

PRACTICE ORIENTATION AND AGREEMENT  
YOUR RIGHTS AND RESPONSIBILITIES AS A CLIENT

- \* You have the right to receive services from clinicians who adhere to the professional code of ethics of their respective disciplines.
- \* You have the right to receive services in accordance with Federal and State regulations and accreditation standards governing behavioral health programs.
- \* You have the right to privacy and confidentiality regarding the service you receive. All information about you and your treatment, whether written or oral, is protected under Federal and State laws, including the HIPAA Privacy Act.
- \* You have the right to informed consent for services offered to you.
- \* Your clinician is responsible for all service coordination.
- \* You have the right to refuse services at any time. You have the right to withdraw your consent to receive services and discontinue services at any time. You have a right to information concerning your treatment/care.
- \* You have the right to know treatment recommendations and the possible outcomes if you choose not to follow these recommendations.
- \* You have the responsibility to assist in planning your treatment at every stage.
- \* You have the right to express any concerns or complaints regarding the services you receive. We encourage you to first contact your clinician to resolve any issues. You may also contact the Rights Advisor and Office Manager, Laura Hitt, for assistance. A description of how to register a concern is posted in our lobby and on our website.
- \* You have the responsibility to be timely for your appointments. Late arrivals may result in rescheduled appointments.
- \* You have the responsibility to arrive for all scheduled sessions, or to notify us 24 hours in advance if you wish to cancel an appointment. **You may be charged a practice fee, up to \$125, for non-cancelled or late cancelled appointments**, when an emergency was not involved, because insurance companies and other third-party payers do not cover missed appointments.
- \* You are responsible for any fees that may be charged to you at the time of service and, also, for knowing your insurance benefits coverage. We check benefits as a courtesy, but this is **NOT** a guarantee of coverage.
- \* Your case will be closed following 45 days of inactivity, unless other arrangements have been made.
- \* You have the right to know we may call the police if someone comes to the practice under the influence of drugs or alcohol and tries to leave the practice driving a motor vehicle.
- \* You have the right to know that no member of our staff is allowed to date or have a personal relationship with current or former clients of the practice.
- \* You have the right to know that staff and therapists are not allowed to accept gifts from clients of the practice, nor are they permitted to enter into any business relationships of any kind with you.
- \* You have the responsibility to conduct yourself in a non-disruptive and non-aggressive manner while on the premises. Wentworth & Associates will never use restraints but emergency responders will be called if necessary.
- \* If we are treating your minor child our policy is to make a concerted effort to engage both parents in the therapeutic process.

Reasons your treatment may be terminated:

- Being under the influence of any illegal substance while on the premises
- Threatening the safety or rights of any client or staff member
- Non-compliance with treatment or an inability of the facility to provide you the care you require
- You have two or more subsequent late cancellations (under 24 hours' notice), or two or more failures to appear at a scheduled appointment without notice.

\*In all instances, you have the right to a referral for a different treatment option

**SERVICES OFFERED**

Wentworth and Associates offers an array of mental health services. These services include: individual psychotherapy, group therapy, family therapy, marital therapy, psychological testing, Psychiatric evaluations and medication therapy are

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also available on site. Your clinician will provide you with a detailed description of the nature of services and expected benefits and potential risks.

#### **CLIENT INPUT**

Wentworth and Associates will be asking you for ongoing feedback regarding the quality and effectiveness of services you receive. We will ask you to complete clinical outcome questionnaires and satisfactions surveys periodically. We will also review and/or investigate any complaints or suggestions you may have (contact Rights Advisor). Your feedback is considered an important part of treatment/care.

#### **OPERATIONS**

Office hours are usually between 7AM and 10PM, 7 days a week. Not all clinicians are available during all open hours. Appointment dates and times and after hours' contacts shall be arranged between you and your treating clinician. An outdoor elevator is located in the back parking lot of the building for individuals with physical disabilities. In emergencies, you can contact the nearest crisis center (Macomb County Crisis Center at 586-307-9100; Oakland Crisis Center at 248-456-0909). You may also contact or go to the nearest emergency room. We practice in a non-smoking, non-vaping environment. Illicit drugs and weapons are not allowed on the premises. Persons in possession of either will be asked to leave immediately.

#### **CONFIDENTIALITY**

Federal and State laws protect the privacy of communications between a client and a clinician. In most situations, release of information about your services/treatment to others can only be done if you sign a written Authorization to Release that meets certain legal requirements. Also, there are some limits to confidentiality, such as if you intend to harm yourself or others.

