



ALINA M GALLIANO-PARDO, MD, DABPN, DABAM

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TMS Evaluation Packet

Please fill out the following information and return it to our office at least 24 hours prior to your appointment. If at any point you have questions, concerns or feel overwhelmed, please call our office and we will be happy to assist you.

BrainsWay TMS – What To Expect During Your Initial Appointment

Initial Assessment

This assessment is a two-part process that involves a review of your medical history and then a second visit for your initial treatment. Both sessions usually last about one and a half hours, but plan on two just to be safe. This first aspect of TMS Treatment is far and away the most intensive. But then again, this is the all-important first step on your road to therapy and recovery.

Here's a look into what you can expect from treatment with our BrainsWay TMS, which is the only Deep TMS device on the market:

The initial assessment, or consultation, will be used to evaluate the appropriateness of TMS Therapy in treating your depression. Dr Galliano-Pardo, your TMS prescribing psychiatrist, will use the assessment to determine a diagnosis and the risks and benefits of TMS compared to other available treatments for your diagnosis. She might also want to discuss the off-label treatments of TMS for symptoms such as bipolar disorder, schizophrenia, and OCD.

The doctor will also want details about previous treatment for your depression including counseling history, names of medications and maximum dosage, duration of treatment, and reasons treatment was discontinued, such as lack of benefit or side effects. You should be prepared to complete formal medical history evaluations and sign consent forms.

There is also a chance that Dr Galliano-Pardo will request a physical examination from your primary care physician. This is not always the case, though, and will vary from patient to patient. If a physical examination is requested, it will most likely be used to carefully screen patients for the presence of medical conditions such as seizure disorder or epilepsy, and underlying risk factors such as the presence of metal within the head, which might make the administration of TMS unsafe clinically.

At the end of the assessment Dr. Galliano-Pardo will decide if you are a candidate for TMS Therapy. If TMS Therapy is right for you, she will create a plan for your treatment. Your next appointment will be your first treatment of TMS and will focus on Motor Threshold and Helmet Placement.

Your first TMS Evaluation will be about 1-1.5 hours long. Your intake with a staff member will take about 15 minutes followed by a 45 minute to an hour meeting with Dr. Galliano-Pardo. Please review the information in the packet, and email them back to us at **least 24 hours prior to your scheduled appointment**. If your information is not received 24 hours prior to your appointment, your appointment may need to be rescheduled. If at any point you have questions, concerns, or feel overwhelmed, please do not hesitate to contact our office. The paperwork can be completed on your computer or printed, filled, and scanned. Also, please send us a copy of a **valid photo ID** and a photo of the front and back of your **insurance card** (primary and secondary) so that we are able to verify your benefits and co-payments prior to your appointment time. We will be able to begin working on the prior authorization for TMS treatment as soon as we receive this information.

Motor Threshold

Your deep TMS treatment will be administered by certified BrainsWay technicians. When you arrive for treatment, your technician will help get you settled before getting you set up for treatment. Deep TMS treatment targets the region of your brain that has been associated with depression called the dorsolateral prefrontal cortex (DLPFC). After determining this specific location, your technician will administer a small magnetic pulse to stimulate movement in the thumb. With each pulse, you will hear a clicking sound and feel a small tapping sensation on your scalp - the "woodpecker" as we call it. Dr. Galliano and your technician will work slowly and adjust the power of the device accordingly to determine your unique motor threshold (MT), which is the least amount of power necessary to illicit a motor reflex response in the thumb. How often your motor threshold is re-evaluated will be determined by your physician. Typically, this value is determined at least once per week by your certified TMS technician.

Fitting the Helmet

For devices such as the BrainsWay, the helmet is fitted by first bringing it forward so that it rests above the front region of the patient's brain. The doctor and TMS operator will make several measurements to ensure that the TMS helmet is properly positioned on the patient's head. Finally, after taking a number of sample readings, Dr. Galliano-Pardo will be able to determine the place on the head where the TMS treatment will be applied which is crucial as it will allow you to receive optimal treatment.

Treatment Schedule

Typical Treatment Schedule consists of daily treatments for 4-5 weeks (Monday-Friday). The treatment frequency following the first 4-5 weeks of treatments varies based on your symptoms but is usually twice a week until treatment is completed. Most patients experience improvements in their mood between weeks 3-6, however some patients may experience a late response.

Office Policies

Office Hours

The Front Office and phone lines are open from 8 am-3 pm. Patient follow up appointments are Monday through Thursday starting at 7:30am and are every 30 minutes until 12:30pm.

