Bray Wellness Counseling
Part of The Craniofacial and TMJ Institute

**Patient Contact Information** **Date:**

Name | DOB | Gender

Address | City | State

Email | Zip

Phone | Type | Can we leave message? ☐ Yes ☐ No

Employment | Occupation Type

**Emergency Contact Information** ☐ None

Name | DOB | Gender

Address | City | State

Phone | Zip

**Parent/Guardian/Spouse/Partner**
**(Must be complete if patient is under 18.)** ☐ **Not a minor nor need a guardian**

Name | Relationship

All information is the same as Patient above: ☐ Same as above

Address | City | State

Phone | Zip

**Physician/Primary Care Information** ☐ None

Name | Office

Address | City | State

Phone | Zip

☐ **Medical information can be shared with this physician if request by patient/office**

## Psychiatrist/ANRP/PMHNRP Information

☐ None

Name | Office

Address | City | State

Phone | Zip

☐ **Medical information can be shared with this physician if request by patient/office**

## Previous/Co-Current Therapist Information

☐ None

Name | Office

Address | City | State

Phone | Zip

☐ **Medical information can be shared with this physician if request by patient/office**

**Are you a patient of The Craniofacial and TMJ Institute?** ☐ Yes ☐ No

**Would you like information shared with The Craniofacial and TMJ Institute?** ☐ Yes ☐ No

List of current medication and/or vitamins (attach if needing more space)

## Patient History

List of current medication and/or vitamins (attach if needing more space)

Please check any of the following conditions you have had with your health

| | | | | |
|---|---|---|---|---|
| ☐ Anemia | ☐ Broken bones | ☐ Epilepsy | ☐ Jaw pain | ☐ Seizures |
| ☐ Allergies | ☐ Cancer | ☐ Head Injury | ☐ Kidney trouble | ☐ Sexual Dysfun |
| ☐ Arthritis | ☐ Chronic pain | ☐ Hepatitis | ☐ Migraines | ☐ Sinus trouble |
| ☐ Articicial joints | ☐ Convulsions | ☐ Hepatitis | ☐ Neck Pain | ☐ Tuberculosis |
| ☐ Asthma | ☐ Dermatitis | ☐ High blood pressure | ☐ Osteoporosis | ☐ Poor circulatio |
| ☐ Bladder trouble | ☐ Diabetes | ☐ Indigestion | ☐ Poor circulatio | |

Other

How would you describe your overall current health?

☐ Poor ☐ Unsatisfactory ☐ Good ☐ Satisfactory ☐ Very Good

Please check any of the following symptoms you have had:

| | | | |
|---|---|---|---|
| ☐ Anger | ☐ Experienced natural diaste | ☐ Jaw clenching | ☐ Past physical abuse |
| ☐ Anxiety | ☐ Fearful | ☐ Lack of concentration | ☐ Past sexual abus |
| ☐ Attention decrease | ☐ Feelings restless/on-edge | ☐ Loss of interest | ☐ Poor memory |
| ☐ Avoid crowds | ☐ Feelings of wothlessness | ☐ Mania | ☐ Relationship Issues |
| ☐ Brain fog | ☐ Financial problems | ☐ Mood swings | ☐ Ruminations |
| ☐ Childhood issues | ☐ Grief | ☐ Nausea | ☐ Sadness |
| ☐ Change in weight | ☐ Headaches | ☐ Neglect | ☐ Sleep changes |
| ☐ Crying | ☐ Hearing things | ☐ Nervous | ☐ Seeing things |
| ☐ Day dreaming | ☐ Hopeless | ☐ Nightmares | ☐ Self-inflected injuries |
| ☐ Depression | ☐ Hyperactivity | ☐ No interest | ☐ Self-inflected pain |
| ☐ Don't trust othe | ☐ Head Injury | ☐ No motivation | ☐ Suicide attemp |
| ☐ Drugs/alcohol | ☐ Increased heart rate | ☐ No sleep/insomnia | ☐ Uncontrolled laughing |
| ☐ Easily startled | ☐ Increased talking | ☐ Panic feeling/attacks | ☐ Unwanted thoughts |
| ☐ Eating issues | ☐ Irritable | ☐ Past childhood abuse | |

Other:

Please briefly describe your reason for seeking treatment today?

Rate the intensity of the problem (1 being mild and 5 being severe)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

When did the problem start?