Information about privacy and limits to confidentiality will be provided by your primary clinician and is also provided in our Notice of Privacy Practices. **STATE LAW REQUIRES REPORTING OF SUSPECTED CHILD ABUSE/NEGLECT, ELDER ABUSE.**

#### **FINANCIAL RESPONSIBILITY**

You are expected to pay for service at the time it is rendered, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. A fee adjustment or a payment installment plan may be negotiated in circumstances of unusual financial hardship. All clients will be informed of payment fee schedules prior to rendering services. Although we are likely to inform you of your insurance deductible and co-pays (if any), you are ultimately responsible for knowing this information and for paying both in full. *A \$25 charge may be required for returned checks. You may be charged up to \$25.00 if you request records to be sent out. If your client balance exceeds \$200.00 service may be suspended, and you will be offered a referral to another clinic where you will be able to continue your treatment.*

If your account has not been paid for more than 90 days and arrangements for payment have not been agreed upon, legal action may be used to secure the payment. This may involve hiring a collection agency or going through small claims court, which will require disclosure of otherwise confidential information. In most collection situations, the only information released regarding a client's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its cost will be included in the claim.

If I am paying privately, based on my ability to pay, I agree to pay \_\_\_\_\_ for an Intake Evaluation, \_\_\_\_\_ for Individual Therapy, \_\_\_\_\_ Family Therapy, \_\_\_\_\_ for Testing and \_\_\_\_\_ for Extended Sessions.

#### **MINORS & PARENTS**

Clients under 18 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. They should also be aware that clients over age 14 can consent to (and control access to information about) their own psychosocial treatment, although that treatment cannot extend beyond 12 sessions or 4 months. While privacy is very important, particularly with teenagers, parental involvement is also essential to successful treatment. Therefore, it is Wentworth and

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Associates policy to request (but not require) an agreement from any client between 14 and 18 and his/her parents allowing to share general information with parents about the progress of treatment and the child's attendance at scheduled sessions.

**FAMILY INVOLVEMENT IN TREATMENT**

While family treatment may be useful at times, involvement of family members is to be negotiated with the client and therapist. Unless family therapy is warranted and all member consent to treatment, it is up to the client and therapist to determine the level of family (or other persons) involvement in sessions. In any case, the therapist may not release any information to anyone regarding the client without the client's written consent. In the case of minors, it is strongly suggested to keep most of the client's treatment between the client and therapist and only involve family members in treatment when necessary.

**CONSENT FOR CASE CONFERENCING**

I hereby give my informed consent to have my case presented at case conferencing or group supervision meetings at Wentworth and Associates, PC only.

I understand that my therapist will make every effort to protect my confidentiality and will not be using names or other specific identifying information. I understand that the purpose of presenting my case at these case meetings is to get a multidisciplinary team approach in order to improve my treatment.

I understand that any clinical staff person or student may attend these meetings and that they are facilitated by the CEO, Dr. Lawrence T. Wentworth, PhD, Licensed Psychologist.

I understand that the staff members are not liable in any way for treatment suggestions, case conceptualizations or recommendations made to my therapist in an effort to improve my care.

I understand that I may revoke my authorization at any time.

Please check one:

I consent to have my case discussed in case conferencing \_\_\_\_\_

I DO NOT consent to have my case discussed in case conferencing \_\_\_\_\_

My initials below indicate that I:

\_\_\_\_\_ Have been made aware of my rights and responsibilities and how to file a grievance or complaint

\_\_\_\_\_ Have been informed of the name, discipline, and credentials of my primary clinician

\_\_\_\_\_ Have been informed of practice-specific information and given an orientation to services including fees

\_\_\_\_\_ Have been informed of privacy practices, confidentiality, and limits to confidentiality

\_\_\_\_\_ Have been informed of all the emergency evacuation procedures of the practice and its premises.

My signature below indicates that I consent to receive services at Wentworth and Associates, and that I understand I may discuss any questions I have regarding services and that I maintain the option to terminate my consent at any time.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client's Name Printed

\_\_\_\_\_  
Signature of Client's Representative Date

\_\_\_\_\_  
Wentworth & Associates, PC Staff Signature Date

## Life and History Health Questionnaire- Insurance and Emergency Data

**Purpose of this questionnaire:** The purpose of this questionnaire is to obtain a comprehensive picture of your background. In psychotherapy, records are necessary, since they permit a more thorough dealing with one's problems. By completing these questions as fully and as accurately as you can, you will facilitate your therapeutic program. Please answer these routine questions in your own time, rather than using up your actual consulting time. If there are any questions that you prefer not to answer, merely write, "do not care to answer."

Name: \_\_\_\_\_ Today's Date \_\_\_\_\_  
Address: \_\_\_\_\_ Gender \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Phone Number: \_\_\_\_\_  
Email \_\_\_\_\_ Social Security Number \_\_\_\_\_  
How did you come to be referred to Wentworth and Associates, P.C.? \_\_\_\_\_  
Emergency Contact: Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_ Phone Number \_\_\_\_\_  
City, State, Zip code \_\_\_\_\_

### Primary Insurance Company: \_\_\_\_\_

Effective date: \_\_\_\_\_ Contract number: \_\_\_\_\_  
Group number: \_\_\_\_\_ Insurance company phone number \_\_\_\_\_  
Full name of subscriber: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Subscriber's DOB: \_\_\_\_\_ Subscriber's place of employment: \_\_\_\_\_

