Neuro Harmony, LLC

Client Registration Form

CLIENT INFORMATION:

Client Name: _____
(Last) (First) (Middle Initial) (Nickname/Preferred Name)

Current Address: _____ _____ _____ _____
(Street) (City) (State) (Zip Code)

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

SSN_____ Email Address: _____

*Note text and emails may not be confidential

□ ok to leave messages about billing
□ ok to leave detailed voice message
□ ok to text messages
□ appointment reminders

□ ok to leave messages about billing
□ ok to leave detailed voice message
□ ok to text messages
□ appointment reminders

□ ok to leave messages about billing
□ ok to leave detailed voice message
□ ok to text messages
□ appointment reminders

Birth Date: ____/____/____ Gender Identity: __Male __Female __Transgender Male/Trans Man/FTM
__Transgender Female/Trans Woman/MTF __Genderqueer, neither exclusive Male or Female

Additional Gender Category or other, please specify_____ Choose not to disclose _____
Marital Status: □ Married □ Single □ Other _____
Employment Status: □ Full/part time Student □ Unemployed □ Employer _____

EMERGENCY/SPOUSE/PARTNER CONTACT:

Contact Name:_____ Relationship to Client:_____
(Last) (First)

Home Phone: (____) _____ Cell Phone: (____) _____ Email: _____

□ ok to leave detailed voice message
□ ok to leave messages about billing

□ ok to leave detailed voice message
□ ok to text messages
□ appointment reminders

□ ok to send appointment reminders
□ ok to send detailed correspondence
□ ok to leave messages about billing

If you are registering a "MINOR CHILD" (age of 17 or younger) please fill out below

Name of Parent or Guardian: _____ Relationship to Client: _____
(Last) (First)

Address (if different than above): _____ _____ _____ _____
(Street) (City) (State) (Zip Code)

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

□ ok to leave detailed voice message

□ ok to leave detailed voice message
□ ok to text messages
□ appointment reminders

□ ok to leave voice message

Person responsible for these charges: _____ Relationship to Client _____

REFERRALS:

□ Doctor _____ □ Insurance Plan □ Hospital □ Family □ Friend
□ Location is close to home/work □ Internet Search □ Other:_____

Neuro Harmony, LLC

Consent to Treat

CLIENT INFORMATION:

Client Name: _____ _____
(Last) (First) (Middle Initial) (Date of Birth)

Current Address: _____ _____ _____ _____
(Street) (City) (State) (Zip Code)

Phone _____ Parents of Minor _____

Consent to Treatment:
I authorize and request that Neuro Harmony, LLC provide psycho-therapeutic services determined to be clinically appropriate for myself, the client. By signing below, I certify that I have read and understand the terms stated in the Treatment Consent Form, Notice of Privacy Practice Summary and Insurance Assignment, Release & Authorization Form. I fully understand the scope of the services, session structure, fees, cancellation/no-show policies, payment policy, insurance reimbursement, confidentiality. I agree to abide by the terms stated throughout the course of our therapeutic relationship.

Consent to Treatment of Minors:
I authorize and request that Neuro Harmony, LLC provide psycho-therapeutic services determined to be clinically appropriate for my child. I understand that the primary goal of these services is to help my child be at his/her most successful emotionally, socially and academically. I hereby represent that I have the legal authority to obtain medical treatment and counseling for the minor child for whom I am requesting treatment. I am a biological parent or legal guardian. If group home or foster family settings, I am designated to authorize treatment. If divorced, I am the primary custodial parent and can secure treatment without the authorization of the other parent.

Limits of Relationship and Confidentiality:
I understand that communications between a client and clinician are confidential and protected by law. I also understand that exceptions include when a client is a danger to themselves or to others, or when there is a reasonable suspicion of sexual or physical abuse, child or elder abuse. Then, by the Illinois State Law, Neuro Harmony, LLC is obligated to report this information to the Illinois Department of Children and Family Services or if a court of law orders the information; or when information is shared with your insurance company to process your claims.

