# Brain Injury Foundation of St. Louis (BIFSTL)

## BILLING INFORMATION

Name of Patient: _____

Person responsible for payment of services:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Telephone: _____ Cell Phone: _____

E-mail Address: _____

Telephone: _____

Patient Referred by: _____

**Brain Injury Foundation of St. Louis (BIFSTL) will provide you with an invoice after each visit which you may mail to your insurance company if you are planning to file.**

**HSA credit cards are not accepted.**

➔**Required Information**
Name on Card _____ Account #: _____
Expiration Date: _____ Security Code: _____

I accept financial responsibility for expenses incurred at Brain Injury Foundation of St. Louis (BIFSTL) by the above-named patient.

___ Please charge my credit card for each visit
___ I will pay by check or cash at the time of my visit

_____
Signature of Responsible Party Date

# Brain Injury Foundation of St. Louis (BIFSTL)

## INFORMED CONSENT FOR PSYCHOTHERAPY/COUNSELING SERVICES

**Welcome to our practice.** This document contains important information about our professional services and business policies. Please read it carefully. When you sign this document, it will represent an agreement with Brain Injury Foundation of St. Louis (BIFSTL).

**Psychotherapy/Counseling Services**
Psychotherapy and counseling involve a collaborative process between you and a psychotherapist to work on areas of dissatisfaction in your life and assist you in creating change. For therapy to be most effective, it is important that you take an active role in the process. Psychotherapy and counseling are not identical processes for everyone. There are many different methods your therapist may use to address the problems that you identify together. The type and extent of services that you receive will be determined by your psychotherapist. If you have any questions about therapy procedures, you are always free to discuss them with your therapist.

**Benefits and Risks**
Psychotherapy and counseling have benefits and risks. Since therapy often involves discussing difficult aspects of your life, you may experience uncomfortable feelings like sadness, guilt, or anger. Patients' experiences and outcomes are unique and depend on their circumstances.

**Fees for Additional Services**
If you request that your psychotherapist provide non-therapy services, charges for those services will normally be higher than the usual rate for in-office therapy services. If you become involved in legal proceedings that require your therapist's participation, you will be expected to pay for this professional time even if the therapist is called to testify by another party. Because of the difficulty of legal involvement, charges for such services are higher than those for regular therapy services. Psychotherapists, at their discretion, may charge for time spent on phone calls between therapy sessions. This includes calls you make to your therapist as well as calls the psychotherapist makes to others at your request.

**Contacts and Emergencies**
You may contact your psychotherapist through the BIFSTL office phone number, 314-645-7230. In case of an emergency, please call 911 or go to your nearest emergency room. Your therapist is not on-call at all times and may be unreachable. You may leave an emergency message on his or her office voicemail, and your therapist will return your emergency call when he or she is able.

**Confidentiality and Professional Records**
The privacy of all records and communications between a patient and a psychotherapist is protected by law. In general, we can only release your information with your written permission. But there are a few exceptions:

- When a valid court order is issued for records and/or testimony on the part of the psychotherapist, the therapist is bound by law to comply with such an order.

- When there is risk of imminent harm to you or to another person, the therapist is ethically bound to take necessary steps to prevent such harm. This notification may include notifying an intended target of violence, notifying the police, informing a family member about the situation, or seeking appropriate hospitalization.
- When there is suspicion that a child has been sexually, physically or mentally abused or neglected, the therapist is legally required to inform the proper authorities.
- Ethical psychotherapists consult with professional colleagues about their cases, in order to provide patients with the best possible services. If your therapist consults with a colleague, your therapist will not share your name or identifying information.

**Electronic Transmissions**

BIFSTL cannot ensure the confidentiality of any form of communication through electronic media. You are advised that any text, email, or internet-enabled communication between you and your psychotherapist involves greater risk to confidentiality than does traditional in-person communication. BIFSTL strongly discourages any electronic communication between clients and their therapists.

**Termination**

At any time, you have the right to seek a second opinion with another qualified mental health professional. You also have the right to terminate therapy at any time. If you choose to do so, your therapist may offer to provide you with names of other professionals whose services you might prefer.

