ADULT INTAKE PACKET

INFORMED CONSENT FOR THERAPY SERVICES

Welcome to the Anxiety Treatment Center, LLC. In this packet, you will find a number of questionnaires that will help us to learn more about you and your symptoms.

About The Anxiety Treatment Center, LLC

We specialize in cognitive behavioral therapy, or CBT, which is proven to be an effective treatment for many psychological problems including anxiety-related and mood-related symptoms. This form of treatment focuses on teaching new skills and behaviors, helping you practice those skills in a variety of situations, learning healthier ways of coping with stressful situations, increasing awareness of the way you think in critical situations, and helping you make changes in your thinking patterns. Repeated studies have shown that CBT leads to reduction of symptoms, enhanced quality of life, and positive changes in brain functioning.

CBT differs from other forms of psychological therapy in several ways. First, CBT is a collaborative and active therapy, meaning that you and your treatment provider will work together toward reducing your symptoms. Therefore, what is discussed and learned in treatment sessions is intended to be practiced outside of those sessions. By learning to apply new skills in everyday life, significant changes are more likely to occur. Second, whereas some other treatments focus on understanding the reasons behind your symptoms, CBT focuses on how you are thinking, behaving, and communicating presently and emphasizes learning how to reduce and manage your symptoms. Third, CBT is designed to be time-limited rather than ongoing like some other forms of therapy.

Your first visit will consist of a thorough assessment of your problems. This is done in order to make sure that you receive the right kind of treatment and to assist in developing an individualized treatment plan. You will work with your treatment provider to identify specific goals during the evaluation phase. These goals can be modified as you continue. After the assessment, your provider will recommend a course of treatment. You should evaluate this information and decide if you feel comfortable working with the treatment provider. If you have questions about your provider's procedures, you are encouraged to discuss them whenever they arise.

We want you to know as much as possible about your condition and the treatment you are receiving. Your treatment provider will share information, but you are also encouraged to ask questions such as: What is the name of my condition? How common is it? What kinds of treatment are available for this condition? What evidence is there to show that this treatment will be helpful? We believe that people who are well informed will make the best choices and will benefit the most from treatment. If you have any unanswered questions about any of the procedures used in the course of your treatment, please do not hesitate to ask for clarification. We wish you a productive experience and hope that the time you spend with us results in changes that are positive, meaningful, and long-lasting.

If you are unhappy with what is happening in therapy, we encourage you to talk with your treatment provider so that he/she can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that the provider refer you to another clinician and you are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about the treatment provider's specific training and experience.

Risks & Benefits of Treatment

In general, there is little risk participating in CBT. But, because the process of therapy often requires exploring unpleasant feelings, emotions, and experiences you are likely to experience uncomfortable feelings, such as worry, anger, frustration, sadness, guilt, and/or helplessness. These feelings may be more frequent and intense during the early stages of treatment and will likely lessen and become more tolerable as treatment progresses. You may also be encouraged to confront situations you would rather avoid, which can lead to temporary stress or anxiety. There is always a risk that your symptoms will return. If they do, your CBT skills should make it easier for you to manage them. So, it is important to keep practicing the skills, even after you feel better.

CBT has been shown to have benefits for those who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, and improved skills for managing stress and resolving specific problems. CBT requires active effort and is most effective when you are motivated and engage in the assigned home activities between sessions.

Professional Records

We are required to keep appropriate records of the psychological services that we provide. Records are maintained in a secure location in the office. We keep brief records noting the reasons for seeking therapy, diagnoses, medical, social, and treatment history, session dates, treatment goals and progress, topics discussed in treatment sessions, records we receive from other providers, copies of records we send to others, and billing records. You have the right to a copy of your file upon request. Because these are professional records, they may be misinterpreted by untrained readers. For this reason, we recommend that you initially review them with your treatment provider, or have them forwarded to another mental health professional to discuss the contents. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

Confidentiality

All of the information that you provide to us, whether verbal or written, is considered confidential by state law and by the ethical principles of the American Psychological Association, and cannot be shared with other parties without your written permission. The exceptions to this rule are if there is an immediate risk of harm to you or to others, or if your records are subpoenaed by a court of law. If you choose to communicate with us via email, please be aware that it is not considered a secure form of communication, and the confidentiality of any information sent via email cannot be guaranteed. If your treatment provider is working under supervision, the provider will discuss your case with his/her supervisor. More information about your privacy rights is detailed in the Notice of Privacy Practices.

