CLIENT INFORMATION

Therapist: ____ Date: _________________________

CLIENT INFORMATION

Legal Name: _______________________________________ Preferred Name: _____________________________

DOB: _____________________ AGE: ________________

Address: ____

City / State / ZIP: ____

Phone: (home) _________________________ (cell) ________________________ (work) ________________________

This form helps us understand more about your health and potential needs. The more you answer, the better equipped we are to serve you, but we recognize that not every question is comfortable to answer. If you do not feel comfortable answering it here, you can skip it and talk about it during your visit.

Do you think of yourself or Identify as one or more of the following:

☐ Lesbian, gay, or homosexual ☐ Straight or heterosexual ☐ Bisexual ☐ Pansexual ☐ Asexual

☐ Transgender Male/Trans Man/ Female-to-Male (FTM) ☐ Transgender Female/Trans Woman/ Male-to-Female (MTF)

☐ Genderqueer, neither exclusively male nor female ☐ Another Identity: ___________ ______________

☐ I Do not know/questioning ☐ I Decline to Answer ☐ Gender You Prefer to be Identified as: __________________

Birth Gender: ☐ Male ☐ Female ☐ Non-Binary ☐ Not Designated on Birth Certificate ☐ I Decline to Answer

List the Pronouns You are most comfortable in being used:

☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Theirs ☐ Ze/Hir ☐ Other Pronouns: ___________________

Personal Status: ☐ Single/Never Married ☐ Married ☐ Civil Union ☐ Divorced ☐ Legally Separated

☐ Domestic Partnered ☐ Partnered but not living together ☐ Polyamorous/Non-monogamous

☐ Widowed/grieving the loss of partner ☐ I Decline to answer

Employment Status: ☐ Employed Unemployed ☐ Stay-at-Home ☐ Disability

Occupation/Employer Name: ____

Spouse/Partner's Name: ____________________________________ DOB: _____________________________________

Spouse/Partner's Occupation / Name of Employer: ____

APPOINTMENT REMINDERS – I would like to receive appointment reminders via the following method(s):

Phone Call: ______________________________________ Text Message to PH#: ______________________________

Email: ____

INDIVIDUAL RESPONSIBLE FOR INSURANCE: (POLICY HOLDER/SUBSCRIBER INFORMATION)

Relationship to Client: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Name: ____ DOB_____________________________________

Employer Name: ____

OTHER INFORMATION:

Emergency Contact: ____ Relationship to Client: __________________

PH#: __________________________ Address: ____

How did you hear about us? ____

Primary Care Provider/Clinic: ____ PH#: ______________________

Psychiatrist/Clinic: ____ PH#: ______________________

FOR MINOR CLIENT:

Name of Parent/Guardian: ____

Home/Cell Phone: ________________________ Work Phone: _______________________

ACKNOWLEDGEMENT OF RECEIPT OF

NOTICE OF HIPAA PRIVACY POLICIES

I certify that I have received a copy of Notice of HIPAA Privacy Policies. The Notice of HIPAA Privacy Policies describes the types of uses and disclosures of my protected health information (PHI) that might occur in my treatment, payment of my bills, or in the performance of The Attachment and Trauma Center of Nebraska's (ATCN) health care operations. The Notice of HIPAA Privacy Policies also describes my rights and ATCN's duties with respect to my PHI. The Notice of HIPAA Privacy Policies is posted in the corridor near the front door.

The Attachment and Trauma Center of Nebraska reserves the right to change the privacy policies that are described in the Notice of HIPAA Privacy Policies. I may obtain a revised Notice of Privacy Policies by calling the office and requesting a revised copy be sent in the mail, asking for one at my next appointment, or through e-mail.

____

Printed Identified Client Name

____

Signature of Patient or Personal Representative

___________________________________ ___________________________________

Name of Patient or Personal Representative Description of Personal Representative's Authority

____

Date

Rev1.2019

ASSIGNMENT OF INSURANCE BENEFITS

Signature of this contract authorizes payment of medical benefits to The Attachment and Trauma Center, LLC (ATCN) for services rendered (assignment of benefits). I understand my insurance company (if applicable) may be billed the full amount for the session and that aside from my co-pay (if applicable), and providing that ATCN is considered "In Network" with my insurance plan, I am not liable for any difference between the billed amount and the reimbursement amount previously contracted between the insurer and ATCN.