### Secondary Insurance Company: \_\_\_\_\_

Effective date: \_\_\_\_\_ Contract number: \_\_\_\_\_  
Group number: \_\_\_\_\_ Insurance Company phone number \_\_\_\_\_  
Full name of subscriber: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Subscriber's DOB: \_\_\_\_\_ Subscriber's place of employment: \_\_\_\_\_

Please describe the problem that brings you here \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Tell us what goals you have for treatment in your own words \_\_\_\_\_  
\_\_\_\_\_

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When did your concern begin? \_\_\_\_\_

Please select the word that describes the severity of your concern:

Mild    Moderate    Severe    Extremely severe    totally incapacitating

How do the concerns you are currently experiencing get in the way of your regular or daily functioning?

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How did the concerns you are experiencing interfere with your regular or daily functioning in the past?

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This next section is designed to help you describe your current problems in greater detail and to identify problems that might otherwise go unnoticed. This will allow us to design a comprehensive treatment program that is tailored to your needs.

Please check all that apply to you.

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Overeating or bingeing                             | <input type="checkbox"/> Can't go to sleep            | <input type="checkbox"/> Procrastination                           |
| <input type="checkbox"/> Memory problems                                    | <input type="checkbox"/> Take drugs                   | <input type="checkbox"/> Suicidal attempts                         |
| <input type="checkbox"/> Fear of being in public (malls, restaurants, etc.) | <input type="checkbox"/> Vomiting                     | <input type="checkbox"/> Nervous tics                              |
| <input type="checkbox"/> Many fears   | <input type="checkbox"/> Nausea                       | <input type="checkbox"/> Irritability, grouchiness                 |
| <input type="checkbox"/> Rehashing things over and over in your mind        | <input type="checkbox"/> Hearing things               | <input type="checkbox"/> Unable to enjoy life                      |
| <input type="checkbox"/> Compulsive behaviors                               | <input type="checkbox"/> Work too hard                | <input type="checkbox"/> Blackouts                                 |
| <input type="checkbox"/> Impulsive reactions                                | <input type="checkbox"/> Don't like being touched     | <input type="checkbox"/> Dislike self                              |
| <input type="checkbox"/> Difficulty concentrating                           | <input type="checkbox"/> Intense or chronic guilt     | <input type="checkbox"/> Gambling                                  |
| <input type="checkbox"/> Distractibility                                    | <input type="checkbox"/> Shopping                     | <input type="checkbox"/> Changes in sexual functioning             |
| <input type="checkbox"/> Can't get air                                      | <input type="checkbox"/> Feeling unsteady or shaky    | <input type="checkbox"/> Changes in sex drive                      |
| <input type="checkbox"/> Fear that people are talking about you             | <input type="checkbox"/> Unplanned early AM awakening | <input type="checkbox"/> Feel things are far away and unreal       |
|   | <input type="checkbox"/> Odd behavior                 | <input type="checkbox"/> I go away in my mind for periods of time. |
|   | <input type="checkbox"/> Drink too much               |  |
|   | <input type="checkbox"/> Seeing things                |  |

Please check any of the following that apply to you

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Pleasant sexual images      | <input type="checkbox"/> Helpless images       | <input type="checkbox"/> Lonely images    |
| <input type="checkbox"/> Unpleasant childhood images | <input type="checkbox"/> Aggressive images     | <input type="checkbox"/> Seduction images |
| <input type="checkbox"/> Unpleasant sexual images    | <input type="checkbox"/> Images of being loved |   |

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Please explain \_\_\_\_\_

\_\_\_\_\_

Please check any of the following that apply to you.

<input type="checkbox"/> I am worthless, a nobody, useless and/or unlovable <input type="checkbox"/> Everything is against me <input type="checkbox"/> People are out to get me	<input type="checkbox"/> I am crazy, degenerate, and/or deviant <input type="checkbox"/> I am unattractive, incompetent, stupid, and/or undesirable	<input type="checkbox"/> I make too many mistakes, can't do anything right <input type="checkbox"/> Lie is empty, a waste, there is nothing to look forward to
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Please explain: \_\_\_\_\_

\_\_\_\_\_

What personal strengths do you have that will assist you in resolving the problems that bring you here? \_\_\_\_\_

\_\_\_\_\_

As you see yourself now, what do you need to help you recover? \_\_\_\_\_

\_\_\_\_\_

Do you have any preferences about treatment that you would like us to consider? \_\_\_\_\_

\_\_\_\_\_

Do you currently utilize any complementary modes of treatment (i.e. aromatherapy)? \_\_\_\_\_

\_\_\_\_\_

Have you ever been hospitalized for emotional reasons? \_\_\_\_\_

Please give places, dates and circumstances: \_\_\_\_\_

\_\_\_\_\_

Have you had previous counseling? \_\_\_\_\_

Where, when and for what? \_\_\_\_\_

\_\_\_\_\_

Was it helpful? \_\_\_\_\_

Has anyone in your extended family or friendship circle ever ended their own life? \_\_\_\_\_ If yes please explain

