



Manhattan Marriage & Family Therapy

Client Demographic and Clinical Information Form

Today's date: _____

Please briefly complete the following questions.

Note: If you have been a patient here before, please fill in only the information that has changed.

A. Identification

Your name: _____ Date of birth: _____ Age: _____ M or F

Nicknames or aliases: _____ Social Security #: _____

☐ Home street address: _____ Apt: _____ ☐ City:

_____ State: _____ Zip: _____

☐ Home/evening phone: _____ e-mail: _____

Marital Status: _____ Ethnicity/national origin: _____ ☐

Calls or e-mail will be discreet, but please indicate any restrictions (For Instance: do not leave messages, only leave messages at home number, only leave name and number, email is ok):

Please describe the main difficulty that has brought you to therapy:

B. Referral: How did you hear about Manhattan Marriage and Family Therapy?

C. Religious and racial/ethnic identification

Growing up were you Involved In religious or spiritual activities: yes no

If yes, what type: _____

Current religious denomination/affiliation: Protestant Catholic Jewish Islamic Buddhist Hindu

Other (specify): _____

Involvement: none Some/irregular Active

How important Is spirituality in your life? _____

D. Your medical care: From whom or where do you get your medical care?

Clinic/doctor's name: _____ Phone: _____

Address: _____

Have you had any significant operations or illnesses (chronic or childhood):

Have you ever been told you had a mental health diagnosis (I.e. depression, bipolar, anxiety, etc.)

List all prescribed or over the counter medicines you are currently or previously taken for emotional problems:



E. Current Mental Health:

CURRENT SYMPTOM CHECKLIST - Indicate next to each symptom using following (Rate intensity of symptoms currently present)

None This symptom not present at this time • **Mild** Impacts quality of life, but no significant impairment of day-to-day functioning

Moderate Significant impact on quality of life and/or day-to-day functioning • **Severe** Profound impact on quality of life and/or functioning

	N	Mi	Mo	S		N	Mi	Mo	S		N	Mi	Mo	S
depressed mood					bingeing/purging					guilt				
appetite disturbance					laxative/diuretic abuse					elevated mood				
sleep disturbance					anorexia					hyperactivity				
elimination disturbance					paranoid ideation					dissociative states				
fatigue/low energy					circumstantial symptoms					somatic complaints				
psychomotor retardation					loose associations					self-mutilation				
poor concentration					delusions					significant weight gain/loss				
poor grooming					hallucinations					concomitant medical condition				
mood swings					aggressive behaviors					emotional trauma victim				
agitation					conduct problems					physical trauma victim				
emotionality					oppositional behavior					sexual trauma victim				
irritability					sexual dysfunction					emotional trauma perpetrator				
generalized anxiety					grief					physical trauma perpetrator				
panic attacks					hopelessness					sexual trauma perpetrator				
phobias					social isolation					substance abuse				
obsessions/compulsions					worthlessness					other (specify)				

F. Chemical Use

Drug	Age of first use	Last use	How often
alcohol			
amphetamines/speed			
barbiturates/owners			
caffeine			
cocaine			
crack cocaine			
hallucinogens (e.g., LSD)			
inhalants (e.g., glue, gas)			
marijuana or hashish			
nicotine/cigarettes			
prescription			
other			

Treatment history:

- outpatient
- inpatient
- 12-step program)
- stopped on own)

Consequences of substance abuse (circle all that apply):

- hangovers
- withdrawal symptoms
- sleep disturbance
- binges
- seizures
- medical conditions
- assaults
- job loss
- blackouts
- tolerance changes
- suicidal impulse
- arrests
- overdose
- loss of control amount used
- relationship conflicts

G. Your current employer

Occupation: _____ Employer: _____

Address: _____

Work phone: _____ Length of employment: _____

H. Your education and training

Highest grade completed (circle): HS Diploma GED Bachelors Masters Doctorate

Post-secondary Grade school Military Other: _____



I. Marital or Significant nonmarital relationship history

Spouse's name

Has spouse remarried?