☐ Within the last 30 days ☐ 6-12 months ☐ 1 - 4 years ☐ 5 years or more

☐ Adolescence 13-18yrs old ☐ Before 13yrs old ☐ Before 5yr old ☐ Unsure

How is the problem interfering with your day to day functioning?

If you could change one thing today what would it be?

What do you hope to achieve in therapy?

Have you tried to address the problem in the past? ☐ Yes ☐ No

If yes, what have you tried in the past?

How do you handle stress or stressors/cope in your daily life?

Do you know what causes your problem? List any known causes:

## Self-harm/Suicidal Ideation/Harming others

☐ None

Have you ever had thoughts of harming yourself or attempting suicide in the past?

☐ No ☐ Yes

Do you currently have thoughts of harming yourself or attempting suicide?

☐ No ☐ Yes

Have you ever attempted suicide?

☐ No ☐ Yes

Have you self-harmed in the past?

☐ No ☐ Yes

Do you thinking about harming someone besides your self?

☐ No ☐ Yes

Do you feel someone is trying to harm you?

☐ No ☐ Yes

## Past Diagnosis

☐ None

Have you been diagnosed with a mental health condition in the past?

☐ No ☐ Yes

## Family History

Martial Status

Please list other family members wither living in the household or are significant in patient's life?

| Name | Relationship | Age | Gender | Currently living with |
|---|---|---|---|---|
| | | | | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No |

Has a family member been diagnosed with a mental health condition in the past?

☐ No ☐ Yes

| Name | Relationship | Diagnoses |
|---|---|---|
| | | |
| | | |
| | | |

Has anyone in your family or friend attempted or completed suicide?

☐ No ☐ Yes

Do you feel anyone in your family had a narcissistic personality or traits?

☐ No ☐ Yes

Has anyone in your family been in rehabilitation or psychiatric placements?

☐ No ☐ Yes

Do you feel your family is supportive of you in therapy?

☐ No ☐ Yes

Any family history that is important for therapist to know?

☐ No ☐ Yes

Do you feel safe in your home?

☐ No ☐ Yes

Do you have any cultural or religious beliefs that are important for us to be aware of?

☐ No ☐ Yes

☐ **I have complete all information above & agree that all I have provided is truthful and accurate.**

Patient Signature/Electronic Signature

Date

**Patient agreement**

**CONSENT TO TREAT**

I, _____ give my permission and consent to Bray Wellness Counseling to provide me or the person under my guardianship psychotherapeutic treatment to _____.

While Bray Wellness will endeavor to provide you with standard of care treatment, I fully understand that because of factors beyond Bray Wellness's control, particular outcomes cannot be guaranteed. Furthermore, I understand the I/he/she/we may experience emotional strains because of the counseling or therapy, feel worse during the treatment and make life changes which could be difficult.

I understand that Bray Wellness is not providing emergency services, and I have been informed of whom to call upon in an emergency or during such time as treatment from Bray Wellness is unavailable.

I understand that regular attendance as recommended by Bray Wellness will facilitate maximum therapeutic benefits, but that I/we am/are free to discontinue treatment at any time. If I decide to do so I will notify Bray Wellness at least two weeks in advance so that effective planning for continuing care can be implemented.

☐ **I agree and consent to treatment with Kristie Bray, LPCC.**

| | |
|---|---|
| | |
| Patient Signature/Electronic Signature | Date |

**Insurance**

I understand that Bray Wellness Counseling is a fee for service physical therapy provider and Bray Wellness Counseling will **not** bill my insurance company directly. Further, I understand that I am responsible for asking for an itemized receipt from Bray Wellness Counseling which I may provide to my insurance company, if I have insurance. I understand that I am considered a ***self pay patient*** and I am financially responsible for the total amount of the services provided. Bray Wellness Counseling does not verify insurance coverage prior to providing services and does not guarantee reimbursement for services from my insurance company.

_____ (initials)

**Appointments/Cancellations**

Bray Wellness Counseling requires 24 hours notification of cancellations and/or reschedule. In the event I cancel a regularly scheduled appointment with less than 24 hours notice I am responsible for a cancellation fee, $25. If I am not present or available (no show) for a scheduled appointment I will incur a full session fee, $80. If there are 3 consecutive lapses in scheduled attendance I may be removed from the therapist's schedule & will have terminated this agreement.

_____ (initials)

**Payment**

I understand that I am considered a ***self pay patient*** and am responsible for payment at the time of service. Billing will appear on my credit card or debit under the name of *Bluegrass Doctors of Physical Therapy or TMJ Institute.* I understand the cost of session are $80.*

_____(initials)

At Bray Wellness Counseling we highly recommend keeping your credit or debit card on file as a convenient method of payment. Your credit card information is kept confidential and secure and payments to your card are processed the day of your session.