\_\_\_\_\_

Does anyone in your family suffer from depression, anxiety, alcoholism, epilepsy, manic depression (i.e. bipolar disorder) or anything else that might be considered a mental disorder? \_\_\_\_\_

Please explain: \_\_\_\_\_

\_\_\_\_\_

**Health Data**

Physician \_\_\_\_\_ Phone number \_\_\_\_\_

Date of last complete physical \_\_\_\_\_ Was blood work done? \_\_\_\_\_

Results \_\_\_\_\_

Are you currently being treated for any medical issues? \_\_\_\_\_

\_\_\_\_\_

Are you currently taking any prescribed medications? \_\_\_\_\_

If so what medications are you on and what are the dosages?

Medication	Dosage	Length of time on medication	What symptom is this medication targeting	Who prescribed this medication? (Psychiatrist, OB Gyn, PCP)	Is the medication helping? If so what percent?	If you starting this medication recently are you feeling significantly worse?	Are you having any side effects?


What over the counter medications do you take? \_\_\_\_\_

Do you exercise? \_\_\_\_\_ If so what kind? \_\_\_\_\_

Do you eat balanced meals? \_\_\_\_\_ If no please explain \_\_\_\_\_

Do you smoke, vape or use electronic cigarettes? \_\_\_\_\_ How much \_\_\_\_\_ Have you ever tried to become smoke free? \_\_\_\_\_ How many times? \_\_\_\_\_

What methods? \_\_\_\_\_

How much tea, coffee, or caffeinated soft drinks do you consume in a day? \_\_\_\_\_

Have you ever had trauma to the head or a closed head injury? \_\_\_\_\_

If yes, please explain \_\_\_\_\_

Is there anything related to your current sexual functioning and/or sexual orientation that you would like to discuss?  
 \_\_\_\_\_  
 \_\_\_\_\_

Have you ever been told that you had?

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Sickle cell disease | <input type="checkbox"/> Thyroid disease                                | <input type="checkbox"/> HIV                 |
| <input type="checkbox"/> Gout                | <input type="checkbox"/> Anemia   | <input type="checkbox"/> Kidney disease      |
| <input type="checkbox"/> AIDS                | <input type="checkbox"/> Bladder trouble                                | <input type="checkbox"/> Hepatitis A, B or C |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Other serious communicable diseases such as TB | <input type="checkbox"/> Emphysema           |
| <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Allergies                                      | <input type="checkbox"/> Arthritis           |
| <input type="checkbox"/> Rheumatic fever     | <input type="checkbox"/> Epilepsy                                       | <input type="checkbox"/> Ulcers              |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> High blood pressure                            | <input type="checkbox"/> Seizure disorder    |
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> Cancer   | <input type="checkbox"/> Low blood sugar     |
| <input type="checkbox"/> Glaucoma            | What kind? _____  |  |

Do you currently have or have had in the past?

<input type="checkbox"/> Frequent headaches <input type="checkbox"/> Numbness tingling <input type="checkbox"/> Frequent urination <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Hearing difficulty <input type="checkbox"/> Tics, twitches <input type="checkbox"/> Vomiting blood <input type="checkbox"/> Faintness, dizziness	<input type="checkbox"/> Wheezing, gasping <input type="checkbox"/> Blurred/double vision <input type="checkbox"/> Skin rashes <input type="checkbox"/> Difficulty starting urination <input type="checkbox"/> Hot flashes or chills <input type="checkbox"/> Many chest colds <input type="checkbox"/> Swollen feet or ankles <input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Bloody/coffee colored urine <input type="checkbox"/> Dental problems <input type="checkbox"/> Bowel Disturbances <input type="checkbox"/> Rectal bleeding or unusual painful discharge <input type="checkbox"/> Convulsions, feeling shaky or trembling
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<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Worsening of eyesight	
<input type="checkbox"/> Sexual disturbances	<input type="checkbox"/> Muscle spasms	
<input type="checkbox"/> Frequent coughing	<input type="checkbox"/> Night sweats	

Please explain any you have checked: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**History of chemical/alcohol use**

Are there heavy drinkers in your family or origin? \_\_\_\_\_

Do you consider yourself a "normal" drinker? \_\_\_\_\_

Have you ever driven while intoxicated? \_\_\_\_\_ If so please explain: \_\_\_\_\_

Has anyone expressed concern over your drinking or use of drugs? \_\_\_\_\_ Please explain? \_\_\_\_\_

\_\_\_\_\_

Have you had treatment for alcohol or other chemical dependency? \_\_\_\_\_ If so where and when? \_\_\_\_\_

\_\_\_\_\_

Please check any of the following recreational chemicals that you have used:

