Phone (541) 423-8151   Fax (541) 423-8508

Patient Registration Form

Patient name ______________________________ Date of birth ____________________

Mailing address ________________________ City ____________ State ______ Zip__________

Home Phone ________________ Cell Phone ____________________ SSN# ______-______-______

Is it okay to leave medical information on your voicemail if we are unable to reach you? Yes________ No ________

Email: ______________________________ Is it ok if we email you? Yes________ No ________
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Gender Preference _____ Single _____ Married _____ Divorced _____ Widowed _____ Preferred Pronouns__________________

Employer ________________________ Phone ________________

Race/Ethnic Ancestry:

White, not Hispanic Hispanic Black Pacific Islander Black, not Hispanic
American Indian/Alaskan Unknown/Other Hispanic, White Asian

Spouse's name ______________________________ Date of birth ________________

Phone ________________________

Emergency Contact

Referred by (if any):

Doctor Pastor Family member Friend Website Other:

Medical Insurance Information

Primary Insurance ____

ID Number __________________________ Group Number __________________

Insured name __________________________ Date of birth __________________

Secondary Insurance ____

ID Number __________________________ Group Number __________________

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Scheduling Agreement

Welcome to Pinnacle Health Services. We look forward to partnering with you in your care. It is our priority to make our clinic an environment where patients will receive the highest quality of professional care. The Providers with Pinnacle Health Services are committed to maintaining a cooperative and effective relationship with their patients who have entrusted their care to us. Please review the scheduling conditions below:

- Coordination of Care
  - Should my **care lapse for 90 days or more** between sessions without my provider's recommendation, I will be transitioned to an inactive patient status.
  - I understand that I can resume my care at any time but may be asked to re-establish with my provider depending on length of absence.
- Scheduling
  - I understand that I am responsible for scheduling all my appointments.
  - I understand that appointments cannot be scheduled for more than 1 month in advance without my provider's recommendation.
  - I understand that should I reschedule often, even with notice; I may be limited to how many appointments can be scheduled at a time and/or be limited to scheduling too far in advance.
- No Show/Late Cancellation Policy
  - I understand that should I need to cancel my appointment I am required to give Pinnacle Health Services a full **48 hours' notice.**
  - I understand that should I not give **48 hours'** notice; my cancelation will be considered a late cancellation or no notice occurrence.
  - I understand that a late cancellation of no notice appointment can incur a fee of $70 per occurrence.
  - I understand I am limited to 3 no notice or late cancelations before I will be discharged from Pinnacle Health Services.
- Payment Authorization
  - I give permission to Pinnacle Health Services to hold my credit card on file and authorize automatic payment should I incur any cancellations/no show fees.
    - I have given the credit card ending in: __________ (last 4) and agree to maintain a valid card on file as long as I remain an active patient.
  - I understand my card will be charged on the same day of the scheduled appointment.

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My signature acknowledges that I understand and agree to the terms and conditions listed above. I understand my responsibilities as a patient with Pinnacle Health Services. Initial Below and sign form:

___If patient arrives more than 10 minutes late for a follow up appointment, patient is unable to be seen and will be charged as a "No-Notice/No Show" occurrence. Late arrivals for a follow-up appointment may be subject to a $70.00 fee.

Printed Name: ______________________________ Date: ______________

Signature: ____

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Therapy Agreement & Informed Consent

MY PROVIDER (provider name): ____________________________________

Before starting mental health therapy, it is important to know what to expect, and to understand your rights as well as commitments. This consent form is an attempt to be as transparent with you as I can about the therapy process, so you are fully informed prior to starting treatment. I will give you a copy to take home.

Treatment Philosophy

- Mental health therapy is a process of opening up about your life experiences and your genuine thoughts and feelings in order to increase your self-awareness of psychological and emotional conflicts that keep you stuck in unwanted patterns. This means we will focus on helping you uncover the root causes, thought patterns, emotions, and actions that contribute to current life distress. For the therapy to be most successful, you will have to work on things we discuss both during our sessions and at home. I may also make other appropriate referrals if I find it necessary (I.e., psychiatric evaluation; neuropsychological evaluation). Remember, you always retain the right to request change in treatment or to refuse treatment at any time.

- The therapy may involve temporary periods of discomfort as you begin to work through past trauma or confront psychological conflicts you have previously been avoiding. You may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness and helplessness. On the other hand, therapy has been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress.

- Your psychotherapy sessions will be approximately 50-60 minutes in length and are generally conducted once per week. We will discuss if a different meeting frequency (i.e., once every two weeks) will work best depending on your specific situation.