# Brain Injury Foundation of St. Louis (BIFSTL)

## INFORMED CONSENT FOR THERAPY SERVICES

## Consent to Treatment:

I voluntarily consent to receive mental health assessment, care, and treatment. I authorize my psychotherapist through BIFSTL to provide such professional services. I understand and agree that I will participate in the planning of my treatment and that I may stop these services at any time. By signing below, I acknowledge that I have both read and understood the information in Brain Injury Foundation of St. Louis' *Informed Consent for Therapy Services* document and agree to its terms. This consent ends when I notify my therapist that I am terminating therapy or one year following my last therapy session.

**Name of Patient: _____ Date: _____**

**Signature of Patient: _____ Date: _____**

# Brain Injury Foundation of St. Louis (BIFSTL)

## NOTICE OF PRIVACY PRACTICES

The privacy of your personal information is important to Brain Injury Foundation of St. Louis (BIFSTL). BIFSTL will maintain the privacy of your information and will not disclose your information to others unless you tell BIFSTL to do so, or unless the law authorizes or requires BIFSTL to do so. A federal law commonly known as HIPAA requires that BIFSTL take additional steps to keep you informed about how BIFSTL may use information that is gathered in order to provide health care services to you. As part of this process, BIFSTL is required to provide you with the attached Notice of Privacy Practices and to request that you sign the written acknowledgement that you received a copy of the Notice. The Notice describes how BIFSTL may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. This Notice also describes your rights regarding personal information BIFSTL maintains about you and a brief description of how you may exercise these rights. If you have any questions about this Notice, please contact BIFSTL at 314-645-7230.

# Brain Injury Foundation of St. Louis (BIFSTL)

## NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

BIFSTL is required by applicable federal and state law to maintain the privacy of your health information. It is also required to give you this Notice about privacy practices, legal obligations, and your rights concerning your health information ("Protected Health Information" or "PHI"). It must follow the privacy practices that are described in this Notice (which may be amended from time to time). For more information about privacy practices, or for additional copies of this Notice, please contact BIFSTL using the information listed in Section II G of this notice.

### I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI)

#### A. Permissible Uses and Disclosures without Your Authorization

BIFSTL may use and disclose PHI without your written authorization, excluding Psychotherapy Notes as described in Section II, for certain purposes as described below. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures that are permissible under federal and state law.

**1. Treatment:** BIFSTL may use and disclose PHI in order to provide treatment to you. For example, BIFSTL may use PHI to diagnose and provide psychotherapy and counseling services to you. We may also disclose your information in order to remind you of appointment times. We may disclose your information to any family members or significant others that you voluntarily decide to bring to and include in a therapy session. We may disclose your PHI, except for identifying information, during professional clinical supervision and/or consultation, in order to ethically provide you the highest quality services.

**2. Payment:** BIFSTL may use or disclose PHI so that services you receive are appropriately billed and payment is collected. By way of example, it may disclose PHI to permit your health plan to take certain actions before it approves or pays for treatment services.

**3. Health Care Operations:** BIFSTL may use and disclose PHI in connection with our health care operations, including quality improvement activities, training programs, accreditation, certification, licensing or credentialing activities.

**4. Required or Permitted by Law:** BIFSTL may use or disclose PHI when it is required or permitted to do so by law. For example, it may disclose PHI to appropriate authorities if it reasonably believes that you or a child are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. In addition, it may disclose PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. Other disclosures permitted or required by law include the following: disclosures for public health activities; health oversight activities including disclosures to state or federal agencies authorized to access PHI; disclosures to judicial and law enforcement officials in response to a court order or other lawful process; disclosures for research when approved by an institutional review board; and disclosures to military or national security agencies, coroners, medical examiners, and correctional institutions or otherwise as authorized by law.

**B. Uses and Disclosures Requiring Your Written Authorization**

**1. Psychotherapy Notes:** Notes recorded by your clinician documenting the contents of a counseling session with you ("Psychotherapy Notes") will be used only by your clinician and will not otherwise be used or disclosed without your written authorization.

**2. Marketing Communications:** BIFSTL will not use your health information for marketing or fundraising communications without your written authorization. You have the right to opt out of any marketing or fundraising communications that you choose not to receive.

**3. Other Uses and Disclosures:** Uses and disclosures other than those described in Section I.A. above will only be made with your written authorization. For example, you will need to sign an authorization form before BIFSTL can send PHI to your life insurance company, to a school, or to your attorney. You may revoke any such authorization at any time.

