CLIENT INFORMATION

Client Name:_____

Date Of Birth:_____ **Today's Date:**_____

Full Address:_____

_____ Employer:_____

_____ Occupation:_____

E-Mail Address:_____ School/Grade (if minor):_____

House Phone:_____ Marital Status:

Cell Phone:_____ ☐ Married ☐ Single ☐ Divorced

Work Phone:_____ ☐ Widowed ☐ Partnered

Parent/Guardian Name (if client is a minor): Emergency Contact Name:_____

_____ Relationship to Client:_____

Phone (if different than above): Phone:_____

_____ Referred By:_____

Phone:_____

WHO LIVES IN YOUR HOUSEHOLD?

Name:_____ Age:_____

Relationship: ☐ Child ☐ Spouse/partner ☐ Sibling ☐ Relative ☐ Other _____

Name:_____ Age:_____

Relationship: ☐ Child ☐ Spouse/partner ☐ Sibling ☐ Relative ☐ Other _____

Name:_____ Age:_____

Relationship: ☐ Child ☐ Spouse/partner ☐ Sibling ☐ Relative ☐ Other _____

Name:_____ Age:_____

Relationship: ☐ Child ☐ Spouse/partner ☐ Sibling ☐ Relative ☐ Other _____

The Mindful Heart LLC
www.TheMindfulHeartLLC.com
4405 East West Highway, Suite 513 Bethesda, MD 20814
10000 Colesville Road Silver Spring, MD 20901

the mindfulheart
happiness ♥ healing ♥ hope

CURRENT SITUATION

Why are you seeking counseling now?_____

Describe the problem:_____

When did it start?_____Who is involved and/or affected by the problem?_____

Have you had previous psychotherapy or counseling? ☐ Yes ☐ No If yes, when?_____

With whom?_____ How long was treatment?_____

Are you currently being prescribed psychiatric medication? ☐ Yes ☐ No

If yes: What type of medication:_____

Who is the prescribing professional?_____

Have you experienced any MAJOR life changes in the past year (i.e. death, move, job change, relationship stress?) ☐ Yes ☐ No

What was the change?_____

_____

MEDICAL HISTORY

Name of Physician_____Date of Last Physical:_____

Address:_____ Phone:_____

Current Medications:_____ Allergies:_____

Medical Conditions/Illnesses:_____ May I contact? ☐ Yes ☐ No

How would you describe your health: ☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Excellent

Are you having problems with your sleep? ☐ Yes ☐ No

If yes: ☐ Sleeping too much ☐ Sleeping too little ☐ Poor sleep quality

How many times per week do you exercise?_____ What type of exercise?_____

Any difficulty with appetite or eating habits? ☐ Yes ☐ No

If yes: ☐ Eating Less ☐ Eating More ☐ Binging ☐ Restricting

Any significant weight change in the last 2 months? ☐ Yes ☐ No If yes, ☐ Gaining ☐ Losing

Do you use alcohol and/or drugs? ☐ Yes ☐ No Are you concerned about your drug/alcohol use? ☐ Yes ☐ No

Have you (or your child) had any suicidal thoughts recently? ☐ Never ☐ Rarely ☐ Sometimes ☐ Frequently

Have you (or your child) had any suicidal thoughts in the past? ☐Never ☐Rarely ☐Sometimes ☐ Frequently

When?_____

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INDIVIDUAL PROBLEM CHECKLIST

Directions: Read through the list of symptoms below. Then, rate the ones you are experiencing on a scale from one to three in the blank next to each symptom. (1=mild, 2=moderate, 3=severe)

Emotional Concerns

Symptom	Rating	Symptom	Rating
Feeling anxious or upset		Feeling unreal, strange, or foggy	
Excessive worrying		Feeling unmotivated	
Not being able to relax		Loss of interest in many things	
Feeling panicky		Having trouble concentrating	
Unable to calm yourself down		Having trouble making decisions	
Dwelling on certain thoughts or images		Feeling the future looks hopeless	
Fearing something terrible is about to happen		Feeling worthless or like a failure	
Avoiding certain thoughts or feelings		Dissatisfied with physical appearance	
Having strong fears		Feeling self-critical or blaming yourself	
Worrying about a nervous breakdown		Having negative thoughts	
Feeling out of control		Crying often	
Fears of being alone or abandoned		Feeling empty	
Feeling guilty		Withdrawing inside yourself	
Having nightmares		Thinking too much about death	
Flashbacks		Thoughts of hurting yourself	
Troubling or painful memories		Thoughts of killing yourself	
Missing periods of time-can't remember		Frequent mood swings	
Trouble remembering things		Feeling resentful or angry	
Feeling numb instead of upset		Feeling irritable or frustrated	
Feeling detached from all or part of your body		Feeling rage	
Having obsessive/ruminating thoughts		Feeling like hurting someone	
		Being unhappy all of the time	