- Treatments supported by research to help people with specific problems are generally shorter-term in nature (e.g., 16-20 sessions). By learning helpful skills and ways of thinking about your concerns in treatment, clients often find they are well equipped to manage on their own or with occasional support.

- **APPOINTMENT RESCHEDULING OR CANCELING**: Once an appointment is set, that time is reserved for you. I cannot typically fill that time within 24 hours. Therefore, APPOINTMENTS MUST BE RESCHEDULED OR CANCELED **48 HOURS IN ADVANCE**; I may make an exception for a true emergency.

- I can be reached at the clinic by calling (541) 423-8151. I am often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. At these times, you may leave a message on the clinic's confidential voicemail and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. If, for any number of unseen reasons, you do not hear from me or I am unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe: 1) contact Jackson County Mental Health Crisis Line (541-774-8201)

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Therapy Agreement & Informed Consent Continued:

2) go to your Local Hospital Emergency Room; 3) Contact the Mental Health National Helpline at 1-800-662-4357; or 4) call 911 and ask to speak to the mental health worker on call.

- According to the laws in many states and all professional ethics codes, any kinds of sexual conduct or asking for sexual conduct, or sexual misconduct by a mental health provider with a client is illegal, as well as unethical.

Initial Intake/Evaluation

- The purpose of the intake process is to fully evaluate your needs and ensure you receive the best treatment possible. The evaluation itself may vary across clients and may include activities such as completing a structured interview (i.e., every client is asked the same questions to ensure comprehensiveness), questionnaires, or several other options.

- By the end of this intake period (first 1-2 sessions), I will be able to offer you an initial impression of your needs and a plan for what treatment might include if you decide to continue with therapy. If we are unable to work together, I will provide you with a list of referrals.

Scope of My Services

- I am qualified to work with a wide variety of clients and problems, but sometimes I may not have the training needed to address a particular concern. If this is the case, I will discuss it with you and make sure that you receive a referral to another professional who is better qualified to serve you.

- Also, if you are having current hallucinations/ delusions, severe thoughts of suicide or self- harm, or extreme mood swings, you may need more support than I can offer you through weekly psychotherapy, and I reserve the right to refer you to a different or more intensive treatment if I believe you exceed the level of care I can offer.

LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. However, there are limits to this confidentiality that you should know about.

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to the legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

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Therapy Agreement Continued...

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/ or legal authorities.

Minors/ Guardianship

Parents or legal guardians of non-emancipated minor clients may have the right to inspect the clients records unless the health care provider determines that access to the client's record would have a detrimental effect on the providers' professional relationship with the minor client, or the minor's physical safety or psychological wellbeing.

GENERAL CONSENT TO DO PSYCHOTHERAPY

- I have read and fully understand these client policies and give my full-informed consent.
- I apply for and consent to psychotherapy with **MY PROVIDER:**________________________________.
- I further understand that I am responsible for payment even though my insurance company may or may not reimburse me at a later time.
- I understand any conversations over five (5) minutes in duration will be charged in fifteen (15) minute increments.

________________________	____________________
Client Signature	Date
________________________	____________________
Parent or Guardian	Date

Name:______________________

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CURRENT FAMILY/LIVING SITUATION

In order to assist us in helping you reach your goals and move forward in the direction you would like to be going in your life, it will be important for us to understand your current difficulties as well as past experiences. We kindly request that you please answer the questions below. Please note: the information you provide here is protected as confidential information.

Marital Status (circle one): Single / Married: How long? ______ Cohabitating/Living Together: How long? ________
Divorced: How long? ______ Number of Marriages: ______

Do you have any children? Yes No

If **yes**, please list their names, gender, ages, and with whom they live:

Name	Age	Gender	With whom they live
1.			
2.			
3.			
4.			
5.			
6.			

SOCIAL HISTORY

What are your living arrangements? (Please check one)
☐ Own house ☐ Renting a house ☐ Rent an apartment ☐ Living with relative ☐ Living with friend/roommate
☐ Homeless -- If homeless, where do you stay? ____________________

Have you been homeless in the past? Yes/ No If yes, please list dates. Dates of homelessness:

Are you using any community resources/services currently? Yes/ No
If yes, please describe.

What do you do for fun? (Hobbies & interests)

What goals do you think we should be working on? What do you think I can do to help? What do you think you can do to help yourself?

Are you interested in trying something new to see if you can improve things, work on your goals of X?