## II. YOUR INDIVIDUAL RIGHTS

**A. Right to Inspect and Copy.** You may request access to your medical record and billing records maintained by BIFSTL in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, BIFSTL may deny access to your records. BIFSTL may charge a fee for the costs of copying and sending you any records requested. If you are a parent or legal guardian of a minor, please note that certain portions of the minor's medical record may not be accessible to you, in accordance with state law. You have the right to an electronic communication of any records that BIFSTL keeps electronically.

**B. Right to Alternative Communications.** You may request, and BIFSTL will accommodate, any reasonable written request for you to receive PHI by alternative means of communication or at alternative locations.

**C. Right to Request Restrictions.** You have the right to request a restriction on PHI used for disclosure for treatment, payment or health care operations. You must request any such restriction in writing addressed to the Privacy Officer as indicated below. BIFSTL is not required to agree to any such restriction you may request. One exception is that, if you self-pay at BIFSTL, you may request that we not disclose these services to your health insurance company and BIFSTL is obligated to honor that request.

**D. Right to Accounting of Disclosures or Breaches.** Upon written request, you may obtain an accounting of disclosures of PHI made by BIFSTL after October 7, 2019. This right is subject to restrictions and limitations. You also have the right to be notified by BIFSTL if a privacy breach of your PHI has occurred. If such a breach occurred, you would be notified within a reasonable time.

**E. Right to Request Amendment.** You have the right to request that BIFSTL amend your health information. Your request must be in writing, and it must explain why the information should be amended. BIFSTL may deny your request under certain circumstances.

**F. Right to Obtain Notice.** You have the right to obtain a paper copy of this Notice by submitting a request to the Privacy Officer at any time.

**G. Questions and Complaints.** If you desire further information about your privacy rights or are concerned that WCPA has violated your privacy rights, you may contact the **Privacy Officer** at 314-645-7230. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. BIFSTL will not

retaliate against you if you file a complaint with the Director or the Privacy Officer.

**III. EFFECTIVE DATE AND CHANGES TO THIS NOTICE**

A. Effective Date. This Notice is effective on October 7, 2019.

B. Changes to this Notice. BIFSTL may change the terms of this Notice at any time. If BIFSTL changes this Notice, it may make the new notice terms effective for all PHI that it maintains, including any information created or received prior to issuing the new notice. If BIFSTL changes this Notice, it will post the revised notice in the waiting area of the office and on our website. You may also obtain any revised notice by contacting the Privacy Officer.

***This Form is educational only, does not constitute legal advice, and covers only federal, not state, law.***

# Brain Injury Foundation of St. Louis (BIFSTL)

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below I, _____, acknowledge that I received a copy of the Notice of Privacy Practices for Brain Injury Foundation of St. Louis (BIFSTL).

Signature of Patient: _____ Date: _____

**If this acknowledgment is signed by a personal representative (e.g., Guardian) on behalf of the patient, complete the following:**

Name of Patient: _____
Personal Representative's Name: _____
Relationship to Patient: _____
Signature: _____ Date: _____

# Brain Injury Foundation of St. Louis (BIFSTL)

## AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION IN CASE OF EMERGENCY

Patient name: _____ Date of birth: _____

**Brain Injury Foundation of St. Louis (BIFSTL) has my permission to contact the following person(s) in case of emergency:**
Name(s): _____
Address: _____
City, State, Zip: _____ Phone Number: _____

**BIFSTL will only exchange information pertinent to the emergency.**

**This authorization ends:** _____ on _____ (date); or
when the following occurs:_____

I may cancel this authorization in writing as allowed by law. This would not affect any actions already taken based upon my original request. There are three ways to cancel this authorization:

1) Sign and date a revocation form. This form is available from BIFSTL; or
2) Write, sign and date a letter to BIFSTL to cancel the authorization; or
3) Sign, date and write "CANCEL" on this original form

I understand that once BIFSTL gives out information, BIFSTL has no control over it. The recipient might re-disclose it. Privacy laws may no longer protect it.

I understand that I am agreeing to the exchange of health care information regarding receiving testing and/or treatment for psychiatric disorders, mental health, behavior, and/or drug and/or alcohol use.

