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.

Today's Date:	**Completed By:** ☐ Self ☐ Other (Name and relationship):

PERSONAL DEMOGRAPHICS

Name (Last, First) :	**DOB:**	**Age:**
Street Address:	**Home Phone:**	
City, State, Zip:	**Cell/Work Phone:**	

Race: ☐ African-American ☐ Asian/Pacific Islander ☐ Caucasian/White ☐ Hispanic ☐ Native American ☐ Other: _____

Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

YOUR PRESENTING CONCERNS

What is your chief complaint (i.e., symptoms, illness, injuries)?

What have you done to try to manage these problems?

What type of assistance do you or others feel you need?

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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)

Outpatient Mental Health/Substance Abuse Treatment (Use back of page if needed).				
Date	**Reason for Treatment and Type of Treatment** (Counseling, AA, NA, Group therapy)	**Treatment Provider**	**Duration of Treatment**	**Treatment Response (Helpfulness)**

Substance Use (List all of the substances that you have used or tried in your lifetime)

Substance	**Age 1st began**	**Highest Use**	**Date of Last Use**
Beer		☐Daily ☐Weekly ☐Monthly	
Wine		☐Daily ☐Weekly ☐Monthly	
Hard liquor Mixed drinks		☐Daily ☐Weekly ☐Monthly	
Marijuana		☐Daily ☐Weekly ☐Monthly	
Cocaine/Crack		☐Daily ☐Weekly ☐Monthly	
Methamphetamine		☐Daily ☐Weekly ☐Monthly	
Heroin		☐Daily ☐Weekly ☐Monthly	
Inhalants		☐Daily ☐Weekly ☐Monthly	
Hallucinogens		☐Daily ☐Weekly ☐Monthly	
Prescription abuse (e.g., pain pills)		☐Daily ☐Weekly ☐Monthly	
Over the counter (to get high)		☐Daily ☐Weekly ☐Monthly	
Other:		☐Daily ☐Weekly ☐Monthly	

Did substance use ever affect your relationships? ☐Yes ☐No

Did substance use ever affect your work? ☐Yes ☐No

Did you ever try to stop using the substance but could not? ☐Yes ☐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?

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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

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.

Signed by client: _____ Date: _____

CONFIDENTIALITY

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:

1) The client authorizes release of information by signature as specified on the Release of Information Form;
2) Where there is a clear threat to do serious bodily harm to yourself or others;
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;
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;
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.

I have read and understand the HIPAA policy statement provided to me by my counselor:

Signed by client: _____ Date: _____

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INFORMED CONSENT FOR TELEPSYCHOLOGY TREATMENT

- I agree and understand that my psychotherapy sessions will be conducted through a telepsychology platform.
    - Currently, Dr. Jordan uses Simple Practice, a HIPAA-compliant technology service that was developed for psychotherapy. This is the same service where clients' contact, session, and billing information are stored.
- **Benefits.** I understand that telepsychology has potential benefits, including easier access to care and the convenience of meeting from a location of my choosing. Confidentiality still applies for telepsychology services, and the session is not recorded.
- **Risks.** I understand there are potential risks using telepsychology, including potential interruptions and technical difficulties.
    - A back-up plan (e.g., telephone call) will be used should technical difficulties occur.
    - A safety plan will be developed, which includes at least one emergency contact, in the event of a crisis situation.
- **Process.** Simple Practice is a very user-friendly program. Prior to the session, Dr. Jordan emails a link to you for the video session. If you are using a computer or tablet, the link should lead directly to the video room. If you are using a smartphone, you may be first directed to download an app. A few helpful tips:
    - Have a secure, strong internet connection.
    - Your device must have a webcam and audio. It is helpful to use headphones or earbuds for privacy and better sound production.
    - Be seated in a comfortable, safe, quiet, private space. No other individuals can be in the same room as you during session, unless discussed prior to the session. Pets are welcome to attend. Have water and Kleenex near you; no alcoholic beverages allowed.
- It may be determined that telepsychology is not appropriate for you, and you may benefit best from in-person sessions, in which case, you will be referred to another provider.

I have read and agreed to the above statements:

Client's signature _____ Date: _____

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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: _____

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