I / We the undersigned acknowledge the my / our insurance company may request clinical information including diagnosis, prognosis and treatment plans and hereby authorize the release of any appropriate information relating to payment of claims submitted to insurance on behalf of myself / us and or dependents. I/we further expressly agree and acknowledge that signature of this document authorizes ATCN to submit claims for insurance benefits, for services rendered, or for services to be rendered, including treatment plans, without obtaining my / our signature as though the undersigned had personally signed the particular claim. I /we therefore authorize the insurance company to pay and hereby assign directly to ATCN all insurance benefits, if any, otherwise payable to me / us for services described on the attached forms. I /we are financially responsible for all charges incurred, whether they are paid by insurance or not. I / we further acknowledge that any insurance benefits, when received and paid to ATCN, will be credited to my / our account, in accordance with the above said statement.

I understand that it is important that I provide at least a 24-hour notice of cancellation of a scheduled appointment, and in not doing so, I will be liable for a charge of $100 for this scheduled time. This charge will be the responsibility of the client. ___________
Initial

It is usual practice, and preferable, to provide payment for the session (or insurance co-pay, deductible if applicable) at the time of check-in before the session begins. Cash, check or credit card are accepted: _______________
Initial

☐ If preferred, and at your request, your credit/debit card information may be maintained within your secure, encrypted EHR (Electronic Health Record) for future co-payments. You may change this at any time. _________
Initial

☐ I understand that I will be charged a $35 service handling fee for any returned form of payment. _________
Initial

CARD HOLDERS SIGNATURE: ____ Date: ___________

☐ ***I/We acknowledge understanding of and agree to the terms of this contract for payment of services.***

____ _________________________

Client/Guardian Signature Date

ATCN

638 N 109TH Plaza, Omaha NE 68154 * 402.403.0190 * FAX 402.932.4121

CONFIDENTIALITY CLARIFICATION & CONSENT TO TREAT

It is important that you fully understand the nature of confidentiality in the context of your relationship with The Attachment and Trauma Center of Nebraska, LLC, here forth referred to as ATCN. ATCN, its therapists, partners, interns, and employees will keep confidential any information disclosed by you in the course of our relationship and this information will not be disclosed to other parties without a written release signed by you. There may be exceptions, however, and it is important that you are aware of the exceptions to this policy.

- Disclosure of Child Abuse, Endangerment, and/or Neglect: If the client discloses information that a child is being abused, endangered or neglected, ATCN therapists, interns, and employees, ***are required by law to report this information to Child Protective Services (CPS).***
- Duty to Warn: If the therapist believes that a client poses a threat to themselves or others, the ***therapist is ethically bound to disclose this information to the appropriate person or agency.***
- Court Subpoena of Records: ***It is within the power of the Court System to subpoena client records*** for a therapist or agency.
- Any Insurance Agent/Company covering a client's mental health treatment will have access to any information necessary for the completion of insurance forms for the determination of benefits.
- All cases may be reviewed during Team Consultation. Treatment is provided with the understanding that case review may be brought to the team for discussion.
- Exchange of information with psychiatrists, therapists, CPS case managers, probation officers, or other persons outside ATCN regarding the client's case with the express written permission by the client (See Consent to Release Form).
- Research Participation: If asked and you agree to participate in therapeutic outcomes research, express written permission which defines the project will be obtained.

If you have any questions regarding confidentiality, please ask. Your therapist will provide you with a copy of this clarification sheet if requested.

I have read, understand, and agree to the above limitations of confidentiality. _________ (Initial)

INFORMED CONSENT: We ask that clients sign the below as a Consent to Treatment. The client may decline specific recommendations during the therapy process at any time**.**

I give my consent for services with the Attachment & Trauma Center of Nebraska, (ATCN) to include evaluation, therapy, education, testing (if applicable) and involvement in the treatment planning processes.

_______________________________________ _________________________________ ________

Identified Client or Legal Guardian Signature Witness Date

I would like a copy of this consent □ YES □ NO

CONTRACT FOR PAYMENT OF SERVICES

I understand that I am assuming responsibility for payment of my / legal dependent / minor child's legal bill at this time of the session, unless other arrangements are made and herein specified. I also understand that should the client account balance remain outstanding, that The Attachment and Trauma Center of Nebraska, LLC (ATCN) utilizes the services of a collection agency and I agree that ATCN may release my name to any necessary party in the course of obtaining payment.

