Andrea Van Steenhouse, Ph.D.
1599 South Uinta Way
Denver, CO 80231
(303) 731-6658
(303) 671-5200 (fax)
vansteenhouse@gmail.com

Name____

Address____

City_____________________________________State___________Zip_________

*Home Phone ______/___________ Work Phone______/_________ Cellular Phone ______/______________

Birth Date _________________ Age______________________ Marital Status _____________________

Social Security: _______________ Religion__________________ Email ____________________________

Name of those living in household | Relation to you | Age | Religion

____
____
____
____

Names and ages of children not living with you:

______________________________ _____
______________________________ _____
______________________________ _____
______________________________ _____

Employer____Occupation______________________________________

Address____City___________State____Zip________

Spouse's Employer____ Occupation______________________________________

Address____City__________State_____Zip_________SS______________

Name of Insured___________________________ Insured's I.D. #___________________ Insured's Date of Birth ____________

Health Insurance Co____ Phone___________________________

Insurance Co Address____City_____________State_____Zip ______________

Insured's Policy Group # _________________________ Insurance Plan Name or Program Name __________________________

Is there another Health Benefit Plan? Yes (pls provide Ins. Policy Name & Group #____________________________ No

How did you learn of our practice? ____

Have you had previous counseling/therapy? ____With Whom?______________When____________________________________

Are you currently in therapy? ______With whom? ____

Briefly describe the difficulties for which you are seeking help:
*Please indicate your preferred telephone contact number.

Medical History Questionnaire

Current Health — On a scale of 1 (very poor) to 10 (excellent) how would you rate your present health?

(circle one) 1 2 3 4 5 6 7 8 9 10

Who is your Primary Care Physician: ______________________________

Most Recent Physical Examination Date______________ Physician__________________________

Chronic and/or Acute Physical Problems or Other Medical Concerns? Please explain.

Drug Use: What prescription medications are you currently taking and why?

What non-prescription medications are you currently taking and why?

Describe your alcohol consumption: What kind____________________________

How frequently________________________

How much____________________________

Has it changed recently?________________

If you have ever tried any of the following drugs, please explain use:

Amphetamines ______________________________

Marijuana ______________________________

Cocaine ______________________________

Others ______________________________

Health of Family Members

Family Member	Age	Health	Date/Cause of Death
FATHER	________	________	________________________
MOTHER	________	________	________________________
SISTER(S)	________	________	________________________
	________	________	________________________
BROTHER(S)	________	________	________________________
	________	________	________________________

Mental Health Questionnaire

Please answer each of the questions below by circling the appropriate number or response appearing at the right side of the page. Each of the items should be answered according to how you currently feel.

	Poor(ly)				Very well/good
How well are you sleeping	1	2	3	4	5
How would you describe your energy level	1	2	3	4	5
How well do you cope with unforeseen problems	1	2	3	4	5
Do you find yourself checking things over and over	1	2	3	4	5
How high is your current level of stress	1	2	3	4	5 (high)
	Hopeless				Very bright
How does your future look to you?	1	2	3	4	5
	Very low				Very high
How motivated are you to finish project?	1	2	3	4	5
	Sad				Happy
How would you describe your recent mood?	1	2	3	4	5
	Disappointed				Satisfied
How do you generally feel about yourself?	1	2	3	4	5
How satisfied are you with your current weight?	1	2	3	4	5
Does your weight affect your relationships? How?	Yes		No		
Has your sleep pattern changed recently?	Yes		No		
Do you worry a great deal?	Yes		No		
Have you been very nervous or anxious recently?	Yes		No		
How would you describe your relationship with:	Poor				Excellent
Your spouse (or significant other)	1	2	3	4	5
Your family	1	2	3	4	5
Your friends	1	2	3	4	5
Are you sexually active?	Yes		No		
How comfortable are you with sexual intimacy?	Not at all				Very
	1	2	3	4	5
Do you eat when you are upset or sad?	Yes		No		
Is there any history of sexual abuse in your family?	Yes		No		
Do you have any trouble concentrating	Yes		No		
Do you have any trouble making decisions?	Yes		No		
Do you have any trouble remembering things?	Yes		No		
	Upset				Accepting
How do you feel about getting older?	1	2	3	4	5

Client Agreement Form

Fee Payment Fees are payable at the time of service. Returned check charge is $20.00

Insurance We will provide you with a statement that you can submit to your insurance company. Or upon your request, we will provide a statement at the end of the year for income tax purposes. Clients agree to pay the full amount of their fees at the time of service.

Cancellations It is our policy to charge in full if you choose to cancel less than **72 hours** prior to a scheduled appointment.

Additional Fees

Telephone Calls There is no charge for brief calls of a business nature. Calls lasting longer than five minutes, however, are charged at the hourly rate

Reports Requests are occasionally received from insurance companies, attorneys, and physicians for written reports related to psychotherapy. These requests can be filled one if the client signs a Release of Information form. Unless the reports are very brief, a charge based on the hourly rate is made for this service.

Consultations Consultations with other individuals, as requested by the client, (i.e., your physician, attorney, schools) are billed at the hourly rate

Legal Proceedings:

If I am required to testify in court in a legal proceeding relating to your treatment, the hourly rate is $250.00 per hour. The charge begins upon arrival at the courthouse and ends upon departure from the courthouse. Travel time to and from court is billed at $100 per hour. Time spent in a deposition is billed at $250 per hour. Preparation time for depositions is charged at the regular hourly rate.

Confidentiality

I will keep the content of your sessions confidential unless certain conditions arise. If a client is a serious danger to self or others, or gravely disabled, I must warn and protect the people at risk. Similarly, if a client reveals circumstances of child abuse, this must be reported to the proper authorities. Under all other conditions, except consultation with a colleague, I must have your written consent to reveal information.

By signing this agreement, I acknowledge that I have read this agreement, understood its terms, and agree to be subject to its provisions.

Signature Date

___________________________________ ________________________

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The Colorado Legislature has enacted House Bill 1026 which regulates the practice of many mental health professions. The law specifies that certain information must be disclosed to all patients.

Degrees:	BA	San Jose State University
	MA	Central Michigan University
	Ph.D.	Michigan State University

Licensure: Colorado #656

Patient Rights:

You are entitled to receive information about methods of therapy, techniques used, expected duration of therapy if known, and fee structure.

You should understand that information provided by you during therapy is legally confidential in the case of psychologists. There are exceptions which will be identified and can be discussed should any such situations arise.

You are encouraged to ask me questions and to tell me about any concerns or complaints you may have regarding my practice.

You may seek a second option from another therapist or terminate treatment at any time.

Sexual intimacy is never appropriate in psychotherapeutic relationships and should be reported to the Grievance Board, as discussed below.

I am a member of the Red Cross Local and National Disaster Team and may occasionally be called for a two-week assignment, usually with very little notice. I will do my best to be available for telephone consultation in my absence and will also have a therapist on call.

The Colorado State Department of Regulatory Agencies regulates the practice of both licensed and unlicensed persons in the field of psychotherapy. Should you need to pursue questions, concerns, or complaints beyond our discussion, regarding the practice of mental health treatment, you can contact the State Board at the address and telephone number listed below:

1560 Broadway, Suite 1340
Denver, CO 80203
(303) 894-7766

Andrea Van Steenhouse, Ph.D.

I have received and read a copy of this Disclosure form.

Signed:____ **Date**: __________________