GEORGIA CENTER FOR
OCD & ANXIETY

INDIVIDUAL ADULT PATIENT INFORMATION SHEET

Full Name:_____

Date of Birth: _____ Age: _____Sex: _____Ethnicity: _____

Address: _____

_____

Daytime Phone: _____ Can we leave messages? ☐Yes ☐No

Cell Phone: _____ Can we leave messages? ☐Yes ☐No

Email Address: _____ Can we leave messages? ☐Yes ☐No

In case of emergency who should I contact?

Name: _____ Relationship: _____ Phone: _____

Marital Status: ☐Single ☐Engaged ☐Partnered ☐Married ☐Remarried ☐Cohabitating ☐Divorced ☐Separated ☐Widowed

How long have you been with your current partner? _____

Education Level: _____

Occupation: _____

Place of Employment: _____

Work Status: ☐Full Time ☐Part Time ☐Unemployed

Present state of health: ☐Excellent ☐Good ☐Fair ☐Poor

Primary Care Physician: _____ Psychiatrist: _____

Current Medical Problems: _____

Current Medications:_____

Describe any significant hospitalizations/accidents/surgeries: _____

Have you ever been treated by a mental health professional? ☐Yes ☐No *If yes, answer the following:*

Outpatient therapy: ☐Yes ☐No Dates: _____

For what problem(s)? _____

Inpatient treatment: ☐Yes ☐No _____

Dates: _____

For what problem(s)? _____

Do you consider yourself to be spiritual or religious? ☐Yes ☐No

If yes, describe your faith or belief: _____

Who gave you my name to call:

Name: _____ Phone: _____

May I thank the person that gave you my name? ☐Yes ☐No

Briefly describe your primary concern and/or symptoms.

How long has this been a major problem?

Did anything happen shortly before your identified problems occurred (loss, death, job change, separation, divorce, birth, adoption, medical diagnosis, relocation, etc.)? ☐Yes ☐No If *yes*, please explain:

Describe briefly your family and current primary relationships:

Other areas of difficulty/concern.

What are your strengths? What is going well?

List any other factors/circumstances that may be relevant to treatment.

What are your goals for counseling?

SYMPTOM CHECKLIST

How often do you experience concerns related to:	Never	Rarely	Sometimes	Often	Almost Always
Work/ academic performance					
Motivation/procrastination					
Life choices/career direction					
Financial matters					
Grieving/significant loss					
Recurrent thoughts of death or dying					
Sexual/sexuality issues					
Family					
Relationships					
Anger					
Mood swings					
Depressed mood					
Fatigue/ decrease in energy					
Hair Pulling					
Skin Picking					
Appearance/weight					
Excessive exercise					
Dieting/restricting food					
Overeating/binging on large quantities of food					
Inducing vomiting, abusing laxatives, or other purging					
Unrealistic/excessive worrying					
Having strong fears					
Unable to calm down or relax					
Anxiety attacks					
A need to repeat things (count, check, clean) until exact					
Having obsessive/ruminative thoughts					
Avoiding certain thoughts, feelings or situations					
Feeling easily distracted					
Difficulty in organizing yourself to get anything done					
Criticism from others for inattentiveness					
Trouble finishing things					
Being told you're impulsive					
Feeling or being told you're more talkative than usual					
Feeling or being told you seem irritable, too energetic					
Flashbacks or memories of traumatic events					
Intentionally cutting or injuring yourself					
Seeing or hearing things no one else does					
Thoughts of harming other people					
Thoughts of harming yourself/suicide					
Hopelessness/worthlessness					
Memory					
Sleep					

SUBSTANCE USE INFORMATION

Please answer the following questions about alcohol/substance by selecting "Yes" or "No"

1.	Have you ever felt you should cut down on your drinking/substance use?	☐Yes	☐No
2.	Have people annoyed you by criticizing your drinking/substance use?	☐Yes	☐No
3.	Have you ever felt bad or guilty about your drinking/substance use?	☐Yes	☐No
4.	Have you ever had a drink first thing in the morning to steady your nerves or to help a hangover?	☐Yes	☐No