	Past	Current
Abuse of over the counter meds	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>
Amphetamines	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine	<input type="checkbox"/>	<input type="checkbox"/>
Crack	<input type="checkbox"/>	<input type="checkbox"/>
Crystal Meth	<input type="checkbox"/>	<input type="checkbox"/>
Ecstasy	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinogens	<input type="checkbox"/>	<input type="checkbox"/>
Heroin	<input type="checkbox"/>	<input type="checkbox"/>
Inhalants	<input type="checkbox"/>	<input type="checkbox"/>
Marijuana	<input type="checkbox"/>	<input type="checkbox"/>
Painkillers	<input type="checkbox"/>	<input type="checkbox"/>
Sedatives	<input type="checkbox"/>	<input type="checkbox"/>
Tranquilizers	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>

How many times per week do you drink or use chemicals? \_\_\_\_\_

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How many drinks or how much substance do you use per occasion? \_\_\_\_\_

Marital Status:

Single   Married   Separated   Widowed   Divorced   Living together   In committed relationship

What is the length of your marriage/relationship? \_\_\_\_\_

On a scale of 1 - 10 (1-low, 10-high) what is the level of commitment to staying with your partner today?

1   2   3   4   5   6   7   8   9   10

Family members:

Name	Relationship	Age	Health	Living with you?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

How would you describe the quality of your family relationships? \_\_\_\_\_

What supportive relationships do you have in your life? \_\_\_\_\_

How many times have you or your partner been pregnant? \_\_\_\_\_

How many children do you have? \_\_\_\_\_

Current spiritual preference \_\_\_\_\_

Raised \_\_\_\_\_

If not active, is there a particular reason? \_\_\_\_\_

Legal Data:

- Traffic Tickets
- Lawsuits against others
- Relatives or loved ones with serious problems with the law

- Misdemeanors
- Lawsuits against you
- Felonies
- Bankruptcy

Military Data:

Active Duty? \_\_\_\_\_ What branch? \_\_\_\_\_ Type of discharge? \_\_\_\_\_

<p>Did any of the following apply to your childhood or adolescence?</p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Happy Childhood</li> <li><input type="checkbox"/> Family Problems</li> <li><input type="checkbox"/> Severe Illness</li> <li><input type="checkbox"/> Sexual Abuse</li> <li><input type="checkbox"/> Unhappy Childhood</li> <li><input type="checkbox"/> Strong religious convictions</li> <li><input type="checkbox"/> Traumas (death of family member, natural disaster, etc.)</li> <li><input type="checkbox"/> Sexually inappropriate behavior</li> <li><input type="checkbox"/> Emotional problems</li> <li><input type="checkbox"/> Drug Abuse</li> <li><input type="checkbox"/> Behavioral problems</li> <li><input type="checkbox"/> Alcohol Abuse</li> <li><input type="checkbox"/> Physical abuse</li> <li><input type="checkbox"/> Emotional abuse</li> <li><input type="checkbox"/> Legal troubles</li> <li><input type="checkbox"/> Medical problems</li> <li><input type="checkbox"/> School problems</li> </ul>
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Birth Order \_\_\_\_\_ Siblings \_\_\_\_\_

Cultural Identification \_\_\_\_\_

Relationship with siblings and parents \_\_\_\_\_

Parents relationship: Divorces?    Yes            No                                    Parental separation    Yes            No

What was your response to parental conflict

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Process of separation/emancipation from parents \_\_\_\_\_

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	<input type="checkbox"/> Emancipation <input type="checkbox"/> Left home as a minor
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History of	<input type="checkbox"/> Abandonment <input type="checkbox"/> Neglect <input type="checkbox"/> Adoption <input type="checkbox"/> Removal from Home <input type="checkbox"/> Deaths <input type="checkbox"/> Physical Abuse <input type="checkbox"/> Sexual Abuse
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Do you make friends easily? \_\_\_\_\_ Do you keep them? \_\_\_\_\_  
Were you ever bullied or severely teased? \_\_\_\_\_ When? \_\_\_\_\_  
For what? \_\_\_\_\_

Describe any relationship that gives you joy: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe any relationship that gives you grief: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you been exposed to accidents and/or traumas as an adult that affect your life now? \_\_\_\_\_  
If so please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What do you do for fun and relaxation? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any changes in this recently? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Education:

<input type="checkbox"/> High School Graduate	From where? _____
<input type="checkbox"/> GED	From where? _____
<input type="checkbox"/> College	Which school? _____ How many years? _____
	How many credits? _____

Work History  
What do you do? \_\_\_\_\_  
How many hours per week do you work? \_\_\_\_\_  
Shift work? \_\_\_\_\_

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Other work you have done \_\_\_\_\_