Please be advised – if a client is 12 years or older, their records are sealed and confidential and cannot be released to anyone without their written consent.

Signature(s) _____ Date _____

CONSENT for TREATMENT of CHILDREN and ADOLESCENTS
(under the age of 12 years old.)

I/We consent that _____ may be treated as a client(s) at Neuro Harmony.

Parent/Guardian Signature(s) _____ Date_____

Revised 7/18/19

Neuro Harmony, LLC

Fees &Services

Diagnostic and clinical interview	$175.00
Individual psychotherapy * Session times are defined by your insurance	
-45-50 min	$155.00
-30-45 min	$135.00
-25-30 min	$120.00
Couples therapy	
-50 minutes	$155.00
Family psychotherapy	
-45-50 minutes	$155.00
Group therapy	
-1.0 hours	$ 40.00
**Does not include purchase of workbooks	
Correspondence 15-60 minutes	$ 45.00 -$155.00/per hr
-phone or written; other than in-office session	
*These services are client's responsibility and are not billed to insurance.	
Returned Check fee for any reason	$ 30.00
Case summary, reports	$155.00/hr
Court	
-court prep or attendance	$500.00 base fee plus $200.00/hr
-chart review or report	$155.00 per hour
-mileage	federal reimbursement rate
Missed or No-Show Appointments	**$75.00 per session**
*Failure to appear for a session or without **4 hr notice of cancellation** will incur this fee.	
**Payment for this fee is due immediately.	
Late fees	$10.00 monthly for any balance

Financial Agreement & Understanding:

As a courtesy, Neuro Harmony will bill your insurance. However, as a client, you are responsible for and agree to pay all charges incurred by you, your dependent, or your minor child. You agree to pay any deductible, copay, co-insurance and/or balance denied by the insurance company, in full immediately or at the time of the next session. Any balance unpaid will be charged **$10 per month until paid in full**. You agree to pay any costs Neuro Harmony incurs to collect debt owed by you, including all reasonable attorney's fees, filing fees, court costs, collection agency costs, service fees, late fees, and other collection costs or contingencies. You authorize Neuro Harmony and/or its agents to report unsatisfactory balances to the major credit bureaus. You give Neuro Harmony or any agents or assignees, permission to contact you regarding this transaction or any future transaction at any telephone number of which they are aware including cellular telephones by manually dialing, using an auto-dialer or pre-recorded message.

I have reviewed, understand and agree to pay all my financial responsibility incurred with Neuro Harmony, LLC and the contingencies set in place by Neuro Harmony, LLC.

_____ _____

Client/Guarantor Signature Date Printed Name

Revised 8/1/2019

Neuro Harmony, LLC

1836 Victoria Lane Charleston, Il 61920
Phone: 217-508-7953 Email: info@neuroharmony.org

ENCRYPTED DEBIT OR CREDIT CARD AUTHORIZATION FORM

Credit Card Information

Card Type: ☐Mastercard ☐Visa ☐ Discover ☐ Amex ☐ Other_____

Cardholder Name: (as shown on card)_____

Card Number: _____

CVV code on back: _____ Card Expiration: (mm/yy) _____

Cardholder Billing Address: Street: _____

City: _____

State: _____ Zipcode: _____

By signing below, I authorize Neuro Harmony, LLC to encrypt my debit or credit card to be held on file for the account of _____. I am authorizing my card to be charged for any balance incurred on this account including missed appointment fees, monthly late fees, bank retrieval fees, insurance copays, co-insurance or any amount determined to be this patient's responsibility. I understand that these amounts will be charged to may debit or credit card as the expenses are incurred. I understand that my information will be encrypted and held on file for future transactions on this account. I understand that if my card is declined, I will be charged a late fee of $10.00 per month from this day forward until my account is paid in full.

