



4695 N M37 Hwy, Suite D, Middleville, MI 49333  
phone: 269-205-2366 ♦ fax: 269-205-2728  
e-mail: [admin@striving2thriving.com](mailto:admin@striving2thriving.com)  
website: [striving2thriving.com](http://striving2thriving.com)

---



Hello,

**Thank you** for contacting Striving2Thriving for scheduling an appointment. We look forward to serving you. We are confident your time with us will prove encouraging and helpful.

Please fill out the enclosed forms and bring them along with you to your first appointment. This will save valuable time and give us more time to discuss your needs.

Our office is conveniently located at 4695 N M37 Hwy, Suite C, Middleville, MI 49333.

Payment is due before your scheduled appointment; you can prepay online through our website or bring your payment with you the day of your appointment.

We look forward to meeting you soon.

Sincerely,  
Staff Counselor



4695 N M37 Hwy, Suite D, Middleville, MI 49333  
phone: 269-205-2366 ♦ fax: 269-205-2728  
e-mail: admin@striving2thriving.com  
website: striving2thriving.com



**CONSENT FOR SERVICES AND FEE AGREEMENT**

To acquaint you further with the procedures and policies of our practice, we are providing you with the following information. Please sign at the bottom of this form indicating your acceptance of the following terms for client name:

\_\_\_\_\_

**Office Hours:** Our normal business hours are Monday and Thursday, 9:00am–5:00pm. You may leave a message via voicemail or email (*admin@wocounseling-recovery.com*). We will make every effort to return your call as soon as possible.

**Appointment/Missed Appointments:** Services are by appointment only by calling our office at (269)205-2035. To cancel an appointment, please **call** the office as soon as possible. **Appointments cancelled with less than 24 hour notice may be billed to you.** If you miss an appointment without notifying us, you will be charged a \$25 fee. Please note that insurance companies **do not** cover missed appointments.

**Confidentiality:** Your trust in us is extremely important. Your client records are our personal property and shall be treated as highly confidential. Please note that all client charts are kept for seven years following your closing date from counseling, which after that time records will be destroyed. All information shared in sessions is confidential, except in circumstances governed by the laws, including the mandatory reporting of alleged harm to self or others. If we believe a consultation with another professional is important for your care, your confidentiality is protected under the "Privacy Practices" mandated by HIPAA (Health Insurance Portability and Accountability Act of 1996).

**Emergencies:** In case of a **true** emergency/crisis situation, please call 911 and/or go to the emergency room of a local hospital.

**Financial Responsibility:** Presently the fees may vary for our counseling services; we will discuss the fee structure with you before your counseling session. Extended phone calls, letters or written documents may be charged as a separate fee.

At the time of your initial appointment, please be prepared to provide us with your insurance card(s) – both primary and secondary if applicable. You are fully responsible for payment of all balances not covered by your insurance company. As a courtesy to you, we will verify your mental health benefits and bill your insurance company. If we participate with your insurance plan, contracted insurance rates should apply. In the event of any insurance changes, please notify us via phone at (269)205-2035 or email *info@striving2thriving.com* within 24 hours of your next scheduled appointment so that your new insurance benefits can be verified and our system updated before your appointment time. Failure to follow this policy may result in a postponement of services. We accept cash, check, and credit cards. **Please make all checks payable to Striving2Thriving.** Upon review, a service charge of \$5.00 per month may be added to all unpaid balances over 30 days.

\_\_\_\_\_ I understand that I am responsible to pay my insurance co-pay for counseling on the same day as the counseling session is given. If co-pay payment is not received within 30 days, Striving2Thriving will bill my credit card on file, or if no credit card is on file, my account will be turned over to collections.

We will be happy to answer any questions you may have concerning our policies. We are looking forward to serving you.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Person responsible for payment (If other than client)

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



4695 N M37 Hwy, Suite D, Middleville, MI 49333  
 phone: 269-205-2366 ♦ fax: 269-205-2728  
 e-mail: admin@striving2thriving.com  
 website: striving2thriving.com

## Authorization for Scheduling, Billing and Payment Purposes

This form, when completed and signed by you, authorizes the person(s) whom you have indicated below to contact us on your behalf for scheduling, billing and payment purposes only.

**I authorize** \_\_\_\_\_

*Please indicate your relationship with this person:*

Spouse  Significant other  Parent/Guardian  Other: \_\_\_\_\_

**I authorize** \_\_\_\_\_

*Please indicate your relationship with this person:*

Spouse  Significant other  Parent/Guardian  Other: \_\_\_\_\_

**I authorize** \_\_\_\_\_

*Please indicate your relationship with this person:*

Spouse  Significant other  Parent/Guardian  Other: \_\_\_\_\_

- This authorization will expire once the purpose of this disclosure ceases to exist, but no later than one year from the original date of signing.
- I understand that I have the right to revoke this authorization at any time by giving spoken or written notification to Striving2Thriving.

