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**Basic Information:**

Client's Name: _____ Age: _____ DOB: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: _____ Email: _____

Name of Guardian(s): _____

Address (if different from client): _____

Emergency Contact Name: _____

Emergency Contact Number: _____

**Insurance Information:**

| | Primary Insurance Company | Secondary Insurance Company |
|---|---|---|
| Insurance Company Name | | |
| Member ID # | | |
| Group Number | | |
| Policy Holder | | |
| Policy Holder's DOB | | |
| Relationship to Client | | |
| Employer | | |

Reasons for seeking counseling: _____

_____

What outcomes are you hoping for? _____

_____

**Current Symptom Checklist** - Please mark which symptoms are *currently* troublesome to you.

| **Symptom** | ✔ | **Symptom** | ✔ | **Symptom** | ✔ |
|---|---|---|---|---|---|
| Hopeless | | Shy | | Self-injurious behavior | |
| Helpless | | Racing thoughts | | Suicidal thoughts | |
| Worthless | | Memory problems | | Homicidal thoughts | |
| Feeling tense | | Temper tantrums | | Hallucinations | |

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| | | | | | |
|---|---|---|---|---|---|
| Depressed | | Rage | | Suspiciousness | |
| Always on the go | | Verbal aggression | | Excessive energy | |
| School/work problem | | Physical aggression | | Poor appetite | |
| Impulsivity | | Stubbornness | | Overeating | |
| Hyperactivity | | Fatigue | | Nightmares | |
| Attention problems | | Overly ambitious | | Alcohol/drug problems | |
| Behavior problems | | Unable to relax | | Change in libido | |
| Vocal or motor tics | | Can't make decisions | | Stomach trouble | |
| Sleep problems | | Communication problems | | Increased risky behaviors | |
| Legal trouble | | Problems at home | | Crying spells | |
| Headaches | | Heart palpitations | | Excessive worry | |
| Feeling lonely | | Unable to enjoy activities | | Feeling panicky | |
| Frequent/chronic illness/pain | | Loss of interest | | Tremors | |
| Repetitive thought | | Excessive guilt | | Avoidance | |
| Repetitive behavior | | Increased irritability | | Dizziness | |
| Feeling inferior | | Fainting spells | | | |

**Demographic Information**

❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American
❑ Native Hawaiian or Pacific Islander ❑ Hispanic or Latino ❑ White or Caucasian

**Gender**

❑ Male ❑ Female ❑ Nonbinary

**Sexual Orientation:**

❑ Straight/Heterosexual ❑ Gay/Lesbian/Queer ❑ Bisexual ❑ Pansexual ❑ Questioning

**Are you currently:**

❑ Married ❑ Partnered ❑ Divorced ❑ Single ❑ Widowed

Length of current relationship: _____

Briefly describe your relationship with your significant other: _____

_____

Sexually active: ❑ Yes ❑ No

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Number of prior marriages: _____ Number of children: _____

List age and gender of children: _____

_____

Briefly describe your relationship with your children: _____

_____

List everyone who currently lives with you: _____

_____

**Family Background:**

Birth City: _____ Birth Weight: _____ Were you adopted? ❑ No ❑ Yes Age adopted: ___