_____

Customer Signature Date

Revised 7/22/19

Neuro Harmony, LLC

Missed Appointments/Late Cancellation Policy

Your business is very important to us and we want to make sure we can continue to assist you in meeting your therapy goals. With that in mind Neuro Harmony, LLC must set a standard regarding the time that we set aside for your therapy. We understand that unplanned circumstances may come up resulting in your need to reschedule a session. Neuro Harmony policy requires only a four-hour notice of cancellations so that we may attempt to fill that appointment with another client who may be in need. We feel this is fair for both our clients and our therapy staff.

In order to assure that your schedule changes are made appropriately you may submit cancelations through the client portal, with the Office Manager directly, or by leaving a voice mail; which is date and time stamped.

I agree I am responsible for any missed appointments fees. I understand that Neuro Harmony will charge a fee of $75 to my account as a result of any no show appointments or any cancellations that are not made at least 4 hours prior to the time in which my session is scheduled to begin.

_____

Clients Name

_____ _____

Responsible Party's Signature Date Responsible Party's printed name Date

Revised 7/18/19

Neuro Harmony, LLC

1836 Victoria Lane, Charleston, IL 61920
Phone 217-508-7953

NOTICE OF PRIVACY PRACTICES SUMMARY

Uses and Disclosures of Mental Health Information

We use mental health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

We may use or disclose identifiable mental health information about you without your authorization for several other reasons. Subject to certain requirements, we may give out mental health information without your authorization for public mental health purposes, for billing and claims to bill and collect payment for treatment and services provided, for coordinated care to provide services, for auditing Neuro Harmony to insure compliance with laws, for research studies, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable mental health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area and in each examination room. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

Your Rights

Although your mental health record is the physical property of the mental health practitioner or facility that compiled it, the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- obtain a paper copy of the notice of privacy practices upon request
- inspect and obtain a copy of your mental health record as provided for in 45 CFR 164.524
- amend your mental health record as provided in 45 CFR 164.528
- obtain an accounting of disclosures of your mental health information as provided in 45 CFR 164.528
- request communications of your mental health information by alternative means or at alternative locations
- revoke your authorization to use or disclose mental health information except to the extent that action has already been taken

Following is a statement of your rights with respect to your protected mental health information and a brief description of how you may exercise these rights.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. Regional Manager, Office for Civil Rights, U.S. Department of Health and Human Services, 233 N. Michigan Ave., Suite 240, Chicago, IL 60601, Phone (312)886-2359, FAX (312)886-1807, or TDD (312)353-5693

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

If you have any questions or complaints, please contact: Pamela R. Miller, Policy & Privacy Officer, Neuro Harmony, 217-508-7953, 1836 Victoria Lane, Charleston, IL 61920

WRITTEN ACKNOWLEDGEMENT

I acknowledge that I have reviewed the **Notice of Privacy Practices** which provides a description of information uses and disclosures. I understand that I have the right to request restrictions as to how my mental health information may be used or disclosed and that the organization is not required to agree to the restrictions I request.

_____

Signature of Client or Legal Representative Date

Revised 7/18/19

Neuro Harmony, LLC

Insurance Assignment, Release & Authorization

INSURANCE INFORMATION: (please give your insurance card to the receptionist)

_____

(Client Name)

Primary Insurance: _____

Subscribers Name_____ Subscribers Date of Birth: ____/____/____

Address: _____ _____ ____ _____ Phone Number: (___)_____
(If different than Client) (Street) (City) (State) (Zip Code)

Employer: _____ Employer Phone Number: (_____)_____

Policy Number: _____ **Group Number:** _____

Client's relationship to subscriber: _____

Authorization/Referral Required: □ YES □ NO □ UNKNOWN

Copay:_____ **Co-Insurance:** _____ **Deductible:**_____

INSURANCE ASSIGNMENT, RELEASE & AUTHORIZATION

I hereby authorize the release of Protected Health Information; including any/all medical records relating to my mental health treatment, to the insurance company indicated above. I further agree and acknowledge that my signature on this document authorizes Neuro Harmony LLC to submit claims for payment of services rendered without obtaining my signature for every claim. I understand and agree I will be bound by this signature as though I had personally signed each claim. I hereby authorize the insurance indicated above the authorization to speak with and provide payment directly to Neuro Harmony LLC. I further acknowledge that any insurance benefits paid to Neuro Harmony LLC will be credited to my account in accordance with the above assignment. I understand providing insurance information is not a guarantee of my coverage. I am responsible for payment, in full, of all session fees or other service fees incurred by myself or my minor child.