TMS Treatment Hours

The office is open for TMS treatments from 8:00am- 3:00pm. If these times are not convenient for you, please contact our office for further discussion of possible options.

Contacting Us

Always remember: if you have a potentially life-threatening emergency and need help **IMMEDIATELY, CALL 911 or GO TO AN EMERGENCY ROOM.** You can contact us once the situation is stabilized.

For general questions or concerns you can call our office during hours listed above and speak to a staff member. Be prepared to give a detailed message to the staff member. They will consult with your physician and will call you back. If you chose to leave a detailed voicemail, please be aware that calls are returned within 24 business hours.

If you call after the office is closed you can leave a message and we will call you back on the next business day or you can also send us an e-mail to information@beachesbehavioral.com or tms@beachesbehavioral.com and expect an answer within 24-hours.

We will try our best to get back to you as soon as we can, but remember that urgent matters are handled first. If you have an urgent matter that **can't wait until the next business day**, please email information@beachesbehavioral.com to get a call back.

Appointments

All appointments need to be confirmed within twenty-four (24) business hours of the time scheduled. If your appointment is not confirmed, it is subject to being cancelled and you will be charged the No Show or the Late Cancellation fee. It is your responsibility to come to your appointments on the correct date and time.

If you need to cancel an appointment you will need to do it with at least twenty-four (24) business hours' notice by calling or emailing our office or you will be charged the Late Cancellation fee. Late cancellation fees are as follows: \$100 for Follow up appointments, \$200 for New Patient appointments, and \$50 for TMS treatment appointments.

Please be aware that we will need to obtain a CC on file to hold your appointment.

Electronic Communication Authorization

Beaches Deep TMS & Brain Health may communicate with me using electronic (Non-HIPPA compliant) communications including email, text messages, and voicemail. I may be contacted using the numbers or addresses that I have provided to Deep TMS & Brain Health or that I have used to initiate contact with Beaches Deep TMS & Brain Health. These communications may include appointment information, protected health information and confidential information. I understand that these electronic communications are not encrypted. We use reasonable means to ensure security of communication with these methods, however we can not guarantee the security of non-HIPPA compliant methods.

I Authorize Electronic Communication

I DO NOT Authorize Electronic Communication

CONSENT FOR URINE DRUG SCREEN

Please Read Each Item

Your physician, Alina M. Galliano-Pardo, M.D., **may order** urine specimens to be collected for the purpose of drug screening at any time if it is deemed necessary. You will be tested upon admission and randomly during follow up visits at the doctor’s discretion.

We **require** urine screening if you are taking controlled medication prescribed by this office. If you are taking **any controlled medication** including Buprenorphine (Suboxone/Zubsolv). If you refuse drug screening, you may not be allowed to see the doctor and your prescription(s) may not be renewed.

You may refuse to provide urine for testing at any time. Your physician will be informed of this and could interfere with your participation in treatment at this office.

Most insurance plans **do not** pay for drug screening. If they don’t, you agree to pay our \$25.00 charge. Drug screening charges are already included in self-pay patient visit charges. Patients that come into the office for a drug screen outside of an appointment will be required to pay a \$25.00 charge.

If your drug screening is positive and you believe this is an error, you can request the sample to be sent for confirmation to a certified lab. If your insurance does not cover the external lab charges, you will be responsible for payment of those charges.

Your signature below acknowledges that you have read and understand the policies of Alina M. Galliano-Pardo, M.D. Please check the appropriate box below indicating your informed consent.

- I consent to having urine specimens collected for drug screening.

- I **do not** consent to having urine specimens collected for drug screening.

Patient signature: _____ Date: _____

Witness signature: _____ Date: _____

COVID-19 Informed Consent

Our office is taking all necessary steps and measures to insure the safety of our patients and staff. We are following all recommended CDC and state guidelines to help reduce the spread of COVID-19.

Telehealth Services

For your initial evaluation, you have the option between an in-person appointment or a telehealth appointment. Ongoing follow-ups will be via telehealth. Telehealth appointments are conducted through a HIPPA-compliant platform that requires video and audio capabilities. You will receive an email 24-48 hours before your appointment with instructions. If you have any questions or concerns please contact the office.

For your appointment(s), please make sure:

- You have the proper equipment- video and audio capabilities on a mobile device or computer
- You are in a quiet, private location with reliable service.
- If you are driving, please pull over to a safe location for the duration of your session.