What would you like to do? \_\_\_\_\_

Where do you see yourself in terms of work in the next 5 years? \_\_\_\_\_

**Childhood Developmental and Educational History**

Please answer based on information you have about your childhood

Complications due to pregnancy or delivery	<input type="checkbox"/> Yes <input type="checkbox"/> No
Prenatal Exposure to drugs or alcohol	<input type="checkbox"/> Yes <input type="checkbox"/> No
Birth defects of handicap	<input type="checkbox"/> Yes <input type="checkbox"/> No
Walking, talking, and toilet training on time	<input type="checkbox"/> Yes <input type="checkbox"/> No
What kind of temperament as a child	<input type="checkbox"/> Easy <input type="checkbox"/> Slow to warm up <input type="checkbox"/> Difficult
Schools	<input type="checkbox"/> Public <input type="checkbox"/> Parochial <input type="checkbox"/> Private

Current Grade \_\_\_\_\_

History of Hyperactivity or ADD	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Diagnosed <input type="checkbox"/> Undiagnosed
Medication?	<input type="checkbox"/> Past <input type="checkbox"/> Present Dosage _____
History of Learning disabilities	<input type="checkbox"/> Yes <input type="checkbox"/> No What subjects? _____ _____

History of special education	<input type="checkbox"/> Yes <input type="checkbox"/> No In what grade? _____
Resource room?	<input type="checkbox"/> Yes <input type="checkbox"/> No
T.C.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
History of ?	<input type="checkbox"/> Suspensions <input type="checkbox"/> Expulsions <input type="checkbox"/> Being held back? Grade _____ <input type="checkbox"/> Being accelerated? Grade _____ <input type="checkbox"/> Peer ridicule? Reason? _____
Behavioral Problems	<input type="checkbox"/> Home <input type="checkbox"/> School
Nature of Problems	_____ _____ _____ _____ _____

Please check any of the following words that you might use to describe yourself.

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Intelligent       | <input type="checkbox"/> Confident            | <input type="checkbox"/> Considerate    |
| <input type="checkbox"/> Ambitious         | <input type="checkbox"/> Sensitive            | <input type="checkbox"/> Unlovable      |
| <input type="checkbox"/> Trustworthy       | <input type="checkbox"/> Full of regrets      | <input type="checkbox"/> Stupid         |
| <input type="checkbox"/> Useless           | <input type="checkbox"/> Honest               | <input type="checkbox"/> Incompetent    |
| <input type="checkbox"/> Crazy             | <input type="checkbox"/> Conflicted           | <input type="checkbox"/> Attractive     |
| <input type="checkbox"/> Deviant           | <input type="checkbox"/> Can't make decisions | <input type="checkbox"/> Suicidal ideas |
| <input type="checkbox"/> Confused          | <input type="checkbox"/> Good sense of humor  |   |
| <input type="checkbox"/> Naïve             | <input type="checkbox"/> Worthwhile           |   |
| <input type="checkbox"/> Horrible Thoughts | <input type="checkbox"/> Loyal                |   |
| <input type="checkbox"/> Hardworking       | <input type="checkbox"/> Worthless            |   |
| <input type="checkbox"/> Persevering       | <input type="checkbox"/> Evil                 |   |

**Negative Cognitions:** We all have negative cognitions or self-talk at times. Please review the list of common negative self-statements below. Check those statements that you OFTEN say to yourself. They may not be true, but you may feel this way at times or say these things to yourself.

Thoughts of defectiveness or responsibility

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> I am not good enough | <input type="checkbox"/> I don't deserve love | <input type="checkbox"/> I am a bad person |
| <input type="checkbox"/> I am incompetent     | <input type="checkbox"/> I am                 | <input type="checkbox"/> I am shameful     |
| <input type="checkbox"/> I am not lovable     | worthless/inadequate                          |  |

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> I am ugly/my body is hateful             | <input type="checkbox"/> I deserve only bad things   | <input type="checkbox"/> I am permanently damaged     |
| <input type="checkbox"/> I am insignificant/unimportant           | <input type="checkbox"/> I do not deserve            | <input type="checkbox"/> I am stupid/not smart enough |
| <input type="checkbox"/> I deserve to be miserable                | <input type="checkbox"/> I am a disappointment       | <input type="checkbox"/> I deserve to die             |
| <input type="checkbox"/> I have to be perfect (out of inadequacy) | <input type="checkbox"/> I am different/don't belong |   |

Thoughts concerning Responsibility or Action

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> I should have done something  | <input type="checkbox"/> I did something wrong   | <input type="checkbox"/> I should have known better |
| <input type="checkbox"/> What does this say about you? E.g. I am shameful/ I am stupid/ a bad person | <input type="checkbox"/> I am inadequate or weak |   |

Thoughts concerning safety/vulnerability

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> I cannot trust anyone | <input type="checkbox"/> I cannot protect myself | <input type="checkbox"/> I am in danger                             |
| <input type="checkbox"/> I am not safe         | <input type="checkbox"/> I am going to die       | <input type="checkbox"/> It's not ok(safe) to feel/show my emotions |

Thoughts concerning power and control

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> I am not in control          | <input type="checkbox"/> I am powerless/helpless              | <input type="checkbox"/> I cannot get what I want                |
| <input type="checkbox"/> I cannot stand up for myself | <input type="checkbox"/> I cannot let it out                  | <input type="checkbox"/> I cannot be trusted                     |
| <input type="checkbox"/> I cannot trust myself        | <input type="checkbox"/> I cannot trust my judgement          | <input type="checkbox"/> I am a failure/will fail                |
| <input type="checkbox"/> I cannot succeed             | <input type="checkbox"/> I have to be perfect/please everyone | <input type="checkbox"/> I can't handle it (I am out of control) |

Are you currently being physically, emotionally or sexual abused? \_\_\_\_\_

Please explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Have you seriously considered ending your life?