_____ _____ _____
Patient or legally authorized individual signature Date Time

_____
Relationship to patient if signed on behalf of the patient by legal guardian, personal representative, etc.

# Brain Injury Foundation of St. Louis (BIFSTL)

## INTAKE INFORMATION FORM

**Instructions:** Please answer the following questions about the patient.

**Identifying Information**
Patient's name: _____ Today's date: _____
Date of birth: _____ Age: _____
Marital Status: _____ Occupation: _____

***Please list phone numbers and email addresses where we may contact you and leave a message:***
Home phone #: _____ Cell #: _____
Email address: _____
Home address & zip code: _____
_____
Person completing this form: _____

**How did you learn about this practice?**
_____
_____

I was referred by a _____
Name: _____

**Reason for seeking psychotherapy/counseling: _____**
_____
_____

**Specifics of brain injury**:

When did your brain injury occur? _____
_____

How did your brain injury occur (if known)? _____
_____

Do you remember the events that resulted in your brain injury? Yes ☐ No ☐

What is the last event you remember prior to your injury? Roughly how long before your injury did that event occur? _____

What is the first event you remember after your brain injury? Roughly how long after your injury did that event occur?

How is your life different since your brain injury?

How has your brain injury changed how you feel about yourself? Your family/friends?

**Psychological Symptoms** (please check all that apply):

☐ Depressed mood ☐ Excessive talking ☐ Unreasonable fear
☐ Lost or gained weight ☐ Racing thoughts ☐ Fear of social situations
☐ Not enough sleep ☐ Easily distracted ☐ Repetitive thoughts/behavior
☐ Too much sleep ☐ Overworking yourself ☐ Upsetting memories
☐ Sluggish ☐ Impulsive behavior ☐ Recent loss/grief
☐ Agitated ☐ See/hear things that are not real ☐ Work/school problems
☐ Never tired ☐ Suspect things may not be real ☐ Violent thoughts/behaviors
☐ Cannot concentrate ☐ Tense/unable to relax ☐ Self harm
☐ Afraid to leave home ☐ Excessive worry ☐ Anger outbursts
☐ Inflated self-esteem ☐ Panic attacks ☐ Careless, high-risk behavior
☐ Feel guilty or worthless ☐ Thoughts of death or suicide ☐ Financial problems

**Suicide Risk Assessment:**
Have you ever had feelings or thoughts that you didn't want to live? ( ) Yes ( ) No.
If YES, please answer the following. If NO, please skip to the next section.
Do you **currently** feel that you don't want to live? ( ) Yes ( ) No
How often do you have these thoughts?

When was the last time you had thoughts of dying?

Has anything happened recently to make you feel this way?

On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently?

_____

Would anything make it better?

_____

Have you ever thought about how you would kill yourself?

_____

Is the method you would use readily available?

_____

Have you planned a time for this?

_____

Is there anything that would stop you from killing yourself?

_____

Do you feel hopeless and/or worthless?

_____

Have you ever tried to kill or harm yourself before?

_____

Do you have access to guns? If yes, please explain.

_____

**Medical History:**

Allergies_____ Current Weight _____ Height _____

**List ALL current prescription medications** and how often you take them (if none, write none):

*Medication Name* *Daily Dosage* *Estimated Start Date*

_____

_____

_____

_____

_____

_____

_____

_____

Current over-the-counter medications or supplements:

_____

_____

Current medical problems:

_____

_____

Past medical problems, nonpsychiatric hospitalization, or surgeries:

_____

_____

Have you ever had an EKG? ( ) Yes ( ) No If yes, when _____

Was the EKG ( ) normal ( ) abnormal or ( ) unknown**?**

Do you have any concerns about your physical health that you would like to discuss with us? ( ) Yes ( ) No
Date and place of last physical exam: _____

**Women:** Are you currently pregnant or do you think you might be pregnant? ( ) Yes ( ) No
Are you planning to get pregnant in the future? ( ) Yes ( ) No
How many times have you been pregnant? _____ How many live births? _____

