ADULT HISTORY QUESTIONNAIRE

Name: _____ **Today's Date:** _____

Date of Birth: _____ **Age:** _____

Spouse/Significant Other: _____

Address: _____
_____

Home Phone: _____ **Can I leave a message on this line? Yes No**
Work Phone: _____ **Can I leave a message on this line? Yes No**
Cell Phone: _____ **Can I leave a message on this line? Yes No**
Alternate Phone: _____ **Can I leave a message on this line? Yes No**

If I may need to reach other family members (such as spouse or children), please provide their phone numbers below:

Name of family member: _____

Phone: _____ **Can I leave a message on this line? Yes No**

Occasionally it is easier to communicate about appointments through email than phone. If you would like the option of communicating about issues such as appointments, scheduling, payments, etc, please list email addresses below. It is important to note however, that email is not a 100% secure form of communication and thus privacy cannot be guaranteed. Email will not be used for advice, treatment, or any other form of intervention with your provider. By listing email addresses below, you are acknowledging your understanding of these statements.

Email address: _____

How did you find out about me? _____

Primary Physician's Name: _____
Phone and Fax Number: _____

Please state why you are seeking therapy at this time: _____
_____
_____
_____

At what age was the problem first noticed? _____
_____

What are you hoping to achieve with therapy? _____
_____
_____

ACADEMIC INFORMATION

Highest level of education achieved: _____

Did you receive any formal or informal modifications at school? Please describe: _____
_____
_____

Current Employment Status: _____

Are you satisfied with your employment? _____

FAMILY

Please list family members who live in the home and their ages:
_____
_____
_____
_____

Are there any family members who live elsewhere? If so please list their names, ages and reason for moving out:
_____
_____

Marital Status, if applicable, please include any relevant dates of marriage, divorces, separation, etc: _____
_____
_____

If divorced with children, please describe custody arrangements: _____
_____
_____

RECREATION / SOCIAL

How do you spend free time? _____
_____
_____

What are your favorite hobbies and interests? _____
_____
_____

Are you satisfied with your social network: _____
_____
_____

Please check the following activities in which you participated in the last month:

- ☐ Exercised or played a sport, how frequently? _____
- ☐ Spent time with friends, how frequently? _____
- ☐ Engaged in volunteer activities, what activities? _____
- ☐ Watched TV/played on Internet, how many hours/day? _____
- ☐ Played videogames or computer games, how many hours/day? _____

Please describe your strengths: _____
_____

_____

STRESSORS

Has your family experienced any stressful events in the last year? Please check the following.

- ☐ Death in the family
- ☐ Death of a close friend
- ☐ Serious illness or injury, you
- ☐ Serious illness or injury, a loved one
- ☐ Family fighting
- ☐ Marital problems
- ☐ Divorce or separation
- ☐ Marital reconciliation
- ☐ Problems with child rearing
- ☐ Move to a new home
- ☐ Son or daughter leaves home
- ☐ Conflict with in-laws
- ☐ Change in job - new position, new company, laid off, retired, quit
- ☐ Change in financial status, either more or less money
- ☐ Change in daily responsibilities
- ☐ Change in social network
- ☐ New marriage in the family
- ☐ Outstanding personal achievements

Any other stressors experienced by you or your family? _____

_____

_____

_____

MEDICAL

Do you have any of the following medical problems?

Current	Past		Current	Past	
☐	☐	Heart Problems	☐	☐	Head Injury
☐	☐	Digestive Problems	☐	☐	Surgeries
☐	☐	Hypothyroidism	☐	☐	Tics
☐	☐	Hyperthyroidism	☐	☐	High Blood Pressure
☐	☐	Diabetes, Type I	☐	☐	Unexplained pains
☐	☐	Diabetes, Type II	☐	☐	PMS symptoms
☐	☐	Overweight	☐	☐	Muscle tension
☐	☐	Underweight	☐	☐	Headaches
☐	☐	Back or neck pain	☐	☐	Cancer
☐	☐	Alcohol use/abuse	☐	☐	Drug use/abuse

If you checked any of the boxes above, please describe the problem: _____

_____

_____

Are there any other medical problems not listed above that you experience? _____

_____

_____

Are you currently taking any medications? If so, please list: _____

_____
_____

Please describe your sleep habits? How many hours per night of sleep are typical? Do you have any concerns about your sleep? _____
_____
_____

How much alcohol do you drink per week? _____

Do you use any illicit drugs? If so, which ones and how often? _____
_____

Do you smoke nicotine? If so, how much? _____

Are there any medical problems someone in the family has that may be impacting you? _____
_____
_____

MENTAL HEALTH

How would you describe your overall mood? _____

Have you sought psychotherapy before? If so, what were the circumstances? _____
_____
_____

Did you find therapy helpful? _____

If you are taking medication for emotional or behavioral struggles, what medication(s) and who is the prescribing physician? _____
_____
_____

