

**Vorpahl Psychology Associates, LLC**  
**266 Main Street, Suite 33a**  
**Medfield, MA 02052**  
**Tel:508-242-9666 Fax:815-572-8941**  
**vpa-psychologist.com**

**Attention: All paperwork on pages 1-6 are for you to keep. You do not need to bring them into your appt.**

### **PSYCHOTHERAPY AGREEMENT**

Welcome to Vorpahl Psychology Associates, LLC (VPA). This document (the Agreement) contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that VPA provides you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail, and our practice is in general accordance with HIPAA policies. The law requires that VPA obtains your signature acknowledging that we have provided you with this information prior to commencement of treatment.

Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding unless VPA has taken action in reliance on it or if you have not satisfied any financial obligations you have incurred.

### **PSYCHOLOGICAL SERVICES**

Therapy is a relationship between people that works in part because of the clearly defined rights and responsibilities held by each person. This frame helps to create the safety to take risks and the support to become empowered to create change. As a client in psychotherapy, you have certain rights and responsibilities that are important for you to know about. There are also legal limitations to those rights that you should be aware of. VPA, as your therapist, has corresponding responsibilities to you. These respective rights are described in the following section.

Psychotherapy has both benefits and risks. Risks sometimes include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness. Psychotherapy often requires discussing unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress, and resolutions to specific problems. But, there are no guarantees about what will happen. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things that we discuss outside of sessions.

The first few sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, VPA will be able to offer you some initial impressions of what our work may include. At that point, we will discuss your treatment goals and create a personalized, initial treatment plan, if you decide to continue. You should evaluate this information as well as your own assessment about whether you feel comfortable working with us. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about our procedures, we should discuss them whenever they arise.

## **APPOINTMENTS**

VPA normally conduct an evaluation that will last from 2 to 4 sessions. During this time, you and your therapist will both decide if VPA can provide the services you need in order to meet your treatment goals. Once psychotherapy begins, VPA will usually schedule one 45-minute session (one appointment hour of 45 minutes duration) per week at a time we agree on, although some sessions may be longer or more frequent.

## **CANCELLATION**

Psychological services are most effective when meeting times are regular and consistent. The time scheduled for your appointment is assigned to you and you alone. **If you need to cancel or reschedule a session, it is required that you provide more than 24 hours notice. If you miss a session without canceling, or cancel with less than 24 hours notice, you must pay \$165 for the missed session.** It is important to note that insurance companies do not provide reimbursement for canceled sessions. In addition, you are responsible for coming to your session on time and at the time scheduled. If you are late, your appointment will still need to end on time.

## **FEES, BILLING, AND PAYMENT**

Psychotherapy sessions are 45 minutes and billed at \$200 per session (initial sessions are \$250). Session fees or insurance co-pays are payable at time of service unless alternative arrangements have been made. Fees may be reevaluated periodically. Payment by cash or check, payable to Dr. Vorpahl. If you would like to pay by credit card, please complete the form at the end of the document. Check re-occurrent if you would like to be charged on-going.

**You will be responsible for paying the entire fee if your insurance fails to authorize units of service or if no units of service are available to you. Moreover, legal fees (\$250 per hour of service provided) are not billable to insurance companies and will be charged to the patient directly (eg. court evaluations, court appearances).** Should a balance accrue and no payment is received, VPA reserves the right to seek remuneration by any means legally possible including, but not limited to, the retention of a collection agency.

## **INSURANCE**

VPA accepts payments directly from insurance companies for whom we are participating providers (check with provider to determine if your insurance plan will cover your costs).

## **PROFESSIONAL RECORDS**

VPA is required to keep appropriate records of the psychological services provided to you. Although psychotherapy often includes discussions of sensitive and private information, normally very brief records are kept noting that you have been here, what was done in session, and a mention of the topics discussed. You have the right to a copy of your file at any time. You have the right to request that a copy of your file be made available to any other health care provider at your written request. Your records are maintained in a secure location in the office.

## **CONTACTING VPA**

VPA clinicians are often not immediately available by telephone. While VPA clinicians are usually in the office during normal business hours, they do not answer the phone when they are with a client. If you need to reach any of us between sessions, or in an emergency, you have the right to a timely response. You may leave a message on VPA confidential voicemail. Each VPA clinician indicates days and times they are in the office on their voicemail. An emergency number will be provided on the voicemail. VPA clinicians check their voicemail for messages for the last time at 5:00 PM.

