

Pamela Horton, Ph.D., P.C.

Welcome to my practice. I look forward to meeting with you and assisting you to accomplish the goals that you set for yourself. Your appointment day(s), date(s), and time(s) will be either e-mailed to you or mailed via the postal service.

The forms that I am asking you to download and complete are very important in helping us get off to a fast start and accomplish your goals as soon as possible. Please download, complete and mail your paperwork to me prior to your first appointment. The mailing address is Box 1087 Georgetown, TX 78627 Should you have any questions, please call me at 512/931-2162. If, for any reason, you do not wish to or choose not to download these forms, please call so that you can make arrangements to pick them up prior to your first visit.

Cancellation Policy:

My office policy requires *48 hours notice to cancel or reschedule an appointment without charge*. This policy was established to underscore the importance of keeping your scheduled appointments so that the best treatment can be provided.

Should you need to postpone an appointment, please call and make those arrangements at least forty eight hours in advance.

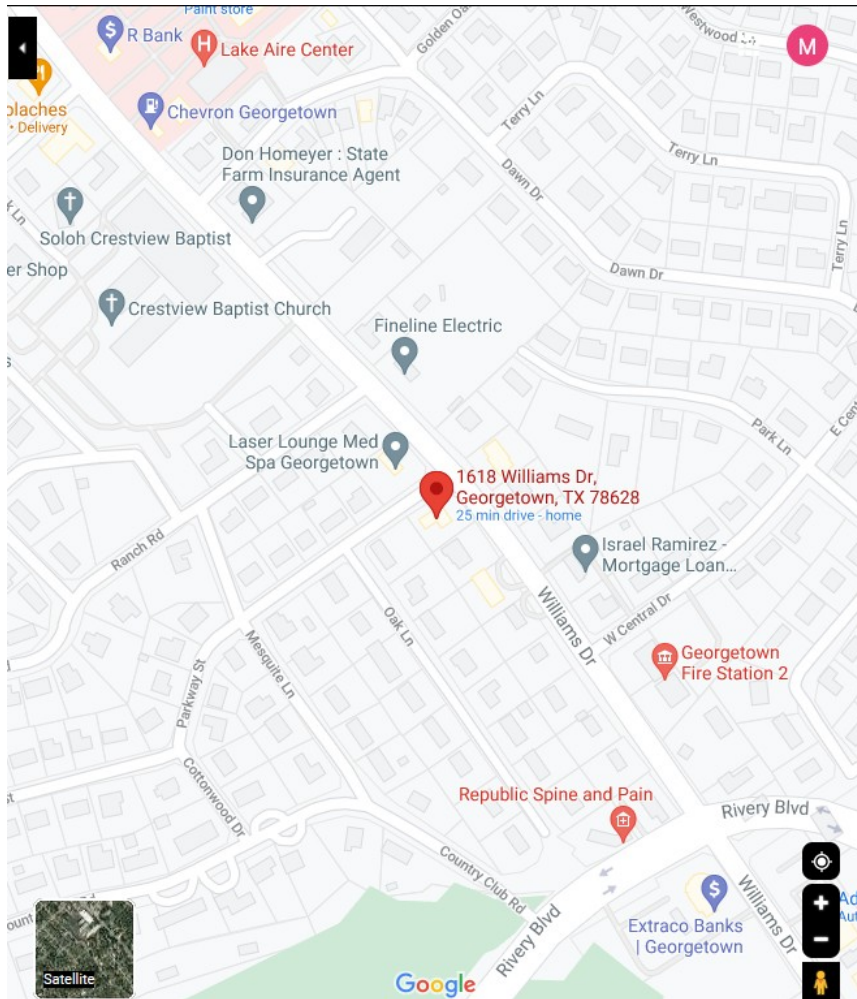
Otherwise, you will be billed for the appointment.

Directions to my office:

The physical address is: 1618 Williams Dr., Suite 6
Georgetown, TX 78628

- The office faces Parkway and my name is on the door. Park in any marked space excepting the covered carport.
- From Austin, take Exit 261-A and turn left at the light.
- Proceed through the light at Rivery.
- Turn left onto Parkway.
- The office is on the corner of Williams and Parkway.
- From north of Georgetown, take Exit 262 and turn right onto Williams.
- Follow driving directions above.

The physical address is: 1618 Williams Dr., Suite 6 Georgetown, TX 78628



I certainly look forward to meeting and working with you.

Be well,

Pamela Horton, Ph.D.

Pamela Horton, Ph.D., FPPR, PC
Clinical Psychologist

CLIENT INFORMATION

Name: _____ Work: _____
Address: _____ Address: _____
City/Zip: _____ City/Zip: _____
e-mail: _____
Phone: _____ Phone: _____
Birthdate: _____ Age: _____ Sex: _____ SS#: _____
Driver's License Number _____ Marital Status: _____
State: _____ Spouse (name): _____ Age: _____
Children: _____ Age: _____ Sex: _____ Work: _____
Emergency Contact: _____
Name: _____ Relationship: _____
Phone: (Day) _____ (Evening): _____

Current Status:

Previous therapy/with whom/year: _____

Reasons for seeking therapy at this time: _____

Have you considered suicide? _____ How long, or often, or recent? _____

If you have ever decided upon suicide, list the method(s) you have considered using: _____

List your three main fears:

- (1)
(2)
(3)

Circle any of the following stresses that apply to you:

| | | | | |
|-------------------------|--------------------|--------------------|-------------------|-----------------|
| Indecisive | Panic attacks | Headaches | Suicidal ideas | Anxious |
| Confused | Insecure | Insomnia (pm/am) | Can't concentrate | Explosive |
| Can't make/hold friends | Job problems | Bowel disturbances | Nightmares | Palpitations |
| Shy | Tremors | Dizziness | Reclusive | Over ambitious |
| Tense | Discouraged | Often angry | Fainting spells | Depression |
| Home situation bad | Memory Problems | Fatigued often | Can't keep job | Cannot relax |
| Stomach trouble | Financial problems | Feel inferior | Sex problems | Short of breath |
| Fearful | Feel driven | Decreased appetite | Lonely | |

I understand that I am fully responsible for any and all payments to Pamela Horton, Ph.D. I authorize Pamela Horton, Ph.D. to release pertinent information to insurance company(ies) in order to expedite claims processing should this be necessary.

Signature _____ Date _____

Mailing address: Box 1087, Georgetown, TX 78627
512-931-2162 FAX: 512-868-0548
mail@drpamelahorton.com

LICENSING INFORMATION

The services you receive from me, Pamela Horton, Ph.D., represent services licensed by the Texas State Board of Examiners of Psychologists. My Clinical Psychology license number is 25250. My Ph.D. is in Clinical Psychology.

INSURANCE INFORMATION

Many insurance companies will cover my services. However, it is up to you to pursue that information with your insurance company. You bear the ultimate responsibility of payment for services rendered.

CONSULTATION

Periodically, I consult with Ingrid Schmidt, M.D., Psychiatrist and Melora Jacober, Ph.D. and Richard Nicastro, Ph.D in order to provide my clients with the best treatment possible. For that reason, a therapy session may occasionally be audio taped, with your knowledge and permission. Your signature indicates that you agree that I have permission to discuss your treatment with the three people named above. These professionals' training, professional reputations, and concern for clients has warranted my trust in their abilities to consult concerning my clients should the need arise

FEE INFORMATION

As work is begun, it is important that you understand fee arrangements. You may be asked to take some tests here in the office and you will complete some tests and other evaluative tools at home. I will then review all the information, conduct a thorough history with you here in the office, and then take all the information into account as I interpret the tests you take and design your treatment program. This process is time-consuming for you and for me in the beginning; however, I have found that it ultimately saves you time and money in that your treatment plan is individually designed and treatment is more focused.