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REFERRAL/PRESENTING PROBLEM INFORMATION

In order to understand your situation, I would like to ask you some questions, if that is okay?

Can you take a few minutes and describe what you see as the problem(s)? What would you like help with?

Give me a recent example of the problem, as you see it...

What happens before...?

What happens after...?

Can you tell ahead of time when this might occur? What signs are there that this might occur (be a "high risk" situation)?

How often does problem occur?

How long does it last? ____________ How serious a problem is this as far as you are concerned? ____________

Who is most bothered by this problem? Who in your home (workplace, etc) most wants this behavior to change?

How have you handled this situation in the past? Give me an example. What else have you tried? How have these strategies worked?

Have you ever sought assistance for these or other problems? Yes/ No **If yes, please describe below:**

Dates	Where	Diagnosis/Reason	Focus of Treatment

Have you ever been *hospitalized* on an inpatient psychiatric unit? Yes / No

Dates	Where	Diagnosis/Reason	Focus of Treatment

Please list any psychiatric medications you are currently taking, the reason they were prescribed, and medication effectiveness. Please list:

Medication(s)	Prescribed for? (mood, anxiety, etc)	Are you taking it?	Is it helping?

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PRESENTING PROBLEM INFORMATION continued...

Are you satisfied with the treatments received? Yes/ No Was it difficult to follow the treatment regimen? Yes/ No

Have you ever seriously considered harming/killing yourself? Yes/ No
Have you ever attempted suicide? Yes/ No If yes, please provide details.

Do you have problems controlling violent behavior/impulses? Yes/ No If yes, please give details.

FAMILY/CHILDHOOD HISTORY- DEVELOPMENTAL INFLUENCES

I'd like to know more about your history and what impacted you most growing up.
Place of birth? ________________________Who raised you? ________________________
Who else lived at home when you were growing up? (e.g., extended family, others?)

Were you ever made to feel ashamed (embarrassed, humiliated)? What happened? What lingers from that experience now?

As you were growing up, were there any adults who were particularly kind to you? Who? What did they do?

Has anyone in your family ever been treated for a psychiatric disorder or emotional problem? If yes, who? And for what?

EDUCATION

Did you graduate from High School? Yes/ No If not, what was your highest grade completed in school? _______
Did or are you attending Trade/Technical School or a College/University? Yes/ No
If yes, what did you study? ____________________
What was your highest year completed in tech school or college? ________Did you earn a degree? Yes / No
If so, what is the degree? ________________________________
Are you in school now? No Part-time Full-time

MEDICAL HISTORY

Do you have any chronic medical problems (e.g., diabetes, high blood pressure, heart problems)? Yes/ No

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DRUG AND ALCOHOL HISTORY

Below are listed most substances that some people may use and/or abuse. For each substance you have previously or are currently using, please fill in the requested information so that we can be aware of possible interactions with your medications and provide better treatment.

Tobacco (cigarettes or chew) Age started: __________ # of years used: __________ Date last used: ___________

Pattern of use: Continuous / Off and on/ Other: _____________ Amount of typical daily use: __________________

How often do you currently use this substance? __________Do you feel you have a problem with this substance? Yes / No/ Not sure

Alcohol Age started: __________ # of years used: __________ Date last used: ___________

Pattern of use: Continuous / Off and on/ Other: _____________Amount of typical daily use: ____________________

How often do you currently use this substance? _________Do you feel you have a problem with this substance? Yes/ No/ Not sure

Marijuana Age started: __________ # of years used: __________ Date last used: ___________

Pattern of use: Continuous/ Off and on/ Other: ________________Amount of typical daily use: _____________________

How often do you currently use this substance? __________ Do you feel you have a problem with this substance? Yes/ No/ Not sure

Cocaine, Crack Age started: __________ # of years used: __________ Date last used: ___________

Pattern of use: Continuous/ Off and on/ Other: ___________________ Amount of typical daily use: ______________

How often do you currently use this substance? __________Do you feel you have a problem with this substance? Yes/ No/ Not sure

Narcotic Pain Medication (abuse) Age started: __________ # of years used: __________ Date last used: ___________

Pattern of use: Continuous/ Off and on/ Other: ___________________ Amount of typical daily use: ____________________

How often do you currently use this substance? __________Do you feel you have a problem with this substance? Yes/ No/ Not sure

Sedatives, Valium, Xanax (abuse) Age started: __________ # of years used: __________ Date last used: ___________