_____ _____

Client/Guarantor Signature Date Printed Name

Revised 7-18-19

Neuro Harmony, LLC

1836 Victoria Lane, Charleston, IL 61920
Phone 217-508-7953 Fax 217-512-2288

RELEASE OF PROTECTED HEALTH INFORMATION

NEURO HARMONY, LLC at 1836 Victoria Lane, Charleston, IL 61920 is hereby authorized to release the following:

Protected Health Information of: _____ _____
(Name of Patient) (Birthdate)

_____
(Address) (City, State, Zip Code)

Party to Receive Protected Health Information:

_____
(Name) (Address) (City, State, & Zip Code) (Phone)

The patient or authorized representative authorizes the use of protected health information to be released. Patient or authorized representative must initial the item, which needs additional protected health information disclosed.

___ Mental Health/Psychiatric ___ Psychotherapy Notes ___ Alcohol and/or Drug Related
___ Abuse ___ HIV/AIDS ___ Other Communicable Disease

The type of protected health information to be used or disclosed is as follows:

[ ] Medical History	[ ] Diagnosis and Prognosis	[ ] Social History
[ ] Psychiatric History	[ ] Psychological History	[ ] Treatment Plan
[ ] Educational History	[ ] Financial History	[ ] HIV Counseling History
[ ] Treatment Progress Notes	[ ] Substance Abuse History	[ ] Legal History
[ ] Employment History	[ ] Summary and Recommendations	[ ] Verify Presence
[ ] Drug Test Results	[ ] HIV Testing Results/History	[ ] Billing

[ ] Other (must be specific information): _____

Method of release: [ ] Photocopies [ ] Verbal [ ] FAX [ ] Written
For the purpose of: [ ] Continued Treatment [ ] Evidence of Care [ ] Legal [ ] Billing

The foregoing authorization was read, discussed, and signed in my presence. I am signing freely and with full knowledge and understanding. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that other healthcare provider records may be a part of my record and I can release them as authorized. I understand that any disclosure of information carries with it the potential for unauthorized disclosure if the recipient(s) as described on this form is not required by law to protect the privacy of the information, and such information is no longer protected by the Federal Health Information Privacy Regulations. The redisclosure of drug and alcohol abuse is generally prohibited with the confidentiality of alcohol and drug abuse patient record rules. I understand that I can contact these departments for questions about disclosures of my protected health information.

I further understand that a refusal to authorize the release of the above information will prevent the disclosure of the information without further authorization or when mandated by law. There is the right to revoke the authorization in writing at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides the insured with the right to contest a claim under my policy.

The date of authorization expiration will be one year (1 year) from date signed.

Signed _____ Date _____

Witness _____ Date _____

Neuro Harmony, LLC

Child Therapy Contract

Prior to the beginning treatment, it is important for you to understand our approach to child therapy and agree to some rules about your child's confidentiality during his/her treatment. The information herein is in addition to the information contained in the Consent to Treat. Under HIPAA and the APA Ethics Code, we are legally and ethically responsible to provide you with informed consent.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and therapists regarding the best interest of the child. If such disagreements occur, we will strive to listen carefully so that we can understand your perspectives and fully explain our perspective. We can resolve such disagreements, or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, you will decide whether therapy will continue. If either of you decides that therapy should end, we will honor that decision however, we ask that you allow Neuro Harmony, LLC the option of having a few closing sessions to appropriately end the treatment relationship.