Have you ever used the following?		**If *yes*, but no current use:**		**If yes, and still currently using:**	
Substance		Date Quit	Lifetime # of uses	Frequency? (i.e 2x/day)	Amount per use?
Tobacco	☐Yes ☐No				
Caffeine	☐Yes ☐No				
Alcohol	☐Yes ☐No				
Marijuana	☐Yes ☐No				
Ecstasy	☐Yes ☐No				
Mushrooms	☐Yes ☐No				
LSD	☐Yes ☐No				
PCP	☐Yes ☐No				
Meth	☐Yes ☐No				
Cocaine	☐Yes ☐No				
Crack	☐Yes ☐No				
Ephedrine	☐Yes ☐No				
Codeine	☐Yes ☐No				
Heroin	☐Yes ☐No				
Darvocet	☐Yes ☐No				
Percocet	☐Yes ☐No				
Oxycontin	☐Yes ☐No				
GHB/Roofies	☐Yes ☐No				
Steroids	☐Yes ☐No				

Have you ever misused over the counter or prescription medications? ☐Yes ☐No

If *yes*, please list: _____

LEGAL INVOLVEMENT INFORMATION

Have you applied or are you in the process of applying for disability benefits? ☐Yes ☐No

If *no*, are you considering applying for disability benefits in the future? ☐Yes ☐No

Have you applied or are you in the process of applying for workman's compensation? ☐Yes ☐No

If *no*, are you considering applying for workman's compensation in the future? ☐Yes ☐No

Are you currently in any legal proceedings? ☐Yes ☐No

If *yes*, please explain: _____

PSYCHOTHERAPY FEE AGREEMENT

Haley Holt

Service:	Fee:
Initial Psychotherapy Evaluation (Intake)	$205
Individual Psychotherapy	$185
Letter Writing/Form Completion	$75 per half hour
Phone Calls **This service is used only in rare circumstances and refers to phone conversations outside of session, initiated by the client with the therapist, either directly or on the client's behalf.*	$75 per 15 minutes, billed at 15-minute increments
Late Cancelations of Appointments **__Please Note__: Cancellations made less than 24 business hours before scheduled appointment time will incur the FULL session fee (not reimbursable by insurance). For example: a 10:00 a.m. Monday appointment must be canceled by 10:00 a.m. Friday.*	$185

By signing below, I agree to the above fee structure.

Patient Printed Name	Parent/Guardian Printed Name
Patient Signature Date	Parent/Guardian Signature Date

CONSENT TO TREATMENT

I acknowledge I have *received*, have *read* (or have had read to me), and *understand* the **Therapist-Client Services Agreement,** and other information about the therapy I am considering. I have had all my questions answered fully.

I acknowledge I have *received*, have *read* (or have had read to me), and *understand* the **Notice of Privacy Practices.** I have had all my questions answered fully.

I consent to treatment by the therapist named below (or consent to treatment for my child) and agree to participate actively in the therapeutic process. I understand that no guarantees have been made regarding the results of treatment.

I may discontinue treatment at any time but remain responsible for payment of services already provided.

I have read the appointment information and understand that appointments must be canceled or rescheduled at least 24 business hours in advance. Cancellations made with less notice, or missed appointments, will be charged the full session fee, which is not reimbursable by insurance.

I agree to the terms in the Billing and Insurance Information section and understand that, if I use insurance, information about my services may be shared with my insurance company or other third-party payer as necessary for billing and payment. I understand that treatment may be discontinued if payment is not made, and referrals to other qualified providers may be offered.

My signature below shows that I understand and agree with all of these statements.