The fee for the initial diagnostic interview is \$250.00. The session is 50 minutes in length and does involve my time outside the session to review and analyze all paperwork submitted.

My fees are as follows:

\$150.00 per 50-minute session for individual
\$150.00 per 50-minute session for couple or family
\$210.00 per 75- minute session for individual, couple, or family

Should a session extend beyond the stated time, a prorated fee will be charged calculated using the per-minute rate based on the fee schedules mentioned above. Telephone calls, home, or hospital visits are billed on a prorated fee calculated using the per- minute rate based on the fee schedules mentioned above.

Telephone calls are billed after the first five free minutes and should be limited to emergency or stabilizing situations. Home or hospital visits are billed at the per-minute rate, beginning when I leave the office and culminating upon my return.

Payment for all sessions is due prior to leaving each session, and can be made via cash, personal check, and credit cards associated with a Health Savings Account.

Should you ever have questions concerning fees or billing, a separate appointment will be scheduled to discuss your questions. You will not be charged for that appointment.

OVERDUE BALANCES

If the balance for an account becomes overdue (is more than 30 days old) and if there is not a written agreement in place concerning payment arrangements that is specific to your situation, then a 5% administrative fee will be applied monthly to the unpaid balance. If the balance becomes more than 60 days old without payment (excepting a written agreement specific to your situation), then the account will be turned over for collection. At that time, a minimum of a \$50.00 fee will be added to the balance due to help cover collection costs.

APPOINTMENTS

Appointments are scheduled three months in advance

Your appointment is time set aside for you and you alone. Should you miss a scheduled appointment without giving 48-hours notice, you will be billed at the full rate for the appointment. Your insurance company will not pay this cost. Payment for a missed appointment can be made in the ways listed below. Please initial beside the one that you authorize should this occur:

Should I fail to give 48 hours notice to cancel an appointment, you can bill my Visa or Mastercard. The card number is _____, expiration date _____. My signature at the end of this document authorizes this expenditure.

Exceptions to this policy are very limited. Please note that the only acceptable way to cancel an appointment is via telephone with a request for a return call to verify receipt of the message. Appointments canceled by letter or e-mail cannot be assured of reaching this office in a timely manner and are therefore unacceptable ways to cancel an appointment.

E-MAIL AND TEXT

E-mails should be limited due to confidentiality issues. The Internet is not secure and information sent via e-mail can never be guaranteed to reach the recipient, to arrive in a timely manner, or to be read in a timely manner. Please do not use e-mail to cancel appointments. Please limit e-mails to material that you would not care for others to see. Due to time constraints, I can deliver only very brief answers to succinct, pointed questions. I do not text, so please always leave a voicemail.

TREATMENT COMPLETION/TERMINATION

The goal for therapy is to feel better and live life more effectively. Sometimes the process is quite rapid. Sometimes, this process is quite tedious and feels as if it will "go on forever". The bottom line is that you are the one who determines the length of your therapy.

If you seek multiple session therapy, there may be times in the course of your therapy that you want to stop treatment. The reasons are many. The following are some of the reasons which may cause you to want to stop treatment: feeling upset with your therapist, having a conflict with your therapist, feeling that you are not making progress, feeling that your therapist is "too nice" and does not help you to push yourself, having financial problems, feeling too embarrassed to talk about certain things, wondering if this is doing you any good, expecting rapid and dramatic change, improving and then sinking back into old feelings, getting better really fast. These are just a few of the reasons that clients may quit therapy before the work is done.

I respect your right to cease therapy at any time. It is better when treatment completion/termination is discussed between therapist and client. It is best that this discussion take place during a scheduled therapy session.

If we are not in agreement that termination of treatment is appropriate, I will offer you my professional opinion as to the reason termination is inappropriate. If you are still of the opinion that stopping your therapy is appropriate, it becomes your responsibility at that point to decide whether you want to pursue therapy with someone else and if so, to locate someone with whom you feel comfortable working. Our therapist/client relationship ends at the conclusion of our discussion. Again, it is best that this discussion take place within the scheduled therapy appointment, not over the telephone or in a letter.

Please let me know your feeling at this time by initialing one of the statements below:

 I make a definite commitment to speak with Dr. Horton in person during a regularly scheduled therapy session before I make any decision to end therapy.

 I am uncertain of my willingness to make such a commitment.

 I am not willing to make that commitment.

EMERGENCIES

This is a private practice and subject to the limitations of a private practice. *There is no one on call 24-hours per day.*

In the unlikely event that you experience a psychological emergency outside the treatment sessions, you may reach me at 512/931-2162. My answering machine will give you my cell phone number. If I am away from the telephone, I will be checking messages periodically and will return your call within 24 hours. If I am out of town, the message on my office answering machine will tell you who is taking calls for me. However, even that person will be a private practitioner and may not be able to get back with you immediately. If you feel that you cannot stabilize yourself while waiting for my return call or if you have no one available to help you immediately and you feel in physical danger, call 911 for assistance. If you or an emergency team decides that hospital admission is advisable, I recommend St. David's Hospital in Austin. If you simply need to talk to someone for stabilization, and I cannot be immediately reached, call the 24-hour Crisis Hotline at 472-4357.

If you feel that you will need more readily available help, then working with me under these circumstances is not in your best interest. Please locate someone in a group or hospital practice with whom you will have more accessibility.

CONFIDENTIALITY

Texas law provides for confidentiality between professional and client with the following exceptions:

1. When a client has waived his/her right to confidentiality in writing, or
2. When a client brings proceedings or litigation against a professional, including but not limited to malpractice, or
3. When an insurance company requests information relating to their client's claim, or
4. When a judge finds that a client, after having been informed that communications would not be confidential, has made statements to the professional in the context of a court ordered examination, or
5. When disclosures from a client's file is relevant in any suit affecting the parent-child relationship, or
6. In any proceeding regarding the abuse or neglect or the cause of any abuse or neglect of a resident of an "institution" as defined by law, or
7. When there is reason to believe that a client is a danger to self or others, or there is reason to believe the client has committed an illegal and lethal act against another, or
8. When there is reason to believe that a client is abusing and/or neglecting a minor child or elderly person in his/her care, or
9. When there is reason to believe that a minor or elderly client is being abused by a person or persons, or
10. When there is a criminal case against a client.

CELLULAR PHONE

Occasionally, I am forced to conduct some of my business, including client management, over a cellular phone. By their very nature, cellular phone calls are not private. Occasionally, someone else can overhear a call, either accidentally or by his or her design. I limit the use of my cellular phone to answering emergencies concerning clients.

Please leave voice mails if utilizing my cell phone number. Texting is problematic for me and I rarely, if ever utilize it.

IF MY OFFICE NEEDS TO REACH YOU

___ Dr. Horton or her office staff can leave a message for me with someone at my home number.

Please initial beside the statements to indicate your preferences should I need to contact you.

___ Dr. Horton or her office staff can leave a message for me on my home answering machine.

___ Dr. Horton or her office staff can leave a message for me with someone at my work number.

___ Dr. Horton or her office staff can leave a message for me with my office voice mail or answering service.

THERAPY OUTCOMES

Therapy outcomes can never be guaranteed. However, various studies conducted over the years have shown that some form of psychotherapy is better than none in most cases of mental distress. The types of treatments that I utilize will be explained to you as we work together, and you are free to ask any questions that you desire about them.

The work that we do together will in all likelihood bring about changes in your life. You may be quite pleased with these changes. In the process, however, there may be some unpleasant feelings and some changes which cause you and those with whom you associate some distress. Normally, these are like any other changes, uncomfortable because they are new, but when they become a part of you, the comfort level begins to increase. Prior to beginning therapy, please discuss these possibilities with those people significant to you and please feel free to ask me any questions concerning potential outcomes of therapy.