Describe Relationship

First

Second

J. Children

Current

Name

age

Gender

Living arrangement

K. Relationships in your family of origin.

Please describe the following:

1. Your parents' relationship with each other: _____

2. Your relationship with each parent and with any other adults present:

3. Your relationship with your brothers and sisters in the past and present:

L. Abuse history: Have you ever been abused?

- | | | | |
|-------------|------------------------------|-----------------------------|-----------------------------------|
| Physically | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Not Sure |
| Emotionally | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Not Sure |
| Sexually | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Not Sure |

Was it a problem in your family growing up? Yes No

Is it presently a problem or concern? Yes No

M. Legal history

1. Is your reason for coming to see me related to an accident, injury, divorce or other legal matter? Yes No

If yes, please explain: _____

2. Are you required by a court, the police, or a probation/parole officer to have this appointment? Yes No

If yes, please explain: _____

3. Are there any other legal involvements I should know about?

N. Other

1. What do you consider your major strengths?

2. Is there any other information you think we should know?

3. My support system Includes (circle all that apply): Friends Mentor Religious figure Other _____

O. Emergency information

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?



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Name: _____ Phone: _____ Relationship: _____

Client Rights

The following briefly summarizes your rights as a participant in therapy with Manhattan Marriage and Family Therapy, PLLC. If you have questions about the following information please ask.

You have the right to know about your treatment and to make your own choices. Your therapist will assist you in acquiring the information you need to consider your options and make informed decisions. You also have the right to know the professional qualifications of your therapist, please feel free to ask about education, experience or professional background.

Your other rights are outlined in the following main areas:

No Discrimination

Manhattan Marriage and Family Therapy, PLLC will not discriminate in the provision of services based on age, sex, race, creed, marital status, religion, national origin, sexual preference, public assistance status or criminal record.

Confidentiality

There is a high value on the confidentiality of the information that you share. Information you provide in therapy is private. The only individual with access to your file is your therapist. Your file is kept for six years before permanent destruction. Persons not mentioned above are not allowed access to your file unless you provide written permission through a signed release of information.

Exceptions to Confidentiality

Therapists of Manhattan Marriage and Family Therapy, PLLC are mandated to report certain information which may be revealed in the course of treatment. This includes information about neglect, physical abuse, sexual abuse, suicidal threats, homicidal threats, harm to vulnerable adults, court orders, and use of illicit drugs during pregnancy. In some circumstances, a court might be able to subpoena your records.

In addition, cases are discussed as part of a multi-disciplinary team process involving other licensed therapists. Such discussions are kept private. Occasionally a case may be presented to an outside consultant who has special expertise in a particular area. Such consultants are obliged to observe data privacy requirements. As stated above, there are other special circumstances where your records may be mandated to be released.

If you are using your insurance benefits your insurance company will be notified that you are attending therapy, dates of therapeutic services, and a DSM code you are given by your therapist. In some instances your insurance provider will ask for additional clinical information as part of their quality assurance process.

Access to Information and Records

You have the right to obtain a summary of your records or a copy of your treatment plan, discharge plan, or comprehensive summary with a written request for information with signature.

Communication

Email and text messages may be used by clients to confirm or cancel appointments or ask for additional information or resources. Therapeutic services can not be obtained through these mediums. Your therapist will use email and text messages or leave a voice mail message to confirm appointments, send tip sheets or other prudent information unless otherwise requested.

Video and Audio Taped Sessions



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For purposes of quality services rendered and for ongoing therapist training, sessions are taped via audio or video as appropriate. Video tapes are not part of the record and can not be used other than for educational purposes. Client will know and consent to taping beforehand. Client can decline or discontinue video or audio taped sessions at any point.

Cancellation of an Appointment

You may cancel an appointment within 24 hours without financial penalty. If an appointment is canceled within 24 hours a \$75 fee will be applied. If there is no call to cancel and no show to your appointment, you will be charged \$75 for the appointment.