Patient Printed Name	Parent/Guardian Printed Name
Patient Signature Date	Parent/Guardian Signature Date

I, the therapist, have discussed the issues above with the patient (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Haley Holt, LCSW	
Therapist Printed Name	Therapist Signature Date

GEORGIA CENTER FOR OCD & ANXIETY

STATEMENT OF MEDICAL DECISION MAKING FOR A MINOR

Client Name: _____ **Client Date of Birth**: _____

I, _____, state and attest that I may legally consent to mental health and/or substance abuse treatment for the above listed minor child under the following authority:

- ☐ Biological Parent
- ☐ Adoptive Parent
- ☐ Department of Human Services representative – Department has custody of child and authority to consent to treatment.
- ☐ Other Legal Guardian – Legal guardian appointed by the court to have medical decision-making authority.
- ☐ Delegated Authority – A parent or legal guardian of minor child has, by power of attorney, delegated the medical decision-making authority for a period of up to twelve months.
- ☐ Other – Please explain: _____

Divorce or Other Legal Proceedings

Have there been any legal proceedings or actions that have affected the decision-making authority regarding the minor child, including but not limited to: a divorce proceeding, a legal separation proceeding, a paternity proceeding, a termination or limitation of parental rights, or an assignment of legal custody/guardianship?

☐ Yes ☐ No

If yes, please explain. _____

If there is a court order or stipulated parenting agreement, which parent has medical decision-making authority for the minor child:

- ☐ Father has sole medical decision-making authority
- ☐ Mother has sole medical decision-making authority
- ☐ Both parents share medical decision-making authority
- ☐ Other – Please explain: _____

Please note: The person signing this statement should provide legal documentation verifying legal authority to make medical decisions for the minor child, unless the person signing is the biological or adoptive parent and there have been no legal proceedings or actions that have affected their decision-making authority regarding the minor child.

_____	_____
Patient Printed Name	Parent/Guardian Printed Name
_____	_____
Patient Signature Date	Parent/Guardian Signature Date

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APPOINTMENT AVAILABILITY

Client Name: _____**Therapist Name**:_____

This form helps us understand your scheduling needs so we can arrange appointments accordingly. Our office hours are Monday through Thursday, with both morning and evening appointments available. Late afternoon and evening appointments are in highest demand and may be limited. We will do our best to match your availability with the next available appointment and appreciate your flexibility when adjustments are needed.

Please cross out the times you are **UNAVAILABLE** and **CANNOT** make appointments.

	Monday	Tuesday	Wednesday	Thursday
8:30am				
9:30am				
10:30am				
11:30am				
12:30pm				
1:30pm				
2:30pm				
3:30pm				
4:30pm				
5:30pm				
6:30pm				

Does your schedule change frequently (i.e. weekly work schedule)?

_____

_____

Are there any potential changes in your schedule in the near future (i.e. changing school schedules)?

_____

_____

Is there any other additional information that would help us in scheduling your appointments?

_____

_____

COMMUNICATION AUTHORIZATION

During treatment, you may communicate with our office by email or other electronic methods. Please be aware that these communications are not completely secure and may be accessed by others, including individuals with access to your devices, your employer (if using work systems), or third parties involved in internet transmission.

If you are concerned about confidentiality, please discuss secure communication options with your therapist.

Please note that appointment reminders may be sent by email, phone, or text. Do not reply directly to these automated messages, as responses are ***not*** monitored. For questions or appointment changes, please contact our office directly.

Georgia Center for OCD & Anxiety may contact me using the following methods:

Email: _____
Ok to send encrypted emails? ☐Yes ☐No
Ok to send *unencrypted* emails? ☐Yes ☐No
Would you like automated email appointment reminders? ☐Yes ☐No
**Please note:* If you prefer to communicate via *unencrypted* email, there may be some level of risk that the information contained in the email could be read by a third party.

Phone: _____
Ok to leave messages? ☐Yes ☐No
Would you like automated phone call appointment reminders? ☐Yes ☐No

Text Messages:
Ok to send texts? ☐Yes ☐No
Would you like automated text appointment reminders? ☐Yes ☐No

Preferred Mailing Address: _____
_____
Would you like correspondence mailed in an unmarked envelope? ☐Yes ☐No

I understand the risks of electronic communication, including potential confidentiality risks when transmitting protected health information through unsecured methods. I have read and understand the Notice of Privacy Practices. I understand that signing this agreement is not required to receive treatment and that I may revoke or update my contact preferences at any time.

_____	_____
Patient Printed Name	Parent/Guardian Printed Name
_____	_____
Patient Signature Date	Parent/Guardian Signature Date