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

\_\_\_\_\_  
 Date



4695 N M37 Hwy, Suite D, Middleville, MI 49333  
phone: 269-205-2366 ♦ fax: 269-205-2728  
e-mail: admin@striving2thriving.com  
website: striving2thriving.com

---



## **Cancellation Policy**

### **What if I need to Cancel or Postpone my Appointment?**

**Please call our office at 269-205-2402 to cancel an appointment**

If for some reason you need to cancel or postpone the appointment, please be considerate of your therapist and other clients and give at least 48 hours notice.

*Given the demand for appointment times, if less than 24 hours notice is given to cancel or reschedule your appointment, or if you fail to show up for your scheduled appointment, you will be charged \$50.00 for the missed session.*

**Insurance does not pay for missed appointments. These charges are your responsibility.**

Payment will be due in full before the beginning of your next session. Future appointments will not be made until the Cancellation Fee has been paid in full.

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

\_\_\_\_\_  
Date



4695 N M37 Hwy, Suite D, Middleville, MI 49333  
phone: 269-205-2366 ♦ fax: 269-205-2728  
e-mail: admin@striving2thriving.com  
website: striving2thriving.com



## PF 1000 NOTICE OF PRIVACY PRACTICES

As required by the Privacy Regulations Created as a Result of the Health Portability and Accountability Act of 1996 (HIPPA)

**THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU (AS A CLIENT IN THIS PRACTICE) MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

### I. Our Commitment to Your Privacy

Our practice is committed to maintaining the privacy of your protected health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide for you. We are required by law to maintain the confidentiality of health information that identifies you. We are also required by law to provide you with this notice of our legal duties and the privacy practices we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the notice that we have in effect at the time.

### II. Uses and Disclosures

**Treatment.** Your PHI may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing clinical conditions, and providing treatment. An example of treatment would be when we consult with another health care provider, such as your family physician or another professional counselor.

**Payment.** Your PHI may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the clinical condition being treated.

**Health care operations.** Your PHI may be used as necessary to support the day-to-day activities and management of Striving2Thriving. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

**Law enforcement.** Your PHI may be disclosed to federal, state or local law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

**Public health reporting.** Your PHI may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

**Appointments.** Your PHI will be used by Striving2Thriving to contact you to schedule an appointment, remind you of an appointment, reschedule an appointment, or notify you of other pertinent information. The contact may be made by phone, U.S. mail, email, or texting.

**Informative Information.** Your PHI may be used to send you information on the treatment and management of your psychological/medical condition that you may find to be of interest. We may also send you information describing psychological/health-related goods and service that we believe may interest you.

\*\*If there is ever a breach of your healthcare information and it comes to our attention, we will inform you as soon as possible.

### **III. Personal Rights**

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your PHI. However, we are not required to agree to a restriction you request.
- The right to receive confidential communications concerning your psychological/medical condition and treatment.
- The right to amend or submit corrections to your protected health information.
- The right to receive a printed copy of this notice.
- The right to file a complaint.
- The right to inspect and/or copy your PHI that may be used to make decisions about you, including client psychological/medical records and billing records, but not including psychotherapy notes. The client's provider can provide a summary of the client's PHI if in the professional judgment of the client's provider, providing the client with unlimited access to his/her PHI would cause emotional/mental distress or endanger the life or physical safety of the client or another person. A client does not have the right to access Psychotherapy Notes relating to him/her except (i) to the extent the client's treating professional approves such access in writing; or (ii) the client obtains a court order authorizing such access. A provider has 30 days to reply.

### **IV. Requests to Inspect PHI**

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting us at 269-205-2402. We may deny your access to PHI under certain circumstances, but in many cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.

### **V. Revise Privacy Practices**

As permitted by law, we reserve the right to amend or modify this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any records that we may create or maintain in the future. We will post a copy of our current Notice in a visible location in our office at all times, and you may request a copy of our most current at any time.

### **VI. Complaints**

If you are concerned that your privacy rights have been violated and you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter (all complaints must be in writing) outlining your concerns to:

Bret Hoxworth MA, LLP  
Striving2Thriving  
4695 M37 Hwy, Suite C  
Middleville, MI 49333

Or contact the Secretary of the Department of Health and Human Services. You will not be penalized or otherwise retaliated against for filing a complaint.