Parent Names: Mother: _____ Father: _____

Parents' Marital Status: _____

Briefly describe your relationship with your parents: _____

_____

Siblings' Name and Ages: _____

_____

**Have any family members been diagnosed with or treated for mental health concerns?**

Parents: ❑ No ❑ Yes Diagnoses: _____

Grandparents: ❑ No ❑ Yes Diagnoses: _____

Siblings: ❑ No ❑ Yes Diagnoses: _____

Children: ❑ No ❑ Yes Diagnoses: _____

**Developmental History:**

**Prenatal and Birth History:**

Prenatal stress or injury: ❑ No ❑ Yes Details: _____

Prenatal drug/alcohol exposure: ❑ No ❑ Yes Details: _____

Birth trauma (forceps, breech, etc.): ❑ No ❑ Yes Details: _____

Anesthesia, pain medications: ❑ No ❑ Yes Details: _____

Anoxia (oxygen deprivation): ❑ No ❑ Yes Details: _____

Premature/late delivery: ❑ No ❑ Yes Details: _____

Medical problems after birth: ❑ No ❑ Yes Details: _____

Other complications not listed: ❑ No ❑ Yes Details: _____

**Growth and Development:**

Activity level: ❑ Typical ❑ More ❑ Less Details: _____

Motor/coordination development: ❑ Typical ❑ More ❑ Less Details: _____

Infections/allergies: ❑ Typical ❑ More ❑ Less Details: _____

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**Growth and Development (continued):**

Emotional development: ❑ Typical ❑ More ❑ Less Details: _____

Behavioral concerns: ❑ Typical ❑ More ❑ Less Details: _____

Handedness development: ❑ Typical ❑ More ❑ Less Details: _____

Appetite/digestion: ❑ Typical ❑ More ❑ Less Details: _____

Language/speech development ❑ Typical ❑ More ❑ Less Details: _____

Met developmental milestones on time? ❑ Yes ❑ No If no, please explain: _____

_____

**Educational/Occupational History:**

Are you (please choose one): ❑ Employed ❑ Unemployed ❑ Student ❑ Disabled ❑ Retired

Client's Employer: _____

Address: _____

Phone: _____ Occupation: _____ Time in position: _____

**Educational/Occupational History (continued):**

Client's School: _____ Grade: _____

Client has: ❑ IEP ❑ 504 ❑ Neither ❑ Details: _____

_____

Highest education level or degree obtained: _____

Have you ever served in the military? ❑ No ❑ Yes ❑ Branch/dates: _____

Discharged: ❑ No ❑ Yes ❑ Honorable ❑ Medical ❑ Other: _____

**Social and Environmental Activities:**

Spiritual/Religious Practices: ❑ No ❑ Yes Details: _____

Groups or Clubs: ❑ No ❑ Yes Details: _____

Volunteering: ❑ No ❑ Yes Details: _____

Other: ❑ No ❑ Yes Details: _____

**Current and past legal history, including arrests:** _____

_____

_____

_____

**Abuse and Neglect:**

Emotional Abuse: ❑ No ❑ Yes, past ❑ Yes, current Details (when/whom): _____

Physical Abuse: ❑ No ❑ Yes, past ❑ Yes, current Details (when/whom): _____

Sexual Abuse: ❑ No ❑ Yes, past ❑ Yes, current Details (when/whom): _____

Neglect: ❑ No ❑ Yes, past ❑ Yes, current Details (when/whom): _____

**Medical History:**

Current height: _____ Current weight: _____ Allergies: _____

_____

List all current medical conditions: _____

_____

Last dates you were seen by:

Primary doctor: _____ Dentist: _____ Eye exam: _____

Have you ever had an EKG? ❑ No ❑ Yes, date: _____ ❑ Normal ❑ Abnormal ❑ Unknown

How many times per week do you exercise? _____

What kind of exercise do you enjoy? _____

How long do you exercise each time? _____

**If Applicable:** Date of last menstrual period: _____ Are you pregnant? ❑ Yes ❑ No

Do you think you might be pregnant? ❑ Yes ❑ No

Are you planning to become pregnant? ❑ Yes ❑ No Timeframe: _____

Birth control method(s): _____

List all current prescription and over-the-counter medications and how often you take them: _____

_____

_____

**Physical Conditions:**

| | | | |
|---|---|---|---|
| Loss of consciousness: | ❑ No | ❑ Yes | Details: _____ |
| Coma: | ❑ No | ❑ Yes | Details: _____ |
| Accidents: | ❑ No | ❑ Yes | Details: _____ |
| High fever: | ❑ No | ❑ Yes | Details: _____ |
| Serious illness: | ❑ No | ❑ Yes | Details: _____ |
| Surgeries: | ❑ No | ❑ Yes | Details: _____ |
| Stroke: | ❑ No | ❑ Yes | Details: _____ |