*****

SELF-PAY FEES AND INSURANCE CO-PAYS ARE EXPECTED AT THE TIME OF SERVICE AND SHOULD BE MADE BEFORE EACH SESSION AT THE TIME OF CHECK-IN WITH THE BUSINESS OFFICE

*****

☐ ***Option A:*** I/We wish to self-pay and NOT use insurance benefits. I/We do not give permission for any confidential information about me (or my partner) and my/our treatment to be released to any third-party payor, employer, or insurance company. Self-payments may be made from a HAS or FSA account via check or credit.

☐ ***Option B:*** I/We wish to use insurance to help pay for services.

☐ Copy of my insurance card will be given to the Business Office or therapist for billing purposes at check-in. ___________
Initial

For clients choosing to use health insurance for treatment, it is client's responsibility to ensure you have current mental health benefits for outpatient office visits. Insurance companies only quote benefits and do not guarantee payment over the phone. Any disagreement regarding payment of a claim by insurance is between the client and his/her insurance company.

ULTIMATELY, PAYMENT OF THE BILL IS THE CLIENTS RESPONSIBILITY AND IT IS EXPECTED THAT PAYMENT BE MADE WITHIN 30 DAYS UNLESS YOU HAVE A PAYMENT PLAN ARRANGEMENT IN PLACE WITH YOUR THERAPIST AND THE BUSINESS OFFICE. _______________
Initial

Name of Primary Insurance: _______________________________________ Member #: _____________________________

Subscriber (Policy Holder): ____ Subscriber DOB: ___________________________

Name of Secondary Insurance: _____________________________________ Member #:______________________________

Subscriber (Policy Holder): ____ Subscriber DOB: ___________________________

We recognize that the identities you carry might differ from legal and insurance identification. In-order to ensure that there are no error's, please fill in the below:

What gender does your insurance company have on record: ___________________________________

What is the name on your insurance card: ____

☐ ***I/We acknowledge understanding of and agree to the terms of this contract for payment of services.***

____ ___________________________
Client/Guardian Signature Date

CLIENT MEDICAL HISTORY

NAME: ____ DATE: _______________

CURRENT PRIMARY MEDICAL CARE PROVIDERS (PHYSCIAN, PSYCHIATRIST, NURSE PRACTIONER)

Name: ____ Title: ________________________________

Phone: _______________________ Address: ____

Name: ____ Title: ________________________________

Phone: _______________________ Address: ____

Name: ____ Title: ________________________________

Phone: _______________________ Address: ____

How would you rate your overall health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

What, if any, concerns do you have about your health: ____

____

When was your last physical exam: ______________________

Please list any medication /substance / food allergies: ____

____

____

Please list any medication sensitives or intolerance: ____

____

____

Health Risk History

☐ **YES** ☐ **NO** Do you smoke? If yes, how long, how many cigarettes per day: ______________________

☐ **YES** ☐ **NO** Have you smoked in the past?

☐ **YES** ☐ **NO** Do you use alcohol? If yes, how often, how much: _______________________________

☐ **YES** ☐ **NO** Do you use drugs? If yes, how often, how much: __________________________________

☐ **YES** ☐ **NO** Have you or your partner(s) ever injected drugs and when: _________________________

☐ **YES** ☐ **NO** Have you ever had a problem with alcohol, drugs, other addiction?

☐ **YES** ☐ **NO** Should you cut down on your drinking or drug use**?**

☐ **YES** ☐ **NO** Have you been annoyed when others question your drug or alcohol use?

☐ **YES** ☐ **NO** Have you ever felt guilty about how much you drink or use drugs?

☐ **YES** ☐ **NO** Have you ever had a drink/used to get going or to treat a hangover?

☐ **YES** ☐ **NO** Has anyone ever complained about your drinking/using?

☐ **YES** ☐ **NO** Have you ever gotten into trouble when drinking/using?

With family members ____ With the law ____ With friends ____ Others ____

☐ **YES** ☐ **NO** Do you usually get into trouble with you drink/use?

# of DUI(s): _______ What year(s): _______ / _______ / _______ / _______ / ______

# of MIP(s): _______ What year(s): _______ / _______ / _______ / _______ / ______

☐ **YES** ☐ **NO** Have you ever had a sexually transmitted disease?

☐ **YES** ☐ **NO** Have you ever been tested for HIV?