## **OTHER RIGHTS**

If you are unhappy with what is happening in therapy, VPA hopes you'll talk with us so that we can respond to

your concerns. Such criticism will be taken seriously and with care and respect. You may also request that VPA refers you to another therapist 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 aspect of the therapy and about your VPA clinician's specific training and experience.

## **NOTICE OF PRIVACY POLICIES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION**

**REVISED 9/16/2013**

**This notice describes how psychological and medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully!**

### **I. Uses and Disclosures for Treatment, Payment and Health Care Operations**

We may use or disclose your *protected health information (PHI)*, for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- “PHI” refers to information in your chart that could identify you.
- “*Treatment, Payment and Health Care Operations*”

**Treatment** is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your PCP or another therapist.

**Payment** is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI 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 practice. Examples of health care operations are quality assessment and improvement activities, business-related matters, such as audits and administrative services, and case management and case coordination.

**Use** applies to activities within our practice, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

**Disclosure** applies to activities outside of our practice, such as releasing, transferring, or providing access to information about you to other parties.

### **II. Uses and Disclosures Requiring Authorization**

We may use or disclose PHI for purposes outside of treatment, payment and health care operations when your appropriate authorization is obtained. An “*authorization*” is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy notes. “*Psychotherapy notes*” are notes we have made about our conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your chart. These notes are given a greater degree of protection than PHI. It is VPA’s policy not to keep separate psychotherapy notes. All documentation we keep is a part of your clinical chart.

We will also obtain an authorization from you before using or disclosing PHI in a way that has not been described in this notice.

We will not use your PHI for marketing or sales purposes under any conditions.

### **III. Uses and Disclosures with Neither Consent nor Authorization**

We may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If any of the clinicians at VPA, in their professional capacity, have reasonable cause to believe that a minor child is suffering physical or emotional injury resulting from abuse inflicted upon him or her which causes harm or substantial risk or harm to the child's health or welfare (including sexual abuse), or from neglect, including malnutrition, they must immediately report such a condition to the Massachusetts Department of Children and Families.
- **Adult and Domestic Abuse:** If any of the clinicians at VPA have reasonable cause to believe that an elderly person (age 60 or older) is suffering or has died as a result of abuse, they must immediately make a report to the Massachusetts Department of Elder Affairs.
- **Health Oversight:** The Board of Registration that applies to our particular license to practice has the power, when necessary, to subpoena relevant records should we be the focus of an inquiry.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law and we will not release information without written authorization from you or your legally-appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the court evaluation is court ordered. You will be informed in this case.
- **Serious Threat to Health or Safety:** If you communicate to any of the clinicians at VPA an explicit threat to kill or inflict serious bodily injury upon an identified person and you have the apparent intent and ability to carry out the threat, they must take reasonable precautions. Reasonable precautions may include warning the potential victim, notifying law enforcement, or arranging for your hospitalization. They must also do so if they know you to have a history of physical violence and they believe there is a clear and present danger that you will attempt to kill or inflict bodily injury upon an identified person. Furthermore, if you present a clear and present danger to yourself and refuse to accept further appropriate treatment and they have a reasonable basis to believe that you can be committed to a hospital, they must seek said commitment and may contact members of your family or other individuals if it would assist in protecting you.
- **Workers Compensation:** If you file a worker's compensation claim, your records relevant to that claim will not be confidential to entities such as your employer, the insurer and the Division or Worker's Compensation.

When the use and disclosure without your consent or authorization is allowed under sections of Section 164.512 of the Privacy Rule and the state's confidentiality law, this includes certain narrowly defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or medical examiner, for public health purposes relating to disease or FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

#### **IV. Patient's Rights and Mental Health Clinician's Duties. Patient's Rights:**

- **Right to Request Restrictions:** You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.
- **Right to Receive Confidential Communications by Alternative Means and Alternative Locations:** You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing us. Upon your request, we will send your bills to another address). This request must be made in writing.
- **Right to Inspect and Copy:** You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases, you may have the decision reviewed. On your written request, we will discuss with you the details of the amendment process.
- **Right to Amend:** You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your written request, we will discuss with you the details of the amendment process.
- **Right to an Accounting:** You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your written request, we will discuss with you the details of the accounting process.
- **Right to a Paper Copy:** You have the right to obtain a paper copy of the notice from us upon written request, even if you have agreed to receive the notice electronically.
- **Right to Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket:** You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket or in full for our services.
- **Right to Be Notified if There is a Breach of Your Unsecured PHI:** You have a right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised.

