PSYCHOTHERAPIST-CLIENT SERVICE AGREEMENT

Welcome to our private practice. TMR which stands for Treat Me Right (TMR) Mental Health Care PC. This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

PSYCHOTHERAPY SERVICES

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I, as your therapist, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness, and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But there are no guarantees about what will happen. Psychotherapy requires a very active effort on your part. To be most successful, you will have to work on things we discuss outside of sessions.

The first 2-4 sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, your counselor. A psychotherapist or psychiatric nurse practitioner will be able to offer you some initial impressions of what our work might include. At that point, we will discuss your treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with me. If you have questions about our procedures, we should discuss them whenever they arise. If your doubts persist, we will be happy to help you set up a meeting with another mental health professional for a second opinion.

APPOINTMENTS

Appointments will ordinarily be 45-60 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, we ask that you provide us with 24 hours' notice. If you miss two sessions consecutively without canceling, or cancel with less than 24-hour notice, our policy is to discharge the youth from the program [unless we both agree that you were unable to attend due to circumstances beyond your control]. If it is possible, we will try to find another time to reschedule the appointment. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

I acknowledge that these terms have been reviewed and agreed upon prior to the start of service provision. I agree to these terms for my minor child if I am signing on behalf of a minor child.

POLICIES OF CONFIDENTIALITY & PRIVILEGE

For many, the decision to see a therapist is an extraordinarily private one. People come to TMR with the expectation that the information that they will share with TMR clinicians will remain private. This expectation is a reasonable one, and in fact, in most instances, a psychotherapist or counselor has a legal obligation to keep clients' confidences and information private.
There are of course some exceptions.

The following is a brief outline of the constraints that a psychotherapist or counselor is under regarding keeping information regarding clients private.

Health Insurance Portability and Accountability Act of 1996 "HIPAA".

Title I of HIPAA was passed in 1996. Title I protects health insurance coverage for workers and their families who change or lose their jobs.

Title II of HIPAA requires the Department of Health and Human Services to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. Title II also addresses the security and privacy of health data, which is the section of the Act important for our purpose. Title II of HIPAA requires medical providers to protect the privacy of patients' medical information by controlling the manner in which a patient's "protected health information" is used and disclosed.

Under HIPAA, patients must be offered certain rights with respect to their information, such as the right to access and copy, the right to request amendments to the information contained in their file, and the right to request an accounting. Medical providers must have proper policies and procedures in place to further protect the privacy of patients' information. Under HIPAA, medical information can be shared with other health care providers for treatment purposes only. HIPAA does not permit mental health professionals to share personal psychotherapy notes of patients, even for treatment purposes, without the patient's authorization.

There are exceptions under HIPAA, which allow medical providers to disclose protected health information under the following situations:

1. Suspected Abuse or Neglect:If the medical provider believes that the patient has been a victim of abuse, neglect or domestic violence protected information may be released. The report must be made to a person authorized by law to receive reports of child abuse or neglect.

2. Serious or Imminent Threat: If the provider believes that disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public,protected information may be released to the appropriate authority.

3. Law Enforcement:If disclosure is necessary for law enforcement authorities to identify or apprehend an individual.

I acknowledge that these terms have been reviewed and agreed upon prior to the start of service provision.

FINANCIAL AGREEMENT

Services provided for this program are funded by Bergen County Youth Services Commission. You will not receive any bills or have any financial responsibility while enrolled in TMR Youth Program. If after 16 weeks you elect to continue psychotherapy services with TMR Mental Healthcare, you will be responsible for the cost of any services provided. At that time you will be asked to sign a new consent form and financial agreement.

I have read, understood, and agreed to TMR’s Financial Agreement. I understand that I am ultimately responsible for payment to TMR for all services rendered and that such payment is

due at the time of the visit. My signature below indicates that I fully understand and agree to these terms.