**Physical Conditions (continued):**

| | | | |
|---|---|---|---|
| Central nervous system infection: | ❑ No | ❑ Yes | Details: _____ |
| Drug overdose/poisoning: | ❑ No | ❑ Yes | Details: _____ |
| Disordered eating (binge/purge/restrict): | ❑ No | ❑ Yes | Details: _____ |

**Mental Health:**

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**Outpatient Psychiatric Treatment:**

Reason: _____ Dates: _____ By Whom: _____

Reason: _____ Dates: _____ By Whom: _____

Reason: _____ Dates: _____ By Whom: _____

**Psychiatric Hospitalization:**

Reason: _____ Dates: _____ Where: _____

Reason: _____ Dates: _____ Where: _____

Reason: _____ Dates: _____ Where: _____

**Current and Past Psychiatric Medications**

| Medication Name | Dates | Response | Medication Name | Dates | Response |
|---|---|---|---|---|---|
| **Antidepressants** | | | | | |
| Prozac (fluoxetine) | | | Cymbalta (duloxetine) | | |
| Zoloft (sertraline) | | | Wellbutrin (bupropion) | | |
| Luvox (fluvoxamine) | | | Remeron (mirtazapine) | | |
| Paxil (paroxetine) | | | Elavil (amitriptyline) | | |
| Celexa (citalopram) | | | Anafranil (clomipramine) | | |
| Lexapro (escitalopram) | | | Pamelor (nortriptyline) | | |
| Effexor (venlafaxine) | | | Tofranil (imipramine) | | |
| **Antianxiety Medications** | | | | | |
| Xanax (alprazolam) | | | Klonopin (clonazepam) | | |
| Ativan (lorazepam) | | | Valium (diazepam) | | |
| Buspar (buspirone) | | | Tranxene (clorazepate) | | |
| **Sedative/Hypnotics** | | | | | |
| Ambien (zolpidem) | | | Restoril (temazepam) | | |

| | | | | | |
|---|---|---|---|---|---|
| Sonata (zaleplon) | | | Desyrel (trazodone) | | |
| Rozerem (ramelteon) | | | Other: | | |
| **ADHD Medications** | | | | | |
| Adderall (amphetamine) | | | Ritalin (methylphenidate) | | |
| Concerta (methylphenidate) | | | Strattera (atomoxetine) | | |
| **Mood Stabilizer/Antipsychotics** | | | | | |
| Tegretol (carbamazepine) | | | Geodon (ziprasidone) | | |
| Lithium | | | Abilify (aripiprazole) | | |
| Depakote (valproate) | | | Clozaril (clozapine) | | |
| Lamictal (lamotrigine) | | | Haldol (haloperidol) | | |
| Topamax (topiramate) | | | Zyprexa (olanzapine) | | |
| Seroquel (quetiapine) | | | Risperdal (risperidone) | | |

**Suicide Risk Assessment:**

| | **Yes** | **No** | **Details** |
|---|---|---|---|
| Have you ever had feelings or thoughts that you didn't want to live? 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? | | | |
| 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 (10 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. | | | |

**Substance Use:**

| | | | |
|---|---|---|---|
| How many **caffeinated** beverages do you drink per day? | _____ Sodas | _____ Coffee | _____ Tea |

| **Tobacco History** | **Yes** | **No** |
|---|---|---|
| Have you ever smoked cigarettes? | | |
| **Tobacco History (continued)** | **Yes** | **No** |
| Do you currently smoke cigarettes? | If yes, how many packs per day? | |
| Have you used pipes, cigars, or chewing tobacco in the past? | If yes, how long?<br>When did you quit? | |
| Do you currently use pipes, cigars, vape, or chewing tobacco? | If yes, how often per day? | |
| Is there a family history of tobacco use? | If yes, list who: | |
| Do you reside with others who smoke? | | |
| Does this affect you or your treatment? | | |