Review of Systems

Please note if you currently have, have ever had, any of the following: Approx. Date

				Approx. Date
Recurrent Night Sweats, Chills, Fever:	☐ **Never**	☐ **Current**	☐ **Past**	__________
Persistent Weight Loss without Dieting:	☐ **Never**	☐ **Current**	☐ **Past**	__________
Weight Problem / Eating Disorder:	☐ **Never**	☐ **Current**	☐ **Past**	__________
Hepatitis A, B, C:	☐ **Never**	☐ **Current**	☐ **Past**	__________
Cancer:	☐ **Never**	☐ **Current**	☐ **Past**	__________
Chronic Fatigue:	☐ **Never**	☐ **Current**	☐ **Past**	__________
Other: _________________________	☐ **Never**	☐ **Current**	☐ **Past**	__________

Do you now have, or have you ever had, conditions involving the following? Please check all that apply and describe your conditions following the condition:

☐ Skin: ____

☐ Eyes: ____

☐ Teeth (Dentures /Missing Teeth, etc.): ____

☐ Lungs (Asthma): ____

☐ Urinary (Chronic Bladder Infections, etc.): ____

☐ Muscles/Joints (Arthritis, Fibromyalgia, etc.): ____

☐ Neurological (Head Injury, Headaches, Seizures, Dizziness, etc.): _________________________________

____

☐ Gastrointestinal (Diabetes, Gastric Reflux, Irritable Bowel Syndrome, etc.): ______________________

____

☐ Reproduction/Sexual (Menstrual or menopausal difficulties, breast disease, prostate problems, erectile difficulties, difficulty with orgasm, sexual difficulties, etc.): ____________________________

____

☐ Endocrinological (Diabetes, hypo or hyperthyroidism, etc.): _______________________________

____

☐ Heart or Blood (High/Low Blood Pressure, High Cholesterol, Anemia, etc.): ____________________

____

☐ Past Injuries/Surgeries: ____

____

Please check the items below which describe medical symptoms you have had I the past 12 months:

☐ Persistent Cough ☐ Shortness of Breath ☐ Thyroid Disease

☐ High Blood Pressure ☐ Abnormal Heartbeat ☐ Balance Problems / Falls

☐ Seizures ☐ Loss of Consciousness ☐ speech problems

☐ Numbness or Weakness of Limbs/Body ☐ Severe/Persistent Headaches

☐ Muscle Weakness ☐ Muscle Pain ☐ Joint/Aches/Pains

☐ Bruising Easily ☐ Kidney Infection/Disease ☐ Trouble Urinating

☐ Urinary Infections ☐ Liver Disease ☐ Stomach/Abdominal Pain

☐ Changes in Visions/Trouble with Eyes ☐ Changes in hearing/hearing loss/trouble with ears

☐ Vomiting ☐ Pain in Mouth or Trouble Swallowing

☐ Feeling Clumsy or Dropping Things ☐ Sore/Swollen Neck/Glands

☐ Pain / Lump / Drainage from Breasts ☐ Vocal Problems

REPRODUCTIVE

Is there any chance you might be pregnant? ☐ **YES** ☐ **NO**

What was your age at the time of your first pregnancy? ______________________

How many abortions have you had? ________________________

How many miscarriages have you had? ______________________

How many stillbirths have you had? _________________________

Referred for Physical Exam: ☐ **YES** ☐ **NO**

To Whom: ______________________________ Accepting Referrals: ☐ **YES** ☐ **NO**

Referred for Psychiatric Evaluation: ☐ **YES** ☐ **NO**

To Whom: ______________________________ Accepting Referrals: ☐ **YES** ☐ **NO**

REV 10.2019

CURRENT AND PAST MEDICATION LIST –

Please feel free to request a copy from your pharmacy, they will print you a current list with the below info.

