Martha Austin White, LCSW

103 Continental Place, Suite 120 / Brentwood, TN. 37027 / Phone: 615.294.7348
EMAIL: Martha@MarthaAustinWhite.com

Demographics

Name:_____ Date: _____

Address: _____

Phone: (H) _____ (C) _____ (W) _____

Email: _____ Method of contact: **Phone** or **Email** (circle one)

Age: _____ DOB: _____ Religious Affiliation: _____

Employer: _____ Occupation: _____

Marital Status: (circle one) **Single** **Married** (years married ___) **Divorced** **Widowed**

Children:	Name	Age
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____

Referred by: _____

Previous Counseling

Previous Counseling? Yes No Who and When? _____

Release of information signed to talk with previous counselors? Yes No

Medical/Mental Health Information

What, if any, medical health problems do you have? _____

Physician _____ Current Medications _____

Are you on disability? _____ Please describe _____

Are you currently taking medication for a mental or emotional condition? _____

Please list conditions and medications: _____

_____

Have you ever been hospitalized for a mental or emotional condition? _____

If so, please list where and when: _____

_____

Do you currently use any alcohol or drugs? _____ If yes, what is your substance of choice?

_____

Are you in treatment? (such as outpatient) or utilizing support groups (such as AA)? _____

If yes, please describe: _____

Reasons for seeking counseling:

_____

_____

_____

_____

Emergency contact information:

Name _____

Relationship: _____ **Phone:** _____

Client Signature: _____ **Date:** _____

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Identification Information

Name: _____ Age: _____ DOB: _____

Address: _____ Telephone: _____ →

City: _____ State: _____ Zip: _____

Email: _____

Is it O.K. to contact you at this number?

Yes No

PRESENT PSYCHOLOGICAL STATUS

Please describe your reason for seeking help		_____ _____
❑ Yes	❑ No	Have you ever seen a counselor or mental health worker before?
		Why were you seeking help?
❑ Yes	❑ No	Was the counseling beneficial?
		Who was the counselor?
❑ Yes	❑ No	Have you ever experienced what some people refer to as a "nervous breakdown?"
❑ Yes	❑ No	Have you ever been hospitalized for any emotional or psychological difficulties?
		What was the concern?
❑ Yes	❑ No	Does anyone in your family have emotional or psychological problems?
❑ Yes	❑ No	Is there anything currently bothering you or causing you to worry?
❑ Yes	❑ No	Are you having disturbances or difficulty with your sleep?
❑ Yes	❑ No	Have you experienced any changes in appetite recently?
❑ Yes	❑ No	Have there been any sudden changes with your weight?
❑ Yes	❑ No	Do you have any health problems (diabetes, heart problems, etc)?
❑ Yes	❑ No	Do you experience times when your heart races and you become short of breath?
❑ Yes	❑ No	Are you having headaches or migraines?
❑ Yes	❑ No	Are you experiencing any stomach problems?
❑ Yes	❑ No	Do you have any problems with depression?
❑ Yes	❑ No	Any suicidal thoughts or attempts? (past or present)
❑ Yes	❑ No	Do you have any unwanted thoughts that you can not seem to get rid of?
❑ Yes	❑ No	Any problems related to thinking, concentrating, or memory?
❑ Short ❑ Medium ❑ Long		How would you rate your temper (fuse)?

FAMILY AND PERSONAL DEMOGRAPHICS

Spouse/Significant Other Name: _____ Age: _____

(If married) Spouse's age at marriage: _____ Occupation: _____

❑ Yes	❑ No	Has your partner been married previously?
❑ Yes	❑ No	Is your partner's occupation a source of conflict in your marriage?

❑ Yes	❑ No	Do you have any children?

Name(s): Age(s):

_____ _____

_____ _____

_____ _____

❑ Good	❑ Fair	❑ Poor	What kind of relationship do you have with your child(ren)?
❑ Good	❑ Fair	❑ Poor	What kind of relationships do your children have with each other?