#### **Mental Health Clinician's Duties:**

- We are required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in the notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect. If we revise our policies and procedures, we will notify current clients and post the new policies in the waiting area.

## **V. Complaints**

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact our Privacy Officer: Kai Vorpahl at 508.333.4300. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

## **VI. Effective Date and Changes to Privacy Policy**

This notice will go into effect September 23, 2013. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will notify current clients of changes in person or by mail and closed client cases can, if interested, call and ask if our policies have changed and obtain a copy by mail or view one in our waiting area.

### **CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION SIGNATURE PAGE**

This form is an agreement between you \_\_\_\_\_ and Vorpahl Psychology Associates, LLC. When we use the word “you” below it will mean your child, relative, or other person if you have written his name here.

When we examine, diagnose, treat, or refer you we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this information here to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing that you have read and understand our Notice of Privacy Policies and you are agreeing to let us use your information here and send it to others in accordance with our written policies. Please make sure you have read and understand our Privacy Policies above before signing this Consent form.

**If you do not sign this consent form agreeing to what is in our Notice of Privacy Policies, we cannot treat you.**

In the future we may change how we use and share your information and so may change our Notice of Privacy Policies. If we do change it, you can get a copy from our website: [www.vpa-psychologist.com](http://www.vpa-psychologist.com), or by calling us at 508.498.9667, or from our privacy officer, Kai Vorpahl.

If you are concerned about some of your information, you have the right to ask us not to use or share some of your information for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations.

However, if we do agree, we promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on but we may already have used or shared some of your information and cannot change that.

**YOU DO NOT NEED TO BRING THE PRECEDING PAGES TO YOUR APPOINTMENT. THEY ARE FOR YOU TO KEEP**

**Your information and signature are required on the next page.  
Please print only the rest of the document and bring to your appt.**

**Vorpahl Psychology Associates, LLC**  
**266 Main Street Suite 33a**  
**Tel:508-242-9666 Fax:815-572-8941**  
**[drvorpahl@yahoo.com](mailto:drvorpahl@yahoo.com) [vpa-psychologist.com](http://vpa-psychologist.com)**

**Acknowledgement of Receipt of Privacy Notice and Vorpahl Psychology Associates Policies & Procedures**

Federal law requires that all patients be given a copy of the privacy notice. The Privacy Notice describes in detail how patient health information is used and shared with others. All reasonable efforts will be made to protect the privacy of patient health information, whether it is maintained on paper or electronically, and regardless of how it is communicated, for example by e-mail or facsimile mail.

**I HAVE BEEN GIVEN A COPY OF THE PRIVACY NOTICE.**

Name (print) \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ Date of Birth \_\_\_\_\_

When patient is a minor, or is unable to give consent, the signature of a parent, guardian, or personal representative is required.

Signature of Representative \_\_\_\_\_ Date \_\_\_\_\_

Name (print) \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

**CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION SIGNATURE.**

\_\_\_\_\_  
Signature of patient or personal representative

\_\_\_\_\_  
Printed name of patient or personal representative

\_\_\_\_\_  
Date of Signature

\_\_\_\_\_  
Date NPP received by patient or representative

**CONSENT TO PSYCHOTHERAPY**

**Your signature below indicates that you have read the Psychotherapy Agreement and agree to its terms.**

Name (print) \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ Date of Birth \_\_\_\_\_

When patient is a minor, or is unable to give consent, the signature of a parent, guardian, or personal representative is required.

Signature of Representative \_\_\_\_\_ Date \_\_\_\_\_

Vorpahl Psychology Associates, LLC  
266 Main Street, Suite 33a Medfield, MA 02052  
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**Request/Authorization for Release of Confidential Records and/or Information**

This form allows your clinician to communicate with other key professionals. I hereby authorize:

Name/Facility: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number: \_\_\_\_\_

Email Address: \_\_\_\_\_

To **obtain/release** (circle one or both) the records/information about:

If you circle obtain, VPA can receive information about the patient named below. If you circle release, then VPA can release information to the person named above. If you circle both, then both parties can release and discuss information about the patient named below.