Pattern of use: Continuous/ Off and on/ Other: ___________________ Amount of typical daily use: ____________________

How often do you currently use this substance? __________Do you feel you have a problem with this substance? Yes/No/ Not sure

Heroin, Opiates, Methadone Age started: __________ # of years used: __________ Date last used: ___________

Pattern of use: Continuous/ Off and on/ Other: ____________________ Amount of typical daily use: ________________

How often do you currently use this substance? __________ Do you feel you have a problem with this substance? Yes/ No/ Not sure

Hallucinogens (Acid, Shrooms) Age started: __________ # of years used: __________ Date last used: ___________

Pattern of use: Continuous/ Off and on/ Other: _____________________Amount of typical daily use: __________________

How often do you currently use this substance? __________Do you feel you have a problem with this substance? Yes/ No/ Not sure

Other: ___________________Age started: __________ # of years used: __________ Date last used: ___________

Pattern of use: Continuous/ Off and on/ Other: ___________________Amount of typical daily use: _______________________

How often do you currently use this substance? __________Do you feel you have a problem with this substance? Yes/ No/ Not sure

Have you had treatment/rehabilitation for addictions? Yes / No If yes, when, and where? Do you attend AA or NA? Yes No

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EMPLOYMENT HISTORY

Are you currently employed? Yes/ No
If yes, what is your job? ________________When did you begin this job? ________________

Are you having any difficulties with your job? Yes/ No
If yes, please describe:

If unemployed, when & what was your last job?
Period of Last Employment Description of Last Job

What is the longest time period you have held a job? _________
What is the longest time period you have been unemployed? ____________
What kind of work have you done in the past? _______________
What kind of work would you like to do in the future?

How are you financially supporting yourself?

Do have you enough money to cover your basic expenses? Yes/ No

SPIRITUAL/PERSONAL INFORMATION

Who or what gives meaning to your life now?

Do you have family and/or friends that you can trust and rely on for emotional support? If so, who and why?

Are you actively involved in religious/spiritual practices? If so, please describe.

How do you view your future?

What helps you get through difficult situations?

Is there anything else that would be important to know that would help in planning your treatment.

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Pinnacle Health Services Screening Questionnaire*

Name: ________________________________

In order to help you move forward in the direction you would like to be going in your life, we would appreciate learning more about what problems or difficulties you might be experiencing as well as what you would like to see change in your life.

Over the ***last two weeks***, how often have you been bothered by any of the following problems? (please circle your answer & **check the boxes that apply to you**)	Not at all	Several days	More than half the days	Nearly Every day	
1. Little interest or pleasure in doing things	0	1	2	3	
2. Feeling down, depressed, or hopeless	0	1	2	3	
3. ☐ Trouble falling or staying asleep, or ☐ sleeping too much	0	1	2	3	
4. Feeling tired or having little energy	0	1	2	3	
5. ☐ Poor appetite or ☐ overeating	0	1	2	3	
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3	
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3	
8. ☐ Moving or speaking so slowly that other people could have noticed, or ☐ the opposite - being so fidgety or restless that you've been moving around a lot more than usual	0	1	2	3	
9. ☐ Thoughts that you would be better off dead, or ☐ hurting yourself in some way	0	1	2	3	**Total**
(10)	add columns:				

1. Feeling nervous, anxious or on edge	0	1	2	3	
2. Not being able to stop or control worrying	0	1	2	3	
3. Worrying too much about different things	0	1	2	3	
4. Trouble relaxing	0	1	2	3	
5. Being so restless that it is hard to sit still	0	1	2	3	
6. Becoming easily annoyed or irritable	0	1	2	3	
7. Feeling afraid as if something awful might happen	0	1	2	3	**Total**
(8)	add columns:				

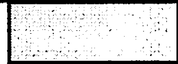
*adapted from PhQ 9, GAD7, PC-PTSD and AUDIT 1/24/11

Please also complete back side →

Are you currently in any physical pain?	No	Yes

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, ***in the past month***, you:

1. Have had nightmares about it or thought about it when you did not want to?	No	Yes
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?	No	Yes
3. Were constantly on guard, watchful, or easily startled?	No	Yes
4. Felt numb or detached from others, activities, or your surroundings?	No	Yes



What are the top 1-3 things you would like to see change in your life right now?

1. ______________________________
2. ______________________________
3. ______________________________

What are the most important reasons why you want to make the changes above?

What goals would you like to work on with a counselor/therapist, if any?

Thank you for taking the time to complete this questionnaire. We look forward to working with you on your goals!