

Center for Professional Psychology
5401 Rogers Ave. Suite 201
Fort Smith, AR 72903
Phone:(479) 242-4560
Fax:(479)242-4561
centerforprofessionalpsych.com

Dear Prospective Patient:

Thank you for the opportunity to work with you and/or your child. We look forward to providing you the highest level of clinical care and expertise. Enclosed in this packet is important information about the services offered and forms for you to complete in preparation for your initial appointment.

You will need to complete all of the enclosed paperwork and gather other records before we can determine if we have the appropriate provider and availability to set your first appointment. Please return these forms as soon as possible. Your forms will be reviewed by the provider you have indicated you wish to see. If you do not select a provider, all forms will be reviewed a provider who specializes in the service you have requested. If for any reason you do not wish for a particular provider to review your paperwork, please indicate that on the first page when completing the forms. If for any reason, you are not established as a patient due to lack of availability or lack of appropriate expertise with your stated issue, this initial paperwork will be shredded and a permanent medical file will not be created. If you would like your paperwork returned to you at that time, please let our office manager know.

To assist you in preparing for the first appointment, a checklist of the materials needed is listed below:

Forms included in this packet:

- Consent documentation
- Contact Information Form
- History Form (**child/adolescent version and adult version attached; please complete the appropriate form**)
- Notice of Privacy Practices

Other materials needed for the first appointment that are not included in this packet:

- Insurance card (if you would like assistance filing a claim with your insurance company)
- Government ID for patient (acceptable identification includes: Driver's license, state-issued ID card, social security card, passport, etc.) – **Please note: This request for patient identification is required by HIPAA**
- Copies of previous evaluations (if applicable)
- Custodial documentation (if applicable)

We may also request additional records and materials in order to provide quality services. Please call if you have any questions or concerns. We want to make this a helpful experience for you. We truly appreciate the chance you have given us to be of professional service to you, and look forward to a successful relationship with you pending availability and expertise with your presenting concerns.

Sincerely,

Providers of the Center for Professional Psychology

Janissa D.Jackson, Ph.D., PLLC
Narissa R. Griffin, Ph.D., PLLC
Benjamin W. Storie, LPC-S
Danielle Wheeler, LMFT, LPC

Consent for Review of Initial Paperwork

I understand that my submitted paperwork will be reviewed by my requested provider or by a provider that provides the requested service unless I indicate that I do not want a particular provider to review my information.

Preferred Provider:

- Janissa D. Jackson, Ph.D., PLLC
- Narissa R. Griffin, Ph.D., PLLC
- Benjamin W. Storie, LPC-S
- Danielle Wheeler, LMFT, LPC

If applicable, I do not wish for _____ to review my paperwork for the following reason:

Signature of patient/Parent/Guardian Date

Printed Name

Relationship to patient:
Signed by: patient guardian personal representative

I understand that this initial paperwork does not formally establish me as a patient at the Center for Professional Psychology. Instead it is a way of ensuring that this clinic has the availability and expertise to meet my needs. If it is determined that this clinic cannot provide the appropriate level of care, my paperwork will be shredded unless I opt to pick it up at that time and appropriate referral sources will be suggested. If I am on a waiting list, my paperwork will be retained. Due to this being a screening measure, a permanent medical record will not be created.

Signature of patient/Parent/Guardian Date

Acknowledgement for Receipt of Privacy Practices

I understand the limits of confidentiality, privacy policies, my rights, and their meanings and ramifications. My signature indicates I have received a copy of the office's privacy practices that will be applicable if I am established as a patient at the Center for Professional Psychology.

Patient's name (please print): _____

Signature: _____ Date: ____/____/____

Signed by: patient guardian personal representative

Consent to Obtain Benefit Information and Submit Private Health Information for Insurance Claims

I authorize the Center for Professional Psychology and it's providers to release any protected health information (PHI) necessary to obtain benefit information and process insurance claims. I also authorize my insurance carrier to make payments to my determined provider.

Signature of Insured/Representative Date

Emergency Plan

I consent to the providers of the Center for Professional Psychology to handle my Protected Health Information unless I have designated an exception in the event of an emergency in which I need to gain access to this information and Dr. Janissa Jackson (the primary privacy officer) or my selected provider is unavailable due to extenuating circumstances.

Patients Name _____ Date _____

Contact Information Form

Date _____ Patient's Social Security # _____ Chart # _____
 Patient's First Name _____ Last Name _____ MI _____
 Address _____ City _____ State _____ Zip _____
 Telephone (Home) _____ (Work) _____
 Birthdate ____/____/____ Age _____ Gender __F__M Race _____
 Name of Parent/Guardian _____ Phone _____
 Address _____ City _____ State _____ Zip _____
 Person Responsible for Payment _____ Soc. Sec. # _____
 Signature of Person Responsible for Payment **X** _____ (Must be signed for services to begin)

Emergency Information

In case of emergency, contact:

Name (1) _____ Relationship _____ Phone _____ Work _____
 Address _____ City _____ State _____ Zip _____
 Physician _____ Phone _____
 Address _____ City _____ State _____ Zip _____
 Psychiatrist _____ Phone _____
 Address _____ City _____ State _____ Zip _____

Current Medications _____

Allergies _____

Employment Information (If patient is a child, use parent's employment)

Patient/Guardian: Place _____ Phone _____ Hrs _____
 Spouse: Place _____ Phone _____ Hrs _____

Referral Source

How did you hear of my office (or from whom)? _____
 Address _____ City _____ State _____ Zip _____
 Phone _____ Relationship to referral source _____

Contact Information:	
Telephone	
Email (password protected)	
Mail	
Please indicate if there is a method you prefer that we <i>not</i> contact you or leave messages.	