Contacting Us

Our treatment providers are often not immediately available by telephone. We do not answer our telephones when we are with clients or outside of our individual office hours. At these times, you may leave a message on your provider's confidential voice mail and your call will be returned as soon as possible. If, for any unforeseen reason, you do not hear from your provider or your provider is unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe, 1) call 211 and press 1 to access a 24-hour-a-day crisis intervention and support service or 2) call 911 or go to your local hospital's Emergency Room. Our providers make every attempt to inform clients in advance of planned absences.

Child Care

We regret that our staff cannot provide child care. Therefore, if you have young children who are not clients at the Anxiety Treatment Center, LLC, please arrange to have someone care for them during your appointment.

If you have any additional questions about the Anxiety Treatment Center, LLC, CBT, or other issues, please ask your treatment provider.

Please sign below to indicate that you have read and agree to the above information and consent to the procedures described above:

_____ _____

Client's Signature Date

Please sign below to indicate that you have received a copy of our Privacy Policy:

_____ _____

Client's Signature Date

The purpose of this packet is to help us get more information about you and your concerns. Please answer all of these questions to the best of your ability. If you do not understand a question, please circle it and ask your clinician about it.

DEMOGRAPHIC INFORMATION

Name: _____ Age: _____ Date of Birth:_____

How do you describe your racial or ethnic identification?

- ☐ Native American or Alaska Native
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Asian
- ☐ White, not of Hispanic origin
- ☐ Native Hawaiian or Pacific Islander
- ☐ Other: _____

Assigned Sex at Birth: ☐ Male ☐ Female

Gender Identity: ☐ Male ☐ Female ☐ Transgender

☐ Other: _____

PRESENTING PROBLEM(S)

Please tell us about the problem(s) for which you are seeking help.

_____

_____

_____

_____

_____

How old were you when the problem(s) began? _____

How long have you been experiencing the problem(s)?

☐ 1 month or less ☐ 1 – 6 months ☐ 6 months – 1 year
☐ 1 – 5 years ☐ 5 – 10 years ☐ More than 10 years

What made you seek treatment at this time?

_____

_____

What have you done to cope? Has it been helpful?

_____

_____

What are your treatment goals?

_____

_____

_____

CGI SELF RATING

<u>Over the past week</u>, how severe is the problem for which you are seeking help? (Circle one)

1	2	3	4	5	6	7
Normal, there is no problem	Borderline problem	Mild problem	Moderate problem	Marked problem	Severe problem	Extreme problem

SHEEHAN INVENTORY

For each area, circle the number that best describes your situation now.

WORK: Because of my problems, my work is impaired:

0	1	2	3	4	5	6	7	8	9	10
Not at All	A little			Somewhat			A lot			Very Severely (cannot go to work)

SOCIAL LIFE/LEISURE ACTIVITIES (with other people at parties, socializing, visiting, dating, outings, clubs, entertaining): Because of my problems, my social life is impaired:

0	1	2	3	4	5	6	7	8	9	10
Not at All	A little			Somewhat			A lot			Very Severely (I never do these)

FAMILY LIFE/HOME RESPONSIBILITIES (relating to family members, paying bills, managing home, shopping, and cleaning): Because of my problems, my family life/home responsibilities are impaired:

0	1	2	3	4	5	6	7	8	9	10
Not at All	A little			Somewhat			A lot			Very Severely (I never do these)

RISK ASSESSMENT

1. Have you ever had feelings or thoughts that you did not want to live? ☐ Yes ☐ No

If YES, please answer the following. If NO, please skip to the next question.

