FACES Professional Services LLC

I_____ authorize _____ at the

above address to:

___ Release of any records regarding results in alcohol & drug assessments, mental health evaluations, urine drug screens, treatment diagnosis and recommendations and information to sent to the following people listed below. I understand these individuals may communicate through fax/email/phone with the above facility and (therapists, specialists, family members, probation officers, state workers or legal entities).

I give permission to release my information to:

1) Name, Address: _____

_____

Email Address: _____

2) Name, Address: _____

_____

Email Address:_____

For the purpose of:

___ A&D Assessment ____ Other: _____

___ Mental Health Evaluation _____

___ Probation or Court Referral _____

___ DCS Referral

Signed :_____ Date:_____

Release of Records:

I am requesting a service provided and agree the service will be provided. I have been invoiced by D. Deneen Bunch through paypal and will be paying for this service provided through paypal. I understand documentation may be provided to prove the service was provided. I understand there are no refunds for this service provided.

Name:_____

Date:_____

Email:_____

Phone:_____

PERSONAL INFORMATION

NAME: _____ AGE: _____ TODAY'S DATE: _____

DATE OF BIRTH: _____ SS#: _____

MAILING ADDRESS: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

SCHOOL/EMPLOYER: _____

ADDRESS: _____ TELEPHONE: _____

DUE TO PRIVACY REGULATIONS, WE CANNOT LEAVE MESSAGES ON ANSWERING MACHINES, OR WITH ANY PARTY WITHOUT YOUR AUTHORIZATION. MAY WE CONTACT YOU BY PHONE? YES NO

PLEASE LIST WHOM WE MAY SPEAK TO: _____

MARRIED: YES/NO; IF MARRIED, NUMBER OF TIMES: _____; NUMBER OF TIMES DIVORCED: _____; WIDOWED: _____

NAMES AND AGES OF CHILDREN: _____

WITH WHOM DO YOU LIVE (RELATIONSHIP, IF ANY): _____

NAME/RELATIONSHIP OF PERSON FILLING OUT FORM, IF NOT PATIENT: _____

FAMILY HISTORY

	FATHER	MOTHER	FATHER'S PARENTS	MOTHER'S PARENTS	SIBLINGS	CHILDREN
Depression						
Anxiety						
Panic Disorder						
Manic Depression						
Schizophrenia						
Alcohol Abuse						
Heart Disease						
High Blood Pressure						
Stroke						
Cancer						
Diabetes						
Epilepsy						
Thyroid Disorder						
Parkinson's Disorder						
Alzheimer's Disorder						
Occupation						
Age at Death						
Cause of Death						

We request a 24 hour advance cancellation notice to avoid a missed appointment charge. Our phone is answered 24 hours a day, seven days a week to take urgent calls and cancellations. Calls for medication refills will be answered the next business day, when your chart is available for review. Please check y our medication regularly and make appointments before the supply is exhausted to discuss any changes and obtain the necessary new prescription. We will file your insurance as a courtesy to you. However, payment is ultimately the responsibility of the patient or the responsible party named below.

I authorize the release of any medical information necessary to process this claim. Additionally, I request payment of payment of medical benefits to the physician or supplier for services rendered to the above named patient.

Signed: _____ Date: _____

Patient Name or Guarantor of Patient

COUNSELING & THERAPY
INTAKE ASSESSMENT SCREENING

GENERAL INFORMATION

Date: _____

Name (self) _____ Date of Birth: _____

Marital Status (check one): ☐Single ☐Married ☐Remarried ☐Separated ☐Divorced ☐Widowed ☐Significant Relationship

Education: What is the last grade completed (degree)? _____

Occupation: _____ How Long?: _____

Who referred you here or how did you hear about these services? _____

Is there a particular problem that brought you here to seek therapy? _____

Can you identify areas that you'd like to work on in therapy? _____

DRUG USAGE HISTORY

Route of Administration: (1) Oral (2) Smoking (3) Inhalation (4) Injection (5) Other
Severity: (0) No Problem (1) Primary (2) Secondary (3) Tertiary

Drug	Amt/Freq	Last Use	Length of Use	Age of 1st Use	Route	Severity

Do you use tobacco products? ☐Yes ☐No If yes, what, how much and how long? _____

Do you use caffeine products? ☐Yes ☐No If yes, what, how much and how long? (Include caffeinated beverages, diet pills, etc.) _____

Withdrawal Symptoms? ☐Yes ☐No List Symptoms: _____

How often do you use alcohol (circle one)? ☐Yearly ☐Monthly ☐Weekly ☐Daily

FAMILY/RELATIONSHIP BACKGROUND

Father's Name: _____ Age: _____

If deceased, indicate age at death and year of heath: _____

Occupation: _____

Briefly describe his alcohol/drug use: _____

Mother's Name: _____ Age: _____

If deceased, indicate age at death and year of heath: _____

Occupation: _____

Briefly describe her alcohol/drug use: _____

If you were not brought up by your parents, who raised you? Between what years? _____

_____

In your family life as a child, list any critical events and your age when they occurred (e.g. deaths, divorce. hospitalization, loss of job, a difficult move, etc.) _____

_____

List the names, ages and occupations of children in your family of origin in order of birth including yourself (brothers and sisters): _____