PROFESSIONAL RECORDS

We are required to keep appropriate records of the mental health / behavioral health services that we provide. Your records are maintained in a secure location electronically. We keep brief records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records we receive from other providers, copies of records we send to others, and your billing records. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and / or upsetting to untrained readers. For this reason, we recommend that you initially review them with us, or have them forwarded to another mental health professional to discuss the contents. If we refuse your request for access to your records, you have a right to have our decision reviewed by another mental health professional, which we will discuss with you upon your request. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

PARENTS & MINORS

While privacy in therapy is crucial to successful progress, parental involvement can also be essential. It is our policy not to provide treatment to a child under age 13 unless s/he agrees that we can share whatever information we consider necessary with a parent. For children 14 and older, we request an agreement between the client and the parents allowing us to share general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy. All other communication will require the child's agreement, unless we feel there is a safety concern (see also above section on Confidentiality for exceptions), in which case we will make every effort to notify the child of our intention to disclose information ahead of time and make every effort to handle any objections that are raised.

CONTACTING US

We are often not immediately available by telephone. We do not answer our phones when we are with clients or otherwise unavailable. At these times, you may leave a message on our confidential voice mail 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 unforeseen reasons, you do not hear from us or we're unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe, 1) If you or a family member are

experiencing the signs or symptoms of a mental illness and feel you are in crisis, and live in New Jersey call 201-262-HELP (4357). Crisis counselors are available 24/7 to guide you through the next steps of getting help. 2) go to your Local Hospital Emergency Room, or 3) call 911 and ask to speak to the mental health worker on call. We will make every attempt to inform you in advance of planned absences, and provide you with the name and phone number of the mental health professional covering your clinical team, when and if an absence occurs.

OTHER RIGHTS

If you are unhappy with what is happening in therapy, we hope you will talk with us so that we can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that we refer you to another therapist and are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about our specific training and experience.

CONSENT TO PSYCHOTHERAPY

Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to their terms**:**

Signature of Client or Personal Representative:

Printed Name of Client or Personal Representative:

Date:

Description of Personal Representative's Authority:

The following has been discussed with me regarding the use of telehealth for services provided by TMR, staff, and affiliates.

- ☐ Schedulin
- ☐ Privacy/security measure
- ☐ Potential risk
- ☐ Mandatory reporting requirement
- ☐ Credentials of care tea
- ☐ Billing arrangement
- ☐ Limits to confidentialit
- ☐ Explicit emergency pla

- Storage of patient information and potential for technical failur
- Procedures for coordinating car
- Protocols for contact between visit
- Prescribing policies (including local and federal regulations
- Conditions where telehealth should be terminated for in-person care

I hereby give my informed consent for the use of telehealth in my medical and mental health care.

Signature of Client or Personal Representative

Printed Name of Client or Personal Representative
Date:

INFORMED CONSENT FOR PSYCHOTROPIC MEDICATIONS

I being an adult of sound mind, (printed name) willfully and voluntarily make this declaration for mental health treatment with the use of psychotropic medications. Your physician or Psychiatric Mental Health Nurse Practitioner will prescribe psychotropic medication(s) after a thorough assessment of your needs, presenting symptoms, and current level of functioning and impairment.

To make an informed decision, you must be provided with information verbally (in your sessions) and/or written including the following:

1. The nature of your psychiatric condition (diagnosis).

2. The reasons for taking such medication(s), include the likelihood of improving or not improving without such medication(s).

3. The name, dosage, frequency, route of administration and duration of prescribed medication(s).

4. The possible side effects of the medication(s) known to commonly occur and may possibly cause birth defects.

5. Additional side effects may occur with continued administration of an Antipsychotic medication(s) if taken for more than three (3) months. Side effects may include persistent involuntary movements of the face, mouth, limbs, and trunk, called tardive dyskinesia. These symptoms may be irreversible and may continue to appear even

after the medication(s) has been discontinued.

6. Duration and continuation of medication(s) will be discussed with you and your treating Psychiatrist/Nurse Practitioner during each visit.

Your signature below acknowledges that:

1. Medication(s) and treatment have been adequately discussed with you and should be taken only as prescribed.

2. You have received all the information you desire concerning such medication(s) and treatment.

3. I have been offered a Medication Information Sheet(s) and have had an opportunity to review with the prescriber the specific benefits and side effects of prescribed medicine(s).

I hereby give my consent to treatment with this medication. I understand that I may seek additional information, and that I may withdraw this consent at any time by stating my intention to any member of the treatment team.

Program Services:
The Treat Me Right program provides integrative comprehensive mental health care. They utilize a holistic and strengths perspective approach to meet the needs of individuals, couples (parents or caregivers), and families. At TMR the services offered are individual, marriage, family, and group psychotherapy; psycho-pharmacology and medication management; and nutrition counseling. They treat mental health issues, concerns and disorders that meet the DSM-V diagnostic criteria with the use of various therapeutic modalities such as Cognitive Behavioral (CBT) Dialectical (DBT) Emotionally Focused Family/ Marital Family Systems Mindfulness-Based (MBCT) Person-Centered Psycho-dynamic Solution Focused Brief (SFBT) Strength-Based and Trauma Focused. Typically, clients are seen once a week over a 12 - 16-week period on average. Positive youth development in a treatment plan for an adolescent may consist of psycho-education regarding substance use and misuse. Difficulty in controlling youth's behavior.

Target Population:
Bergen County youths ages 8-17 at intake (unless referred by Family Court or Probation) with a priority to juveniles who reside in one of the Top Fifteen Municipalities.

Geographic Area Served: Bergen County-You are required to reside in Bergen County in order to participate in this program. Please provide proof of residency such as driver's

license, state ID, utility bill or bank statement.

Goals:

Prevention – to prevent at-risk youth from engaging in anti-social and delinquent behavior and from taking part in other problem behaviors that are pathways to delinquency.

Diversion – to provide services and/or informal sanctions to youth who have begun to engage in low level delinquent behavior in an effort to prevent youth from continuing on a delinquent path.

Disposition - To provide the court with a range of options that match the supervision and service needs of youth in their communities in an effort to reduce recidivism. **Reentry** – to provide youth transition from a JJC residential or day program with additional support for successful reintegration into their communities in an effort to reduce recidivism.

Are you involved with any of the following agencies:

Family Court
Family Crisis Intervention
JCC/Corrections
DCP&P
Alcohol/Drug Treatment (Residential/Non-residential)
CMO Bergen's Promise

Who can we thank for referring you?

School
Parents / Relatives
Family Court
Probation
Police Department
Self
Friends
Other, please specify:

Annual Income of Parents(s) or Guardian(s):

Youth's Employment Status:

Employed- full-time Employed- part-time Job training Disabled Not employed **Other**

Sources(s) of Income:

TMR Youth Program
835 Main St 2nd Flr Hackensack, NJ 07601
Informed Consent for TMR Mental Health Care PC

Family:

Single Parent/Guardian Dual Parent/Guardian Other None

Living Arrangements:

At Home Detention/Correction Foster home Living alone Relative's home
Friend's home Homeless Shelter

Psychiatric hospital Residential placement

Primary Caregiver:

Adoptive Parent(s) Biological Parent(s) Other Relatives(s)
Biological Parent and step parent Grandparent(s) Other Non-Relative(s)

Municipality of Residence:

County of Residence:

Treat Me Right Youth Program (TMR-YP)

Date of Referral: (MM/DD/YEAR)

How can we help?

Individual Psychotherapy

Family/Couples Psychotherapy

Psychiatric Evaluation or Biopsychosocial Assessment

Psychopharmacology

In order to participate in TMR-YP the youth must engage in all services with the exception of psycho-pharmacology as medication will only be prescribed if clinically appropriate.

Youth Demographics

Given or Legal Name:

Preferred Name (if applicable)

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Date of

Birth: Age: Gender: (M, F, X) Language Spoken: Preferred language for sessions:

Caregivers name:

Relationship to youth:

Address:

City: State: Zip Code

Preferred method of contact: Home phone Cell phone (text message call) Email Home phone:

May we leave a message? Yes No Cell phone: May we leave a message? Yes No Email:

May we email? Yes No ***Note: Email is not considered to be a confidential medium of communication.*

Referral Source

Name:

Last First Credentials

Agency:

Address:

City: State: Postal Code Phone: Fax:

E-mail:

Reason for Referral:

Would you like to receive updates on this client while they are in our care? Yes No

Treatment History and Eligibility for TMR-YP

What service/s is the client currently receiving from your agency? Please list below:

Are any other agencies involved? Yes No

If yes, which ones?

Goals of school/agency working with family ?

What school does the youth attend ?