SELF HELP

You are probably making a decision to enter therapy because you are uncomfortable with some areas of your life.

The purpose of our work together is to help you to function in life in more comfortable and productive ways. During the therapy process you may begin to feel better because you solve a personal problem, because you appreciate the support of a therapist who understands and approves of you, because you take some sort of medication which helps, and/or because you do things to help yourself between therapy sessions.

People who help themselves between therapy sessions usually make the most rapid gains. Those unwilling to help themselves between sessions many times show slower and less improvement. You may be asked to do some self-help assignments between sessions which might include schedules of daily activities, mood logs, checklists of various kinds, reading books and/or articles, various types of self-assessment tests, feedback forms concerning your therapy, keeping a notebook, taping your sessions for later review, and other similar activities.

It is important that you decide whether you are willing to make an effort to help yourself as a part of your treatment. Please indicate your decisions with initials at the appropriate statements below.

___ Yes, I understand that Dr. Horton emphasizes self-help as a key to personal growth and I am willing to do things between sessions to help myself.

___ No, I do not agree that self-help is an important key to personal growth.

___ We need to discuss this matter further.

___ No, I am unwilling to do self-help assignments.

WHAT IF YOU HAVE A COMPLAINT?

Should you have a complaint about the therapeutic process, I would appreciate the courtesy of your letting me know. At that time, I will schedule a complimentary appointment, outside your therapy session, to discuss the complaint with you. Every effort will be made to reach a satisfactory resolution to your complaint. If resolution is not forthcoming, you then have the option of registering an official complaint with the Texas State Board of Examiners of Psychologists. Of course, if you choose not to consult with me first, you still have the option of registering your complaint with the Board.

WHAT YOU CAN EXPECT FROM DR. HORTON

I am a facilitator. It is my job to help you to access your own personal strengths and resources to solve your own problems. You are the most important ingredient in a successful outcome. You will receive my undivided attention during your sessions. My goal is to help you realize that you are capable and self-sufficient, able to problem-solve and face the challenges of life in ways that will be beneficial to you and to others. My goal is for you to utilize my services only as long as you need them and no longer.

Successful treatment depends upon rapport and cooperation between therapist and client, and it is important to realize that honesty and forthrightness in dealing with your issues will speed resolution.

Please feel free to ask any questions about the above information or any other matter which comes to mind at this time or at any time during our work together.

Below, please sign and date to indicate that you understand and are willing to accept the terms of your association with me as detailed on the previous pages.

Signature

Date

Notes:

PSYCHOLOGICAL/SOCIALHISTORY

V4.

Instructions: Answer the following questions as they apply to you. On some questions no answers will apply so do not mark anything. Circle the right answers. Some questions will have more than one answer so circle all that apply. Put a check mark by any answers you want to discuss.

NAME _____ AGE _____ DATE _____ SEX _____

OCCUPATION _____

RACE-----

1. What is your race? (1 answer)

- | | |
|----------------------|---------------------|
| 1. Asian | 5. Mexican American |
| 2. Black | 6. Native American |
| 3. Caucasian (white) | 7. Oriental |
| 4. Latin | 8. Other |

FAMILY-----

1. Who primarily raised you? (1 answer)

1. Natural parents
2. Father only
3. Mother only
4. Father and stepmother
5. Mother and stepfather
6. Adoptive parents
7. Foster parents
8. Institutional caretakers
9. Aunt and/or uncle
10. Brother and/or sister
11. Maternal grandparent(s)
12. Paternal grandparent(s)
13. Other

2. How would you characterize your childhood? (answer all that apply)

- | | |
|----------------|---------------------|
| 1. Happy | 5. Hard to remember |
| 2. Frightening | 6. Secure |
| 3. Unhappy | 7. Painful |
| 4. Dull | 8. Regimented |

3. Which descriptor(s) characterize your mother (maternal caretaker)? (answer all that apply)

- | | |
|--------------------|-------------------|
| 1. Warm | 8. Domineering |
| 2. Distant | 9. Abusive |
| 3. Uncaring | 10. Faultfinding |
| 4. Strict | 11. Understanding |
| 5. Unpleasant | 12. Perfect |
| 6. Rejecting | 13. Affectionate |
| 7. Over protective | |

4. Which descriptor(s) characterize your father (paternal caretaker)? (answer all that apply)

- | | |
|--------------------|-------------------|
| 1. Warm | 8. Domineering |
| 2. Distant | 9. Abusive |
| 3. Uncaring | 10. Faultfinding |
| 4. Strict | 11. Understanding |
| 5. Unpleasant | 12. Perfect |
| 6. Rejecting | 13. Affectionate |
| 7. Over protective | |

5. How would you describe your parents'(or parent substitutes') relationship? (answer all that apply)

- | | |
|---------------------|----------------------------|
| 1. Close | 8. Reserved |
| 2. Cold | 9. Distant |
| 3. Ideal | 10. Happy |
| 4. Violent | 11. Domineering/submissive |
| 5. Indifferent | 12. Loving |
| 6. Full of conflict | 13. Hostile |
| 7. Hot and cold | |

6. How many brothers and sisters did you have? (1 answer)

- | | |
|----------|--------------------|
| 1. One | 6. Six |
| 2. Two | 7. Seven |
| 3. Three | 8. Eight |
| 4. Four | 9. More than eight |
| 5. Five | 10. None |

7. Which descriptors characterize you as a child (0 to 12 years of age)? (answer all that apply)

- | | |
|------------------|--------------------|
| 1. Outgoing | 10. Nervous |
| 2. Shy | 11. Rebellious |
| 3. Active | 12. Serious |
| 4. Aggressive | 13. Stubborn |
| 5. Awkward | 14. Unhappy |
| 6. Happy | 15. Calm |
| 7. Friendly | 16. Temperamental |
| 8. Emotional | 17. Self-confident |
| 9. Irresponsible | |

8. What was your order of birth? (1 answer)

- | | |
|-----------|---------------|
| 1. Oldest | 3. Youngest |
| 2. Middle | 4. Only child |

9. What were problems for you as a child (0 to 12 years of age)? (answer all that apply)

1. None
2. Getting along with mother
3. Getting along with father
4. Getting along with sibling(s)
5. Getting along with peers
6. Getting along with teachers
7. Bed-wetting
8. Nightmares
9. Excessive fears or worries
10. Academic
11. Physical/medical problems
12. Nerves
13. Felt I was a burden to my parents
14. Overweight
15. Underweight
16. Having my feelings hurt
17. Fear of failure

10. What did your parents (parental caretakers) argue about? (answer all that apply)

1. Money
2. Discipline of children
3. Relatives interfering
4. Drinking
5. Sex
6. Jealousy
7. Not taking care of the home
8. Not being a good provider
9. Never argued

11. What was your father's (paternal caretaker's) occupation? (1 answer)

1. Homemaker
2. Professional
3. Owner of business
4. Skilled craftsman
5. Office worker
6. Salesperson
7. Skilled laborer
8. Unskilled laborer
9. Unemployed
10. Disabled
11. Government service
12. Personal service (hair stylist, maid)
13. Military service
14. Executive
15. Does not apply