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

To the provider, \_\_\_\_\_, at Vorpahl Psychology Associates for the purpose(s) of:

- \_\_\_\_\_ Further mental health evaluation, treatment, or care
- \_\_\_\_\_ Treatment Planning and coordination of care
- \_\_\_\_\_ Education planning
- \_\_\_\_\_ Other: \_\_\_\_\_

Information should be sent to the postal address/fax/email/phone number in the letterhead at the top of this form

I have had it explained to me and fully understand that this request/authorization to release records and information, including the entire nature of the records, their content, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may rescind this consent at any time within 90 days, except to the extent that action based on this consent has already been taken.

\_\_\_\_\_  
Signature of patient/parent/guardian/representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of signatory above/Relationship to patient



## Parent Questionnaire

Today's Date:

Name:

Date of Birth:

Age:

Home number:

Cell number:

Email:

Emergency Contact Person:

Relationship to you:

Name:

Cell phone number:

Email:

How did you learn about or get referred to VPA?

### Presenting Problems

Please describe the key problems for which your child is currently seeking treatment, and when they began. Please feel free to note situations that are difficult for your child, as well as problematic stressors, moods, thoughts, and behaviors. Are there any other environmental factors that contribute to your child's difficulties (e.g., bullying, friends, divorce, school, illness)?

### Background Information

Marital Status:

Single     Married     Partnered     Other \_\_\_\_\_  
 Separated     Divorced     Widowed

Gender Identity: I experience myself as:

Male     Female     Transgender     Other \_\_\_\_\_

Sexual Identity: I am sexually/romantically attracted to:

Men  Women     Both, Men and Women     Other \_\_\_\_\_

Ethnically, racially and culturally, I identify as

Does religion play an important role in your life? Please describe.

Describe your living situation:

Alone     Apartment     Roommate(s)  
 College/School     House     Spouse/Partner  
 Children     Siblings     Pets

Who are the most emotionally supportive people in your life?

How would you describe your child's friendship network?

What are typical things does he/she do for pleasure or enjoyment, and how often?

Please describe your child's personal strengths:

Briefly describe your family.

Please note immediate family members (spouse/partner, children, siblings, parents, in-laws, etc.):

Name:                      Relationship to you:                      Age:                      Where do they live?

### **Medical History**

Primary Care Physician's Name:

Phone:

Address:

Do you wish to have your child's primary care physician contacted or involved in your mental health treatment?

YES       See Release Form and Complete      NO

*Please list any non-psychiatric medications you are currently taking using:*

Non-psychiatric:Medication                      Dosage                      Reason for taking the medication (e.g., blood pressure)

Please describe your child's current physical health:

Including exercise, diet, sleep, self-care habits.

Please describe any significant current medical problems your child is being treated for:

Please describe any significant past medical problems and treatments (e.g., surgeries):

**Mental Health History**

Prescriber's Name:

Address:

Phone:

Do you wish to have your child's prescriber contacted or involved in your child's mental health treatment?

YES  See Release Form and Complete      NO

Please list any psychiatric medications your child is currently taking using: *Medication, Dosage, Reason for taking the medication (e.g., antidepressant)*

*Which psychiatric medications has your child been on in the past?*

Please describe your past experiences in outpatient treatment (*Therapist, dates of treatment, type of treatment, reason for seeking help:*

Please describe your past experiences in inpatient or day hospital programs:

<i>Facility/program</i>	<i>Dates of treatment (start – end dates)</i>	<i>Type of program</i>	<i>Reasons for seeking treatment</i>
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Does anyone in your family struggle with mental illness? If so, please describe.

Has your child been sexually, physically or mentally abused at any point in your life?

Has your child had any other significant life changing events or traumas that have affected him/her either positively or negatively?

### **Substance Use and Addictive Behaviors**

Have you ever felt your child should cut down on drinking/drug use (including prescription drugs)?

Have people annoyed you by criticizing your child's drinking/drug use (including prescription drugs)?

Has your child ever felt bad or guilty about his/her drinking/drug use (including prescription drugs)?

Has your child ever had a drink/drug (including prescription drugs) first thing in the morning to steady him/her nerves or to get rid of a hangover?

Does she struggle with other addictive behaviors such as using tobacco, gambling, pornography, food, etc.?

### **History of Suicidal Feelings**

Many people think about suicide on occasion. Have you had times in life where you had thoughts about suicide? If so, please briefly describe when, what seemed to be triggering the thoughts, and whether you made a suicide attempt or a suicidal gesture.

Has your child?

Do you engage in any self-harming behaviors? Does your child?

Have you had any thoughts of hurting others? Have you ever physically hurt another person?

Has your child?

### **Other Symptoms**

Below is a list behaviors and issues that are cause for concern to some adults. Please place an "x" or a "✓" next to any and all items that you think might apply to your child. At the end of the list there is space to enter any additional issues or concerns that might apply.

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Aggression/violence | <input type="checkbox"/> Domestic violence  | <input type="checkbox"/> Parenting issues           |
| <input type="checkbox"/> Physical abuse      | <input type="checkbox"/> Anxiety/panic      | <input type="checkbox"/> Suicidal thoughts/gestures |
| <input type="checkbox"/> Sexual abuse        | <input type="checkbox"/> Sexual dysfunction | <input type="checkbox"/> Marital problems           |

- Relationship problems
- Difficulty at school/work
- Financial problems
- Career-related problems
- Homicidal thoughts/gestures
- Sadness/depression
- Loss of appetite
- Sleep difficulty
- Attention/concentration
- Overeating
- Weight gain/loss
- Eating disorder
- Excessive worry
- Difficulty trusting others
- Low self-esteem
- Physical pain/discomfort
- Medical issues
- Issues with elder parents
- Lack of joy/satisfaction in life
- Social withdrawal/isolation
- Stress
- Loneliness
- Feeling disorganized
- Problems with employer/co-worker/employee
- Alcohol
- Marijuana
- Cocaine
- Prescription drugs
- Other illicit substances
- Restlessness/fidgety
- Negativity
- Difficulty forgiving
- Nightmares
- Unemployment
- Feeling tired/fatigued
- Hopelessness
- Easily distracted
- Anger
- Self-injury (cutting, burning, scratching, pulling out hair)
- Hyperactivity
- Guilt
- Obsessive thoughts/fears
- Chronic headache
- Difficulty making decisions
- Poor judgment
- Overly concerned about what other people think
- Irritability
- Trouble with authority
- Legal problems/court involvement
- Separation/divorce
- Mood swings
- Overly sensitive
- Frequent conflicts with others
- Difficulty accepting/making changes
- Risky/dangerous behavior
- Few friends
- Smoking
- Inappropriate/uncomfortable sexual thoughts/urges
- Cruelty/neglect of pets
- Issues from childhood
- Codependency (partner's substance abuse)
- Confusion
- Feeling spacey/detached from one's surroundings
- Crying spells
- Adultery/infidelity
- Feeling empty/dissatisfied
- Feeling like a failure
- Body image
- Gambling
- Phobias (germs, heights, confined places, etc.)
- Loss/grief due to death
- Impulsiveness
- Compulsive behaviors (hand-washing, checking, etc.)
- Housework/home maintenance
- Feelings of inferiority
- Trouble taking responsibility
- Menstrual problems, PMS, menopause
- Lack of motivation
- Children with special needs
- Perfectionism
- Religion/spirituality
- Bad temper
- Self-control
- Procrastination
- Hallucinations

Please take a moment and review the issues or problems you have noted on this questionnaire. Which three items are you most concerned about. In other words, which three concerns would you most like to have addressed in your treatment?

- 1.
- 2.
- 3.

**Other Things I Should Know**

Please describe anything else that is important to know in understanding your life and your difficulties.

VORPAHL PSYCHOLOGY ASSOCIATES, LLC  
Young Adult Information Form

Note: Unless there is a serious risk of injury to you or someone else, the information on this form is confidential. It will not be discussed with your parents without your consent.

Today's date:

Your name:

Your address:

Email:

Your age:

DOB:

Phone #:

**What is bringing you in?**

Please describe the key problems for which you are currently seeking treatment, and when they began. Please feel free to note situations that are difficult for you, as well as problematic stressors, moods, thoughts, and behaviors. Are there any other environmental factors that contribute to your difficulties (e.g., school, friends, divorce, bullying, illness)?