- In the past  
 Currently, if so how? \_\_\_\_\_

Please check any that apply

- I do not feel I fit in or belong anywhere  
 I feel like I am a burden to my family or society  
 I have no qualms or fears of harming myself

Have you ever seriously considered killing someone else?

- In the past  
 Currently, if so whom? \_\_\_\_\_ How \_\_\_\_\_

Please explain: \_\_\_\_\_

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Additional Comments: \_\_\_\_\_

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ACE- Adverse Childhood Experiences:

- 1.) Did a parent or other adult in the household often or very often.....Swear at you, insult you, put you down, or humiliate you? Or Act in a way that made you afraid that you might be physically hurt?  
Yes      No
- 2.) Did a parent or other adult in the household often or very often... Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?  
Yes      No
- 3.) Did an adult or person at least 5 years older than you ever.....Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal or vaginal intercourse with you?  
Yes      No
- 4.) Did you often or very often feel that.....No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?  
Yes      No
- 5.) Did you often or very often feel that.....You didn't have enough to eat, had to wear dirty clothes, had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?  
Yes      No
- 6.) Were your parents ever separated or divorced?  
Yes      No
- 7.) Was your mother or stepmother:  
Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? Or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?  
Yes      No
- 8.) Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?  
Yes      No
- 9.) Was a household member depressed or mentally ill, or did a household member attempt suicide?  
Yes      No
- 10.) Did a household member go to prison?  
Yes      No

Do you have an Advance Directive? (for more information on Advance Directives and planning for important Health Care Decisions go to [www.caringinfo.org](http://www.caringinfo.org) )      Yes or      No



**Wentworth and Associates, P.C.**  
**11111 Hall Rd Suite 303**  
**Utica, Mi 48317**  
[www.wentworthandassociates.com](http://www.wentworthandassociates.com)  
**Phone # 586-997-3153 Fax # 586-997-4956**

Client Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Clinician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Wentworth & Associates, PC  
11111 Hall Road, Suite 303  
Utica, MI 48317  
586-997-3153  
Self Report Questionnaire – Adult

Name: \_\_\_\_\_ Therapist: \_\_\_\_\_ Date: \_\_\_\_\_

Instructions: Looking back **over the last week, including today**, help us understand how you have been feeling. Read each item and mark () the answer that best describes your current situation. For this questionnaire, “**work**” is defined as employment, school, housework, volunteer work, and so forth.

1. **I have trouble falling asleep or staying asleep.**  
O 0 Never   O 1 Rarely   O 2 Sometimes   O 3 Frequently   O 4 Almost always
2. **I feel no interest in things.**  
O 0 Never   O 1 Rarely   O 2 Sometimes   O 3 Frequently   O 4 Almost always
3. **I feel stressed at work, school, or other daily activities.**  
O 0 Never   O 1 Rarely   O 2 Sometimes   O 3 Frequently   O 4 Almost always
4. **I blame myself for things.**  
O 0 Never   O 1 Rarely   O 2 Sometimes   O 3 Frequently   O 4 Almost always
5. **I am satisfied with life.**  
O 4 Never   O 3 Rarely   O 2 Sometimes   O 1 Frequently   O 0 Almost always
6. **I feel irritated.**  
O 0 Never   O 1 Rarely   O 2 Sometimes   O 3 Frequently   O 4 Almost always
7. **I have thoughts of ending my life.**  
O 0 Never   O 1 Rarely   O 2 Sometimes   O 3 Frequently   O 4 Almost always
8. **I feel weak.**  
O 0 Never   O 1 Rarely   O 2 Sometimes   O 3 Frequently   O 4 Almost always
9. **I find my work, school, or other activities satisfying.**  
O 4 Never   O 1 Rarely   O 2 Sometimes   O 1 Frequently   O 0 Almost always
10. **I feel fearful.**  
O 0 Never   O 1 Rarely   O 2 Sometimes   O 3 Frequently   O 4 Almost always
11. **I use alcohol or drugs to get going in the morning.**  
O 0 Never   O 1 Rarely   O 2 Sometimes   O 3 Frequently   O 4 Almost always
12. **I feel worthless.**  
O 0 Never   O 1 Rarely   O 2 Sometimes   O 3 Frequently   O 4 Almost always
13. **I am concerned about family troubles.**  
O 0 Never   O 1 Rarely   O 2 Sometimes   O 3 Frequently   O 4 Almost always
14. **I feel lonely.**  
O 0 Never   O 1 Rarely   O 2 Sometimes   O 3 Frequently   O 4 Almost always
15. **I have frequent arguments.**  
O 0 Never   O 1 Rarely   O 2 Sometimes   O 3 Frequently   O 4 Almost always
16. **I have difficulty concentrating.**  
O 0 Never   O 1 Rarely   O 2 Sometimes   O 3 Frequently   O 4 Almost always
17. **I feel hopeless about the future.**  
O 0 Never   O 1 Rarely   O 2 Sometimes   O 3 Frequently   O 4 Almost always
18. **I am a happy person.**  
O 4 Never   O 3 Rarely   O 2 Sometimes   O 1 Frequently   O 0 Almost always