			If married, how many years have you been married (current marriage)?
			What was your age when you married (current marriage)?
❑ Yes	❑ No		Have you been married previously?
❑ Good	❑ Fair	❑ Poor	How would you describe your current marriage?
❑ Yes	❑ No		Do you have family members that live in the immediate area?
❑ Mother	❑ Father		❑ Sibling(s) ❑ Grandparent(s) ❑ Inlaw(s)
❑ Good	❑ Fair	❑ Poor	How well do you like your living arrangements?
❑ Good	❑ Fair	❑ Poor	Are you able to keep up with your normal chores and responsibilities?
Yes	No		Do you find it difficult to remain focused or attentive with tasks?
			What is your occupation?
❑ Good	❑ Fair	❑ Poor	Are you satisfied with your career/employment?
❑ Yes	❑ No		Is your occupation/employment a source of conflict with your partner?
❑ Yes	❑ No		Do you have any hobbies or other interests?
			What kind of hobbies?
❑ Yes	❑ No		Lately, have you seemed to lose interest in things that normally bring you pleasure?
❑ Yes	❑ No		Do you have an individual with whom you can share problems or worries (confide)?
❑ Yes	❑ No		Do you care for any pet(s)?
			What kind of pet(s)?

CHILDHOOD AND FAMILY OF ORIGIN

❑ Yes	❑ No	Do you have any brothers or sisters?

Name(s): Age(s): Occupation(s):

❑ Good	❑ Fair	❑ Poor	As a child, how did you get along with your brothers/sisters?
❑ Good	❑ Fair	❑ Poor	At present, how do you get along with your brothers/sisters?

What was your father like?

❑ Good	❑ Fair	❑ Poor	What kind of relationship did you have with your father?

What was your mother like?

❑ Good	❑ Fair	❑ Poor	What kind of relationship did you have with your mother?
❑ Good	❑ Fair	❑ Poor	What kind of relationship did your parents have with each other?

As a child, how did you know that your parents loved you?

As a child, how did you know that your parents loved each other?

❑ Yes	❑ No	Are your parents divorced?
	←	How old were you when this happened?
❑ Yes	❑ No	Were you ever abused as a child?
❑ Good ❑ Fair	❑ Poor	How would you describe your health during childhood?
❑ Nailbiting ❑ Bedwetting ❑ Temper tantrums ❑ Running away ❑ Fears ❑ Nightmares ❑ Thumbsucking ❑ Other		Any childhood habits?
❑ Yes	❑ No	Did you get into any trouble as a child?
10 9 8 7 6 5 4 3 2 1 GOOD POOR		How would you characterize your overall childhood?

EDUCATION AND WORK HISTORY

❑ Did not complete high school ❑ High school graduate ❑ College Graduate ❑ Completed vocational/ technical school			Which best describes your educational experience
❑ Yes	❑ No		Are you currently in school?
			If yes, where are you enrolled?
❑ Yes	❑ No		Did you receive any awards or honors in school?
❑ Yes	❑ No		Were you involved in any extra-curricular activities (band, sports, etc)?
❑ Yes	❑ No		Do you have any learning problems or complications?
❑ Above Average ❑ Average ❑ Below Average			What kind of grades did you receive in school?
❑ Good	❑ Fair	❑ Poor	How did you get along with your classmates?
❑ Good	❑ Fair	❑ Poor	How well did you relate with your teachers?
❑ Yes	❑ No		Were you ever in the military?
			What branch did you serve in?
			What was your job/specialty?
			How long did you serve?
Yes	No		Are you currently employed?
Enjoy	It's OK	Dislike	Do you enjoy your present work situation?
Yes	No		Do you have any special job skills or training?
Good	Fair	Poor	How well do you get along with your boss/supervisor?
Good	Fair	Poor	How well do you get along with your co-workers?
Yes	No		Do you have any problems with being late or absent to work?
Yes	No		Have you experienced any accidents or losses while working?
Yes	No		Have you ever been fired from a job before?

Previous jobs you have held? How long at job

(1) _____

(2) _____

Yes	No	Do you have enough money to pay your bills?
Yes	No	Do you have own or have access to a car?