Termination of Treatment

Dr. Alina Galliano-Pardo will deem treatment ineffective and advise a patient to seek treatment elsewhere when a patient’s actions indicate that he or she has disengaged from treatment. Following are some examples of situations warranting termination of treatment:

- The patient misses two or more appointments
- The patient ceases paying for treatment
- The patient is noncompliant with treatment recommendations
- The patient misuses or abuses prescribed medications
- The patient behaves in an abusive, threatening or inappropriate manner toward staff, or other patients
- The patient fails multiple drug screenings (Suboxone or controlled medication patients)

Please check all that apply:

I have reviewed and agree to the Policies of this Office.

I have reviewed and agree to the UDS Consent Form

I have reviewed and agree to the New Patient Registration/Insurance Form

I have received and agree to the COVID-19 Informed Consent

I have reviewed and agree with the Notice of Privacy Practice (Located on our website for your review

I _____ have received, reviewed and agree with the terms of the Office and Financial Policies for Doctor Alina Galliano-Pardo.

Signature

Date



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Card Holder Authorization for Credit Card Charges

Patient Information

Name of Patient: _____

Credit Card Information

First Name (as it appears on credit card): _____

Last Name (as it appears on credit card): _____

Relationship to Patient: _____

Credit Card Type AmEx Discover MC Visa

Credit Card Number: _____ - _____ - _____ - _____

Expiration Date: _____ CCV Code: _____

Credit Card Billing Address

Street/PO Box: _____

City: _____

State/Zipcode: _____

Billing Phone: _____

Acknowledgement

I authorize Alina M. Galliano-Pardo, M.D., P.A. to charge this credit/debit/HAS debit card for any and/or all co-payments, patient responsibility portions of my insurance explanations of benefits (if applicable), fee for the completion of any forms and/or letters I request, lost prescriptions, prescription refills, and missed/no-show or late appointment fees.

I certify that I am an authorized signer on the card provided and that the credit card number provided and signature below are the same as those on file with the credit card issuer.

Cardholder's Signature

Date

Printed Employee Name



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Providing information regarding your family members, friends, and other providers can be helpful in facilitating your care and ensures we are able to provide you with the best possible care. This form is optional and allows you to choose who you would like your informational potentially shared with.

I hereby authorize Beaches Behavioral to release/receive information from my medical record including general medical information as well as Acquired Immunodeficiency Syndrome and/or HIV tests, psychiatric, psychological, drug and/or alcohol records in compliance with Florida Statutes 90.503, 394.459, 395.017, 396.112, 397.053 and Federal Regulation 42 CFR, Part 2. The type of information authorized for disclosure includes, but may not be limited to :

Patient Name:		DOB:	Initial each specific consent to release			
Family Members or Significant Others	Name/Relationship	Purpose: <ul style="list-style-type: none"> To facilitate understanding and support in treatment. To aid in diagnosis and continuity of care. Type of information to be disclosed: <ul style="list-style-type: none"> All medical records <input type="checkbox"/> Progress Notes <input type="checkbox"/> Labs <input type="checkbox"/> Medications <input type="checkbox"/> Evaluations <input type="checkbox"/> Other: _____ _____ 	<input type="checkbox"/> Yes <input type="checkbox"/> No _____ Initial			
	Name/Relationship					
	Name/Relationship					
Mental Health Professionals	Psychiatrist Phone		Purpose: <ul style="list-style-type: none"> To facilitate understanding and support in treatment. To aid in diagnosis and continuity of care. Type of information to be disclosed: <ul style="list-style-type: none"> All medical records <input type="checkbox"/> Progress Notes <input type="checkbox"/> Labs <input type="checkbox"/> Medications <input type="checkbox"/> Evaluations <input type="checkbox"/> Other: _____ _____ 	<input type="checkbox"/> Yes <input type="checkbox"/> No _____ Initial		
	Therapist Phone					
Primary Care Physician	Name/ Group			Purpose: <ul style="list-style-type: none"> To facilitate understanding and support in treatment. To aid in diagnosis and continuity of care. Type of information to be disclosed: <ul style="list-style-type: none"> All medical records <input type="checkbox"/> Progress Notes <input type="checkbox"/> Labs <input type="checkbox"/> Medications <input type="checkbox"/> Evaluations <input type="checkbox"/> Other: _____ _____ 	<input type="checkbox"/> Yes <input type="checkbox"/> No _____ Initial	
	Phone					
Pharmacy					Purpose: <ul style="list-style-type: none"> To facilitate understanding and support in treatment. To aid in diagnosis and continuity of care. Type of information to be disclosed: <ul style="list-style-type: none"> All medical records <input type="checkbox"/> Progress Notes <input type="checkbox"/> Labs <input type="checkbox"/> Medications <input type="checkbox"/> Evaluations <input type="checkbox"/> Other: _____ _____ 	<input type="checkbox"/> Yes <input type="checkbox"/> No _____ Initial
Other Specialists	Name/ Group/ Phone	Purpose: <ul style="list-style-type: none"> To facilitate understanding and support in treatment. To aid in diagnosis and continuity of care. Type of information to be disclosed: <ul style="list-style-type: none"> All medical records <input type="checkbox"/> Progress Notes <input type="checkbox"/> Labs <input type="checkbox"/> Medications <input type="checkbox"/> Evaluations <input type="checkbox"/> Other: _____ _____ 				<input type="checkbox"/> Yes <input type="checkbox"/> No _____ Initial
	Name/ Group/ Phone					
	Name/ Group/ Phone					
Referrals			Purpose: <ul style="list-style-type: none"> To facilitate understanding and support in treatment. To aid in diagnosis and continuity of care. Type of information to be disclosed: <ul style="list-style-type: none"> All medical records <input type="checkbox"/> Progress Notes <input type="checkbox"/> Labs <input type="checkbox"/> Medications <input type="checkbox"/> Evaluations <input type="checkbox"/> Other: _____ _____ 			<input type="checkbox"/> Yes <input type="checkbox"/> No _____ Initial