- 19. Disturbing thoughts come into my mind that I cannot get rid of.**  
 0 Never     1 Rarely     2 Sometimes     3 Frequently     4 Almost always
- 20. People criticize my drinking (or drug use).**  
 0 Never     1 Rarely     2 Sometimes     3 Frequently     4 Almost always
- 21. I have an upset stomach.**  
 0 Never     1 Rarely     2 Sometimes     3 Frequently     4 Almost always
- 22. I am not working or studying as well as I used to.**  
 0 Never     1 Rarely     2 Sometimes     3 Frequently     4 Almost always
- 23. I have trouble getting along with friends and close acquaintances.**  
 0 Never     1 Rarely     2 Sometimes     3 Frequently     4 Almost always
- 24. I have trouble at work/school because of drinking or drug use.**  
 0 Never     1 Rarely     2 Sometimes     3 Frequently     4 Almost always
- 25. I feel that something bad is going to happen.**  
 0 Never     1 Rarely     2 Sometimes     3 Frequently     4 Almost always
- 26. I feel nervous.**  
 0 Never     1 Rarely     2 Sometimes     3 Frequently     4 Almost always
- 27. I feel that I am not doing well at work/school.**  
 0 Never     1 Rarely     2 Sometimes     3 Frequently     4 Almost always
- 28. I feel something is wrong with my mind.**  
 0 Never     1 Rarely     2 Sometimes     3 Frequently     4 Almost always
- 29. I feel "blue".**  
 0 Never     1 Rarely     2 Sometimes     3 Frequently     4 Almost always
- 30. I am satisfied with my relationships with others.**  
 4 Never     3 Rarely     2 Sometimes     1 Frequently     0 Almost always

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**Wentworth and Associates Issue Specific Questions**

- Please list the issue that prompted you to seek treatment: \_\_\_\_\_
- Regarding this issue, how much distress is it causing you at this time? Please circle the number that corresponds to your level of distress:  
 No distress    0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10    A lot of distress
- Please rate your level of satisfaction with the treatment you have received at Wentworth and Associates thus far.  
 No treatment    0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10    Very Satisfied

Staff Use:  
Check One

- Intake Assessment  
 Quarterly Assessment  
 Discharge Assessment

Wentworth & Associates, P.C.  
COORDINATION OF CARE CONSENT FORM

Patient's name:

DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

SSN#        -        -

I, \_\_\_\_\_ hereby \_\_\_\_\_ authorize

\_\_\_\_ do not authorize Wentworth & Associates, P.C. to release  
and/ or obtain confidential information \_\_\_\_\_ my child's/ward's patient records to and from the  
following physician(s): (Info Primary Care Physician, check here \_\_\_ and sign below.)

My Primary Care Physician \_\_\_\_\_  
Physician's Name

Address or Fax Number \_\_\_\_\_

Information to be disclosed:

\_\_\_ Diagnoses \_\_\_\_\_

\_\_\_ Medical Information \_\_\_\_\_

\_\_\_ Assessments/Testing Information \_\_\_\_\_

\_\_\_ Other \_\_\_\_\_

Instructions/Requests:

\_\_\_\_\_  
\_\_\_\_\_

Purpose of such disclosure:

\_\_\_ Coordination of Care \_\_\_\_\_

\_\_\_ Other \_\_\_\_\_

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_

*The use of this consent by Wentworth & Associates, P.C. is effective for one year from the date of signature, and may be revoked by myself, in writing at any time. This consent is being signed voluntarily and under no circumstances is a precondition of treatment.*

Date Condition or Event for Revocation of this form \_\_\_\_\_

Please send requested information to:

\_\_\_\_\_

Requesting Clinician's name

Wentworth and Associates, P.C.                      or                      FAX 586-997-4956  
11111 Hall Rd Suite 303  
Utica, MI 48317

This form was \_\_\_ Mailed \_\_\_ Faxed \_\_\_ other (Specify) to the PCP above

Original: Clinical record                      Copy: Primary Care Physician

Rev 02/09/2016

**Note: For your child's protection, children under the age of 12, MUST be accompanied by an adult in our waiting rooms**

*All cases will be reviewed by Kristi LeBeau, Clinical Director, and Robert Burnstein, M.D. our Medical Director*