Payment

You have the right to know before or during the first appointment what the financial obligation to attend therapy will be. You will know about the process for collecting insurance reimbursement, co pays and other balances that insurance will not cover. When you sign the bottom of this page you are putting your signature on file. **Payment is collected at the time services are rendered in cash or check.**

Terminating Treatment

At all times you have the right to end services. If you choose to discontinue receiving services due to dissatisfaction with the treatment, we ask that you follow the Grievance Procedure to help us resolve the difficulty.

Grievance Procedure

Please speak with your therapist about any dissatisfaction you are experiencing in writing or verbally. If you do not feel comfortable discussing your concerns with your therapist or feel after communication your dissatisfaction is not resolved you can contact the Director of Manhattan Marriage and Family Therapy, PLLC Amanda Craig PhD, LMFT , New York Board of Marriage and Family Therapy or the Department of Education which your therapist is licensed under.

New York Marriage and Family Therapy Board
www.nyamft.org

New York Department of Education
www.op.nysed.gov
518-474-3817 x 400

Signature

Therapist Signature

Date



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Consent to Use and Disclose Your Health Information

This form is an agreement between you, and me/us, When we use the words “you” and “your” below, this can mean you, your child, a relative, or some other person if you have written his or her name here: .

When we examine, test, diagnose, treat, or refer you, we will be collecting what the law calls “protected health information”

(PHI) about you. We need to use this information in our office to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you. By signing this form, you are also agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information.

If you do not sign this form agreeing to our privacy practices, we cannot treat you. In the future, we may change how we use and share your information, and so we may change our notice of privacy practices. If we do change it, you can get a copy.

If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to accept these limitations. However, if we do agree, we promise to do as you asked. After you have signed this consent, you have the right to revoke it by writing to our privacy officer. We will then stop using or sharing your PHI, but we may already have used or shared some of it, and we cannot change that.

Signature of client or his or her personal representative

Printed name of client or personal representative

Signature of authorized representative of this office or practice

Date



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Notice of Privacy Practices (Brief Version)

Our commitment to your privacy

Manhattan Marriage and Family Therapy, PLLC is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We are also required by law to keep your information private. These laws are complicated, but we must give you this important information. This is a shorter version of the attached, full, legally required notice of privacy practices. Please talk to our privacy officer (see the end of this form) about any questions or problems.

How we use and disclose your protected health information with your consent

We will use the information we collect about you mainly to provide you with **treatment**, to arrange **payment** for our services, and for some other business activities that are called, in the law, **health care operations**. After you have read this notice we will ask you to sign a **consent form** to let us use and share your information in these ways. If you do not consent and sign this form, we cannot treat you. If we want to use or send, share, or release your information for other purposes, we will discuss this with you and ask you to sign an authorization form to allow this.

Disclosing your health information without your consent

There are some times when the laws require us to use or share your information. For example:

1. When there is a serious threat to your or another's health and safety or to the public. We will only share information with persons who are able to help prevent or reduce the threat.
2. When we are required to do so by lawsuits and other legal or court proceedings.
3. If a law enforcement official requires us to do so.
4. For workers' compensation and similar benefit programs.

There are some other rare situations. They are described in the longer version of our notice of privacy practices.

Your rights regarding your health information

1. You can ask us to communicate with you in a particular way or at a certain place that is more private for you. For example, you can ask us to call you at home, and not at work, to schedule or cancel an appointment. We will try our best to do as you ask.
2. You can ask us to limit what we tell people involved in your care or the payment for your care.
3. You have the right to look at the health information we have about you, such as your medical and billing records. You can get a copy of these records, but we may charge you for it. Contact our privacy officer to arrange how to see your



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records. See below.

4. If you believe that the information in your records is incorrect or missing something important, you can ask us to make additions to your records to correct the situation. You have to make this request in writing and send it to our privacy officer. You must also tell us the reasons you want to make the changes.

5. You have the right to a copy of this notice.

6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our privacy officer and with the Secretary of the U.S. Dept. of Health and Human Services. Complaints must be in writing.