School Status:

Passing

Failing

School refusal/poor attendance

Suspended Expelled

Current Grade**:**

Is the client covered under an insurance plan? Yes No

If yes, state their insurance provider:

Is the youth and youth's caregiver aware of the referral? Yes No If

yes, what is their attitude towards the referral?

Any special needs for the youth?

Is the youth currently taking medication and/or have any diagnoses that you're aware of?

Yes No

*** If accessible please provide us with any documentation related to previous mental health treatment. This information will help us better support this youth and their family. You can email or fax this information at your convenience. Or call our Client Care Coordinator at 201- 678-1802 if you prefer to discuss and provide this information over the phone***

Additional Comments:

TMR Youth Program
835 Main St 2nd Flr Hackensack, NJ 07601
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TMR Mental Health Care PC

Licensed Psychotherapists, Psychiatric Nurse Practitioners, Registered Dietitians

835 Main St 2nd Flr
Hackensack, NJ 07601

Call: 201-678-1802
Fax: 201-322-3738

Youth Name: Date of Birth:

Two-Way Authorization for Release of Information

I authorize TMR Mental Health Care PC (Treat Me Right- Youth Program) and its affiliates to receive and release information from or to the persons, agencies or facilities named below, either verbally or in writing, as indicated in this authorization.

Therapist
Contracted Systems Administrator
Division of Child Protection and Permanency (DCP&P)
Physician
NJ Division of Mental Health Services
NJ Juvenile Justice Commission NJ Parole Board
Other (specify)
NJ Division of Developmental Disabilities
NJ Division of Medical Assistance and Health Services (Medicaid)
Commercial
NJ Division of Child System of Care (DCSCOC)
Private Health Insurance
Unified Case Management Organization (UCM)
Current School
Children's Crisis Intervention Services (CCIS)
Mobile Response and Stabilization System (MRSS)

Specify information to be released:

Entire Record, Discharge Summary Evaluations, Treatment Plans, Admission Documentation, Transfer Summary, Assessments & Tests, Psychotherapy Notes, ISPs & IAPs, Physical Exam
Lab Reports Consultations (include name of consultant) Psychiatry Notes Neuropsych Testing Other (specify)

Purpose for the authorization:

To coordinate care, facilitate billing Referral Obtain insurance, financial or other benefits other purpose (please specify):

A copy of this authorization shall be considered as valid as the original.

I understand that I have a right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released pursuant to this authorization. This authorization will expire (specify a date, time period) or, if nothing is specified, it will expire in one year. I understand that authorizing the use or disclosure of the information identified above is

voluntary. I need not sign this form to receive treatment or services from TMR-YP and/or the other named person, facility or agency. However, lack of ability to share or obtain information may prevent TMR Mental Health Care PC, and/or the other named person., facility or agency, from providing appropriate and necessary care.

Parent / Caregiver Signature

Youth Signature (If 14 or older)

Print Parent / Caregiver Name

Print Name of Youth

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Problem areas

Please identify areas that you believe should be the focus of you or your child's psychotherapy treatment at this time:

Actively Rejecting Help
Alcohol Abuse
Alcohol Dependence
Antisocial/Pro Criminal Attitudes
Attention Deficit/Hyperactivity Disorder
Callous, Little Concern For Others
Criminal Behavior - Family
Defies Authorities
Delinquent Friends
Difficulty in Controlling Youths Behavior
Disruptive Behavior In School
Domestic Violence In Family
Dropout
Drug Abuse
Drug Dependence
Family Exposure To Community Violence
Functioning Below Grade Level
Illiteracy
Inadequate Supervision
Inappropriate Discipline
Inconsistent Parent Figure
Inflated Self-Esteem
Lack Of Independent Living Skills
Lack Of Job Skills
Lack Of Remorse/Acceptance Of Responsibility
Lack Of Teen Parenting Skills
Lack Of Vocational/Technical Skills

Low Self-Esteem
Marital Conflict
Medical Problems/Family
Medical Problems/Juvenile
Mental Illness - Family
Neglect - Juvenile
No/Few Positive Friends
Physically Aggressive
Poor anger management
Poor Frustration Tolerance
Poor Interpersonal Skills
Poor Problem Solving Skills
Poor Relationship - Female Parent Figure
Poor Relationship - Male Parent Figure
Poor School Performance
Post - Traumatic Stress

Suicidal Ideation/Gestures
Repeated Suspensions
Runaway Behavior
Serious Mental Illness
Sexually Acting out
Short Attention Span
Substance Abuse - Family
Teen Pregnancy
Truancy/Not attending
Verbally Aggressive
Victim of Physical Abuse - Juvenile
Victim of Sexual Abuse/Incest - Juvenile

Functional Impairment Assessment

Patient Name Patient DOB Provider Name Date

Functional Impairment Assessment
World Health Organization Disability Assessment Schedule 2.0

This questionnaire asks about **difficulties due to health conditions**. Health conditions include diseases or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs.

Think back over the **past 30 days** and answer these questions, thinking about how much difficulty you had doing the following activities. For each question, please select one response.

In the past 30 days, how much difficulty did you have in:

1. Standing for long periods of time, such as 30 minutes? 0 1 2 3 4 2. Taking care

of household responsibilities? 0 1 2 3 4

3. Learning a new task, for example, learning how to 0 1 2 3 4 get a new place?

4. How much of a problem did you have joining in 0 1 2 3 4 community activities in the same way as anyone else can?
(for example, festivities, religious or other activities)

5. How much have you been emotionally affected by your 0 1 2 3 4 health problems? 6.

Concentrating on doing something for ten minutes? 0 1 2 3 4 7. Walking a long

distance such as a half mile[or equivalent]? 0 1 2 3 4 8. Washing your whole body? 0 1 2

3 4 9. Getting dressed? 0 1 2 3 4 10. Dealing with people you do not know? 0 1 2 3 4 11.

Maintaining a friendship? 0 1 2 3 4 12. Your day-to-day work? 0 1 2 3 4 **Functional**

Impairment Assessment (continued)

H1. Overall, in the past 30 days, how many days were these difficulties present? (please estimate if you are not sure) days

H2. In the past 30 days, for how many days were you totally unable to carry out your usual activities or work because of any health condition? (please estimate if you are not sure) days

H3. In the past 30 days, not counting the days that you were totally unable, for how many days did you cut back or reduce your usual activities or work because of any health condition? (please estimate if you are not sure) days

Depression Assessment

Depression Assessment
Patient Health Questionnaire-9

This questionnaire will help you to better identify, understand and track your patients' depressive symptoms.

Over the last 2 weeks, how often have you been bothered by any of the following problems?

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 0 1 2 3 failure or have let yourself or your family down

7. Trouble concentrating on things, such as reading 0 1 2 3 the newspaper or watching television

8. Moving or speaking so slowly that other people 0 1 2 3 could have noticed. Or the opposite being so fidgety
or restless that you have been moving around a lot

more than usual

9. Thoughts that you would be better off dead, 0 1 2 3 or of hurting yourself In

the **past year** have you felt depressed or sad most days, even if you felt okay

sometimes? Yes No

If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?

Not difficult at all Somewhat difficult Very difficult Extremely difficult Has there been a time in the **past month** when you have had serious thoughts about ending your life?

Yes No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

Yes No

Anxiety Assessment

Anxiety Assessment
Generalized Anxiety Disorder-7

This questionnaire will help you to better identify, understand and track your

patients anxiety symptoms.

Over the last 2 weeks, how often have you been bothered by any of the following problems?

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

Youth Mental Health Test

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Pediatric Symptom Checklist - Youth Report

The questionnaire that follows can be used to see if you are having emotional, attentional, or behavioral difficulties. For each item please mark how often you:

Complain of aches or pains	**Never**	**Sometimes**	**Often**
Spend more time alone			
Tire easily, little energy			
Fidgety, unable to sit still			
Have trouble with teacher			
Less interested in school			
Act as if driven by motor			

Daydream too much			
Distract easily			
Are afraid of new situations			
Feel sad, unhappy			
Are irritable, angry			
Feel hopeless			
Have trouble concentrating			

Less interested in friends			
Fight with other children			
Absent from school			
School grades dropping			
Down on yourself			
Visit doctor with doctor finding nothing wrong			
Have trouble sleeping			
Want to be with parent more than before			
Feel that you are bad			

Take unnecessary risks			
Get hurt frequently			
Seem to be having less fun			
Act younger than children your age			
Do not listen to rules			
Do not show feelings			
Do not understand other people's feelings			

Tease others			

Blame others for your troubles			
Take things that do not belong to you			
Refuse to share			

Do you have any emotional or behavioral problems for which you need

help? No Yes

Please take a moment to answer the following optional questions. Your answers are totally anonymous—we won't be able to identify you based on this information. Your answers help us provide better information and support for people like you.