Behavioral and Physical Concerns

Symptom	Rating	Symptom	Rating
Not having an appetite		Trouble falling asleep	
Having obsessive behaviors such as: hand-washing, checking, counting, etc.		Early morning awakening	
Eating in binges		Sleeping too much (Hours per night?)	
Self-induced vomiting for weight control		Sleeping too little (Hours per night?)	

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Using laxatives for weight control		Aggressive toward others	
Eating too much		Impulsive reactions	
Eating too little		Working too hard	
Losing weight----How much?		Using alcohol too much	
Gaining weight----How much?		Being alcoholic	
Avoiding being with people		Using drugs	
Being tired and lacking energy		Driving under the influence	
Excessive exercise		Black outs after drinking	
Trouble finishing things		Lack of exercise	
Cutting or harming self		Not having leisure activities	
Trouble sleeping		Smoking cigarettes	
		Often spending money in binges	

- 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

Intimate Relationship Concerns

Symptom	Rating	Symptom	Rating
Feeling misunderstood in relationship		Frequent arguments	
Not feeling close to partner		Trouble resolving conflict	
Trouble communicating with partner		Partner being demanding and controlling	
Not trusting partner		Partner putting you down	
Lack of respect by partner		Violent arguments	
Partner being secretive		Emotional abuse in relationship	
Lack of fairness in relationship		Physical abuse in relationship	
Problem dividing household tasks		Sexual abuse in relationship	
Disagreeing about children		Partner having alcohol or drug problem	
Lack of affection		Self or partner having an affair	
Unsatisfactory sexual relationship		Feeling uncommitted to relationship	
Lack of time together		Wanting to separate	
Lack of shared interests		Discussing separating or divorce	
Lack of positive interaction		Problems with in-laws	
Lack of time with other couples		Problems with ex-partner	

Sexual Concerns

Symptom	Rating	Symptom	Rating

Worrying about getting pregnant		Feeling a lack of sexual desire	
Having miscarriages		Wanting to have sex more often	
Not able to become pregnant		Feeling neglected sexually	
Not enjoying sexual affection		Feeling used sexually	
Too tired to have sex		Feeling unable to have orgasm	
Too anxious to have sex		Being unable to sustain an erection	
		Feeling negatively about sex	

When Growing up to Present Time

Symptom	Rating	Symptom	Rating
Being physically abused-by whom?		Close family member dying-who? Your age at time of death?	
Being emotionally abused-by whom?		Felt neglected or unloved-by whom?	
Being sexually abused-by whom?		Having an unhappy childhood	
Having an alcoholic parent-which?		Having serious medical problems-what?	
Having a drug-abusing parent-which?		Having drug or alcohol problem	
Having a depressed parent-which?		Frequent moves	
Having a parent with emotional problems-which?		Having learning problems-what?	
Having parents separate or divorce and your age at time of divorce?		Having emotional problems	
		Having attempted suicide-when? At what age?	

Stress During the Past Several Years

Symptom	Rating	Symptom	Rating
Death of family member or friend-who?		Important relationship ending-who?	
Birth or adoption of child		Losing or changing job	
Self or family member hospitalized-who?		Financial trouble	
Moved/changed address		Legal problems	
Being harassed or assaulted		Natural disaster	
Frequent family or couple arguments		Serious or chronic illness-what?	
Separation/divorce		Other	

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STATEMENT OF POLICIES FOR CLIENTS AND CLIENTS' GUARDIANS

Thank you for choosing us as your mental health provider.
Please read the following information.