Why do you think you are here? Please tell me in your own words.

What would you like to see happen or change because of this counseling?

**Basic Information**

Name of School & Grade: \_\_\_\_\_

Gender Identity: I experience myself as:

Male       Female       Transgender       Other \_\_\_\_\_

Sexual Identity: I am sexually/romantically attracted to:

Men  Women       Both, Men and Women       Other \_\_\_\_\_

Ethnically, racially and culturally, I identify as

Does religion play an important role in your life? Please describe.

Parents Marital Status:

Single       Married       Partnered       Other \_\_\_\_\_  
 Separated       Divorced       Widowed

Describe your living situation:

Both Parents       Split time with Divorced Parents  
 Not Parents       Parents Divorced only live with one  
 Siblings in home       Siblings in college       Pets in home

Birth Parents' Names:  
Address: Phone #: Email:

Adoptive Parents'/guardians' Names:  
Address: Phone #: Email:

How would you describe your parents' relationship with each other?

What kinds of problems are you having with:  
Parents/stepparents/guardians?

Parents' live-in friends or boyfriends/girlfriends?

Brothers or sisters (or stepbrothers or stepsisters)?

Your friends/boyfriends/girlfriends?

Briefly describe growing up in your family.

Please note immediate family members (spouse/partner, children, siblings, parents, in laws,etc.) using the categories below:

*Name:* \_\_\_\_\_ *Relationship to you:* \_\_\_\_\_ *Age:* \_\_\_\_\_ *Where do they live?* \_\_\_\_\_



**Physical Information:**

What physical or medical problems do you have now, or have you had in the past?

Do you take any medication? If yes, what is it and why?

How do you feel about your body?

Please describe how much sleep you get on a school night and weekend?

How often do you exercise and what do you like to do?

**Personal Information:**

Are you content with your grades?

IEP? 504?

Do you like school? Why?

Favorite subject and least favorite subject?

What do you do after school? Other activities/hobbies.

Do you work? Where? Problems there?

Have you ever been bullied? Is it still going on?

How do you feel about your sexuality? Do you feel confused? Secure? Not Sure?

Describe your social media use and how it impacts your life.

How would you describe your friendship network? Do you have friends you feel close to? Do they live locally?

Are you dating or in a romantic relationship?

**Emotional Information:**

What are typical things you do for pleasure or enjoyment, and how often?

What typically worries or upsets you?

What makes you sad?

What makes you angry?

How do you manage your emotions?

Who are the most emotionally supportive people in your life?

What do you do to take care of yourself, emotionally?

Have you had any other significant life changing events or traumas that have affected you either positively or negatively?

**Substance Use and Addictive Behaviors**

Have you ever felt you should cut down on your drinking/drug use (including prescription drugs)?

Have people annoyed you by criticizing your drinking/drug use (including prescription drugs)?

Have you ever felt bad or guilty about your drinking/drug use (including prescription drugs)?

Have you ever had a drink/drug (including prescription drugs) first thing in the morning to steady your nerves or to get rid of a hangover?

Do you struggle with other addictive behaviors such as using tobacco, gambling, pornography, food, etc.?

**History of Suicidal Feelings**

Many people think about suicide on occasion. Have you had times in life where you had thoughts about suicide? If so, please briefly describe when, what seemed to be triggering the thoughts, and whether you made a suicide attempt or a suicidal gesture.

Do you engage in any self-harming behaviors?

Have you had any thoughts of hurting others? Have you ever physically hurt another person?

Have you at any point in your life or are you currently being sexually, physically or mentally abused?

**Other Symptoms**

Below is a list behaviors and issues that are cause for concern to some adults. Please place an “✖” or a “✓” next to any and all items that you think might apply to you. At the end of the list there is space to enter any additional issues or concerns that you might have.