12. What was your mother's (maternal caretaker's) occupation? (1 answer)
 1. Homemaker
 2. Professional
 3. Owner of business
 4. Skilled craftsman
 5. Office worker
 6. Salesperson
 7. Skilled laborer
 8. Unskilled laborer
 9. Unemployed
 10. Disabled
 11. Government service
 12. Personal service (hair stylist, maid)
 13. Military service
 14. Executive
 15. Does not apply
13. How would you describe your mother's method of discipline? (1 answer)

| | |
|------------------|-----------------|
| 1. Strict | 4. Lenient |
| 2. Fairly strict | 5. Inconsistent |
| 3. Fair | |
14. How would you describe your father's method of discipline? (1 answer)

| | |
|------------------|-----------------|
| 1. Strict | 4. Lenient |
| 2. Fairly Strict | 5. Inconsistent |
| 3. Fair | |
15. What fears did you have as a child (0 to 12 years of age)? (answer all that apply)
 1. No significant fears
 2. Death
 3. Might fail
 4. Might become seriously injured/ill
 5. Strangers
 6. Might be laughed at
 7. Might be abandoned - lose my parents
 8. Animals
 9. Other children
16. How would you characterize your sexual experiences? (1 answer)
 1. Pleasant
 2. Neutral
 3. Unpleasant

EDUCATION

1. How far did you go in school? (1 answer)
 1. Completed less than 6 grades
 2. Completed elementary school
 3. Completed junior high (9th grade)
 4. Attended high school (no diploma)
 5. Received a g.e.d.
 6. Graduated high school
 7. Vocational / business school training
 8. Attended college (did not graduate)
 9. Graduated college-four year degree
 10. Completed graduate level courses
 11. Earned a masters degree
 12. Earned a doctoral degree
2. How would you rate your intellectual ability? (1 answer)

| | |
|------------------|--------------------|
| 1. Below average | 3. Above average |
| 2. Average | 4. Superior/gifted |
3. Were you ever held back in school? (1 answer)
 1. No
 2. Yes
4. In general, what grades did you make in school? (1 answer)
 1. Many D's and F's
 2. Mostly C's
 3. Mostly B's and A's
 4. Mostly A's

5. Old you ever get in trouble while in school? (1 answer)
 1. No
 2. Occasionally
 3. Often
6. Old you have any problems learning to read? (1 answer)
 1. No
 2. Yes
7. Did you have any problems learning math? (1 answer)
 1. No
 2. Yes
8. Did your peers ridicule, tease or make fun of you more than other kids? (1 answer)
 1. No
 2. Yes

FINANCIAL

- Rate your family's economic status during childhood and adolescence. (1 answer)
1. Poverty level (received welfare)
 2. Working class
 3. Middle class
 4. Upper middle class
 5. Wealthy
 2. Who provided the main source of Income for your family? (1 answer)

| | |
|---------------|----------------------------|
| 1. Mother | 4. Social service agencies |
| 2. Father | 5. A friend of the family |
| 3. A relative | 6. Other |
 3. Did your parents agree on how money should be spent? (1 answer)
 1. Agreed most of the time
 2. Disagreed
 3. Disagreed frequently
 4. Did your family experience any financial problems? (1 answer)
 1. No
 2. Occasionally
 3. Often
 5. Currently, how much money does your household earn? (1 answer)

| | |
|----------------------|-----------------------|
| 1. less than \$8,000 | 5. \$20,000- \$30,000 |
| 2. \$8,000- \$12,000 | 6. \$30,000- \$45,000 |
| 3. \$12,000-\$15,000 | 7. More than \$45,000 |
| 4. \$15,000-\$20,000 | |
 6. Have you had any major changes in Income during the last 2 years? (1 answer)
 1. No
 2. Decreased significantly
 3. Increased significantly
 7. What is your family's primary source of Income? (1 answer)
 1. My earnings
 2. My partner's earnings
 3. Relatives
 4. Disability payments
 5. Unemployment
 6. Welfare
 7. Investments
 8. Other
 8. Is providing enough Income for your family a big stress in your life? (1 answer)
 1. No
 2. Yes

EMPLOYMENT

1. Are you presently employed? (1 answer)
 1. No
 2. Yes
2. How long have you been working at this job? (1 answer)

| | |
|-----------------------|-----------------------|
| 1. Less than 6 months | 6. 10 To 15 years |
| 2. 6 months to 1 year | 7. 15 To 20 years |
| 3. 1 To 3 years | 8. More than 20 years |
| 4. 3 To 5 years | 9. Does not apply |
| 5. 5 To 10 years | |

3. How many hours per week do you work? (1 answer)
 1. Less than 10
 2. 10 To 20
 3. 20 To 30
 4. 30 To 45
 5. More than 45
 6. Does not apply
4. In general, how do you enjoy your work? (1 answer)
 1. Enjoyable
 2. Neutral
 3. Unenjoyable
 4. Does not apply
5. Have you ever been fired? (1 answer)
 1. No
 2. Yes
6. Have you ever been laid off? (1 answer)
 1. No
 2. Yes
7. What Is the longest period of time you held one Job? (1 answer)
 1. Less than 1 year
 2. 1 To 3 years
 3. 3 To 5 years
 4. 5 To 10 years
 5. More than 10 years
8. Since starting full time work, what is your longest unemployed period? (1 answer)
 1. Less than 1 month
 2. 1 to 6 months
 3. 6 months to 1 year
 4. 1 To 3 years
 5. 3 To 5 years
 6. 5 To 10 years
 7. More than 10 years
9. Do you have any problems at work? (1 answer)
 1. No
 2. Yes
10. What kinds of work have you performed in the past? (answer all that apply)
 1. A homemaker
 2. A professional
 3. An owner of business
 4. A skilled craftsman
 5. An office worker
 6. A salesperson
 7. A skilled laborer
 8. An unskilled worker
 9. Have never worked
 10. In government service
 11. Personal service (hair stylist, maid)
 12. An executive
 13. Other
 14. None of above

MILITARY _____

1. Have you ever served in the military? (1 answer)
 1. No
 2. Yes
2. Which branch did you serve in? (1 answer)
 1. Air Force
 2. Army
 3. Navy
 4. Marines
 5. Coast Guard
 6. Does not apply
3. How long did you serve? (1 answer)
 1. Less than 3 months
 2. Less than 1 year
 3. 1 to 2 years
 4. 2 to 4 years
 5. 4 to 6 years
 6. 6 to 10 years
 7. 10 to 15 years
 8. More than 15 years
 9. Does not apply

4. What kinds of problems did you experience while In the military? (answer all that apply)
 1. Getting used to rules & regulations
 2. Taking orders
 3. Nerves
 4. Began using drugs
 5. Began using alcohol to excess
 6. Was reprimanded for my conduct
 7. Had to do special duty for conduct
 8. Did time in the stockade/brig
 9. Was court martialled
 10. Went AWOL
 11. Other
 12. None or does not apply
5. Were you stationed in a combat zone? (1 answer)
 1. No
 2. Yes, for less than 3 months
 3. Yes, for 3 to 6 months
 4. Yes, for 6 months to 1 year
 5. Yes, for 1 to 2 years
 6. Yes, for 2 to 3 years
 7. Yes, for 3 to 4 years
 8. Yes, for longer than 4 years
 9. Does not apply
6. What was the highest rank you attained? (1 answer)
 1. Enlisted person
 2. Noncommissioned officer
 3. Officer
 4. Does not apply
7. What were the terms of your discharge? (1 answer)
 1. Still on active duty
 2. Honorably discharged (mental prob.)
 3. Honorably discharged (physical prob.)
 4. Honorable discharge
 5. Dishonorably discharged
 6. Does not apply
8. Did you ever see a psychologist or psychiatrist while in the military? (1 answer)
 1. No
 2. Was hospitalized for mental problems
 3. For evaluation & treatment (Out.Pt.)
 4. For evaluation only
 5. Does not apply
9. Do you have a service-connected disability? (1 answer)
 1. No
 2. Physical
 3. Mental
 4. Physical and mental
 5. Does not apply