1) Confidentiality
All information that you or your child gives to us is kept strictly confidential except in the following circumstances:

- You sign a release of information stating that we can communicate with a particular person or entity
- You or your child presents as a danger to self or others
- There is evidence of abuse or neglect of a child or vulnerable adult

We may consult regarding cases with licensed mental health professionals, who are bound to keep the details of such cases confidential, for the purpose of providing the highest quality of care. During these consultations we only discuss clinically relevant details, and do not provide identifying information such as names, places of work, etc.

2) Evaluation and Methods of Treatment
Prior to beginning treatment, we will conduct an evaluation and determine a mental health diagnosis or diagnoses, if indicated. We will then develop a treatment plan together that may include individual, family, couples, and/or group psychotherapy, as well as advocacy/case management services. We will discuss options for treatment and we may make referrals for you, your family, or your child to receive other services (psychiatric, educational, recreational, medical, etc.).

3) Policy regarding missed appointments
You are responsible for paying for your scheduled time unless you cancel more than 24 hours in advance.

4) Payment Policies
Payment is due at the time of service, unless otherwise agreed upon. At the first session, a credit card authorization form is required and will be kept on file to cover miscellaneous fees such as late cancellations, correspondence, phone sessions, etc. We accept payment by check, cash, credit card or PayPal. If PayPal is used for payment, a $5.00 processing fee will be added to the cost of each session. We charge a $50 fee for returned checks. When applicable, we will provide you with a monthly bill that can be used to obtain reimbursement from insurance companies or other sources.

5) Home-Based Therapy Services
May be available depending on client need and per the discretion of the therapist.

CREDIT CARD AUTHORIZATION

Card Holder Information:

Name on Card: _____

Home Address: _____

_____

Phone Number: _____

Card Number: _____

Expiration Date:_____

Three-Digit Security Code:_____

Card Type:_____(MasterCard, Visa, Discover, American Express)

Zip Code Associated with the Credit Card: _____

"I authorize The Mindful Heart LLC to charge this credit card for each appointment unless otherwise specified."

Cardholder Signature:_____

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INFORMED CONSENT FOR PSYCHOTHERAPY

I have read and discussed the information provided by The Mindful Heart LLC covering the various aspects of therapy for my child, my family, or myself. These include The Mindful Heart's methods of evaluation and treatment, and alternatives to treatment. I have also discussed scheduling, fee policies regarding missed appointments, matters related to insurance and, if applicable, preauthorization and utilization review. I have also read the information provided on confidentiality and have had any questions answered. I understand that there are limits to confidentiality in this relationship.

Signature of client or client's guardian Date

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NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed in any form are kept properly confidential. It gives health providers permission to use and disclose your medical information only for the purposes of treatment, payment, and healthcare operations. You have the right to request restrictions on certain uses and disclosures of protected health information. You also have the right to receive confidential communications of your health information, to inspect and copy your health information, to amend your health information, to receive an accounting of disclosures of health information, and to obtain a paper copy of this notice upon request.

You have the right to file a complaint with the U.S. Department of Health and Human Services if you feel your rights have been violated. The contact information is: The US Department of Health and Human Services, Office of Civil Rights, 200 Independence Avenue, S.W., Washington, DC 20201. Phone numbers: (202) 619-0257 or 1-877-696-6775.

I have read and understand this notice.

Signature of client or client's guardian Date

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RELEASE OF INFORMATION

I, _____, give permission for The Mindful Heart LLC to exchange information about

(Circle One) Myself My Child/Children

Name:_____

with the following person, persons, or entities:

Name:			
Relationship to Client:			
Address:			
Phone:		**Email:**	
Information to be released:	**(Check one or more of the following)** ___No limitations ___Diagnosis ___Treatment Plan ___Treatment Progress ___Billing ___Other: _____		

Signature: _____

Date:_____

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PRICING

Service	*Pricing*	*Details*
Initial Assessment	$195	75-90 minutes
Individual Therapy	$165	45-50 minutes
Family Therapy	$165	45-50 minutes
Couples' Therapy	$165	45-50 minutes
Double Session	$210	90 minutes
Correspondence	$75	• Meetings/phone consultations with other providers (i.e. physicians, mental health professionals, lawyers, teachers, etc.) • Drafting or filling out reports/letters/forms • This fee will be charged on a monthly basis and calculated based on the amount of correspondence in that particular month

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