_____

_____

MARRIAGE/LONG TERM PARTNERSHIP (CURRENT)

What is your partner's age? _____ How long have you been a couple? _____

What is your partner's occupation? _____

What is your partner's pattern of alcohol/drug use? _____

Indicate your level of satisfaction with the relationship: 1= Very Dissatisfied……5=Very Satisfied

1----------2----------3----------4----------5

Do you have any children? ☐Yes ☐No If yes, how many? _____

Please give their name, ages and sexes: _____

_____

Do any of your children present special problems? ☐Yes ☐No Please list: _____

_____

LEGAL HISTORY

Have you been arrested in the last (2) years? ☐Yes ☐No If yes, how many times? _____

Are you presently incarcerated? ☐Yes ☐No If yes, what is your release date? _____

Upcoming court dates? ☐Yes ☐No If yes, please list when, where and why: _____

_____

MEDICAL INFORMATION

Who is your personal or family physician? _____ Phone #: _____

Clinic: _____ Address: _____

Pregnant: ☐Yes ☐No Hepatitis: ☐Yes ☐No If yes, What type? _____

TB Test: ☐Yes ☐No Date: _____

Allergies: _____

Do you have any current concerns about your physical health? Please specify: _____

_____

_____

Have you had any significant medical problems in the past? Please specify: _____

_____

_____

Have you ever been hospitalized for psychological problems? ☐Yes ☐No

If yes, when and where? _____

Previous or current therapy/counseling. Please list any therapy/counseling that you or other members of your family/household have received. What led you to seek therapy/counseling at that time or times? How would you describe the results of that therapy/counseling? _____

_____

_____

Are you taking any medications for anxiety, depression or nervous tension? If so, what and how much? Who prescribed the medication? _____

_____

_____

Please list any medications you are currently taking, or have taken during the past year: _____

_____

_____

Have you had any previous Mental Health, Alcohol or Drugs and/or Psychiatric Treatment? ☐ Yes ☐ No

If yes, Where? _____ When? _____

Reason: _____

Current/Past Suicidal Ideation: ☐Yes ☐No Plan: ☐Yes ☐No

Current/Past Homicidal Ideation: ☐Yes ☐No Plan: ☐Yes ☐No

Explain: _____

Date: _____

Patient Name: _____ DOB: _____

Brief Psychiatric Questionnaire

Medical History: Check any current or previous health problems.

____ Anxiety or Panic Attacks
____ Alcohol or Drug Problems
____ Emotional, Physical or Sexual Abuse
____ Forgetfulness Resulting in Accidents
____ Frequent Pain such as Headache or Backache
____ Heart Problems or High Blood Pressure
____ Serious Illness or Operation
____ Stroke or Prolonged Fainting Spells
____ Several Unexplained Physical Problems
____ Problems Not Listed Above: _____

____ Appetite or Weight Changes
____ Asthma or Lung Problems
____ Family Psychiatric Problems
____ Hallucinations
____ Head Injury or Seizures
____ Loss of Energy or Motivation
____ Suicidal Thoughts or Attempts
____ Thyroid/Endocrine Problems
____ Violent Behavior

Habits: Describe if answer is "Yes".

____ Smoke Cigarettes _____
____ Drink Caffeine _____
____ Use Alcohol or Recreational Drugs _____
____ Have you ever felt you should cut down on your use of alcohol or recreational drugs?
____ Have people annoyed you by criticizing your use of alcohol or recreational drugs?
____ Have you ever felt guilty about your use of alcohol or recreational drugs?
____ Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to relieve a hangover?

Prescribed Medications and Drug Allergies:

Please list your prescribed medications, including dosage.

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Are you allergic to any medication? ____ If yes, please list medication: _____

Background Information:

The highest level of school completed during your formal education was _____.
During adulthood, I have worked as _____.

Stressful Life Events: Please "X" if happened to you in the past, or "XX" if during the past 12 months.

__ Death of Spouse
__ Jail Term
__ Personal Injury/Illness
__ Retirement
__ Child Leaving Home
__ Problems with Family Members
__ Gain of a New Family Member
__ Marital Separation
__ Death of friend/family member
__ Marriage
__ Sexual Difficulties
__ Work Dissatisfaction
__ Change in Social/Recreational Activities
__ Divorce
__ Fired from Job
__ Financial/Legal Problems
__ Changing Residence
__ Spouse Starts/Ends Work

Background Information:
The highest level of school completed during your formal education was _____.
During adulthood, I have worked as _____.

Stressful Life Events: Please "X" if happened to you in the past, or "XX" if during the past 12 months.

__ Death of Spouse
__ Jail Term
__ Personal Injury/Illness
__ Retirement
__ Child Leaving Home
__ Problems with Family Members
__ Gain of a New Family Member
__ Marital Separation
__ Death of friend/family member
__ Marriage
__ Sexual Difficulties
__ Work Dissatisfaction
__ Change in Social/Recreational Activities
__ Divorce
__ Fired from Job
__ Financial/Legal Problems
__ Changing Residence
__ Spouse Starts/Ends Work

Date: _____

Patient Name: _____ DOB: _____

The following is a rating scale of Anxiety and Depression. Please use the following rating system: 1 = Never, 2 = Sometimes, 3 = Often and 4 = Usually; to answer the following questions.

Anxiety: