



# Mandy Jordan, PhD

## Trauma Specialist

**Note:** Please write neatly and answer all questions in order that you receive the best treatment possible. Use the back of pages as necessary to answer questions when you need more room.

<b>Today's Date:</b>	<b>Completed By:</b> <input type="checkbox"/> Self <input type="checkbox"/> Other (Name and relationship):
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PERSONAL DEMOGRAPHICS		
<b>Name (Last, First) :</b>	<b>DOB:</b>	<b>Age:</b>
<b>Street Address:</b>	<b>Home Phone:</b>	
<b>City, State, Zip:</b>	<b>Cell/Work Phone:</b>	
<b>Race:</b> <input type="checkbox"/> African-American <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Other: _____		
<b>Marital Status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		

YOUR PRESENTING CONCERNS
<b>What is your chief complaint (i.e., symptoms, illness, injuries)?</b>
<b>What have you done to try to manage these problems?</b>
<b>What type of assistance do you or others feel you need?</b>

**MENTAL HEALTH HISTORY**

**Have you ever seen a psychologist, psychiatrist, or counselor?**    Yes    No

If yes, please note the year(s) you saw the provider, name of provider, main area(s) addressed, and whether the outcome was beneficial (use back page if needed):

1.

2.

3.

4.

5.

**List all mental health or substance abuse diagnoses you have had:**

**Have you ever:**    Had suicidal thoughts    Had thoughts of harming others    Attempted suicide

**Has anyone in your family had substance abuse or mental health problems?**    Yes    No If Yes, Who?

**Psychiatric Medications:** (List any prescription or over the counter medications that you are taking for mental health reasons)

Name of Drug	Reason for Taking it	Date Started	Frequency/Strength	Has it been helpful

Do you generally take your medications as prescribed?     Yes     Take too much     Don't always take

What other psychiatric medications have you taken in the past?

**Mental Health/Substance Abuse Hospitalizations:** List all hospitalizations Use back of page if needed.

Date	Reason for Hospitalization	Name of Facility	Duration (length of stay)

<b>Outpatient Mental Health/Substance Abuse Treatment (Use back of page if needed).</b>				
<b>Date</b>	<b>Reason for Treatment and Type of Treatment</b> (Counseling, AA, NA, Group therapy)	<b>Treatment Provider</b>	<b>Duration of Treatment</b>	<b>Treatment Response (Helpfulness)</b>
<b>Substance Use (List all of the substances that you have used or tried in your lifetime)</b>				
<b>Substance</b>	<b>Age 1<sup>st</sup> began</b>	<b>Highest Use</b>		<b>Date of Last Use</b>
Beer		<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly		
Wine		<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly		
Hard liquor Mixed drinks		<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly		
Marijuana		<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly		
Cocaine/Crack		<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly		
Methamphetamine		<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly		
Heroin		<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly		
Inhalants		<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly		
Hallucinogens		<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly		
Prescription abuse (e.g., pain pills)		<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly		
Over the counter (to get high)		<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly		
Other:		<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly		
<b>Did substance use ever affect your relationships?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>Did substance use ever affect your work?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>Did you ever try to stop using the substance but could not?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No				

**MEDICAL HISTORY**

Have you ever had a head injury or been hit on the head?  Yes  No

Did you lose consciousness?  Yes  No

Are you currently pregnant?  Yes  No Any History of Miscarriages?  Yes  No

**Current Non-Psychiatric Medications:**

List any medications (prescription, over the counter, homeopathic, vitamins, traditional or alternative medicine remedies, or herbs) you are taking for conditions other than mental illness and/or that you did not mention earlier:

Medication	Reason for Taking It	When Began Taking it

**Medical Conditions and Serious Illness** (Please list all conditions, serious injuries, or severe illnesses that you have or have had).

Condition/Injury/Surgery	Date Began/Year	√ If currently a problem	√ If Receiving Treatment

**Do your current medical condition(s) create problems in how you deal with life, including pain?**  Yes  No  
If Yes, explain:

**SOCIAL FUNCTIONING**

How often do you talk to others on a daily basis?  All the time  Occasionally  Not at all

Who do you regularly talk to in your family?

How many close friends do you have? Do you feel you have adequate emotional support?

What types of activities do you enjoy during your leisure time?

# of times married \_\_\_ Please provide the following details for each marriage:

Marriage #	Your age then	# of children	Length of marriage	Reason for it ending

Are you currently in a relationship?  Yes  No If so, what is the quality of this relationship?

How many children do you have?	How old are they?	Who do they live with?

**EARLY PERSONAL HISTORY**

What city and state were you born in?

How many siblings do you have? \_\_\_ full-brothers \_\_\_ full-sisters \_\_\_ half-brothers  
 \_\_\_ half-sisters \_\_\_ step brothers \_\_\_ step sisters

Where are you in the birth order?

Your parents are:  Still married  Never married  Divorced since \_\_\_  Separated  
 Mom deceased (year of death \_\_\_\_\_)  Father deceased (year of death: \_\_\_\_\_)

Mother's occupation: \_\_\_\_\_ Father's Occupation: \_\_\_\_\_

Who raised you?  Both parents  Mother  Father  Grandparents  Foster Home  Other \_\_\_\_\_

Describe your early home life:

Have you ever been:  Physically abused?  Sexually abused?  Emotionally abused?