### **VII. Contact Person**

For further information concerning our privacy practices, you can contact:

Bret Hoxworth MA, LLP  
Striving2Thriving  
4695 M37 Hwy, Suite C  
Middleville, MI 49333  
269-205-2402



4695 N M37 Hwy, Suite D, Middleville, MI 49333  
 phone: 269-205-2366 ♦ fax: 269-205-2728  
 e-mail: admin@striving2thriving.com  
 website: striving2thriving.com

**PF 2000 CONSENT TO USE AND DISCLOSURE OF  
 PROTECTED HEALTH INFORMATION**

**Uses and Disclosure of Your Protected Health Information**

Your protected health information will be used by Striving2Thriving or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

**Notice of Privacy Practices**

You should review the "Notice of Privacy Practices" document for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

**Requesting a Restriction on the Use or Disclosure of your Information**

You may request a restriction on the use or disclosure of your protected health information. Striving2Thriving may or may not agree to restrict the use or disclosure of your protected health information. If Striving2Thriving agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

**Revocation of Consent**

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

**Reservation of Right to Change Privacy Practices**

Striving2Thriving reserves the right to modify the privacy practices outlined in the notice.

**Signature**

I have reviewed this consent form and received a copy of the Striving2Thriving "Notice of Privacy Practices" and give my permission to Striving2Thriving to use and disclose my health information in accordance with it.

\_\_\_\_\_

Date

\_\_\_\_\_

Name of Client (Print or Type)

\_\_\_\_\_

Client Signature

\_\_\_\_\_

Signature of Client Representative

\_\_\_\_\_

Relationship of Client Representative



4695 N M37 Hwy, Suite D, Middleville, MI 49333  
 phone: 269-205-2366 ♦ fax: 269-205-2728  
 e-mail: admin@striving2thriving.com  
 website: striving2thriving.com



**Notification & Coordination with Primary Care Physician / Psychiatrist**

**(THIS IS A RELEASE OF INFORMATION FORM – NOT A REQUEST FOR MEDICAL RECORDS)**

**Authorization of Release/Exchange of Information**

<b>Client Name:</b> _____	<b>Client DOB:</b> _____	
Parent/Guardian (if applicable): _____		
<b>Physician Name/Clinic:</b> _____		
Phone #: _____	Fax #: _____	
<b>Current Psychiatric Services</b> <input type="checkbox"/> Yes or <input type="checkbox"/> No		
Treating Psychiatrist/Clinic: _____		
<b>List All Current Medications: *If more room needed, please attach separate sheet</b>		
Medication Name: _____	Dosage: _____	Reason: _____
Medication Name: _____	Dosage: _____	Reason: _____
Medication Name: _____	Dosage: _____	Reason: _____

***It is helpful for your therapist to coordinate with your PCP/Psychiatrist. Please indicate below whether you chose to give consent for the release of any or all information in this Coordination With PCP / Psychiatrist form.***

I acknowledge that information cannot be disclosed without my written informed consent unless otherwise provided by law. I understand I have the right to revoke this consent at any time; the revocation may be made verbally or in writing. Any information previously authorized and released cannot be subject to a revocation. HIPAA protects the privacy of health information. Re-disclosure of this information is prohibited by the Michigan Mental Health Code and also by Title 42 of the code of federal regulations. I understand that I am not required to sign this release/exchange of information and that I will not be denied services if I refuse to sign. I have a right to obtain a copy of the information disclosed. If no expressed or written revocation is issued, this authorization will expire one year from the date signed or at the termination of services.

**PLEASE CHOOSE AND SIGN ONE OF THE FOLLOWING:**

I understand the information being released and exchanged. My signature indicates **my consent to release and exchange information** contained in this document with the physician/clinic identified above. I hereby authorize, Striving2Thriving its director or designee, to release and/or exchange protected health information to the individual(s) or organization(s) listed above.

**Extent of information to be disclosed:**  Verbal Exchange or Written Summary or  Other: \_\_\_\_\_

Signature of client, parent, guardian and/or authorized representative	Date	Signature of Witness	Date
---	------	----------------------	------

-----OR-----

My therapist has explained to me the importance of coordinating medical and mental health services. At this time, **I choose not to sign** a release for the exchange and release of information with my primary care physician.