How often do you have these feelings? _____

When was the last time you had thoughts of dying? _____

Has anything happened recently to make you feel this way? ☐ Yes ☐ No

If YES, please describe: _____

Do you currently feel that you do not want to live? ☐ Yes ☐ No

Have you ever tried to kill or harm yourself before? ☐ Yes ☐ No

2. Have you ever hurt your body (e.g., cut, carve, burn, scratch really hard, punch) on purpose but without wanting to end your life? ☐ Yes ☐ No

If YES, please answer the following. If NO, please skip to the next question.

When was the last time you intentionally hurt yourself? _____

Approximately on how many total occasions have you intentionally hurt yourself? _____

How old were you the first time you intentionally hurt yourself? _____

On what areas of your body have you intentionally hurt yourself? _____

What did you do to hurt yourself? _____

3. Have you ever had feelings or thoughts of hurting or harming someone else?

☐ Yes ☐ No

If YES, please describe: _____

4. Have you ever been or are you currently involved with the legal system? ☐ Yes ☐ No

If YES, please describe: _____

5. Have you ever been abused? (check all that apply)

☐ Verbally ☐ Physically ☐ Emotionally ☐ Sexually ☐ Neglected

6. Have you ever experienced a traumatic event?

☐ Yes ☐ No

Examples include, but are not limited to: Natural disaster, Serious accident/injury, Combat or being in a combat zone, Life-threatening illness, Accidental death, murder, or suicide of close friend or family member, Aggravated assault, Being beaten or witnessing severe violence, Rape or attempted rape.

TREATMENT HISTORY

Have you seen a counselor, psychologist, psychiatrist, or other mental health professional before? ☐ Yes ☐ No

If YES, please list all outpatient psychologists, psychiatrists, counselors, or other mental health professionals that you have had.

Dates of Treatment	Provider's Name	Reason	Treatment Received (check all that apply)
			☐ Therapy ☐ Medication
			☐ Therapy ☐ Medication
			☐ Therapy ☐ Medication
			☐ Therapy ☐ Medication

Have you ever been hospitalized for psychiatric reasons? ☐ Yes ☐ No

If YES, please list all inpatient psychiatric hospitalizations.

Dates	Hospital	Reason

Please list all medications you are currently taking.

Medication	Dosage	Date Started	Prescribing Physician	Problems Addressed

HEALTH HISTORY

Sleep

Average hours of sleep per night: _____

Please check any sleep problems that you have experienced in the past month:

☐ Difficulty falling asleep ☐ Difficulty getting out of bed

☐ Difficulty staying asleep ☐ Not feeling rested in the morning

Appetite/Eating

Have you experienced any changes in your eating or appetite? ☐ Yes ☐ No

If YES, please describe: _____

Do you worry a lot about your weight? ☐ Yes ☐ No

Please check any behaviors that you have engaged in during the past month:

☐ Difficulty controlling your eating ☐ Binging/Eating a lot of food at one time

☐ Dieting, using medications or laxatives, exercising a lot, or vomiting to control your weight/avoid weight gain

How many caffeinated beverages do you drink per day? **Coffee** _____ **Soda** _____ **Tea** _____

Exercise

Do you exercise? ☐ Yes ☐ No

How many days per week do you exercise? _____

What kind of exercise do you do? _____

_____

Substance Use

Do you drink alcohol? ☐ Yes ☐ No
If YES, *how much* and *how often* do you drink? _____

Do you use tobacco products? ☐ Yes ☐ No
If YES, *how often* do you use tobacco products? _____

Do you use other substances? ☐ Yes ☐ No
If YES, please complete table below.

Other Substances:

Drug	Ever Used?	Age at 1st Use	Date of Last Use	Approx. Use in Past 30 days
Marijuana				
Pain Killers (not as prescribed)				
Cocaine				
Heroin				
Methamphetamine				
LSD or Hallucinogens				
Ecstasy				
Other: _____				
Other: _____				

Have you ever been treated for alcohol or drug use/abuse? ☐ Yes ☐ No
If YES, for which substances? _____

Have you ever felt that you ought to cut down on your drinking or drug use? ☐ Yes ☐ No

Medical History

Do you have any known health problems? ☐ Yes ☐ No

If YES, please list, include treatment.

_____

_____

_____

Family Medical History

Do medical illnesses run in your family? ☐ Yes ☐ No

If YES, please list. Include medical issue, person(s) affected, and treatment(s).