Is the medication helpful? _____

Have you taken medication in the past for emotional or behavioral struggles? If so, what medication(s) and effective was each one? _____
_____
_____

Do you have any history of abuse? _____
_____
_____

Please check all that apply:

	Self, current	Self, past	Mother	Father	Sibling	Other
Depression, sadness						
Anxiety / Excessive Worries						
Obsessions and/or Compulsions						
Autism/PDD/Asperger's						
Tourette's Syndrome						
Panic Attacks						
Obsessions and/or Compulsions						
Suicidal thoughts / Suicide attempt						
PTSD						
Learning Disabilities						
Attention Deficit/Hyperactivity						
Problems with Anger						
Problems with Assertiveness						
Oppositionality/Defiance						
Schizophrenia or Psychosis						
Bipolar or manic episodes						
Heavy Alcohol Use						
Drug Use/Abuse						
Eating Disorder						
Abused in any way						
Other:						

Do you have any other comments that you think would be helpful? _____
_____
_____
_____
_____
_____
_____

THANK YOU!

AMALYSSA J. JOHNSON, PH.D.
Clinical Psychologist

NOTICE OF PRIVACY PRACTICES

IN ACCORDANCE WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA), HEALTH INFORMATION TECHNOLOGY FOR ECONOMIC AND CLINICAL HEALTH ACT (HITECH), TEXAS MEDICAL PRIVACY ACT (TX HB300), THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AS WELL AS HOW YOU MAY GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY AND SIGN THE ACKNOWLEDGEMENT OF RECEIPT.

Protecting Your Personal and Health Information

This notice will explain how we handle your medical/mental health information. Applicable federal and state laws require us to maintain the privacy of clients' persal and health information. In this Notice, your personal or protected health information is referred to as "health information" or "PHI" and includes information regarding your health care and treatment with identifiable factors, such as your name, age, address, income or other financial information. Because state and federal laws, combined with our professional ethics, are very complicated, some parts of this notice are very detailed and may seem difficult to understand. Please know AMALYSSA J. JOHNSON, PH.D. is committed to protecting the privacy of your health and personal information and is available to answer any questions you may have.

How We Protect Your Health Information

AMALYSSA J. JOHNSON, PH.D. protects your health information by treating all of your health information that she collects as confidential (for exceptions to confidentiality see Uses and Disclosures Not Requiring Consent or Authorization), by training all staff in federal and state confidentiality policies and practices per HIPAA, HITECH, AND TX HB300, by restricting access to your health information only to those office staff that need to know your health information in order to provide service to you, and by maintaining physical, electronic, and procedural safeguards to comply with federal and state regulations guarding your health information. Your health information is maintained on file after termination of services for a minimum of 7 years, or three years after the age of majority, whichever is greater.

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

AMALYSSA J. JOHNSON, PH.D. may use or disclose your protected health information for treatment, payment, and health care operations purposes if you have given consent to receive evaluation or treatment services.
Clarification of terms:
PHI- information in your health record that could identify you.
ePHI- information in your health record available in electronic format.
Treatment, Payment, and Health Care Operations
Treatment- when office provides, coordinates, or manages your health care and other services related to your health care. An example of treatment would be when our office consults with another health care provider, such as your family physician.
Payment- when you provide reimbursement for the services you receive in the office. An example of payment would be when our office discloses your PHI/ePHI 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 our office. Examples of health care operations are quality assessment and improvement activities, business related matters such as audits and administrative services, case management and care coordination, and conducting training and educational programs or accreditation activities.
Use – Activities within the office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
Disclosure – Activities outside of the office, such as releasing, transferring, or providing access to information about you to other parties.

Uses and Disclosures Requiring Authorization

AMALYSSA J. JOHNSON, PH.D. and any administrators of her may use or disclose PHI/ePHI for purposes outside Treatment, Payment, or Health Care Operations when your authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when the office is asked for information for purposes outside of Treatment, Payment, or Health Care Operations, we will obtain an authorization from you before releasing this information.
Specific authorization is also obtained before releasing your psychotherapy notes. Psychotherapy notes are notes made about treatment and are given a greater degree of protection than PHI/ePHI.
You may revoke all such authorizations at any time, provided each revocation is in writing. After that time, we will not use or disclose your information for the purposes originally agreed upon. However, we cannot take back any information already disclosed with your permission or that we had used in our office.

Uses and Disclosures Not Requiring Consent or Authorization

The law requires AMALYSSA J. JOHNSON, PH.D. use or disclose PHI/ePHI without your consent or authorization in some cases. Here are some examples of when this might occur:

When Required by Law - Suspected child abuse must be reported. Also, if you are involved in a lawsuit or legal proceeding and the provider receives a subpoena, discovery request, or other lawful process, some of your PHI/ePHI may have to be released. This will occur only after trying to tell you about the request, consulting your lawyer, or trying to get a court order to protect the information being requested. Finally, some information has to be disclosed to governmental agencies, which check on providers to see that privacy laws are being obeyed.