| **Please check if you have ever tried the following:** | **Yes** | **No** | **First Use** | **Last Use** | **Highest Amount** |
|---|---|---|---|---|---|
| Methamphetamine | | | | | |
| Cocaine | | | | | |
| Stimulants (pills) | | | | | |
| Heroin | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| LSD or Hallucinogens | | | | | |
| Marijuana/Cannabis | | | | | |
| Pain Killers (not as prescribed) | | | | | |
| Methadone | | | | | |
| Tranquilizer/sleeping pills | | | | | |
| Alcohol | | | | | |
| Ecstasy | | | | | |
| Other: | | | | | |

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**The Holmes-Rahe Scale:** Read each of the events listed below and check the box next to any event which has occurred in your life in the last two (2) years. There are no right or wrong answers. The aim is to identify which of these events you have experienced lately.

| Life Events | Life Crisis Units | ✔ | Life Events | Life Crisis Units | ✔ |
|---|---|---|---|---|---|
| Death of spouse | 100 | | Son or daughter leaving home | 29 | |
| Divorce | 73 | | Trouble with in-laws | 29 | |
| Marital separation | 65 | | Outstanding personal achievement | 28 | |
| Gone to jail | 63 | | Spouse begins or stops work | 26 | |
| Death of close family member | 63 | | Begin or end school | 26 | |
| Personal injury or illness | 53 | | Change in living conditions | 25 | |
| Marriage | 50 | | Revision in personal habits | 24 | |
| Fired at work | 47 | | Trouble with boss | 23 | |
| Marital reconciliation | 45 | | Change in work hours or conditions | 20 | |
| Retirement | 45 | | Change in residence | 20 | |
| Change in health of family member | 44 | | Change in schools | 20 | |
| Pregnancy | 40 | | Change in recreation | 19 | |
| Sexual difficulties | 39 | | Change in church activities | 19 | |
| Gain of new family member | 39 | | Change in social activities | 18 | |
| Business readjustment | 39 | | Mortgage or loan less than $30,000 | 17 | |
| Change in financial state | 38 | | Change in sleeping habits | 16 | |
| Death of close friend | 37 | | Change in number of family get-togethers | 15 | |
| Change to different line of work | 36 | | Change in eating habits | 15 | |
| Increase in arguments with spouse | 35 | | Vacation | 13 | |
| Mortgage over $100,000 | 31 | | Christmas alone | 12 | |
| Foreclosure of mortgage or loan | 30 | | Minor violations of the law | 11 | |
| Change in responsibilities at work | 29 | | TOTAL SCORE: | | |

Signature: _____ Date: _____

Guardian Signature (if under age 19): _____ Date: _____

Reviewed by: _____ Date: _____

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## Welcome to Focus C3, PC

Focus C3 is committed to the professional delivery of essential human service skills to provide the maximum potential to individuals, teams, and organizations in their accomplishment of personal, professional, and organizational goals. These services include but are not limited to medication management, counseling, coaching, and consulting. Helping individuals, teams, and organizations to be able to move forward is the singular focus of Focus C3.

**INFORMED CONSENT:** I, _____ (client, parent/guardian) authorize Focus C3, PC and its practitioners to provide _____ (client) with services, including but not limited to counseling, coaching, or consulting. I understand that these services may include individual, marital, family, or group therapy, as well as psychological, psychiatric or chemical dependency testing, parent education, coaching, or consulting. Treatment is not limited to these services and may include other services that may be considered appropriate or necessary for my individual service plan. I have the right to an explanation as to the nature and purpose of the services I receive and have my questions about these services answered at any time. I have the right to withdraw this consent to treatment at any time, either verbally or in writing. I understand that my service provider may want to discuss this with me, but that I reserve the right to stop services.

The remainder of this document is intended to inform you of our policies, State and Federal Laws, and your rights. If you have other questions or concerns, please ask and we will try our best to give you all the information you need.