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I understand that my medical records may contain information regarding testing, drug, and/or alcohol diagnosis and treatment, a communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, or the human immunodeficiency virus also known as acquired immune deficiency syndrome (AIDS) and/or tuberculosis. I understand that such information is confidential and is protected by federal law. I understand that the provision of health care treatment to me cannot be conditioned upon my agreement to sign an authorization for the use of my health care information for purposes other than for treatment, payment, and healthcare operations. I understand that the potential exists for health information that is released with my authorization to be re-disclosed by the recipient, and to be no longer protected by the Federal HIPPA law. I understand that I have the right to revoke this authorization at any time by giving written notice to Beaches Behavioral Office, except to the extent that action has already been taken in reliance on it.

Patient Signature

Date

Guardian/ Representative

Date

Witness Signature

Date

PATIENT DEMOGRAPHICS			
Last Name:	First Name:	Middle Name:	
Address:	City:	State:	Zip:
Home Phone:	Cell Phone:		
Social Security Number:	DOB:	Gender: M	F <input type="radio"/>
Marital Status:	Ethnicity:		
Employer Name:			
Employer Address and Phone:			
PRIMARY INSURANCE INFORMATION			
Insurance Carrier:	Policy ID:	Group Number:	
Policy Holder's Name:	Group Name:		
Policy Holder's DOB:	Relationship to Patient:		
Policy Holder's Social Sec Number:			
Policy Holder's Employer:			
Employer Address and Phone:			
SECONDARY INSURANCE INFORMATION			
Insurance Carrier:	Policy ID:	Group Number:	
Policy Holder's Name:	Group Name:		
Policy Holder's DOB:	Relationship to Patient:		
Employer Address and Phone:			
<small>IF YOU HAVE A SECONDARY INSURANCE POLICY, IT IS YOUR RESPONSIBILITY TO ADVISE THE STAFF WHICH IS THE PRIMARY AND WHICH IS THE SECONDARY INSURER. FAILURE TO DO SO MAY CAUSE SUBMISSION TO THE INCORRECT INSURANCE COMPANY. INSURERS HAVE TWO (2) YEARS TO RECOUP MONIES THAT HAVE BEEN DISPENSED IN ERROR, AND ONCE THE NOTICE OF RECOUPMENT IS RECEIVED, IT IS LIKELY THAT THE TIMELY FILING LIMIT FOR THE CORRECT INSURER HAS PASSED. IF THAT SHOULD HAPPEN, IT BECOMES THE PATIENT'S RESPONSIBILITY FOR THE CHARGES INCURRED.</small>			
			PATIENT'S INITIALS:
EMERGENCY CONTACT INFORMATION			
Emergency Name:	Relationship:		
Emergency Address:	City:	State:	Zip:
Emergency Phone #1:	Emergency Phone #2:		
FINANCIALLY RESPONSIBLE PARTY INFORMATION			
<input type="checkbox"/> Same as patient demographics			
Last Name:	First Name:	Middle Name:	
Address:	City:	State:	Zip:
Relationship to Patient:			
Home Phone:	Cell Phone:		
Social Security Number:	DOB:	Gender: M	<input type="radio"/> F <input type="radio"/>
Employer Address and Phone:			
DO YOU HAVE A HEALTH CARE SURROGATE OR A LEGAL GUARDIAN? YES <input type="radio"/> NO <input type="radio"/>			
Surrogate/Guardian Name:		Relationship:	
Surrogate/Guardian Address:		City:	State: Zip:
Surrogate/Guardian Phone #1:		Surrogate/Guardian Phone #2:	