GENERAL HEALTH

		Who is your family physician?
		When was the last time you saw a physician (approximate)?
Yes	No	Are you currently taking any medications?
		If yes, please list the medications
Yes	No	Have you ever been prescribed sedatives to help you sleep?
Yes	No	Have you ever been prescribed medication to help with depression?
Yes	No	Are you allergic to any medications?
Yes	No	Do you drink (alcohol) on a regular basis?
Yes	No	Do you smoke?
Yes	No	Have you ever taken/used any illegal drugs? (If yes please indicate)
		Cocaine/Crack Amphetamines (speed) PCP (Angel dust)
		Marijuana Hallucinogens (LSD, Peyote, "magic mushrooms")
		Inhalants (gas, glues, thinners) Heroin (morphine)
Yes	No	Do you have any sexual concerns?
GOOD 10 9 8 7 6 5 4 3 2 1 POOR		How would you rate your current overall health? (please circle)

SPIRITUAL INVENTORY

What relationships have the greatest influence in your life right now?

_____

_____

Yes	No	
1)		Are there any persons from your past that have played a significant part in shaping your view of life? (If yes, please list each)
2)		

Yes	No	Has there been an event in your life (either positive or negative) which was so intense that it permanently affected your outlook on life? (If yes, please describe briefly)

_____

_____

_____

What beliefs or values have been most important in guiding your life?

_____

_____

What feelings or emotions do you have when you think of God; is there any particular image that comes to mind?

_____

_____

Yes, a lot Somewhat Not at all	Is your faith/spirituality helpful to you?

Is there anything you do to help nurture or maintain your faith/spirituality?

_____

_____

Consistent Inconsistent Almost never		How successful are you in regularly maintaining these practices?
Yes	No	Are there any conflicts between your beliefs and your partner's beliefs?
Yes	No	Are there any conflicts between your beliefs and anything you are presently doing? (sexually, morally, etc.)
Yes	No	Do you believe you have committed an unpardonable sin?

CURRENT STATUS

Please answer the following questions so that we might have a better idea of how you are doing (circle the correct number):

	Not at all			Some			A lot
During the past week, how concerned or worried have you been about your health?	1	2	3	4	5	6	7
During the past week, how anxious, nervous, or tense have you been?	1	2	3	4	5	6	7
During the past week, how much have you been bothered by feelings of guilt?	1	2	3	4	5	6	7
During the past week, have you felt super-efficient or like you have unlimited energy, special talents or powers?	1	2	3	4	5	6	7
During the past week, how depressed have you felt?	1	2	3	4	5	6	7
During the past week, how irritable or angry have you been?	1	2	3	4	5	6	7
During the past week, how much distrust of others have you felt (or how much did it seem like others were out to hurt you)?	1	2	3	4	5	6	7
During the past week, did you hear or see things around you that others did not see?	1	2	3	4	5	6	7
During the past week, how much difficulty have you had with your thinking?	1	2	3	4	5	6	7

Martha Austin White, LCSW

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Credentials

I have been in practice for 25 years, most recently, for the past 15 years, with Heritage Medical Associates.

Confidentiality

The information provided by you during psychotherapy is confidential. Release of information is controlled by you and requires your written consent. Two exceptions provided for by law include cases in which I believe imminent danger exists to the client and/or other persons, and situations involving current or recent child abuse.

Office Hours, Emergencies and Electronic Communication

I schedule appointments on Tuesdays, Wednesdays, and Thursdays. To reach me by phone in an emergency, leave a message on my voice mail. I check it frequently during business hours, daily on weekends. I am happy to be in touch for primarily routine matters by text or email. While no one has access to my email, transmission cannot be considered to be completely secure.

Can I reach you, as needed, by text or email? _____yes _____no

Fees

The standard fee for an initial intake appointment is $200 for a 60-minute session and thereafter the fee is $175 for a 50-minute session. Payment is expected at the time of service. Forms of payment accepted are debit, credit, or HSA/FSA cards or Venmo to be provided at the beginning of each session. If you will be filing with your insurance company or a Health Savings Account for reimbursement, I will provide you with a receipt and a generic insurance form if you need one.