Privacy/confidentiality - Therapy is most effective when a trusting relationship exists between the therapist and the client. Privacy is especially important in building and maintaining that trust. One goal of treatment is to promote a stronger and better relationship between children and their parents. However, it is often necessary for children to develop a "zone of privacy" whereby they feel free to discuss personal matters with greater freedom. This is particularly true for adolescents or teens who are naturally developing a greater sense of independence and autonomy.

Parent Involvement – It is also vital that the parent is involved in the treatment of said child. Parental involvement is required at Neuro Harmony, LLC. It is imperative that at least once a month you, the parent, guardian or GAL, are available in our office for a consultation with your child's therapist. You child's therapist will make every effort to communicate with you at least monthly regarding your child's progress.

Treatment Status – It is our policy to provide you with general information about treatment status. However, if your child is 12 years or older, we are unable to share with you what your child has disclosed unless your child authorizes that information.

Risk – If your child is an adolescent or teen it is possible that he/she will reveal sensitive information regarding sexual contact, alcohol and drug use, or other potentially problematic behaviors. Sometimes these behaviors are within the range of normal adolescent experimentation, but at other times they may require parental intervention. If we ever believe that your child is at serious risk of harming him/herself or another, Neuro Harmony, LLC will inform you as soon as possible.

Court or Legal Involvement – Although our responsibility to your child may require our involvement in conflicts between the two of you, we need your agreement that Neuro Harmony's involvement will be strictly limited to that which will benefit your child. This means, among other things, that you will treat anything that is said in session with a Neuro Harmony therapist as confidential. Neither of you will attempt to gain advantage in any legal proceeding between the two of you from our involvement with your children. We need your agreement that in any such proceedings, neither will ask Neuro Harmony, LLC, its therapist or representatives to testify in court, whether in person, or by

affidavit. You will also agree to instruct your attorneys not to subpoena any Neuro Harmony, LLC therapist or representatives or to refer in any court filling to anything we may have said or done.

Note that such agreement may not prevent a judge from requiring our testimony, even though Neuro Harmony, LLC will work to prevent such an event. If we are required to testify, we are ethically bound not to give opinions about either parent's custody or visitation suitability. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, Neuro Harmony, LLC will provide information as needed (if appropriate releases are signed or a court order is provided), but "WILL NOT" make any recommendation about the final decision. Furthermore, if your child's therapist is demanded to appear in court, the party responsible for our participation agrees to pay a $500 fee to begin court preparations and agrees to pay the current rate of $200.00 per hour for time spent traveling, preparing reports, testifying, attendance and any other case-related costs. These expenses are not refundable.

ABBREVIATED CONTRACT SUMMARY

- If you decide to terminate treatment, Neuro Harmony, LLC reserves the right of having a few closing sessions with your child to properly end the treatment relationship.
- Your child's therapist will inform you if your child does not attend the treatment sessions.
- At the end of treatment, your therapist can provide you with a summary that includes a general description of goals, progress made, and potential areas that may require intervention in the future.
- If necessary, to protect the life of your child or another person, Neuro Harmony, LLC has the ethical responsibility to disclose information to you without your child's consent.
- You agree that your child's therapist's role is limited to providing treatment and that you "WILL NOT" involve them in any legal dispute, especially a dispute concerning custody or custody arrangements (visitations, etc.).
- You also agree to instruct your attorneys to **"NOT" subpoena Neuro Harmony, LLC** or any of Neuro Harmony LLC's representatives or to refer in any court filing to anything said or done.
- If there is a court appointed evaluator or Guardian Ad Litem and if appropriate releases are signed and a court order is provided, Neuro Harmony, LLC will provide general information about the child which "WILL NOT" include recommendations concerning custody or custody arrangements.
- If, for any reason, Neuro Harmony, LLC or your child's therapist is required to appear in court, the party responsible for the participation agrees to pay a $500 fee to being court preparation and agrees to pay the current rate of $200.00 per hour for time spent traveling, preparing reports, testifying, attendance and any other case-related cost. These expenses are not refundable.