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New Patient Medical History Form

Please complete all information on this form and email it to information@behavirolbeaches.com prior to your first visit. Please get it to our office **24 hours before** your scheduled appointment

Name _____

Email: _____

What are the problem(s) for which you are seeking help?

1. _____
2. _____
3. _____

What are your treatment goals?

Pharmacy Name & Location _____ Phone # _____

Secondary Pharmacy _____ Phone# _____

Medical History

Do you have any known allergies? () Yes () No

If yes please explain:

Do you have any adverse drug reactions? () Yes () No

If yes please explain:

What are your other **non-psychiatric** medical diagnoses? (ie. Asthma, diabetes, high blood pressure etc.)

List ALL medications you are currently taking (**non-psychiatric**) including dosage and how often you take them. Please include everything you take from vitamins, OTC medications, and prescribed medications

Medication Name	Diagnosis	Daily Dose	How Often

Do you take your medication as prescribed? () Yes () No

List any non-psychiatric hospitalizations including year. (ie. Severe flu, stomach pain etc) If none write N/A

List any surgeries including type of surgery, location, and year

Do you exercise regularly? () Yes () No

How much alcohol do you consume? _____

How many caffeinated beverages do you drink a day? Coffee _____ Soda _____ Other _____

Do you use recreational drugs () Yes () No If yes, which ones _____

Do you have trouble sleeping?() None () Yes, falling asleep () Yes, staying asleep () Both

On average, how many hours of sleep do you get per night? _____

Are there any sources of stress in your life? () Yes () No

If yes, explain:

Do you use tobacco products? () Yes () No

If yes, what form and how often:

Do you suffer from chronic pain? () Yes () No

If yes, include location, severity and timing of pain:

Name of Primary care Provider: _____ Last Seen: _____

Any other non-psychiatric medical providers currently being seen (Example: Cardiologist, OBGYN, ect.):

List any recent diagnostic testing (labs or imaging). Include type date and location where testing was done

Have you received the COVID-19 Vaccine? Yes No

If you have: Date of 1st Dose: _____ Date of 2nd Dose: _____

If you have not received it, do you plan on getting it? Yes No

Past Psychiatric History

List any previous psychiatrists you have seen in the **last 5 years**, including years/dates of treatment, and treatment outcome.

List any previous therapists you have seen in the **last 5 years**, including years/dates of treatment and treatment outcome

List any psychiatric disorders you have been diagnosed with including: the age you began treatment and which doctor gave you the diagnosis:

List any psychiatric hospitalizations including the provider name, dates, reason and outcome

Provider Name	Dates	Reason	Outcome
---------------	-------	--------	---------

In the past, have you tried electroconvulsion therapy (ECT)? () Yes () No

If you answered yes, please complete the following questions:

Name of Facility _____

Dates: _____

Reason: _____

Number of Sessions _____

Outcome: _____

In the past have you tried Ketamine or Esketamine treatment? () Yes () No

If you answered yes, please complete the following questions:

Name of Facility _____

Dates: _____

Reason: _____

Number of Sessions _____

Outcome: _____

List any previous psychotherapy treatment including the provider name, dates, reason and outcome

Provider Name	Dates	Reason	Outcome
---------------	-------	--------	---------

List any Outpatient treatments including when, by whom and nature of treatment. Please also describe the outcome of the treatment

Reason	Dates/ Length	Provider Name	Outcome

In the past have you been suicidal or self-injurious? Yes No
In the past, have you ever made a suicidal attempt? Yes No
 If yes, please indicate the year(s) it occurred

In the past, have you been assaultive towards someone else? Yes No
Do you have a history of substance abuse? Yes No
 If yes, include what substance, when, how long, and date of last use:

Have you done a genetic testing for psychotropic medications (ie. GeneSight) Yes No
If yes, please send the office a copy of your results prior to your appointment.
If yes, what is the date of testing: _____

List any psychological/neuropsychological testing you have completed including the name of the provider, year, and reason for testing. **If you have, please send the office a copy of your results prior to your appointment.**

Name of Provider	Year	Reason

List any pharmacies you have used in the last **5 years**. Please include the name , location and phone number of the pharmacy.

