings.

Your mental health diagnosis—and any accompanying records—may be revealed if you sign a release

of information for disclosure of your medical records to any other agency or individual (e.g. school,

probation officer, family physician).

**Privileged Communication, CRS 12-43-214 (1) (d):**

The information provided by a patient during therapy is legally confidential, the therapist cannot be forced to disclose information without the client's consent except as provided in section 12-43-218

of the Colorado Revised Code. Legal confidentiality does not apply in a criminal or delinquency proceeding or to supervised unlicensed therapists [Section 12-43-214 (1) (d) (iv) and 12-43-218]. There are other exceptions that I will identify to you as the situations arise during therapy.

It is important to remember that electronic communication such as e-mail, faxes and cell

phone calls are not secure. Please keep this in mind when there is communication with a

therapist. If you have any questions about confidentiality, please discuss them with me.

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**PATIENT INFORMATION AND CONSENT(cont.)**

**Therapeutic process and objective:**

The theoretical orientations I draw from include: Person-centered, Existential, Gestalt and Cognitive-Behavioral therapies. The needs of each patient will guide the process of therapy and is holistically focused to include body, mind, and spirit.

While not all therapy and homework may meet your expectations, and your symptoms may become more pronounced at different points during the course of therapy, therapy is hopeful labor. This work can ultimately help with shifting your inner perspective in a healthy way, which assists in dealing with painful feelings or grief, making sense of difficult memories, changing thinking and behavioral patterns, or resolving problems in relating to others. Your feedback is always welcome. I want to focus on your goals in a manner that works for you.

The frequency of sessions and the length of the therapy are aspects of the work that you and I will decide together as we proceed. Generally, our therapy will continue until you and I together decide that our work is complete.

**Therapeutic relationship:**

The relationship between therapist and patient should promote a warm, caring, supportive, trusting environment where self-awareness, goal setting, and change can take place. Honesty and patient commitment are integral for positive change. Also, this relationship is a professional relationship in which appropriate boundaries must be maintained. The therapist-patient relationship is important. For this reason, I cannot be involved in a social relationship or friendship that extends beyond the therapy room. Limiting outside interactions will help to keep the working relationship free of possible outside conflict.

**Consent:**

I have been informed of my therapist's degrees, credentials and licenses. I have also read the preceding information and understand my rights as a patient. I consent to therapy, including evaluation, treatment and/or referral.I understand that my records are protected by HIPPA regulations. I understand that I must fill out a specific Authorization for Release of Information form indicating to whom and for what purpose my records are being requested per HIPPA standard. I/we do also hereby state that this agreement and contract is to be in effect for the life of my/ourselves and that even after death this contract shall stay in effect.

**Request for additional services:**

Please be advised of the following fee schedule for work done by Dr. DeMoss outside of actual therapy sessions:

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**PATIENT INFORMATION AND CONSENT(cont.)**

* Hourly rate for any legally related work including but not limited to:

Compiling, reviewing, copying and/or mailing records @ $150/45 minutes,

pro-rated as needed, in addition to the cost of materials, processing,

copying and or mailing.

* Phone calls, email or other correspondence with legal counsel; case review

with counsel; depositions or court testimony @ $200/45 minutes, pro-rated as

needed, including any travel time and mileage calculated at .45/mile.

* Any work which includes travel, other than the above @ $200/45 minutes,

pro-rated as needed for the actual travel time, and calculated at mileage

at .45/mile

Should there be other needs by a patient they will be discussed and agreed upon at the time, but will be paid at a rate of no less than $200/45 minutes.

This will certify that I have read and understand the above information and will comply with the rules described herein.

**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Therapist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**