By signing below I/we understand and agree to abide by this Neuro Harmony, LLC Child Therapy Contract.

_____

Parent/Guardian Date

_____

Parent/Guardian Date

Neuro Harmony, LLC

Client History Form

_____

(Client Name)

Please answer the following questions to the best of your ability. These questions are intended to help your clinician with your therapy process. All information is completely confidential.

BACKGROUND INFORMATION:

1. Are you currently receiving, or have you had any mental health counseling or mental health hospitalizations before today? □ Yes □ No
   Please identify when, where and for what reasons.

a.	Prior Treatment:
b.	Symptoms:
c.	Diagnosis:
d.	Hospitalization:
e.	Suicide attempts:
f.	Self-injurious behaviors:

Reason for change: _____

2. In the last 30 days how often have you been bothered by any of the following problems?

		Not at all	Several Days	More than half the days	Nearly every day
a.	Little interest or pleasure in doing things	□	□	□	□
b.	Feeling down, depressed, or hopeless	□	□	□	□
c.	Trouble falling or staying asleep, or sleeping too much	□	□	□	□
d.	Feeling tired or having little energy	□	□	□	□
e.	Poor appetite or overeating	□	□	□	□
f.	Feeling bad about yourself, or that you are a failure, or have let yourself or your family down	□	□	□	□
g.	Trouble concentrating on things, such as reading the newspaper or watching television	□	□	□	□
h.	Moving or speaking so slowly that other people could have noticed. Or opposite-being so fidgety or restless that you have been moving around a lot more than usual	□	□	□	□
i.	Thoughts that you would be better off dead, or of hurting yourself in some way	□	□	□	

3. In the last 30 days have you had an anxiety attack suddenly feeling fear or panic? □ Yes □ No

		Yes	No
a.	Has this ever happened before?	□	□
b.	Do these attacks bother you a lot or are you worried about having another attack?	□	□
c.	Do some of these attacks come suddenly out of the blue that is, in situations where you don't expect to be nervous or uncomfortable?	□	□
d.	During your bad anxiety attack, did you have symptoms like shortness of breath, sweating, heart racing, or pounding, dizziness or fainting, tingling or numbness, nausea or upset stomach?	□	□

4. In the past 30 days have you felt:

a.	□ Extreme depressed mood	□ Mood swings	□ Rapid speech
b.	□ Extreme anxiety	□ Phobias	□ Disturbed sleep
c.	□ Memory lapse	□ Time loss	□ Hallucinations
d.	□ weight loss or weight gain		
e.	□ Repetitive thoughts	□ Repetitive behaviors	□ Trouble planning
f.	□ Homicidal thoughts	□ Suicide attempts	□ Relationship trouble

****If you have checked off <u>any</u> problems on this form so far, how difficult have these problems made it for you to do your work, take care of things at home or to get along with other people?**

□ Not difficult at all □ Somewhat difficult □ Very difficult □ Extremely difficult

5. In the last 30 days how much have you been bothered by:

		Not bothered	Bothered a little	Bothered a lot
a.	Worrying about your health	□	□	□
b.	Your weight or how you look	□	□	□
c.	Little or no sexual desire or pleasure during sex	□	□	□
d.	Difficulties with husband/wife, partner/lover, boyfriend/girlfriend	□	□	□
e.	The stress of taking care of children, parents, or other family members	□	□	□
f.	Stress at work outside of the home or at school	□	□	□
g.	Financial problems or worries	□	□	□
h.	Having no one to turn to when you have a problem	□	□	□
i.	Something bad that happened **recently**	□	□	□
j.	Thinking or dreaming about something terrible that happened to you in the past - like your house being destroyed, a severe accident, being hit or assaulted, or being forced to commit a sexual crime.	□	□	□

