BRIDGEWAY
Counseling Center
324 5th Street Ste 102 Lewiston, ID 83501
Phone 208-746-6776 Fax 208-746-1938

New Patient Demographics

Todays Date ____________

Patient Name ______________________________________

DOB ____/____/______ SS#____-_____-________

Phone _____-______-_________ OK to leave message? Y N

Phone _____-______-_________ OK to leave message? Y N

Drivers License or Picture Here

Home Address ______________________________________

Employed at:_______________________________________

Has Office Staff Made a Copy of Your Insurance Card? Yes or NO

Owner of insurance: Self Spouse Parent or ______________________

Name of Owner If **NOT** self: ____________________________

DOB: _________ Address: ______________________________

EMERGENCY Contact Name: ___________________________

Phone _____-______-_______ OK to leave message? Y N

Family Dr. ____________________________ Last Dr. visit ____________ Dr. Phone _____-_______-________

Who provided **Mental Health** services last 2 years?____

Is there an Advance Health Directive? Y N Details ____

If Patient is Minor Is there a legal document giving patient's rights to others? (Power of Attorney, Guardianship, Divorce Custody, etc.)

Y N Details ____________________________________ We asked for a copy? Y N ___________________

If yes, we must have a copy ____

How did you choose us? Google, Bridgeway website, Psychology Today website, Yellow pages, Dr. Referral, word of mouth,

____

Patient Signature: __________________________________ Date: ______/______/_______

Parent or Guardian Signature: __________________________________ Date: ______/______/_______

Insurance Cards Here

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Psycho-Social Information

Name: ______________________________ Race: Cau, N.A., or _________________ Date of Appointment _________

Comes Alone or With: ______________________________ Info from: Patient Family DOB: _________ Age: ___

Sex: M F Marital Status: Sing Mar Div Widow Employed Y N Where _________________________

Occupation: ____________________________

Reason ~ seeking treatment: __ Medication Management __ Counseling __ Psych Assess __ Patient new to provider

Referred by: __________________________________ What is the main Problem: ______________________________

____ How Long ___________________

What happened to make you start counseling now? ____

____

Health History: Height: ______ Weight______ Primary Care Physician: __________________________________

Allergies: ____

Surgeries: ____

Medical hospitalizations: ____

Chronic Health Problems: ____

__ Seizure _____________________________________ __ Head Injuries ____________________________________

__ Prenatal exposure to drugs/alcohol: ____

__ Any significant birth or early childhood trauma: ____

Education G.E.D. H.S. B.S. M.S. ____

Employment (main jobs) ____

____

No. of Marriages:____ Children from each ____

____

Mental Health Counseling none or Diagnosis ____

Years & Locations ____

Mental Health Inpatient none or Diagnosis ____

Years & Locations ____

Chemical Abuse Outpatient none or Substances ____

Years & Locations ____

Chemical Abuse In-Patient none or Substances ____

Years & Locations ____

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Current Psychiatric Medications & Dosage

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

Past Med Failures: ______________________________

Past Meds ~worked well: ______________________________

Family Psychiatric History: (Circle Below)

__ Depression:	Children	Spouse	Mother	Father	Siblings	Grandparents	Aunt	Uncle
__ Suicide Attempt / Complete:	Children	Spouse	Mother	Father	Siblings	Grandparents	Aunt	Uncle
__ Bipolar:	Children	Spouse	Mother	Father	Siblings	Grandparents	Aunt	Uncle
__ PTSD	Children	Spouse	Mother	Father	Siblings	Grandparents	Aunt	Uncle
__ Schizophrenia:	Children	Spouse	Mother	Father	Siblings	Grandparents	Aunt	Uncle
__ Anxiety/Panic Attacks:	Children	Spouse	Mother	Father	Siblings	Grandparents	Aunt	Uncle
__ OCD:	Children	Spouse	Mother	Father	Siblings	Grandparents	Aunt	Uncle
__ Alcohol/Abuse:	Children	Spouse	Mother	Father	Siblings	Grandparents	Aunt	Uncle
__ Drug Abuse:	Children	Spouse	Mother	Father	Siblings	Grandparents	Aunt	Uncle
__ Psychiatric Hospital	Children	Spouse	Mother	Father	Siblings	Grandparents	Aunt	Uncle
__ Substance TX Facility	Children	Spouse	Mother	Father	Siblings	Grandparents	Aunt	Uncle
__ Prison:	Children	Spouse	Mother	Father	Siblings	Grandparents	Aunt	Uncle

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Life Experiences Scale

On scale of 0 (none) to 10 (lots) write a number to show how <u>significant</u> each statement below is for <u>you</u>.