ALCOHOL _____

1. Which of the following have you used? (select all that apply)
 1. None
 2. Cocaine
 3. Barbiturates
 4. Amphetamines
 5. Hallucinogenics
 6. Opium
 7. Quaaludes
 8. Heroin
 9. Marijuana
 10. Tranquilizers without prescription
 11. Pain pills without prescription
 12. Pep
2. Have you ever felt there was a time you drank too much alcohol? (1 answer)
 1. No
 2. Yes, on one occasion
 3. Yes, on several occasions
 4. Yes, on more than several occasions

3. On the average, how often do you drink alcohol? (1 answer)
 1. Never
 2. Once or twice a year
 3. Once a month
 4. Once a week
 5. Several times a week
 6. Daily
4. How would you describe your Illegal drug usage? (1 answer)
 1. Never used drugs
 2. Once or twice a year
 3. Once or twice a month
 4. Once a week
 5. A couple times a week
 6. Daily
5. Have you ever been Involved In an alcoholism or drug treatment program? (1 answer)
 1. No
 2. Yes
6. Old your parents have a problem with alcohol when you were a child? (1 answer)
 1. No
 2. Mother only
 3. Father only
 4. Both parents did
 5. The person who raised me did
7. Do you smoke cigarettes? (1 answer)
 1. No, never have
 2. No, I quit smoking
 3. Yes, a pack a week or less
 4. Yes, about one-half pack a day
 5. Yes, a pack a day
 6. Yes, more than a pack a day

MEDICAL

1. Have any family members ever experienced mental Illness? (answer all that apply)
 1. No
 2. I have
 3. Mother
 4. Father
 5. Sibling(s) [brother(s)/sister(s)]
 6. Grandparent
 7. Outside the immediate family
2. Old you have any bad Illnesses as a child (e.g. hospitalizations)? (1 answer)
 1. No
 2. Yes
3. Have you had any significant accidents in the past 3 years? (1 answer)
 1. No
 2. Yes
4. Have you had any major Illnesses or hospitalizations In the past 3 years? (1 answer)
 1. No
 2. Yes
5. Rate your general level of health. (1 answer)
 1. Excellent
 2. Good
 3. Fair
 4. Poor
 5. Extremely poor
6. Are you currently under the care of a physician? (1 answer)
 1. No
 2. Yes

7. What medications are you currently taking? (1 answer)
 1. None
 2. Pain pills
 3. Antibiotics
 4. Anti-inflammatory pills
 5. Anticonvulsant pills
 6. Heart pills
 7. High blood pressure pills
 8. Tranquilizers
 9. Antidepressants
 10. Vitamins
 11. Insulin
 12. Allergy pills
 13. Stomach pills
 14. Other

MARITAL STATUS

1. What is your marital status? (1 answer)
 1. Single (involved in relationship)
 2. Single
 3. Divorced
 4. Separated
 5. Married
 6. Widowed
2. Have you ever been divorced? (1 answer)
 1. No
 2. Yes
3. How long have you been with your current partner? (1 answer)

| | |
|---------------------|------------------------|
| 1. Does not apply | 8. More than 5 years |
| 2. Less than 1 year | 9. More than 10 years |
| 3. 1 Year | 10. More than 15 years |
| 4. 2 Years | 11. More than 20 years |
| 5. 3 Years | 12. More than 25 years |
| 6. 4 Years | 13. More than 30 years |
| 7. 5 Years | |
4. How many children do you have? (1 answer)

| | |
|------|----------------|
| 1. 1 | 6. 6 |
| 2. 2 | 7. 7 |
| 3. 3 | 8. 8 |
| 4. 4 | 9. More than 8 |
| 5. 5 | 10. None |
5. How would you describe your partner? (answer all that apply)

| | |
|-------------------|--------------------|
| 1. Warm | 11. Perfect |
| 2. Unhappy | 12. Indifferent |
| 3. Distant | 13. Argumentative |
| 4. Uncaring | 14. Boring |
| 5. Happy | 15. Stimulating |
| 6. Unpleasant | 16. Unforgiving |
| 7. Enjoyable | 17. Tense |
| 8. Abusive | 18. Affectionate |
| 9. Fault finding | 19. Does not apply |
| 10. Understanding | |
6. Are you having problems with your children's behavior? (1 answer)
 1. No
 2. Yes
 3. Does not apply
7. Is the frequency of sex a problem? (1 answer)
 1. No
 2. Yes
8. What are your living arrangements? (1 answer)
 1. Living with relatives in their home
 2. Living with friends in their home
 3. Renting a home
 4. Renting an apartment
 5. Buying own home
 6. Own my home
 7. Boarder
 8. Living in a dorm
 9. Other

9. How often do you and your partner argue? (1 answer)
1. Never
 2. Rarely
 3. Once a month
 4. Once a week
 5. Several times a week
 6. Daily
 7. Several times a day
 8. Does not apply
10. Has your relationship ever been threatened by an affair? (1 answer)
1. No
 2. Yes, my affair
 3. Yes, my partner's affair
 4. Does not apply
11. What interests do you and your partner share? (answer all that apply)
- | | |
|------------------------------|--------------------------|
| 1. None | 11. Television |
| 2. Children | 12. Religious activities |
| 3. Work-related | 13. Club activities |
| 4. Sports | 14. Talking |
| 5. Hobbies or crafts | 15. Games |
| 6. Movies | 16. Camping |
| 7. Theater | 17. Hunting/fishing |
| 8. Music | 18. Other |
| 9. Politics | 19. Does not apply |
| 10. Socializing with friends | |
12. How well do you feel your partner fulfills his/her role with you? (1 answer)
- | | |
|----------------|-------------------|
| 1. Very well | 4. Very poorly |
| 2. Fairly well | 5. Does not apply |
| 3. Poorly | |
- DIET
1. Do you eat a balanced diet? (1 answer)
1. No
 2. Yes
2. Do you participate in a regular exercise program? (1 answer)
1. No
 2. Yes
3. How would you characterize your size? (1 answer)
- | | |
|------------------|------------------------|
| 1. Very thin | 4. A little overweight |
| 2. Thin | 5. Overweight |
| 3. About average | 6. Very overweight |
- PSYCHOLOGICAL
1. Which of the following have you experienced in the past two years? (answer all that apply)
1. Marital reconciliation
 2. Jail term
 3. Retirement
 4. Fired at work
 5. Change in health of family member
 6. Marital separation
 7. Divorce
 8. Death of spouse/partner
 9. Pregnancy
 10. More or less arguments with partner
 11. None
2. Which of the following have you experienced in the past two years? (answer all that apply)
1. Death of a close friend
 2. Marriage
 3. Death of close family member
 4. Change in financial state
 5. Personal injury or illness
 6. Change to different line of work
 7. Business readjustment
 8. Gain of a new family member
 9. Sex difficulties
3. How would you rate your ability to cope with life? (1 answer)
- | | |
|--------------|---------|
| 1. Very good | 3. Fair |
| 2. Good | 4. Poor |
4. How would you describe yourself? (answer all that apply)
- | | |
|-------------------|-----------------|
| 1. Quiet | 11. Stubborn |
| 2. Outgoing | 12. Easygoing |
| 3. Talkative | 13. Friendly |
| 4. Shy | 14. Smart |
| 5. Active | 15. Impatient |
| 6. Aggressive | 16. Responsible |
| 7. Temperamental | 17. Rebellious |
| 8. Self-confident | 18. Serious |
| 9. Wild | 19. Unassertive |
| 10. Carefree | |
5. How would you describe your mental state? (answer all that apply)
- | | |
|-------------------|-------------------|
| 1. Tense | 11. Regretful |
| 2. Depressed | 12. Irritable |
| 3. Forgetful | 13. Calm |
| 4. Sad | 14. Scared |
| 5. Worried | 15. Hyperactive |
| 6. Fearful | 16. Nervous |
| 7. Angry | 17. Happy |
| 8. Unenthusiastic | 18. Distrustful |
| 9. Confused | 19. None of above |
| 10. Disappointed | |
6. Have you ever had legal problems (answer all that apply)
1. No
 2. Civil (e.g. divorce)
 3. Arrested
 4. Convicted
- PRE
1. What is the primary problem bothering you?
- | | |
|--------------------|-------------------------|
| 1. Marriage | 8. Physical (ill/tired) |
| 2. Family | 9. Alcohol |
| 3. Loneliness | 10. Drugs |
| 4. Moodiness | 11. Sex |
| 5. Depression | 12. Memory |
| 6. Anxiety | 13. Work |
| 7. Self-confidence | 14. Other |
2. How long ago did you begin to be troubled by this problem? (1 answer)
1. Within the past month
 2. Between 1 and 6 months
 3. Between 6 and 12 months
 4. Between 1 and 2 years
 5. Between 2 and 5 years
 6. Between 5 and 10 years
 7. Over 10 years
 8. All my life
 9. Does not apply
3. Rate the degree to which this problem has affected your life. (1 answer)
- | | |
|------------------|-------------------|
| 1. Very little | 4. A good deal |
| 2. A little | 5. A great deal |
| 3. A fair amount | 6. Does not apply |
4. How often do you experience this problem? (1 answer)
- | | |
|-------------------------|--------------------------|
| 1. Many times a day | 6. Several times a month |
| 2. Several times a day | 7. Monthly |
| 3. Daily | 8. Several times a year |
| 4. Several times a week | 9. Less than once a year |
| 5. Once a week | 10. Does not apply |
5. What other kinds of problems are bothering you? (answer all that apply)
- | | |
|-------------------------|--------------------|
| 1. Marriage | 9. Alcohol |
| 2. Family | 10. Drugs |
| 3. Loneliness | 11. Sex |
| 4. Moodiness | 12. Memory |
| 5. Depression | 13. Work |
| 6. Anxiety | 14. Other |
| 7. Self-confidence | 15. Does not apply |
| 8. Physical (ill/tired) | |