**APPOINTMENTS**: Clients meet with our providers by appointment only. If you need to cancel an appointment, please give us 24 hours' notice. Please see below for cancellation policy.

**APPOINTMENT REMINDERS AND COMMUNICATION:** Our office may need to communicate with you outside of your regularly scheduled appointment. Please let us know how you would like for us to communicate with you. You have the right to request how our office communicates with you.

I would like to receive appointment reminders by:
___ Phone (__ Messages) left at: _____
___ Email at: _____
___ Text to: _____

I would like all other communication to be by
___ Phone (__ Messages) left at: _____
___ Email at: _____
___ Text to: _____

**FINANCIAL/INSURANCE ISSUES:** As a courtesy, we will bill your insurance company, HMO, responsible party, or third-party payer for you if you wish. We ask that at each session, you pay your copayment or coinsurance amount. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover your service, we ask that you pay the balance due at that time of service. If your balance exceeds $200.00 we will need to ask that you pay for services when rendered. If an account is overdue and turned over to our collection agency, the client or responsible party will be held responsible for any collection fee charged to our office to collect the debt owed. You may put a credit

card on file to pay for charges not covered by your insurance. Following this meeting, we ask you to notify us immediately as to any change in your health insurance, place of employment, home address, or other information pertinent to our records. (Failure to do this may result in our no longer being able to process insurance claims for you and you would be held responsible for full payment of each session not covered by your insurance). The financial responsibility for your treatment is ultimately yours.

_____ (Initial) I am requesting that a claim for services be filed with my insurance, HMO, responsible party, or third-party payer on my behalf and that any authorized payments be submitted directly to Focus C3, PC or appropriate parties.

_____ (Initial) I acknowledge that I, the client or responsible party, are liable for any amounts for service not covered by a third-party payer including, but not limited to copay, coinsurance, or deductibles in accordance with the agreements arranged by my third-party payer.

**POLICY ON NON-COVERED SERVICES:** In order to offer you consistent quality care and to coordinate this care with other providers or organizations, we may need to charge for services that are not typically covered or reimbursed by your insurance company. A list of these services is provided below. When we provide these services, we will bill you directly. These services are billed at the standard hourly rate for your provider. If you have any questions regarding this policy, please ask our staff. The following are a list of some of the services not covered by insurance companies. These services are billed at the standard hourly rate:

- Court ordered and legal related services
- Preparing reports or letters for other providers or organizations
- Completing documents (for disability claims, insurance reviews, workers' compensation, etc.)
- Consultations by telephone or email
- Duplication of your medical records
- Evaluating, testing, or treatment services not covered by your insurance

We sincerely appreciate your cooperation and if you have questions regarding insurance, fees, balances, or payments, please feel free to ask one of the staff.

**MISSED APPOINTMENT CANCELLATION POLICY:** We consider it an honor and privilege to be of service and hope for a mutually satisfying relationship. We do understand there may be extenuating circumstances; however, we request that any cancellation or rescheduling of your appointment be made at least 24 hours in advance. We value your time and hope that you value yours. Missed appointments or appointments canceled less than 24 hours in advance affect us all and prevent us from being able to serve others in need. Because of this, we have created a cancellation and missed appointment policy outlined here:

You may be charged a $100.00 fee for missed appointments or appointments not canceled at least 24 hours in advance of the scheduled visit. We provide reminder calls before your appointment as a courtesy. You are still responsible for remembering your scheduled appointment. Stating that you did not receive a reminder call or that

the call was made after the 24-hour deadline does not make your missed or canceled appointment an exception. Furthermore, we have a 3-late cancel/no show policy. If you are late, cancel, or no show for 3 appointments, we reserve the right not to reschedule you. We appreciate your consideration of our time and will express the same consideration for yours. We realize there may be emergency situations where a 24-hour cancellation notice is not possible, and those situations will be dealt with individually. Questions? Please ask your therapist.

**NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS:** I/We have been offered a copy of the 'Notice of Privacy Practices' and the 'Client Rights' document to read.

Initials _____ Date _____

**CONFIDENTIALITY AND EMERGENCY SITUATIONS:** Your verbal communication and clinical records are strictly confidential except for the following situations: a) information (diagnosis and date of service) shared with your insurance company to process your claims; b) information you and/or your child or children report about physical, sexual, or elder abuse; then, by Nebraska State Law, this information must be reported to the Department of Children and Family Services; c) where you sign a release of information to have specific information shared; d) if you provide information that you are in danger of harming yourself or others; or e) when required by law. In an emergency for which you feel immediate attention is necessary, please call 9-1-1 or go to the closest hospital.

**RISK OF NON-COMPLIANCE:** It is important that you follow through with the recommendations of the treatment provider. If you choose to stop treatment or not follow the recommendations of treatment, Focus C3 and their contractors are not held responsible. If you disengage in treatment and have not shown or spoken to your provider within three days of the last appointment, then you will be automatically discharged from services. If there are barriers to treatment, please speak with your provider of Focus C3 management to address those barriers.

**PROFESSIONAL REFERRALS:** Our providers can make referrals to other providers including but not limited to psychiatrists and/or psychologists as appropriate.

**COORDINATION OF TREATMENT:** It is important that all healthcare providers work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for six months. Please understand that you have the right to revoke this authorization, in writing, at any time by sending notice. If you prefer to decline consent, no information will be shared. If other providers, case managers, etc. need to be communicated with, you will be provided a release of information form to be completed for each additional person.

____You may communicate with my physician ___ I decline to allow communication with my physician

Name of Physician: _____ Location: _____

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Phone Number: _____ Fax Number: _____

**Prescription Refill Policy**

Focus C3's nurse practitioners participate with electronic prescribing directly to your mail order and local pharmacies. Our goal is to assist our patients with prescription requests in an efficient and timely manner. Due to the volume of prescription requests, we have created the following guidelines to help meet these goals.

1. It is the patient's responsibility to notify the office in a timely manner when refills are necessary. Approval of your refill may take up to three (3) business days, so do not wait to call. If you use a mail order pharmacy, please contact us fourteen (14) days before your medication is due to run out.
2. Medication refills will only be addressed during regular office hours (Monday – Friday (8:00am – 5:00pm). Please notify your provider on the next business day if you find yourself out of medication after hours. No prescriptions will be refilled on Saturday, Sunday or Holidays.
3. Prescription refills require close monitoring by your provider to ensure its safety and effectiveness. Your provider will prescribe the appropriate number of prescription refills to last until your next scheduled appointment. Generally, when you are down to zero refills, it is time to schedule a follow up appointment.
4. Patients requesting new prescriptions must be seen for an appointment. They are not prescribed over the phone because it generally requires an office visit.
5. Refills can only be authorized on medication prescribed by providers from our office. We will not refill medications prescribed by other providers.
6. Some medications require prior authorization. Depending on your insurance, this process may involve several steps by both your pharmacy and your provider. The providers and pharmacies are familiar with this process and will handle the prior authorization as quickly as possible. Neither the pharmacy nor the provider can guarantee that your insurance company will approve the medication. Please check with your pharmacy or your insurance company for updates.
7. It is important to keep your scheduled appointment to ensure that you receive timely refills. Repeated no shows or cancellations will result in a denial of refills.
8. If you have any questions regarding medications, please discuss these during your appointment. If for any reason you feel your medication needs to be adjusted or changed, please contact us immediately to schedule an appointment.

By signing this form, I acknowledge that I have read and that I understand this consent.

Client Name: _____ Client Signature: _____ Date: _____

If a client is under 19 years of age, the Parent/Legal Guardian must complete the information below.

Parent/Legal Guardian's Signature: _____ Date: _____

Relationship to Client: _____

Staff/Provider's Signature:_____ Date: _____