_____

_____

_____

Family Psychiatric History

Has anyone in your family been diagnosed with or treated for a mental health problem?
☐ Yes ☐ No

If YES, please list. Include diagnosis/mental health issue, person(s) affected, and treatment(s).

_____

_____

_____

SOCIAL HISTORY

Relationship Status: ☐ Single ☐ Married/Domestic Partnership
☐ Living Together ☐ Divorced or Separated
☐ Widowed ☐ Other: _____
How long? _____

If not married, are you currently in a relationship? ☐ Yes ☐ No

If YES, how long? _____

Sexual Orientation: ☐ Heterosexual/Straight ☐ Gay or Lesbian ☐ Bisexual
☐ Unsure/Questioning ☐ Other: _____

Do you have children? ☐ Yes ☐ No

If YES, provide gender and age for each child:

_____ _____ _____

_____ _____ _____

Do you consider yourself as belonging to any particular religion or spiritual group?

☐ Yes ☐ No If YES, which one? _____

What is your level of involvement? _____

Do you find your involvement helpful for your presenting concerns, or does your involvement make things more stressful for you? ☐ Helpful ☐ Stressful

EDUCATION/WORK HISTORY

Education

Highest grade level completed:

☐ Some High School ☐ High School Graduate ☐ Associates Degree/Some College
☐ Bachelor's Degree ☐ Master's Degree ☐ Ph.D., M.D., or equivalent

Have you served in the military? ☐ Yes ☐ No
If YES, briefly describe: _____

Employment

Employment Status: ☐ Full-time ☐ Part-time ☐ On Disability
☐ Student ☐ Retired ☐ Unemployed

Employer's Name: _____ Occupation:_____

How long have you been with your current employer? _____

SCREENING QUESTIONNAIRE

This form will ask you about problems that you may have had. Please respond to each question by circling “Yes,” “No,” or “Maybe/Unsure.”

	CIRCLE ONE:		
PD: Do you have times when you feel a sudden rush of intense fear or discomfort?	YES	NO	MAYBE/UNSURE
AG: Do you feel panicky in any situations or avoid them because you might feel panicky?	YES	NO	MAYBE/UNSURE
AG: Are you apprehensive about entering situations due to the fear that you may develop such symptoms as diarrhea, vomiting, dizziness, etc.?	YES	NO	MAYBE/UNSURE
SoP: In social situations where you might be observed or evaluated by others or when you are meeting new people, do you feel fearful, anxious, or nervous?	YES	NO	MAYBE/UNSURE
SP: Are you overly concerned that you may do and/or say something that might embarrass or humiliate yourself in front of others, or that others may think badly of you?	YES	NO	MAYBE/UNSURE
GAD: Over the last several months, have you been continually worried or anxious about a number of events or activities in your daily life?	YES	NO	MAYBE/UNSURE
OCD: Are you bothered by thoughts, images, or impulses that keep recurring to you that seem inappropriate or nonsensical but that you can’t stop from coming into your mind?	YES	NO	MAYBE/UNSURE
OCD: Do you feel driven to repeat some behavior or to repeat something in your mind over and over again to try to feel less uncomfortable?	YES	NO	MAYBE/UNSURE
SpP: Do you fear or feel a need to avoid such things as flying, seeing blood, getting a shot, heights, closed places, or certain kinds of animals or insects?	YES	NO	MAYBE/UNSURE
MDE: Have you ever experienced a period of two weeks or more when you felt depressed, sad, empty, or lost interest or pleasure in your usual activities?	YES	NO	MAYBE/UNSURE
DyD: Over the past two years, have you frequently had days where you felt down, blue, or depressed for most of the day?	YES	NO	MAYBE/UNSURE