How To Make Your Counseling More Effective

Client's Initial Questionnaire

Setting Goals and Finding Solutions is the Important First Step:

Your opinions, thoughts and feelings are most important. How you describe what you want to change can help you and your therapist set specific therapy goals and find solutions more quickly and easily.

This booklet is designed to help you provide the kind of details that will make your therapy more effective.

Please take a few minutes now to complete each item. When finished, give this booklet to your therapist. This is an important part of your therapy. Thank you!

Instructions:

There is a total of 15 questions. Most items have two parts, (a) and (b). Just write simply number that best represents how you feel the problem has changed in the months.

Then, in paragraph, briefly describe in your own how the problem has bothered or distressed you within the last 12 months.

Go through the questions quickly, putting down the first thing that comes to mind (please print clearly). Now, please read these instructions again, then begin....

BOSS /i

BROWNING OUTCOMES SURVEY SCALE
for Brief Therapy

1. (a) How would you rate the problem today as compared to a few months ago?
- | 2 | 3 | 4 | 5 | 6 | 7 |
|------------|------------------|----------------|----------------|-------------------|---------------------|
| Much Worse | Moderately Worse | Slightly Worse | About The Same | Slightly Improved | Moderately Improved |
- (b) Please briefly describe the problem that brought you for counseling as it affects you now:

3. (a) Compared to a few months ago, how would you rate any physical or medical symptoms caused by your problem?
- | 2 | 3 | 4 | 5 | 6 | 7 |
|------------------|----------------|----------------|-------------------|---------------------|---------------|
| Moderately Worse | Slightly Worse | About The Same | Slightly Improved | Moderately Improved | Much Improved |
- (b) Please briefly state how the problem affects you physically or medically? (For example, physical symptoms, doctors visits, medications, etc.):

2. (a) How well do you understand the problem today as compared to a few months ago?
- | 2 | 3 | 4 | 5 | 6 | 7 |
|-----------------|-----------------------|---------------------|----------------|---------------------|-----------------------|
| Much Less Aware | Moderately Less Aware | Slightly Less Aware | About The Same | Slightly More Aware | Moderately More Aware |
- (b) In your own words, briefly state what or whom you think (a) causes the problem to occur, (b) makes the problem worse, and (c) helps make the problem better:
- Causes the problem:

- Makes the problem worse:

- Helps make the problem better:

4. (a) How is the problem affecting your work or school performance now as compared to a few months ago?
- | 2 | 3 | 4 | 5 | 6 | 7 |
|------------|------------------|----------------|----------------|-----------------|-------------------|
| Much Worse | Moderately Worse | Slightly Worse | About The Same | Slightly Better | Moderately Better |
- (b) The problem causes me to (check one or more):
- Be late for work ☐ Miss work completely ☐
 - Have conflicts with people at work ☐ Have trouble concentrating ☐
 - Have poor work performance ☐
- (c) In your own words, briefly describe how the problem affects your work performance:

5. (a) How Is the problem affecting your relationships with others today as compared to a few months ago?

| | 2 | 3 | 4 | 5 | 6 | 7 |
|------------|------------------|----------------|----------------|-------------------|---------------------|---------------|
| Much Worse | Moderately Worse | Slightly Worse | About The Same | Slightly Improved | Moderately Improved | Much Improved |

- (b) Briefly comment on how the problem affects your relationships with others at **this** time:

6. (a) How do you think others who know you would rate your problem today compared to a few months ago?

| | 2 | 3 | 4 | 5 | 6 | 7 |
|------------|------------------|----------------|----------------|-------------------|---------------------|---------------|
| Much Worse | Moderately Worse | Slightly Worse | About The Same | Slightly Improved | Moderately Improved | Much Improved |

- (b) In your own words, briefly state how you think others who know you would describe your problem now:

7. (a) Compared to a few months ago, how does your problem affect your attitude and feelings about yourself?

| | 2 | 3 | 4 | 5 | 6 | 7 |
|------------|------------------|----------------|----------------|-------------------|---------------------|---------------|
| Much Worse | Moderately Worse | Slightly Worse | About The Same | Slightly Improved | Moderately Improved | Much Improved |

- (b) Briefly state how you think the problem affects your attitudes and feelings about yourself?

8. (a) How much are you aware of sources of help for the problem now as compared to a few months -a go?

| | 2 | 3 | 4 | 5 | 6 | 7 |
|-----------------|---------------------|----------------------|----------------|-------------------|---------------------|---------------|
| Totally Unaware | Aware But Don't Use | Aware But Use Rarely | About The Same | Use Slightly More | Use Moderately More | Use Much More |

- (b) Aside from therapy, what resources are you aware of that can help you handle the problem?

9. (a) How effective are you today handling the problem as compared to a few months ago?

| | 2 | 3 | 4 | 5 | 6 | 7 |
|---------------------|---------------------------|-------------------------|----------------|-------------------------|---------------------------|---------------------|
| Much Less Effective | Moderately Less Effective | Slightly Less Effective | About The Same | Slightly More Effective | Moderately More Effective | Much More Effective |

- (b) In your own words, briefly describe what you've tried to do to handle the problem until now:

10. (a) When you think about the problem now, how would you rate your thoughts and feelings about the future compared to how you felt a few months ago?

| | 2 | 3 | 4 | 5 | 6 | 7 |
|-------------------|-------------------------|-----------------------|----------------|-----------------------|-------------------------|-------------------|
| Much Less Hopeful | Moderately Less Hopeful | Slightly Less Hopeful | About The Same | Slightly More Hopeful | Moderately More Hopeful | Much More Hopeful |

- (b) When you think about the problem, describe your thoughts and feelings about the future:

11. (a) To what extent have you been able to control self-destructive habits or patterns on your own?

| | 2 | 3 | 4 | 5 | 6 | 7 |
|--------------|----------|------------|-------------|-----------|-------------------|------------|
| "Not at all" | Slightly | Moderately | Quite a bit | Very much | Almost completely | Completely |

- (b) Describe the efforts you've made on your own to control self-destructive habits or patterns in your life

12. (a) To what extent do you believe that therapy can enable you to find solutions to your problems?

| | 2 | 3 | 4 | 5 | 6 | 7 |
|-------------------|-----------------|----------|---------------|-----------------|-------------|-----------|
| Moderately Unable | Slightly Unable | Not Sure | Slightly Able | Moderately Able | Quite a bit | Very much |

- (b) What are the solutions you hope to find through your counseling?