Signature of client, parent, guardian and/or authorized representative	Date	Signature of Witness	Date
---	------	----------------------	------

**For Office Use Only:**

Therapist Name: _____
Current Diagnosis: _____
Striving2Thriving Staff – Faxed by: _____ Date: _____



4695 N M37 Hwy, Suite D, Middleville, MI 49333  
 phone: 269-205-2366 ♦ fax: 269-205-2728  
 e-mail: admin@striving2thriving.com  
 website: striving2thriving.com



### ADULT INTAKE FORM

To help your clinician understand your concerns, please answer the following questions on this form and bring it with you to your first appointment.

Client's Legal Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Gender Identity** (optional)

Male  Female  Transgender  Cisgender  Non-binary

**Sexual Identity** (optional)

Heterosexual  Gay  Lesbian  Bisexual  Pansexual  Undecided

**RACE/ETHNICITY** (optional)

Please check the box that best represents your race/ethnic background. Please check all that applies.

African-American/Black  Arab American  Asian or Pacific Islander  Hispanic  Multi-racial  Native American  
 White/Caucasian  Other: \_\_\_\_\_

**DSM-5 – Rated Level 1 Cross-Cutting Symptom Measure – Adult**

	During the past <b>TWO (2) WEEKS</b> , how much (or how often) have you been bothered by the following problems? <i>(circle appropriate answer, 0-4)</i>	None Not at all	Slight Rare, less than a day or two	Mild Several days	Moderate More than half the days	Severe Nearly every day	Highest Domain Score (clinician)
I.	1. Little interest or pleasure in doing things?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
	2. Feeling down, depressed, or hopeless?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
III.	4. Sleeping less than usual, but still have a lot of energy?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
	5. Starting lots more projects than usual or doing more risky things than usual?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
	7. Feeling panic or being frightened?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
	8. Avoiding situations that make you anxious?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
	10. Feeling that your illnesses are not being taken seriously enough?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
VI.	11. Thoughts of actually hurting yourself?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	

	During the past <b>TWO (2) WEEKS</b> , how much (or how often) have you been bothered by the following problems? <i>(circle appropriate answer, 0-4)</i>	<b>None</b> Not at all	<b>Slight</b> Rare, less than a day or two	<b>Mild</b> Several days	<b>Moderate</b> More than half the days	<b>Severe</b> Nearly every day	<b>Highest Domain Score</b> (clinician)
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
XII.	19. Not knowing who you really are or what you want out of life?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
	20. Not feeling close to other people or enjoying your relationships with them?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
	22. Smoking any cigarettes, a cigar, or pipe, using snuff or chewing tobacco?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers like sleeping pills or Valium], or drugs like marijuana, cocaine or crack, club drugs [like ecstasy], hallucinogens [like LSD], heroin, inhalants or solvents [like glue], or methamphetamine [like speed])?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	

Are there other concerns (not listed above) that you want to discuss? \_\_\_\_\_

\_\_\_\_\_

### HISTORY OF PRESENT PROBLEM

What is your reason for seeking therapy today? \_\_\_\_\_

\_\_\_\_\_

### PAST PSYCHIATRIC HISTORY

#### Previous Counseling:

Outpatient (place and year) \_\_\_\_\_

Inpatient (place and year) \_\_\_\_\_

Intensive Outpatient Program/Partial (place and year) \_\_\_\_\_

### FAMILY AND SUPPORTIVE RELATIONSHIPS

Marital Status:  Single  Married  Divorced  Widowed  Committed partnership

Name	Age	Relationship (e.g. Spouse, Child, Friend, Neighbor, Roommate, Parents)	Quality of Relationship?	Living with you?
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No

## TRAUMA HISTORY

Have you had a history of trauma, abuse, or neglect?  Yes  No

If yes, what type of abuse or trauma occurred?  Physical  Sexual  Emotional  Neglect  Verbal

## FAMILY PSYCHIATRIC HISTORY

Do you have any family members that have been diagnosed with mental conditions (depression, attempted suicide)?

Yes  No If yes, what? \_\_\_\_\_

What is their relationship to you? \_\_\_\_\_

## MEDICAL CONDITIONS & HISTORY (Optional)

Please check all medical issues for which you have had treatment:

- |   |  |
|---|--|
| <input type="checkbox"/> Allergies<br>(e.g., allergic reactions, seasonal allergies, etc.)                          | <input type="checkbox"/> Blood disease<br>(e.g., anemia, bleeding disorders, etc.)                                   |
| <input type="checkbox"/> Bone disease<br>(e.g., osteoporosis, arthritis, broken bones, etc.)                        | <input type="checkbox"/> Digestive system disease<br>(e.g., ulcers, heartburn, Celiac Disease, IBS, etc.)            |
| <input type="checkbox"/> Endocrine disease<br>(e.g., diabetes, hypothyroid, low testosterone etc.)                  | <input type="checkbox"/> Genetic disease<br>(e.g., Sickle Cell, Fetal Alcohol, other syndromes, etc.)                |
| <input type="checkbox"/> Head and brain illness or injury<br>(e.g., fainting, concussion, seizures, dementia, etc.) | <input type="checkbox"/> Heart/cardiovascular disease<br>(e.g., heart arrhythmia, heart attack, high blood pressure) |
| <input type="checkbox"/> Immune disease<br>(e.g., serious infections, MRSA, Rheumatoid Arthritis, etc.)             | <input type="checkbox"/> Lungs and breathing disease<br>(e.g., asthma, COPD, emphysema, etc.)                        |
| <input type="checkbox"/> Mouth and teeth disease<br>(e.g., gum disease, cold sores, canker sores, etc.)             | <input type="checkbox"/> Muscle and movement disease<br>(e.g., tremors, tics, restless legs, Parkinson's, etc.)      |
| <input type="checkbox"/> Poisoning & chemical exposure<br>(e.g., overdose, lead exposure, work fumes, etc.)         | <input type="checkbox"/> Serious injuries and wounds<br>(e.g., burns, cuts, stabs, crushed limbs, etc.)              |
| <input type="checkbox"/> Other: _____   |  |

Do you have problems with pain?  Yes  No

If yes: Severity of your pain? (low)  1  2  3  4  5  6  7  8  9  10 (high)

Location of your pain: \_\_\_\_\_

Have your medical concerns interfered with your ability to work, relate to others, or be involved in activities outside of your home?  Yes  No If yes, please explain: \_\_\_\_\_

## CURRENT MEDICATIONS

Please list all current medications and supplements you are currently taking:

(Attach another page if needed, or bring a list to your appointment)

Name of Medication	Dosage/Amount	Frequency

Have you had an allergic reaction to medication(s)?  Yes  No If yes, list below:

Name of medication: \_\_\_\_\_ Explain reaction: \_\_\_\_\_

Name of medication: \_\_\_\_\_ Explain reaction: \_\_\_\_\_

**SUBSTANCE USE**

Do you use alcohol?  Yes  No If yes, number of drinks and frequency: \_\_\_\_\_

Do you use recreational/illegal drugs?  Yes  No

If yes, drug(s) of choice and frequency: \_\_\_\_\_

Have others viewed your use as a problem?  Yes  No

Have you ever tried to cut down on your alcohol or drug use or quit using?  Yes  No

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

Has alcohol/drug use interfered with family, work, or interpersonal life?  Yes  No

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

Have you had any prior substance abuse treatment?  Yes  No If yes, list below:

**When?**

**Where?**

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

**FAMILY HISTORY**

Please describe what life was like growing up (please include siblings, step-siblings, and birth order). \_\_\_\_\_

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

**SOCIAL HISTORY**

Were you sheltered/kept private?  Yes  No Did you relate to others well?  Yes  No

**DEVELOPMENTAL HISTORY**

Childhood diagnoses of ADHD?  Yes  No Autism?  Yes  No Other: \_\_\_\_\_

\_\_\_\_\_

**EDUCATIONAL / OCCUPATIONAL HISTORY**

Highest level completed:

High School  Attended college or technical school  College degree  Graduate degree  Other \_\_\_\_\_

Employed  Unemployed  Disabled  Retired  Stay-at-home Parent

**Finances:** Overall stress level:  High  Medium  Low

**LEGAL HISTORY**

Involved with the legal system, Friend of the Court or Child Protective Services?  Yes  No

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

\_\_\_\_\_

Do you currently have a probation or parole officer?  Yes  No

If yes, name: \_\_\_\_\_

Have you been involved with the legal system in the past?  Yes  No

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

\_\_\_\_\_





4695 N M37 Hwy, Suite D, Middleville, MI 49333  
phone: 269-205-2366 ♦ fax: 269-205-2728  
e-mail: admin@striving2thriving.com  
website: striving2thriving.com



**EMERGENCY CONTACT AUTHORIZATION FORM**

Client Name \_\_\_\_\_

**Personal Contact Info:**

Home Address \_\_\_\_\_

City, State, ZIP \_\_\_\_\_

Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_

**Emergency Contact Info:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

City, State, ZIP \_\_\_\_\_

Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

City, State, ZIP \_\_\_\_\_

Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_

**Medical Contact Info:**

Doctor Name \_\_\_\_\_ Phone # \_\_\_\_\_

I have voluntarily provided the above contact information and authorize \_\_\_\_\_  
and its representatives to contact any of the above named on my behalf in the event of an emergency.

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