Missed Appointments

It is expected that appointments be cancelled at least 24 hours in advance to avoid a missed appointment charge (amount of the regular fee). If you don't cancel a scheduled appointment, you will be charged the full fee. If a health emergency arises and you are unable to cancel within the 24-hour period, please talk with me about a reduced missed appointment charge.

If you have questions or concerns about any of the above, please discuss them with me. If you understand and agree to these policies, indicate by your signature below.

Signature_____Date_____

I hereby give permission for Martha Austin-White to send an acknowledgment (no personal information) to the referral source listed below if that person is a health or mental health professional.

Permission given_____ Permission denied_____

Signature_____

Referral source_____ Telephone (if known)_____
Address (if known)_____

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HIPAA Privacy Practices

We are required by law to follow the practices described in this letter. This letter is a summary of our Privacy Practices. This notice applies to personal medical/mental health information that we have about you, and which are kept in or by this facility. With some exceptions, we must obtain your authorization to disclose (or release) your health care information. There are some situations in which we do not have to obtain your authorization. We can use your protected health information and share it with members of our organized health care arrangement (like a community provider). Neither this pamphlet nor the full Notice of Privacy Practices covers every possible use or disclosure. If you have any questions, please contact the Privacy Office for this facility.

Who Has Access to Your Personal Information?

Medical/Mental health information about you can be used to:

- Plan your treatment and services. This includes releasing information to qualified professionals who work at our facility and are involved in your care or treatment. It may also include provider agencies whom we pay to provide services for you. We will only release as little as possible for them to do their jobs.
- Submit bills to your insurance, Medicaid, Medicare, or third-party payers.
- Obtain approval in advance from your insurance company.
- Exchange information with Social Security, Employment Security, or Social Services.
- Measure our quality of services.
- Decide if we should offer more or fewer service to clients.

Without your permission, we may use your personal information:

- To exchange information with other State agencies as required by law.
- To treat you in an emergency.
- To treat you when there is something that prevents us from communicating with you.
- To inform you about possible treatment options.
- To send you appointment reminders.
- For agencies involved in a disaster situation.
- When there is a serious public health or safety threat to you or others.
- As required by State, Federal or local law. This includes investigations, audits, inspections, and licensure.
- When ordered to do so by a court.
- To communicate with law enforcement if you are a victim of a crime, involved in a crime at our facility, or you have threatened to commit a crime.
- To communicate with coroner, medical examiners and funeral homes when necessary for them to do their jobs.
- To communicate with federal officials involved in security activities authorized by law.
- To communicate with a correctional facility if you are an inmate.

What Are Your Rights?

- To see and get a copy of your record (with some exceptions).
- To appeal if we decide not to let you see all or some parts of your record.
- To ask for the record to be changed if you believe you see a mistake or something that is not complete.
- You must make this request in writing. We may deny your request if:
    1. We did not create the entry
    2. The information is not part of the file we keep; or
    3. The information is not part of the file that we would let you see; or
    4. We believe the record is accurate and complete.
- To know to whom, we have sent information about you for up to the last six years.
- The first request in a 12-month period is free. We may charge you for additional requests.
- To limit how we use or disclose information about you. For example-not to release information to your spouse or a provider agency. This must be made in writing, and we are not required to agree to the request.
- To ask that we communicate with you about medical matters in a certain way or at a certain location. This must be made in writing.
- To tell us (authorize) other released of your personal information not described above. You may change your mind and remove the authorization at any time (in writing).

Signature of Responsible Party(ies):_____

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NOTICE OF PRIVACY PRACTICES RECEIPT AND ACKNOWLEDGMENT OF NOTICE

Patient/Client

Name:_____

DOB:_____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Martha Austin White's privacy practices. I understand that if I have any questions regarding the notice of my privacy rights, I can contact Martha Austin White, LCSW.

_____

Signature of Patient/Client Date

_____

Signature of Parent, Guardian or Personal Representative* Date

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.)

_____

Patient/Client Refuses to Acknowledge Receipt

_____

Signature of Staff Member Date