**Personal and Family Medical History:**

| | **You** | **Family** |
|---|---|---|
| Aphasia ---------- | ( ) | ( ) |
| Asthma/COPD ---------- | ( ) | ( ) |
| Cancer ---------- | ( ) | ( ) |
| Chronic Fatigue ---------- | ( ) | ( ) |
| Chronic Pain ---------- | ( ) | ( ) |
| Diabetes ---------- | ( ) | ( ) |
| Epilepsy or Seizures ---------- | ( ) | ( ) |
| Fibromyalgia ---------- | ( ) | ( ) |
| Gastrointestinal Condition ---------- | ( ) | ( ) |
| Head Trauma ---------- | ( ) | ( ) |
| Heart Disease ---------- | ( ) | ( ) |
| High blood pressure---------- | ( ) | ( ) |
| High Cholesterol ---------- | ( ) | ( ) |
| Kidney Disease ---------- | ( ) | ( ) |
| Liver Disease ---------- | ( ) | ( ) |
| Stroke---------- | ( ) | ( ) |
| Other ---------- | ( ) | ( ) |

Is there any additional personal or family medical history? ( ) Yes ( ) No If yes, please explain:
_____
_____
When your mother was pregnant with you, were there any complications during the pregnancy or birth? _____
_____

**Past Psychiatric History:**
**Outpatient treatment** ( ) Yes ( ) No If yes, please describe:

| *Reason* | *Dates Treated* | *by Whom* |
|---|---|---|
| | | |
| | | |
| | | |

**Psychiatric Hospitalization** ( ) Yes ( ) No If yes, please describe:

| *Reason* | *Date Hospitalized* | *Where* |
|---|---|---|
| | | |
| | | |
| | | |

**Past Psychiatric Medications:** If you have ever taken any of the following medications, please indicate the dates, dosage, and how helpful they were. If you can't remember all the details, just write in what you do remember.

**Antidepressants**
Anafranil (clomipramine) _____
Celexa (citalopram) _____
Cymbalta (duloxetine) _____
Effexor (venlafaxine) _____
Elavil (amitriptyline) _____
Lexapro (escitalopram) _____
Luvox (fluvoxamine) _____
Pamelor (nortriptyline) _____
Paxil (paroxetine) _____
Prozac (fluoxetine) _____
Remeron (mirtazapine) _____
Serzone (nefazodone) _____
Tofranil (imipramine)_____
Wellbutrin (bupropion) _____
Zoloft (sertraline) _____

Other _____

**Mood Stabilizers**
Depakote (valproate) _____
Lamictal (lamotrigine) _____
Lithium_____
Tegretol (carbamazepine)_____
Topamax (topiramate) _____
Other _____

**Antipsychotics/Mood Stabilizers**
Abilify (aripiprazole) _____
Clozaril (clozapine) _____
Geodon (ziprasidone) _____
Haldol (haloperidol) _____
Prolixin (fluphenazine) _____
Risperdal (risperidone) _____
Seroquel (quetiapine) _____
Zyprexa (olanzapine) _____
Other _____

**Sedative/Hypnotics**
Ambien (zolpidem) _____
Desyrel (trazodone) _____
Restoril (temazepam) _____

Rozerem (ramelteon)_____
Sonata (zaleplon) _____
Other _____

**ADHD medications**
Adderall (amphetamine) _____
Concerta (methylphenidate) _____
Ritalin (methylphenidate) _____
Strattera (atomoxetine) _____
Other _____

**Antianxiety medications**
Ativan (lorazepam) _____
Buspar (buspirone) _____
Klonopin (clonazepam) _____
Tranxene (clorazepate) _____
Valium (diazepam) _____
Xanax (alprazolam) _____
Other _____

**Your Exercise Level:**
Do you exercise regularly? ( ) Yes ( ) No
How many days a week do you get exercise?

_____
How much time each day do you exercise?

_____
What kind of exercise do you do?

_____

**Family Psychiatric History:**
Has anyone in your family been diagnosed with or treated for:

| | |
|---|---|
| Anxiety ( ) Yes ( ) No | Alcohol abuse ( ) Yes ( ) No |
| Anger ( ) Yes ( ) No | Bipolar disorder ( ) Yes ( ) No |
| Depression ( ) Yes ( ) No | Other substance abuse ( ) Yes ( ) No |
| Post-traumatic stress ( ) Yes ( ) No | Schizophrenia ( ) Yes ( ) No |
| Suicide ( ) Yes ( ) No | Violence ( ) Yes ( ) No |

If yes, who had each problem?

_____
_____

Has any family member been treated with a psychiatric medication? ( ) Yes ( ) No If yes, who was treated, what medications did they take, and how effective was the treatment?