CLIENT NAME: ____ DOB: _______________ DATE: _______________

Please list all your current medications:

- Medication: ____ Dose: _________________________

Diagnosis/Purpose: ____ How Long on Rx:________________________

Side Effects: ____Cautions: ______________________________

Prescribing Physician: ____ Ph #:_________________________________

Pharmacy: ____ Ph#:__________________________________

- Medication: ____ Dose: _________________________

Diagnosis/Purpose: ____ How Long on Rx:________________________

Side Effects: ____Cautions: ______________________________

Prescribing Physician: ____ Ph #:_________________________________

Pharmacy: ____ Ph#:__________________________________

- Medication: ____ Dose: _________________________

Diagnosis/Purpose: ____ How Long on Rx:________________________

Side Effects: ____Cautions: ______________________________

Prescribing Physician: ____ Ph #:_________________________________

Pharmacy: ____ Ph#:__________________________________

- Medication: ____ Dose: _________________________

Diagnosis/Purpose: ____ How Long on Rx:________________________

Side Effects: ____Cautions: ______________________________

Prescribing Physician: ____ Ph #:_________________________________

Pharmacy: ____ Ph#:__________________________________

- Medication: ______________________________ Dose: ______________

Diagnosis/Purpose: ______________________________ How Long on Rx:______________

Side Effects: ______________________________Cautions: ______________

Prescribing Physician: ______________________________ Ph #:______________

Pharmacy: ______________________________ Ph#:______________

- Medication: ______________________________ Dose: ______________

Diagnosis/Purpose: ______________________________ How Long on Rx:______________

Please list any medications you have tried and have discontinued in the past 2 years/24 months below:

Medication	Length of Time Taken	Reason for D/C Medication
______________	______________	______________
Medication	**Length of Time Taken**	**Reason for D/C Medication**
______________	______________	______________
Medication	**Length of Time Taken**	**Reason for D/C Medication**
______________	______________	______________
Medication	**Length of Time Taken**	**Reason for D/C Medication**
______________	______________	______________
Medication	**Length of Time Taken**	**Reason for D/C Medication**
______________	______________	______________
Medication	**Length of Time Taken**	**Reason for D/C Medication**
______________	______________	______________
Medication	**Length of Time Taken**	**Reason for D/C Medication**
______________	______________	______________
Medication	**Length of Time Taken**	**Reason for D/C Medication**
______________	______________	______________
Medication	**Length of Time Taken**	**Reason for D/C Medication**
______________	______________	______________
Medication	**Length of Time Taken**	**Reason for D/C Medication**
______________	______________	______________
Medication	**Length of Time Taken**	**Reason for D/C Medication**
______________	______________	______________
Medication	**Length of Time Taken**	**Reason for D/C Medication**
______________	______________	______________

REV 10.2019

INTAKE FORM

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Name of Spouse / Partner: ____ Age: _________________

Date of your present marriage / partnership: ____________________

Date(s) of any previous marriages: ____

Date(s) of any previous divorces: ____

Names of individuals living in your home:

____

Name	Age	Relationship to you
Name	Age	Relationship to you
Name	Age	Relationship to you
Name	Age	Relationship to you

How would you describe the relationship between you and your spouse/partner?

☐ Cold / Distant ☐ Stormy / Argumentative ☐ Love / Close ☐ Tolerant / Put up with each other

☐ Abusive / Verbal and-or physical fights

If a parent, how would you describe the relationship between you and your children?

☐ Cold / Distant ☐ Stormy / Argumentative ☐ Love / Close ☐ Tolerant / Put up with each other

☐ Abusive / Verbal and-or physical fights

If you are single, how would you describe the relationship between you and most of your past partners?

☐ Cold / Distant ☐ Stormy / Argumentative ☐ Love / Close ☐ Tolerant / Put up with each other

☐ Abusive / Verbal and-or physical fights

If applicable, how would you describe the relationship between you and your in-laws?

☐ Cold / Distant ☐ Stormy / Argumentative ☐ Love / Close ☐ Tolerant / Put up with each other

☐ Abusive / Verbal and-or physical fights

If applicable, how would you describe the relationship between you and your blood relatives?

☐ Cold / Distant ☐ Stormy / Argumentative ☐ Love / Close ☐ Tolerant / Put up with each other

☐ Abusive / Verbal and-or physical fights

If applicable, how would you describe the relationship between you and those who raised or are raising you?

☐ Cold / Distant ☐ Stormy / Argumentative ☐ Love / Close ☐ Tolerant / Put up with each other

☐ Abusive / Verbal and-or physical fights

If applicable, how would you describe the relationship between you and your parents?