13. What specific actions have you been taking to deal with the problem?

14. On a scale of 1 to 10, rate the seriousness of the problem *right now*:

| | | | | | | | | | |
|--|---|---|---|---|---|---|---|-------------------------------------|-----------------------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Unbearable, Unable to cope. Desperate for help | | | | | | | | Handling things great. Need help | No problems, Everything great. |

15. Suppose that you accomplish all your goals in therapy and the problem is greatly improved or solved. Briefly describe how you think things would be different in your life:

(Please Print)

Your Name _____ Today's Date _____

Your Therapist's Name _____

Thank you for taking the time to share your thoughts
and feelings. This will be a helpful reflection.
Please give the completed booklet to your therapist.

Pre-Therapy Testing *

Instructions: This packet contains three self-assessment tests which measure depression, anxiety, and satisfaction in personal relationships, respectively. Please complete each one and bring them to your therapist at the initial evaluation. They will only require a few minutes.

Your therapist may ask you to take these tests once a week throughout the therapy. If so, you will be given a fresh set of tests along with answer sheets and scoring keys at your first session. The tests are easy to complete and can help you and your therapist accurately track your progress.

Your therapist may also ask you to complete a fourth test called the Empathy Scale between sessions. This will give you a chance to indicate what you liked and disliked about your most recent session. This information can be invaluable, and will often make the therapy much more meaningful and rewarding.

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Burns Depression Checklist *

Instructions: Place a check (✓) in the box to the right of each of the 15 symptoms to indicate how much this type of feeling has been bothering you in the past several days.

| | 0—NOT AT ALL | 1—SOMEWHAT | 2—MODERATELY | 3—A LOT |
|---|--------------|------------|--------------|---------|
| 1. Sadness: Have you been feeling sad or down in the dumps? | | | | |
| 2. Discouragement: Does the future look bleak or hopeless? | | | | |
| 3. Low self-esteem: Do you feel worthless or think of yourself as a loser? | | | | |
| 4. Inferiority: Do you feel inadequate or inferior to others? | | | | |
| 5. Guilt: Do you get self-critical and blame yourself? | | | | |
| 6. Indecisiveness: Is it hard to make decisions? | | | | |
| 7. Irritability and frustration: Have you been feeling angry or resentful? | | | | |
| 8. Loss of interest in life: Have you lost interest in your career, hobbies, family, or friends? | | | | |
| 9. Loss of motivation: Do you feel overwhelmed and have to push yourself hard to do things? | | | | |
| 10. Poor self-image: Do you think you're looking old or unattractive? | | | | |
| 11. Appetite changes: Have you lost your appetite? Or, do you overeat compulsively? | | | | |
| 12. Sleep changes: Is it hard to get a good night's sleep? Are you tired and sleeping too much? | | | | |
| 13. Loss of libido: Have you lost your interest in sex? | | | | |
| 14. Hypochondriasis: Do you worry a lot about your health? | | | | |
| 15. Suicidal impulses: Do you think life is not worth living or think you'd be better off dead? ** | | | | |
| Total Score on items #1 - #15 → | | | | |

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** Anyone with suicidal urges should seek immediate help from a mental health professional.

Burns Anxiety Inventory *

Instructions: Place a check (✓) in the box to the right of each of the 33 symptoms to indicate how much this type of feeling has been bothering you in the past several days.

CATEGORY I: ANXIOUS FEELINGS

| | 0—NOT AT ALL | 1—SOMEWHAT | 2—MODERATELY | 3—A LOT |
|---|--------------|------------|--------------|---------|
| 1. Anxiety, nervousness, worry or fear | | | | |
| 2. Feeling things around you are strange or foggy | | | | |
| 3. Feeling detached from all or part of your body | | | | |
| 4. Sudden unexpected panic spells | | | | |
| 5. Apprehension or a sense of impending doom | | | | |
| 6. Feeling tense, stress, "uptight" or on edge | | | | |
| CATEGORY II: ANXIOUS THOUGHTS | | | | |
| 7. Difficulty concentrating | | | | |
| 8. Racing thoughts | | | | |
| 9. Frightening fantasies or daydreams | | | | |
| 10. Feeling on the verge of losing control | | | | |
| 11. Fears of cracking up or going crazy | | | | |
| 12. Fears of fainting or passing out | | | | |
| 13. Fears of illnesses, heart attacks or dying | | | | |
| 14. Fears of looking foolish in front of others | | | | |
| 15. Fears of being alone, isolated or abandoned | | | | |
| 16. Fears of criticism or disapproval | | | | |
| 17. Fears that something terrible will happen | | | | |

(continue on next page)

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Burns Anxiety Inventory *

Instructions: Place a check (✓) in the box to the right of each of the 33 symptoms to indicate how much this type of feeling has been bothering you in the past several days.

CATEGORY III: PHYSICAL SYMPTOMS

| | 0—NOT AT ALL | 1—SOMEWHAT | 2—MODERATELY | 3—A LOT |
|---|--------------|------------|--------------|---------|
| 18. Skipping, racing or pounding of the heart | | | | |
| 19. Pain, pressure or tightness in the chest | | | | |
| 20. Tingling or numbness in the toes or fingers | | | | |
| 21. Butterflies or discomfort in the stomach | | | | |
| 22. Constipation or diarrhea | | | | |
| 23. Restlessness or jumpiness | | | | |
| 24. Tight, tense muscles | | | | |
| 25. Sweating not brought on by heat | | | | |
| 26. A lump in the throat | | | | |
| 27. Trembling or shaking | | | | |
| 28. Rubbery or "jelly" legs | | | | |
| 29. Feeling dizzy, lightheaded or off balance | | | | |
| 30. Choking or smothering sensations | | | | |
| 31. Headaches or pains in the neck or back | | | | |
| 32. Hot flashes or cold chills | | | | |
| 33. Feeling tired, weak or easily exhausted | | | | |
| Total Score on Items #1 - #33 → | | | | |

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4

Relationship Satisfaction Scale *

Instructions: Place a check (✓) in the box to the right of each category that best describes the amount of satisfaction you feel in your closest relationship.

| | 0 - very dissatisfied | 1 - moderately dissatisfied | 2 - slightly satisfied | 3 - neutral | 4 - slightly satisfied | 5 - moderately satisfied | 6 - very satisfied |
|--|-----------------------|-----------------------------|------------------------|-------------|------------------------|--------------------------|--------------------|
| 1. Communication and openness | | | | | | | |
| 2. Resolving conflicts and arguments | | | | | | | |
| 3. Degree of affection and caring | | | | | | | |
| 4. Intimacy and closeness | | | | | | | |
| 5. Satisfaction with your role in the relationship | | | | | | | |
| 6. Satisfaction with the other person's role in the relationship | | | | | | | |
| 7. Overall satisfaction with your relationship | | | | | | | |
| Total Score on Items #1 - #7 → | | | | | | | |

Note: Please indicate who you had in mind when filling out this test:

Please indicate the type of relationship (spouse, colleague, friend, etc.):

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Pamela Horton, Ph.D., FPPR, P.C.