_____
_____

**Substance Use:**
Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No
If yes, for which substances?

_____
If yes, where were you treated and when?

_____

_____
How many days per week do you drink any alcohol? _____
What is the least number of drinks you will drink in a day? _____
What is the greatest number of drinks you will drink in a day? _____
In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? _____
Have you ever felt you ought to cut down on your drinking or drug use? ( ) Yes ( ) No
Have people annoyed you by criticizing your drinking or drug use? ( ) Yes ( ) No
Have you ever felt bad or guilty about your drinking or drug use? ( ) Yes ( ) No
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ( ) Yes ( ) No
Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No
Have you used any street drugs in the past 3 months? ( ) Yes ( ) No
If yes, which ones?

_____
Have you ever abused prescription medication? ( ) Yes ( ) No
If yes, which ones and for how long?

_____

_____

**Check if you have ever tried the following:**
If yes, how long and when did you last use?
Alcohol ( ) _____
Cocaine ( ) _____
Ecstasy ( ) _____
Heroin ( ) _____
LSD / Hallucinogens ( ) _____
Marijuana ( ) _____
Methamphetamine ( ) _____
Methadone ( ) _____
Pain killers (not as prescribed) ( ) _____
Stimulants (pills) ( ) _____
Tranquilizer/sleeping pills ( ) _____
Other _____

**How many caffeinated beverages do you drink a day?** Coffee ____ Soda _____ Tea _____

**Tobacco History:**
Have you ever smoked cigarettes? ( ) Yes ( ) No
Currently? **( )** Yes **( )** No How many packs per day on average? ____ How many years? _____

In the past? **( )** Yes **( )** No How many years did you smoke? ____ When did you quit? _____
**Pipe, cigars, or chewing tobacco**: Currently? **( )** Yes **( )** No In the past? **( )** Yes **( )** No
What kind? _____ How often per day on average? _____ How many years? _____

**Family Background and Childhood History:**
Were you adopted? ( ) Yes ( ) No Where did you grow up? _____
List your siblings and their ages: _____
_____
What is/was your father's occupation?
_____
What is/was your mother's occupation?
_____
Did your parents divorce? ( ) Yes ( ) No If so, how old were you when they divorced? _____
If your parents divorced, who did you live with?_____
Describe your father and your relationship with him: _____
_____
_____
Describe your mother and your relationship with her: _____
_____
_____
How old were you when you left home? _____
Has anyone in your immediate family died? ( ) Yes ( ) No
If Yes, who and when? _____

**Trauma History:**
Have you been abused emotionally, sexually, physically or by neglect? ( ) Yes ( ) No.
Please describe when, where and by whom: _____
_____

**Educational History:**
What is your highest educational level or degree/s attained? Where? Major/s?
_____
_____

**Occupational History:**
Are you currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired?
How long in present position? _____
What is/was your occupation? _____
Where do you work? _____
Have you ever served in the military? _____ If so, what branch and when? _____
Honorable discharge ( ) Yes ( ) No ( ) Other type discharge

**Relationship History and Current Family:**
Are you currently: ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( )Widowed?
How long? _____
If not married, are you currently in a relationship? ( ) Yes ( ) No If yes, how long? _____

Are you sexually active? ( ) Yes ( ) No
How would you identify your sexual orientation?
( ) straight/heterosexual ( ) lesbian/gay/homosexual ( ) bisexual ( ) transsexual
( ) unsure/questioning ( ) asexual ( ) other ( ) prefer not to answer
What is your spouse or significant other's occupation?

_____

Describe your relationship with your spouse or significant other:

_____

Have you had any prior marriages? ( ) Yes ( ) No. If so, how many? _____
How long? _____
Do you have children? ( ) Yes ( ) No If yes, list ages and gender: _____

_____

Describe your relationship with your children:

_____

List everyone who currently lives with you:

_____

_____

**Legal History:**
Have you ever been arrested? _____
Do you have any pending legal problems? _____

**Spiritual Life:**
Do you belong to a religious or spiritual group? ( ) Yes ( ) No
If yes, what is the level of your involvement? _____
Do you find your involvement helpful during this illness, or does the involvement make things more difficult or stressful for you? ( ) more helpful ( ) stressful

**Other Current Concerns:**_____

_____

_____

_____

_____

_____

_____

_____

**Is there anything else that you would like us to know?**

_____

_____

_____

_____

_____

_____

_____