6 Have you ever been hit, slapped, kicked, or otherwise physically hurt by someone, or has anyone forced you to have an unwanted sexual act? □ Yes □ No

_____

_____

_____

7 In the last 30 days have you used any drugs or alcohol? □ Yes □ No

8 In the last 30 days have you used any illegal drugs? □ Yes □ No
What drugs or substances have you used? _____

9 Have you ever been in drug treatment before? □ Yes □ No
When and what treatment facility? _____

TRAUMA HISTORY:

7. Trauma (health, medical, surgeries, sexual assault, sexual abuse, physical violence, divorce, deaths or other traumas)

a.	Nature of trauma (what happened):
b.	Date trauma occurred:
c.	Person/people involved:

8. Family Psychiatric History: Is there mental illness in my family of origin? □ Yes □ No

Please provide information about your family history. If yes, please indicate the family member affected.

			Identify Family Member
Depression	□ Yes	□ No	_____
Anxiety Disorder	□ Yes	□ No	_____
Bipolar Disorder	□ Yes	□ No	_____
Panic Attacks	□ Yes	□ No	_____
Alcohol/Substance Abuse	□ Yes	□ No	_____
Eating Disorder	□ Yes	□ No	_____
Learning Disability	□ Yes	□ No	_____
Trauma History	□ Yes	□ No	_____
Domestic Violence	□ Yes	□ No	_____
Obesity	□ Yes	□ No	_____
Obsessive Compulsive Behavior	□ Yes	□ No	_____
Schizophrenia	□ Yes	□ No	_____

OTHER INFORMATION:

9. What Highschool did you attend and what year?_____
10. Did you graduate or did you receive a GED? What year? _____
11. Did you attend college? If so, what college and year did you graduate or attend?

    _____

12. Are you currently employed? □ Yes □ No

    - If yes, who is your employer? _____
    - What is your position? _____

13. Are you happy or fulfilled in your current position? □ Yes □ No
14. No Does your work make you stressed? □ Yes □ No
15. If yes, what are your work-related stressors? _____
16. Are you currently in a romantic relationship? □ Yes □ No-

    If yes, how long have you been in this relationship? _____

17. On a scale from 1-10, how would you rate the quality of your relationship (10 being great)? _____
18. Do you practice a religion? □ Yes □ No

    - If yes, what is your faith? _____
    - If no, do you consider yourself to be spiritual? □ Yes □ No

19. In the last year, have you had any major life changes
    (e.g. new job, new home, illness, relationship change, etc.)? □ Yes □ No

    _____

    _____

20. What is the most stressful thing in your life right now?

    _____

    _____

21. What are some ways you cope with obstacles and stress?

    _____

    _____

22. List your strengths/limitations:

    _____

23. What is your goal for therapy?

    _____

Neuro Harmony, LLC

Medication Disclosure

I am **NOT** currently taking any medications either over the counter or by prescription.

________________________ (Client, Parent/Guardian signature) ________________ (Date)

I **AM** currently taking the following medications (prescription & over the counter):

Medication: ________________ Dosage: ________
Date prescribed: ________ Reason: ____________
Doctor: ____________ City/State: ____________

Medication: ________________ Dosage: ________
Date prescribed: ________ Reason: ____________
Doctor: ____________ City/State: ____________

Medication: ________________ Dosage: ________
Date prescribed: ________ Reason: ____________
Doctor: ____________ City/State: ____________

Medication: ________________ Dosage: ________
Date prescribed: ________ Reason: ____________
Doctor: ____________ City/State: ____________

Medication: ________________ Dosage: ________
Date prescribed: ________ Reason: ____________
Doctor: ____________ City/State: ____________

Medication: ________________ Dosage: ________
Date prescribed: ________ Reason: ____________
Doctor: ____________ City/State: ____________

Medication: ________________ Dosage: ________
Date prescribed: ________ Reason: ____________
Doctor: ____________ City/State: ____________

________________________ (Client, Parent/Guardian signature) ________________ (Date)

Revised 7/24/19