Clinical Psychologist

TEXAS NOTICE FORM

Notice of Psychologists' Policies and Practices to Protect the Privacy of
Your Health Information

THIS NOTICE IS CUMBERSOME; HOWEVER, IT IS REQUIRED BY LAW TO MEET NEW PRIVACY RULES WHICH HAVE BEEN ENACTED. IT DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY AND THEN SIGN THE ACKNOWLEDGEMENT FOUND ON THE LAST PAGE. YOU WILL KEEP THIS COPY OF THE NOTICE AND I WILL MAKE THE ACKNOWLEDGEMENT APART OF YOUR FILE.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your *protected health information (PHI)*, for *treatment, payment, and health care operations* purposes with your *consent*. Your consent to these uses and disclosures will appear with your signature on the last page. To help clarify these terms, here are some definitions:

- "*PHI*" refers to information in your health record that could personally identify you.
- "*Treatment, Payment and Health Care Operations*"
 - *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
 - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
 - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within my practice such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my practice such as releasing, transferring, or providing access to information about you to other parties.

Texas mailing address: Box 1087, Georgetown, TX 78627 512-
931-2162 Fax: 512-868-0548 mail@drpamelahorton.com

ll. Uses and Disclosures Requiring Authorization

As a general rule, I may use or disclose PHI for purposes outside of treatment, payment, and health care operations only when your appropriate authorization is obtained. There are some exceptions which will be outlined under III.

An "authorization" is your written permission above and beyond the general consent that that these pages address. In those instances when I am asked for information for purposes outside of treatment, payment, and health care operations, I will obtain an authorization from you before releasing this information. I must also obtain an authorization before releasing your psychotherapy notes. "Psychotherapy notes" are notes I have made about our conversation during a private, group, joint, or family counseling session. It is rare indeed that I ever release copies of my psychotherapy notes. Be assured that you will always be informed if these notes are requested. They will not be released without your authorization unless I am compelled to do so by a court order.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time. You must do so in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

m. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse: If I have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, I must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.
- Adult and Domestic Abuse: If I have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, I must immediately report such to the Department of Protective and Regulatory Services.
- Health Oversight: If a complaint is filed against me with the State Board of Examiners of Psychologists, they have the authority to subpoena confidential mental health information from me relevant to that complaint.

- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law. I will not release information, without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **Serious Threat to Health or Safety:** If I determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, I may disclose relevant confidential mental health information to medical or law enforcement personnel.
- **Worker's Compensation:** If you file a worker's compensation claim, I may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- *Right to Request Restrictions* -You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of Pill by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of Pill and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the Pill is maintained in the record. I may deny your access to Pill under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- *Right to Amend*- You have the right to request an amendment of PHI for as long as the Pill is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

- *Right to an Accounting* - You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy*- You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will notify you in writing at a scheduled therapy session if you are involved in regularly scheduled therapy sessions or by a stamped, self-addressed envelope if you are no longer involved in regularly scheduled therapy sessions.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact me and schedule an appointment for which you will not be charged. This appointment will be for the purposes of discussing your concerns.

If you believe that your privacy rights have been violated and wish to file a complaint with me, you may send your written complaint to me at Box 1087 Georgetown, TX 78627.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. Should you need contact information, I will provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on April 5, 2003.

I will limit the uses or disclosures that I will make as follows:

1. Obtaining information concerning your insurance benefits if you are utilizing an insurance policy to claim benefits.
2. Transmitting information to your insurance company for reimbursement of services rendered. This information normally includes information such as your name, address, date of birth, social security number, policy number, employer, date services were performed, type of service performed, length of service performed, diagnosis, and fee for the service. If you are being insured under a policy carrying another person's name, I may be asked to disclose information such as the name, address, date of birth, social security number, policy number, and employer of the insured.
3. Discussing your treatment with another health care provider without giving identifiable information. The forms you will read and sign concerning my therapy practice will list some specific professionals with whom I may discuss your treatment.
4. Contracting with an individual to either mail appointment reminders or call to remind you about appointments. This individual would have access to your name, address, telephone number, and date and time of scheduled appointment.
5. Analyzing treatments, diagnoses, demographics, cost effectiveness, outcomes, and other types of information necessary in developing, maintaining, and enhancing my practice. In these cases, the information would be aggregated and compiled and utilized only by me and would not be specifically identifiable.
6. Retaining a collection agency should the need arise. In this instance, the agency would have access to information such as your name, address, telephone number, driver's license number, social security number, billing ledger, and payment history. A collection agency is never employed until I have exhausted all efforts to receive full payment for services rendered. You would be given every opportunity to clear your balance with me prior to my retaining a collection agency.
7. Making other disclosures as allowed by law and which may not be specifically mentioned here.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for as long as I maintain. I will provide you with a revised notice by mailing you a copy in a stamped, self-addressed envelope that you provide. If you are having therapy sessions with me at the time, I will give you a copy of the revised notice in a regularly scheduled therapy session.

Notice of Psychologists' Policies and Practices to Protect the
Privacy of Your Health Information Acknowledgment Form

I, _____ (please print your full name),
have received a copy of the Notice of Psychologists' Policies and
Practices to Protect the Privacy of Your Health Information from
Pamela Horton, Ph.D. I will read it and keep it for future reference. If
I have any questions, I will contact Dr. Horton at 512/931-2162.

I am consenting to the uses of PHI as outlined by Dr. Horton and by
law.

I will provide Dr. Horton a stamped, self-addressed envelope. If
there are revisions to this notice, she can mail them to me,
assuming that I am no longer having regular therapy sessions with
her.

If I fail to provide a stamped, self-addressed envelope to Dr. Horton
and am no longer having regular therapy sessions with her, I am
assuming the responsibility to contact Dr. Horton to receive notice
of revision in these policies. I understand that it is my responsibility
to provide the SSE and that I will receive no further reminders
concerning it. I also understand that it is my responsibility to provide
Dr. Horton with a current address should my address change at any
time in the future.

Signature of Client

Date

Confidential Health History

Please write or print clearly

Name: _____

Address: _____

Email address: _____ How often do you check email? _____

Telephone- Work: _____ Home: _____ Cell: _____

Age: _____ Height: _____ Date of Birth: _____ Place of Birth: _____

Current weight: _____ Weight six months ago: _____ One year ago: _____

Would you like your weight to be different? _____ If so, what? _____

Relationship status: _____

Children: _____ Pets: _____

Occupation: _____ * Hours of work per week: _____

Please list your main health concerns: _____

Other concerns and/or goals? _____

At what point in your life did you feel best? _____

Any serious illnesses/hospitalizations/injuries? _____

How is/was the health of your mother? _____

- How is/was the health of your father? _____

What is your ancestry? _____ What blood type are you? _____

Do you sleep well? _____ How many hours? _____ Do you wake up at night? _____

Why? _____

-- Any pain, stiffness or swelling? _____

Constipation/Diarrhea/Gas? Please explain: _____

Do you take any supplements or medications? Please list: _____

Any healers, helpers or therapies with which you are involved? Please list: _____

What role does sports and exercise play in your life? _____

What foods did you eat often as a child?

Breakfast

| | | | | |
|-------|-------|-------|-------|-------|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

What's your food like these days?

Breakfast

| | | | | |
|-------|-------|-------|-------|-------|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

Will family and/or friends be supportive of your desire to make food and/or lifestyle changes? _____

What percentage of your food is home cooked? _____ Do you cook? _____

Where do you get the rest from? _____

Do you crave sugar, coffee, cigarettes, or have any major addictions? _____

The most important thing I should change about my diet to improve my health is: _____

Anything else you want to share? _____