Pharmacy Name	Location	Phone Number

Past Psychiatric Medications: If you have ever taken any of the following medications, please indicate the dates, dosage, and how helpful they were (if you can't remember all the details, just write in what you do remember). When describing the reason stopped please indicate whether it was ineffective or if you experience side effects and if so, what side effects.

Antidepressants	Dates	Dosage	Reason Stopped
Prozac (fluoxetine)			
Zoloft (sertraline)			
Luvox (fluvoxamine)			
Paxil (paroxetine)			
Celexa (citalopram)			
Lexapro (escitalopram)			
Effexor (venlafaxine)			
Cymbalta (duloxetine)			
Wellbutrin (bupropion)			
Remeron (mirtazapine)			
Serzone (nefazodone)			
Anafranil (clomipramine)			
Pamelor (nortrptyline)			
Tofranil (imipramine)			
Elavil (amitriptyline)			
Other			

Mood Stabilizers	Dates	Dosage	Reason Stopped
Tegretol (carbamazepine)			
Lithium			
Depakote (valproate)			
Lamictal (lamotrigine)			
Tegretol (carbamazepine)			
Topamax (topiramate)			
Other			

Typical Antipsychotics	Dates	Dosage	Reason Stopped
Haldol (haloperidol)			
Loxitane (loxapine)			
Mellaril (thioridazine)			
Moban (molindone)			
Navane (thiothixene)			
Prolixin (fluphenazine)			
Serentil (mesoridazine)			
Stelazine (trifluoperazine)			
Thorazine (chlorpromazine)			
Trilafon (perphenazine)			

Past Psychiatric medications (continued)

Atypical Antipsychotics	Dates	Dosage	Reason Stopped
Abilify (aripiprazole)			
Clozaril (clozapine)			
Risperdal (risperidone)			
Seroquel (quetiapine)			
Zyprexa (olanzepine)			
Geodon (ziprasidone)			
Rexulti (Brexpiprazole)			
Vraylar (Cariprazine)			
Other			

Sedative/Hypnotics	Dates	Dosage	Reason Stopped
Ambien (zolpidem)			
Sonata (zaleplon)			
Rozerem (ramelteon)			
Restoril (temazepam)			
Desyrel (trazodone)			
Other			

ADHD Medications	Dates	Dosage	Reason Stopped
Adderall (amphetamine)			
Concerta (methylphenidate)			
Ritalin (methylphenidate)			
Strattera (atomoxetine)			
Vyvanse (Lisdexamfetamine)			
Other			

Antianxiety medications	Dates	Dosage	Reason Stopped
Xanax (alprazolam)			
Ativan (lorazepam)			
Klonopin (clonazepam)			
Valium (diazepam)			
Tranxene (clorazepate)			
Buspar (buspirone)			
Centrax (prazepam)			
Librium (chlordiazepoxide)			
Inderal (propranolol)			
Serax (oxazepam)			
Tenormin (atenolol)			
Hydroxyzine			
Other			

Has anyone in your family been diagnosed with a behavioral health disorder? () Yes () No
If yes, explain which family member?

Social History

Where were you born: _____
Who were you primarily raised by: _____
What is your birth order and how many siblings do you have? _____
How would you describe the quality of your childhood? _____
Were there any sources of family stressors growing up? _____
How is the relationship quality with your family member? _____

Education History

Have you received your high school diploma? () Yes () No
Have you received a GED certificate? () Yes () No
Have you attended college () Yes () No
Have you graduated from college () Yes () No
If so, please list area of study _____

Employment History

Occupation: _____
Length of Current position: _____
How would you describe your work quality? _____

Relationship/ Marriage

Are you currently married? () Yes () No
Length of current marriage? _____ Quality of current marriage? _____
How many times have you been married? _____

Children Information

Do you have any children? () Yes () No If yes, how many _____
Are they from your current marriage or previous marriage? _____
How is your relationship with your child/ children _____

Have you ever been in the Military? () Yes () No

If yes, include what branch, type of discharge (if applicable), and any trauma as a result:

Have you ever been arrested? () Yes () No

If yes, please explain:

Who is currently in you support system?

FOR IN OFFICE USE ONLY

Reviewed by: _____ Date: _____