I _____ authorize Bray Wellness Counseling to charge the portion of my bill to the following credit or debit card:

Account Type: Credit Card #: _____ Expiration Date _____

CVV _____ Address Numbers only _____ Zip Code _____

☐ **I agree to have my card on file and be charged the day of service. I agree to the cancelation terms an**

_____ _____

Patient Signature/Electronic Signature Date

☐ **I do not want my card on file.**

**Other Information**

I understand I may also be charged for therapy products, educational materials and for other administrative expenses, including copies of medical records past the one copy I am entitled, & that I will be notified of these charges at the time of service. I understand that Bray Wellness is part of The Craniofacial and TMJ Institute and only uses Bray Wellness Counseling to differentiate patients schedule and needs.

_____(initials)

**PATIENT'S SIGNATURE**

This agreement must be signed by Bray Wellness patient/Patient unless the patient/Patient is a minor, incompetent, or physically incapable of signing. I have read and fully understand the content of this Patient Agreement and hereby agree to and authorize the foregoing provisions.

As used in this document, the terms "I', "me" and "my" refer to and include, in addition to the undersigned, the patient/Patient named above and others for whom the undersigned is responsible or for whom the undersigned has assumed responsibility in engaging Bray Wellness Counseling to provide services to the patient/Patient.

☐ **By signing this agreement, I acknowledge that I have read, understand and agree to the above terms**

_____ _____

Patient Signature/Electronic Signature Date

**Confidentiality Agreement**

**Please read all carefully**

**Privacy Notice Acknowledgement**

I understand that Bray Wellness Counseling will maintain my privacy to the highest standards and may use or disclose my health information for the sole purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment and/or payment**.**

_____(initials)

**LIMITS OF CONFIDENTIALITY**

The contents of counseling, intake and/or assessment sessions are confidential. Both verbal information and written records about a Patient cannot be shared with another party without the written consent of the Patient or the Patient's legal guardian, except as required by law. It is the policy of this center not to release any information about a Patient without a signed release of information, or as otherwise required by law. Noted exceptions are as follows:

**DUTY TO WARN AND PROTECT**

When a Patient discloses intentions or a plan to harm another person, Bray Wellness is required by law to warn the intended victim and report identifying information to legal authorities. In cases in which the Patient discloses or implies a plan for suicide, Bray Wellness is required to notify legal authorities and make reasonable attempts to notify the family of the Patient.

**ABUSE OF CHILDREN AND VULNERABLE ADULTS**

If a Patient discloses or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult); or a child (or vulnerable adult) is in danger of abuse, Bray Wellness is required to report this information to the appropriate social service and/or legal authorities.

**PRENATAL EXPOSURE TO CONTROLLED SUBSTANCES**

Bray Wellness is required by law to report admitted prenatal exposure to controlled substances that are potentially harmful.

**IN THE EVENT OF A PATIENT'S DEATH**

In the event of a Patient's death, the spouse or parents of a deceased Patient have a right to access a Patient's treatment records.

**PROFESSIONAL MISCONDUCT**

Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

**COURT ORDERS**

Health care professionals are required to release records of Patients when a court order has been entered.

**MINORS/GUARDIANSHIP**

Parents or legal guardians of non-emancipated minor Patients have the right to access the Patient's records.

**Communication**
In the event Bray Wellness must telephone or e-mail the Patient for purposes such as appointments, cancellations or reminders or to give or receive other information, efforts are made to preserve confidentiality. Please state on page 1 where we may reach you by phone and/or e-mail and if you would like us to identify ourselves other than Bray Wellness how you would like us to identify ourselves. For example, you might request that when we phone you at home or work, we do not say the name of the clinic or the nature of the call, but rather the mental health professional's first name only.

If this information is not provided to us (below) we will adhere to the following procedures when making phone calls: First we will ask to speak to the Patient (or guardian) without identifying the name of the clinic. If the person answering the phone asks for more identifying information we will say that this is a personal call. We will not identify the clinic to protect confidentiality. If we reach an answering machine or voice mail we will follow the same guidelines.

☐ **I AGREE TO THE ABOVE LIMITS OF CONFIDENTIALITY AND UNDERSTAND THEIR MEA**

Patient Signature/Electronic Signature

Date

Patients Guardian/Parent Signature/Electronic Signature