Who abused you and how? \_\_\_\_\_

How old were you when this happened? \_\_\_\_\_

**ACADEMIC HISTORY**

What was the last grade you completed: \_\_\_\_\_ Did you graduate from high school?  Yes  No

If you did not graduate from high school, why? \_\_\_\_\_

Which grade, if any did you repeat? \_\_\_\_\_

Have you ever been told you have special education needs? If yes, what was done about it (testing, special education, special classes, and alternative school)

Did you have problems in school with:  Grades  Behavior  Suspension  Expulsion  Bullying

Are you currently involved in an educational or vocational training program?  Yes  No

**LEGAL HISTORY**

How many juvenile arrests have you had? \_\_\_\_\_ How many adult arrests? \_\_\_\_\_

When and what were they for?

How many times have you been ...in jail? \_\_\_ convicted? \_\_\_ to prison? \_\_\_ on probation? \_\_\_ violated probation? \_\_\_

**OCCUPATIONAL HISTORY**

Have you ever served in the military?  Yes  No Branch? \_\_\_\_\_

When and how long?

How old were you when you started working? \_\_\_\_\_

What types of jobs have you had?

How long is the longest length of time you have had a single job? \_\_\_\_\_

What and where was it?

Are you currently working?  Yes  No If Yes, where and for how long? \_\_\_\_\_

If not, what was your most recent employment? \_\_\_\_\_

For how long were you working there? \_\_\_\_\_ Why did it end?

How many times have you been terminated and why? \_\_\_\_\_

**YOUR OPINIONS AND PLANS**

Is there anything else important that you think I should know about you in order to best help you?



# Mandy Jordan, PhD

## Trauma Specialist

NEW CLIENT INFORMATION		
LAST NAME:	FIRST NAME:	MIDDLE NAME:
ADDRESS:		
CITY:	STATE:	ZIP:
DATE OF BIRTH:	REFERRED BY:	
HOME PHONE: (    )	LEAVE A MESSAGE?    ___ YES ___ NO	
CELL PHONE: (    )	LEAVE A MESSAGE?    ___ YES ___ NO	
WORK PHONE: (    )	LEAVE A MESSAGE?    ___ YES ___ NO	
EMAIL ADDRESS:		
OK to leave confidential, detailed message? ___ Yes    ___ No		
PERSON TO CONTACT IN CASE OF EMERGENCY:		
RELATIONSHIP TO YOU:	CONTACT PHONE: (    )	

INFORMED CONSENT FOR TREATMENT
<p>I authorize and request that Mandy Jordan, PhD, carry out psychological assessments, diagnostic procedures and/or treatments which, now or during the course of my care as a client, as advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may, at times, be difficult and uncomfortable.</p> <p>Signed by client: _____ Date: _____</p>

CONFIDENTIALITY
<p>All information between counselor and client is held in strict confidence by the counselor. There are specific and limited exceptions to this confidentiality which include the following:</p> <ol style="list-style-type: none"> <li>1) The client authorizes release of information by signature as specified on the Release of Information Form;</li> <li>2) Where there is a clear threat to do serious bodily harm to yourself or others;</li> <li>3) Where there is reason to suspect the occurrence of abuse or neglect of a child, a dependent adult or a person with developmental disabilities;</li> <li>4) In response to a subpoena that is associated with a regulatory complaint or in response to a subpoena from a court of competent jurisdiction;</li> <li>5) Information that must be provided to insurance companies and/or EAP entities as required for the payment of claims, certification/authorization or case management or other purposes related to the benefits of client's health plan.</li> </ol> <p>I have read and understand the HIPAA policy statement provided to me by my counselor:</p> <p>Signed by client: _____ Date: _____</p>





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### OFFICE POLICIES

- ❖ **FEES:** The initial appointment, the intake session, is 75 minutes and the session fee is \$225. Individual sessions are 45 minutes (unless otherwise discussed); the session fee is \$150. Payments are made at the end of each session, unless other arrangements have been made. Payment is made via cash, check, charge/debit; HSA cards are also accepted.
  - If you want to use your health insurance, I am happy to provide you with documentation needed for out of network providers, and you would file it yourself.

I have read and agreed to the above statement:

Client's signature \_\_\_\_\_ Date: \_\_\_\_\_

- ❖ **MISSED APPOINTMENTS:** To make progress in therapy it is very important for you to keep your therapy appointments. If you are unable to keep your appointment, please notify me immediately. If an appointment is missed or cancelled without 24 hours notice, you will be charged for the session. Insurance companies do not reimburse for missed sessions.

I have read and agreed to the above statement:

Client's signature \_\_\_\_\_ Date: \_\_\_\_\_

- ❖ **AFTER HOUR TELEPHONE CALLS AND EMAILS:** You may leave a message or email me, and I will return your message as soon as I am able. A phone call that lasts more than 20 minutes will be charged a session fee, which is not reimbursed through insurance.

I have read and agreed to the above statement:

Client's signature \_\_\_\_\_ Date: \_\_\_\_\_

- ❖ **I give my permission to keep my credit card on file. The credit card information will be kept with your records on Simple Practice, a secure online program designed for mental health professionals and is the electronic medical record data base used for this practice. Any late cancellations or no-shows will be charged to the card on file.**

I have read and agreed to the above statement:

Client's signature \_\_\_\_\_ Date: \_\_\_\_\_