<input type="checkbox"/> Aggression/violence	<input type="checkbox"/> Medical issues	<input type="checkbox"/> Guilt
<input type="checkbox"/> Physical abuse	<input type="checkbox"/> Issues with parents	<input type="checkbox"/> Obsessive thoughts/fears
<input type="checkbox"/> Sexual abuse	<input type="checkbox"/> Lack of joy/satisfaction in life	<input type="checkbox"/> Chronic headache
<input type="checkbox"/> Domestic violence	<input type="checkbox"/> Social withdrawal/isolation	<input type="checkbox"/> Difficulty making decisions
<input type="checkbox"/> Anxiety/panic	<input type="checkbox"/> Stress	<input type="checkbox"/> Poor judgment
<input type="checkbox"/> Sexual dysfunction	<input type="checkbox"/> Loneliness	<input type="checkbox"/> Overly concerned about what other people think
<input type="checkbox"/> Social Media Addiction	<input type="checkbox"/> Feeling disorganized	<input type="checkbox"/> Irritability
<input type="checkbox"/> Suicidal thoughts/gestures	<input type="checkbox"/> Problems with teachers	<input type="checkbox"/> Trouble with authority
<input type="checkbox"/> Relationship problems	<input type="checkbox"/> Alcohol	<input type="checkbox"/> Legal problems/court involvement
<input type="checkbox"/> Difficulty at school/work	<input type="checkbox"/> Marijuana	<input type="checkbox"/> Separation/divorce
<input type="checkbox"/> Financial problems	<input type="checkbox"/> Cocaine	<input type="checkbox"/> Mood swings
<input type="checkbox"/> Homicidal thoughts/gestures	<input type="checkbox"/> Prescription drugs	<input type="checkbox"/> Overly sensitive
<input type="checkbox"/> Sadness/depression	<input type="checkbox"/> Other illicit substances	<input type="checkbox"/> Frequent conflicts with others
<input type="checkbox"/> Loss of appetite	<input type="checkbox"/> Restlessness/fidgety	<input type="checkbox"/> Difficulty accepting/making changes
<input type="checkbox"/> Sleep difficulty	<input type="checkbox"/> Negativity	<input type="checkbox"/> Risky/dangerous behavior
<input type="checkbox"/> Attention/concentration	<input type="checkbox"/> Difficulty forgiving	<input type="checkbox"/> Few friends
<input type="checkbox"/> Overeating	<input type="checkbox"/> Nightmares	<input type="checkbox"/> Smoking
<input type="checkbox"/> Weight gain/loss	<input type="checkbox"/> Unemployment	<input type="checkbox"/> Inappropriate/uncomfortable sexual thoughts/urges
<input type="checkbox"/> Eating disorder	<input type="checkbox"/> Feeling tired/fatigued	<input type="checkbox"/> Cruelty/neglect of pets
<input type="checkbox"/> Excessive worry		

<input type="checkbox"/> Difficulty trusting others <input type="checkbox"/> Low self-esteem <input type="checkbox"/> Physical pain/discomfort <input type="checkbox"/> Feeling spacey/detached from one's surroundings <input type="checkbox"/> Crying spells <input type="checkbox"/> Feeling empty/dissatisfied <input type="checkbox"/> Feeling like a failure <input type="checkbox"/> Body image <input type="checkbox"/> Procrastination <input type="checkbox"/> Hallucinations	<input type="checkbox"/> Hopelessness <input type="checkbox"/> Easily distracted <input type="checkbox"/> Anger <input type="checkbox"/> Self-injury (cutting, burning, scratching, pulling out hair) <input type="checkbox"/> Hyperactivity <input type="checkbox"/> Compulsive behaviors (hand-washing, checking, etc.) <input type="checkbox"/> Lack of motivation <input type="checkbox"/> Perfectionism <input type="checkbox"/> Religion/spirituality <input type="checkbox"/> Bad temper <input type="checkbox"/> Self-control	<input type="checkbox"/> Confusion <input type="checkbox"/> Feelings of inferiority <input type="checkbox"/> Trouble taking responsibility <input type="checkbox"/> Menstrual problems, PMS, menopause <input type="checkbox"/> Phobias (germs, heights, confined places, etc.) <input type="checkbox"/> Loss/grief due to death <input type="checkbox"/> Impulsiveness
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Please take a moment and review the issues or problems you have noted on this questionnaire. Which three items are you most concerned about. In other words, which three concerns would you most like to have addressed in your treatment?

- 1.
- 2.
- 3.

**Other Things I Should Know**

Please describe anything else that is important to know in understanding your life and your difficulties. Thanks for your honesty. This will remain confidential.