For Law Enforcement Purposes – Information may be released if your provider is asked to do so by a law enforcement official to investigate a crime or criminal.

For Public Health Activities – Some of your PHI/ePHI might be disclosed to agencies which investigate diseases or injuries.

For Specific Government Functions – PHI/ePHI of military personnel and veterans may be disclosed to government benefit programs relating to eligibility and enrollment. PHI/ePHI may also be disclosed to Workers Compensation and Disability Programs, to correctional facilities if you are an inmate, and for national security reasons.

To Prevent a Serious Threat to Health or Safety – If your provider believes that there is a serious threat to your health or safety or that of another person or the public, the provider can disclose some of your PHI/ePHI. This disclosure will only be provided to persons who can prevent the danger.

Therapist's Incapacity or Death – In the event that your provider becomes incapacitated or dies, it will become necessary for another therapist to take possession of your files and records.

Patient Rights and Provider's Duties

Patient Rights:

Rights to Request Restrictions – You have the right to request that your provider limits what is told to people involved in your care or the payment of your care, such as family members and friends. AMALYSSA J. JOHNSON, PH.D. may not be able to accept your request; however, if accepted she will uphold it except in case of emergency or if it is against the law.

Right to Receive Confidential Communications by Alternative Means/Locations – You have the right to request and receive confidential communications of PHI/ePHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are being seen at the office. On your request, communications will be sent to an alternate address.)

Right to Inspect and Copy – You have the right to inspect and/or obtain a copy of your records. A reasonable fee may be charged for copying. Access to your records may be limited or denied under certain circumstances, but in most cases you have a right to request a review of that decision. On your request, we will discuss with you the details of the request and denial process.

Right to Amend – You have the right to request in writing an amendment of your health information for as long as PHI/ePHI records are maintained. The request must identify which information is incorrect and include an explanation of why you think it should be amended. If the request is denied, a written explanation stating why will be provided to you. You may also make a statement disagreeing with the denial, which will be added to the information of the original request. If your original request is approved, we will make a reasonable effort to include the amended information in future disclosures. Amending a record does not mean that any portion of your health information will be deleted.

Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI/ePHI. If your health information is disclosed for any reason other than treatment, payment, or operation, you have the right to an accounting for each disclosure of the previous six (6) years. The accounting will include the date, name of person or entity, description of the information disclosed, the reason for disclosure, and other applicable information. If more than one (1) accounting is requested in a twelve (12) month period, a reasonable fee may be charged.

Electronic vs. Paper – If you received this notice electronically (e.g., accessing a website) you have the right to obtain a paper copy of the notice from the office upon request.

Duties of AMALYSSA J. JOHNSON, PH.D. :

Provider is required by law to maintain the privacy of PHI/ePHI and to provide you with this notice of legal duties and privacy practices.

AMALYSSA J. JOHNSON, PH.D. reserves the right to change the privacy policies and practices and terms of this Notice at any time, as permitted by applicable law. She reserves the right to make the changes in privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Unless we notify you of such changes, however, the office is required to abide by the terms currently in effect.

Provider is also required to notify you if there is a breach of your PHI/ePHI which would allow your clinical or financial information to be identified or compromised.

Questions and Complaints

For questions regarding this Notice of our Privacy Practices, or if you are concerned that your privacy rights may have been violated, please contact AMALYSSA J. JOHNSON, PH.D. . You may also make a written complaint to the US Department of Health and Human Services, whose address can be provided upon request. If you choose to make a complaint with the US Department of Health and Human Services, or with me, I will not retaliate in any way.

AMALYSSA J. JOHNSON, PH.D.
12946 Dairy Ashford, Suite 260
Sugar Land, Texas 77478
281-242-2595

AMALYSSA J. JOHNSON, PH.D.
Clinical Psychologist

CONSENT FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

In my notice of Privacy Practices, I provide you with information about how I can use or disclose your personal and health information. As described in my Notice of Privacy Practices, I request your consent for use or disclosure of mental health and medical information to carry out treatment, payment, or health care operations. You have a right to review my Notice of Privacy Practices before signing this Consent form.

By signing this Consent form, you: (1) Acknowledge that a copy of the Notice of Privacy Practices has been provided to you; and (2) Consent to our use and disclosure of your health information for treatment, payment, or health care operations, as described in the Notice of Privacy Practices.

You have the right to revoke this Consent in writing any time, except where we have already used or disclosed your health information in reliance upon this Consent.

I am required by law to notify you if there is a breach of your PHI/ePHI which would allow your clinical or financial information to be identified or compromised.

_____
Patient's Name (Printed)

_____ _____
Signature of Patient, Parent, or Legal Representative Date