☐ Cold / Distant ☐ Stormy / Argumentative ☐ Love / Close ☐ Tolerant / Put up with each other

☐ Abusive / Verbal and-or physical fights

SCHOOL / WORK / FINANCIAL

Highest level of education completed: ____

If you graduated from college, what is your area of study: ____

What kinds of grades did you usually make (high school & beyond):____

Please list schools attended beyond high school: ____

What is your present occupation / job: ____

How long have you had this job: ______________________________

How do you feel about your work: ☐ Hate it ☐ Tolerate it ☐ Enjoy it ☐ Love it

What future job or profession do you hope to have: ____

How would you describe your present financial condition: ☐ Very bad ☐ Fair ☐ Good ☐ Excellent

SPIRITUAL / COMMUNITY INVOLVEMENT / HEALTH / ABUSE

Do you have spiritual or religious beliefs which you draw on: ☐ YES ☐ NO

How do you honor or attend to these beliefs: ____

Do you participate in any community activities or organizations: ☐ YES ☐ NO

If yes, please list: ____

____

Do you consider yourself to be in: ☐ Excellent Health ☐ Good Health ☐ Fair Health ☐ Poor Health

Have you ever been in the hospital: ☐ YES ☐ NO If yes, explain: ____________________________________

____

Please list medications and doses currently taking: ____

____

____

Have you ever seen a therapist (Psychiatrist, Psychologist, Counselor, Social Worker): ☐ YES ☐ NO

If yes, when: ________________________ Reason for treatment: ____

If yes, what was helpful about the therapy/treatment: ____

____

Check any of the following you have experienced:

☐ Verbal Abuse / By Whom: ____

☐ Physical Abuse / By Whom: ____

☐ Sexual Harassment / By Whom: ____

☐ Sexual Abuse / By Whom: ____

☐ Rape / By Whom: ____

SUBSTANCE ABUSE: Check all that apply to you:

☐ Have you ever felt you ought to cut down on your drinking or drug use

☐ Have people annoyed you by being critical about your drinking or drug use

☐ Have you ever felt bad or guilty about your drinking or drug use

☐ Have you ever had a drink or drug first thing in the morning to steady your nerves or get over a hangover

RE-READ THE 4 QUESTIONS ABOVE AND CONSIDER THE FOLLOWING:

Shopping – Have you or others in your life been concerned about your shopping: ☐ YES ☐ NO

Gambling - Have you or others in your life been concerned about your gambling: ☐ YES ☐ NO

Eating - Have you or others in your life been concerned about your eating: ☐ YES ☐ NO

Sexual Behavior - Have you or others in your life been concerned about your sexual behavior: ☐ YES ☐ NO

Internet Usage - Have you or others in your life been concerned about your internet use: ☐ YES ☐ NO

Other addictive behavior, you may be concerned about: ____

____

ARE ANY OF THE FOLLOWING CONDITIONS A CONCERN OR PROBLEM TO YOU AT THIS TIME (CHECK ALL THAT APPLY)

☐ Anxiety	☐ Self Esteem	☐ Relationship with parents
☐ Grief	☐ Stress	☐ Relationship with children
☐ Depression	☐ Substance Abuse	☐ Relationship with spouse/partner
☐ Irrational Fear(s)	☐ Binge Eating	☐ Loss of meaning in life
☐ Nervousness	☐ Chronic Fear(s)	☐ Legal concerns

☐ Parenting ☐ Guilt Feelings ☐ Conflicts at work

☐ Parenting ☐ Suicidal Feelings ☐ Loss of Work/Job

☐ Marriage problems ☐ Loss of Hope ☐ Life/Career Planning

☐ Sexual Concerns ☐ Rage ☐ Other (List Below

☐ Domestic Violence ☐ Trauma ☐ ______________________________

IF ANY OF THESE STATEMENTS ARE TRUE, CHECK ANY/ALL THAT APPLY

☐ I have thoughts of harming myself or others

☐ My thoughts of harming myself or others are a frequent occurrence

☐ I dwell on these thoughts and wonder if I can control them

☐ I have sought professional help because of these thoughts or feelings

---

WHAT ARE YOUR GREATEST STRENGTHS: ____

____

____

OTHER INFORMATION THAT WE SHOULD KNOW AS WE START COUNSELING: ________________________________

____

____

WHAT WOULD YOU LIKE TO SEE HAPPEN AS A RESULT OF PSYCHOTHERAPY OR COUNSELING: ___________________

____

____

Thank you for taking the time to complete this form!

ATCN *638 N 109TH Plaza, Omaha NE 68154 * 402.403.0190 * FAX 402.932.4121