MaE: Have you ever experienced a period of several days or more when you felt unusually or excessively high or irritable?	YES	NO	MAYBE/UNSURE
Hyp: Over the last several months, have you continually feared or believed that you might have a serious physical disease or illness?	YES	NO	MAYBE/UNSURE
Som: Have you had a lot of physical problems in your life?	YES	NO	MAYBE/UNSURE
MixAD: Do you often have days when you feel somewhat down or depressed or maybe anxious or keyed up?	YES	NO	MAYBE/UNSURE
Conv: Have you ever experienced a loss or change in your physical functioning such as paralysis, seizures, or severe pain?	YES	NO	MAYBE/UNSURE
Psy: Has there ever been a period of time when you had strange or unusual experiences such as hearing or seeing things that other people didn't notice, hearing voices when no one was around, or seeing visions that no one else saw?	YES	NO	MAYBE/UNSURE
Psy: Has there ever been a period of time when you had the feeling that something odd was going on around you, that people were doing things to test you or antagonize or hurt you so that you felt you had to be on guard constantly?	YES	NO	MAYBE/UNSURE

DASS

Please read each statement and circle a number 0, 1, 2 or 3 that indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

Rating Scale: 0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree, or a good part of time
3 Applied to me very much, or most of the time

1	I found myself getting upset by quite trivial things.	0 1 2 3
2	I was aware of dryness of my mouth.	0 1 2 3
3	I couldn't seem to experience any positive feeling at all.	0 1 2 3
4	I experienced breathing difficulty (e.g., excessively rapid breathing, breathlessness in the absence of physical exertion).	0 1 2 3
5	I just couldn't seem to get going.	0 1 2 3
6	I tended to over-react to situations.	0 1 2 3
7	I had a feeling of shakiness (eg, legs going to give way).	0 1 2 3
8	I found it difficult to relax.	0 1 2 3
9	I found myself in situations that made me so anxious I was most relieved when they ended.	0 1 2 3
10	I felt that I had nothing to look forward to.	0 1 2 3
11	I found myself getting upset rather easily.	0 1 2 3
12	I felt that I was using a lot of nervous energy.	0 1 2 3
13	I felt sad and depressed.	0 1 2 3
14	I found myself getting impatient when I was delayed in any way (e.g., elevators, traffic lights, being kept waiting).	0 1 2 3
15	I had a feeling of faintness.	0 1 2 3

Rating Scale: 0 Did not apply to me at all 1 Applied to me to some degree, or some of the time 2 Applied to me to a considerable degree, or a good part of time 3 Applied to me very much, or most of the time		
16	I felt that I had lost interest in just about everything.	0 1 2 3
17	I felt I wasn't worth much as a person.	0 1 2 3
18	I felt that I was rather touchy.	0 1 2 3
19	I perspired noticeably (eg, hands sweaty) in the absence of high temperatures or physical exertion.	0 1 2 3
20	I felt scared without any good reason.	0 1 2 3
21	I felt that life wasn't worthwhile.	0 1 2 3
22	I found it hard to wind down.	0 1 2 3
23	I had difficulty in swallowing.	0 1 2 3
24	I couldn't seem to get any enjoyment out of the things I did.	0 1 2 3
25	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat).	0 1 2 3
26	I felt down-hearted and blue.	0 1 2 3
27	I found that I was very irritable.	0 1 2 3
28	I felt I was close to panic.	0 1 2 3
29	I found it hard to calm down after something upset me.	0 1 2 3
30	I feared that I would be "thrown" by some trivial but unfamiliar task.	0 1 2 3
31	I was unable to become enthusiastic about anything.	0 1 2 3
32	I found it difficult to tolerate interruptions to what I was doing.	0 1 2 3
33	I was in a state of nervous tension.	0 1 2 3

Rating Scale: 0 Did not apply to me at all 1 Applied to me to some degree, or some of the time 2 Applied to me to a considerable degree, or a good part of time 3 Applied to me very much, or most of the time		
34	I felt I was pretty worthless.	0 1 2 3
35	I was intolerant of anything that kept me from getting on with what I was doing.	0 1 2 3
36	I felt terrified.	0 1 2 3
37	I could see nothing in the future to be hopeful about.	0 1 2 3
38	I felt that life was meaningless.	0 1 2 3
39	I found myself getting agitated.	0 1 2 3
40	I was worried about situations in which I might panic and make a fool of myself.	0 1 2 3
41	I experienced trembling (eg, in the hands).	0 1 2 3
42	I found it difficult to work up the initiative to do things.	0 1 2 3