You can answer as many or as few questions as you would like. When you are done, scroll to the bottom of the survey and click "submit" to receive your screening results.

About You

Age Range

Gender

Please check this box if you identify as transgender.

Race/Ethnicity

Which of the following populations describes you?
Select all that apply.

Veteran or active duty military
Caregiver of someone living with emotional or physical illness
LGBTQ+

Student
Trauma survivor
New or expecting mother
Healthcare worker

About Your Mental Health

Have you ever been diagnosed with a mental health condition by a professional (doctor, therapist, etc.)?

Yes No

Have you ever received treatment/support for a mental health problem?

Yes No

Think about your mental health test. What are the main things contributing to your mental health problems right now?
Choose up to 3.

Coronavirus
Social life or relationships

Past trauma
Current events (news, politics, etc.)
Loneliness or isolation
Grief or loss of someone or something
Family's financial problems
Difficulties at school (academics or learning)
Being Bullied
Other…

About Your Health

Do you currently have health insurance?
Yes No

Do you have any of the following general health conditions?
Select all that apply.

Heart disease
Diabetes

Cancer
Arthritis or other chronic pain
COPD or other lung conditions
Movement Disorders (involuntary tics, tardive dyskinesia)
HIV/AIDS
Other…

Comprehensive Patient Medical History Form

Your answers on this form will help your clinician understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details or dates. Thank you!

Personal Information

Preferred Name: DOB: Date: Current Health Concerns:

Medications: (Prescription and non-prescription medications, vitamins, birth control pills, and herbs supplements)

Medication	Dose	Frequency	Medication	Dose	Frequency

Drug Allergies or Reactions to Medications/Food/Other Agents: Yes No Please list:

Personal Medical History:

Do you have any of the following?

Acid Reflux (heartburn)
Alcoholism Allergies (environmental)
Anxiety
Asthma
Atrial Fibrillation
Cancer (list below)
Cholesterol Problem
Coagulation (bleeding) Problem
Chronic Low Back Pain
Depression Diabetes Erectile Dysfunction Gout
High Blood Pressure Heart Disease (explain below)

Migraines	Problems
Osteopenia/Osteoporosis Prostate	Thyroid Problems

Other Chronic or Recurring Medical Problems. (If you are completing this form for a child who has any developmental delays or special needs please list below)

List of Medicatio

Please let us know if you are or have taken any of these medications. Select all that app

Generic Brand Generic Brand imipramine Tofranil levomilnacipran Fetzima desipramine Nopramin phenelzine Nardil amitriptyline Elavil tranylcypromine Parnate notriptyline Aventyl, Pamelor selegiline Emsam (patch) clomipramine Anafranil lithium carbonate Eskalith, Lithonate trazodone Oleptro olanzapine, fluoxetine Symbyax nefazo Generic Only carbamazepine Tegretol, Equetro fluoxetine Prozac, Sarafem divalp Depakote bupropion Wellbutrin lamotrigine Lamictal sertraline Zoloft oxcarbazepi Trileptal paroxetine Paxil methylphenidate Ritalin venlafaxine Effexor methylpheni Concerta desvenlafaxine Pristiq methylphenidate Metadate fluvoxamine L methylphenidate Methylin mirtazapine Remeron methylphenidate Daytrana (patch) citalopram Celexa methylphenidate Quillivant XR (liquid) escitalopram Lexapro

dexmethrylphenidate Focalin duloxetine Cymbalta dextroamphetamine Dexedri vilazodone Viibryd lisdexamfetamine Vyvanse atomoxetine Strattera d l-amphetamine Adderall vortioxetine Trintellix modafinil Provigil, Sparlon armod Nuvigil