EXAMPLE: Stressed Out	**L**				
I Hold Anger Inside		I've Hit or Yelled or thrown Things when Angry		I Don't Know Right Way to be Angry	
I get Anxious		I get Frightened		I Have Had Panic Attacks	
I have had My Heart Raced for no reason		At times I Can't Breathe		I feel Powerless to Accomplish Goals	
I Feel Powerless to Protect Myself		I Can't Stop Thinking Certain Thoughts		I Can't Stop Doing Certain Things	
I Have Been Told I Have a Mental Problem		I can Hear Someone Else's Thoughts		I've had Someone put Thoughts in my Head	
I Have Avoided Eating for a Long time		I have thrown-up on purpose after over-eating		Sometimes I Eat Way To Much	
I have Unwanted Recent Weight Gain		I have Unwanted Recent Weight Loss		I hate my body	
I Drink too Much Alcohol		I've over-used Prescription Medication / Drugs		I Might be Addicted to Something	
I have Heard Sounds No One Else Hears		I've had Something Like Hepatitis, Asthma, Diabetes or _____________		I've Heard Sounds Inside or Outside of My Head	
I Sometimes Think About Harming Myself		I Have Hurt Myself		I've Seen Things Inside my Head	
I am Depressed Now		I have Been Depressed Sometime		Sometimes I Have a Sleep Problem	
I Have Attempted Suicide		I Have Threatened Suicide		I Have had Thoughts of Suicide	

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Item	☐	Item	☐	Item	☐
I have had a Migraine		I have had a Seizure		I've had an Out of Body Experience:	
I Have Problems in a Relationship		I've seen Things That People say Aren't Real		I've Heard Things That Aren't There	
I've Been in Experiments		I've had Dizziness or a 'Spinning Mind'		I've Sometimes Argued in my Head	
My Mood Changes Quickly		My Mood Changes For Few Days at a Time		Mood Changes for Weeks or Months	
My Sexual Interest is Low		I've Sometimes Spaced-out During Sex		I can Hear Someone Else's Thoughts	
I've Experienced an Really Scary Event		I've Experienced a Very Sad Event		I've Blocked Thoughts of Bad Experiences	
I Had Trauma when a Child		As a Child, Someone I Knew had Trauma		I Learned About Sex When to Young	
I've had a Flashbacks of a bad Event		A Bad Thing happed, but I Can't Remember it		I've had Nightmares of a bad Event	
I've had Memory Problems		I've Traveled & Not Remembered Part of Trip		My mind Sometimes goes Blank	
Sometimes I Space Out		I've had time passes without me Noticing		I've had Blackouts	
I Really Don't Know Why I do Some Things		I've done something & not Remembered Doing it		I Sometimes Become Confused	
Sometimes My Hand Writing Is Different		I have Felt or Behaved Like 2 Different People		A Different Part of Me can do Things	
I Have More Than one Personality		I have had a UFO Experience		I've had Conversations in my Head	
I have Unreasonable Fear of Bugs, Cartoon Character, Clown, Doctor, Policeman, Needles, Priest, Height, Small Room or (explain)				I Know About Things I am Never Supposed to Talk About	

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Informed Consent

By signing at the bottom of this page, I Agree To & Authorize all of the following:

* Release of information as per policy & charges to my insurance Co's. for services and payment by them to this provider
* To be responsible for all costs of service and to pay for any services not paid by my insurance or EAP company
* To accept statements and other communication from Bridgeway Counseling or Frank Shull at my mailing address
* The use of copies of documents within my chart in place of the original documents
* Our counseling duties DO NOT include any other activities. All other activities such as: writing reports, testifying, giving depositions, preparation and travel time to perform the preceding will be billed at $90.00 per hour.

Private Pay Fee: **Counseling:** Intake $_____ 85 min $_____ 55 min $_____

Attendance / No-Show Policy: I agree to the following:

- I will cancel appointments I cannot attend one business day ahead of time (**except illness**) or pay the fee below
- The "No-Show" or "Late Cancel" charges is: **$ 45.00 for 55 minute appointment and $75.00 for Intake.**
- All "balance" amounts must be paid to us before your session. **WE ACCEPT CREDIT CARDS**

Potential Risks & Benefits of Counseling:

EAP counseling (50 minutes) is not psychotherapy, but for current problems or to provide an employee with consultation, evaluation and referral. We are time-limited by your EAP plan authorizations, usually 4-8 sessions.

Psychotherapy: Therapy is the Greek word for change. Counseling helps you make changes within yourself. We will take all the time you need and not rush the change process. Some change cannot occur until a person faces difficult issues. If you choose to confront those issues, you may experience some of the following: sadness, anger, anxiety, confusion or other emotions. It is likely that you will benefit from working through those feelings not avoiding them.

Patient Statement: I have a choice of Mental Health provider agencies. I have chosen Bridgeway Counseling Center. My provider, Frank E. Shull, M.Ed., LCPC and I have discussed my treatment. No promises have been made to me about the results of treatment other than the explanation above. I understand that this chart can be opened in **only ONE name**, even for couples counseling. A couples Info Release has explicit limitations.

Emergency / 24 Hour Crisis Service below We **do not provide crisis services**.

The following agencies have provided crisis service in our area, but **telephone numbers may have changed**:

- YWCA in Lewiston (746-9655 crisis-line)
- Quality Behavioral Health (758-3341) daytime or (1-888-475-5665 crisis-line) nights.
- If you think you might hurt yourself or somebody else, tell someone, go to a hospital ER, or dial 911.

By signing here, I acknowledge I understand and agree to all the conditions stated above on this page.

Patient Signature: ______________________________ Date: _____/______/________

______________________________ ______________________________ _____/______/________

Printed Name of parent, guardian, etc. Signature Date

This patient meets our Inclusion policy requirements: Y N Copy offered to patient: __ accepted __ declined
As their provider, I have discussed the issues above with the patient or representative. My observations of this person's behavior and responses give me no reason to believe they are not fully competent to give informed consent to treatment.

Frank E. Shull, M.Ed., L.C.P.C. Signature: ______________________________ Date ____________