Patient History (if the patient is <18 years of age)

Patient's name: _____ Date: _____

Gender: ___ F ___ M Date of birth: _____ Age: _____ Grade in school: _____

Form completed by (if someone other than patient): _____

If you need any more space for any of the following questions please use the back of the sheet.

Primary reason(s) for seeking services:

Anger management Anxiety Coping Depression
 Eating disorder Fear/phobias Mental confusion Sexual concerns
 Sleeping problems Addictive behaviors Alcohol/drugs Hyperactivity
 Attention problems Learning/School Motivation Developmental
 Autism Challenging behaviors (please specify): _____

Other mental health and/or behavioral concerns (specify): _____

Family History**Parents**

With whom does the child live at this time? _____

Are parent's divorced or separated? _____

If Yes, who has legal custody? _____

Were the child's parents ever married? ___ Yes ___ No

Patient's Mother

Name: _____ Age: _____ Occupation: _____

Where employed: _____ Work phone: _____

Mother's education: _____

Is the child currently living with mother? ___ Yes ___ No

___ Natural parent ___ Step-parent ___ Adoptive parent ___ Foster home

___ Other (specify): _____

Is there anything notable, unusual or stressful about the child's relationship with the mother?

___ Yes ___ No If Yes, please explain: _____

How is the child disciplined by the mother? _____

For what reasons is the child disciplined by the mother? _____

Patient's Father

Name: _____ Age: _____ Occupation: _____

Where employed: _____ Work phone: _____

Father's education: _____

Is the child currently living with father? Yes No

Natural parent Step-parent Adoptive parent Foster home

Other (specify): _____

Is there anything notable, unusual or stressful about the child's relationship with the father?

Yes No If Yes, please explain: _____

How is the child disciplined by the father? _____

For what reasons is the child disciplined by the father? _____

Patient's Siblings and Others Who Live in the Household

Names of Siblings	Age	Gender	Lives	Quality of relationship with the patient		
				home	away	
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> home <input type="checkbox"/> away	<input type="checkbox"/> poor	<input type="checkbox"/> average	<input type="checkbox"/> good
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> home <input type="checkbox"/> away	<input type="checkbox"/> poor	<input type="checkbox"/> average	<input type="checkbox"/> good
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> home <input type="checkbox"/> away	<input type="checkbox"/> poor	<input type="checkbox"/> average	<input type="checkbox"/> good
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> home <input type="checkbox"/> away	<input type="checkbox"/> poor	<input type="checkbox"/> average	<input type="checkbox"/> good
Others living in the household			Relationship (e.g., cousin, foster child)			
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	_____	<input type="checkbox"/> poor	<input type="checkbox"/> average	<input type="checkbox"/> good
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	_____	<input type="checkbox"/> poor	<input type="checkbox"/> average	<input type="checkbox"/> good
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	_____	<input type="checkbox"/> poor	<input type="checkbox"/> average	<input type="checkbox"/> good
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	_____	<input type="checkbox"/> poor	<input type="checkbox"/> average	<input type="checkbox"/> good

Comments: _____

Family Health History

Have any of the following diseases occurred among the child's blood relatives? (parents, siblings, aunts, uncles or grandparents) Check those which apply:

- | | | |
|--|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Deafness | <input type="checkbox"/> Muscular Dystrophy |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glandular problems | <input type="checkbox"/> Perceptual motor disorder |
| <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> Heart diseases | <input type="checkbox"/> Mental Retardation |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Spinal Bifida |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Suicide |
| <input type="checkbox"/> Cleft lips | <input type="checkbox"/> Migraines | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Cleft palate | <input type="checkbox"/> Multiple sclerosis | _____ |

Comments re: Family Health: _____

Childhood/Adolescent History

Pregnancy/Birth

Has the child's mother had any occurrences of miscarriages or stillborns? Yes No

If Yes, describe: _____

Was the pregnancy with child planned? Yes No Length of pregnancy: _____

Mother's age at child's birth: _____ Father's age at child's birth: _____

Child number of total children.

How many pounds did the mother gain during the pregnancy? _____

While pregnant did the mother smoke? Yes No If Yes, what amount: _____

Did the mother use drugs of alcohol? Yes No If Yes, type/amount: _____

While pregnant, did the mother have any medical or emotional difficulties? (e.g., surgery, hypertension, medication)
 Yes No

If Yes, describe: _____

Length of labor: _____ Induced: Yes No Caesarean? Yes No

Baby's birth weight: _____ Baby's birth length: _____

Describe any physical or emotional complications with the delivery: _____

Describe any complications for the mother or the baby after the birth: _____

Length of hospitalization: Mother: _____ Baby: _____

Infancy/Toddlerhood Check all which apply:

<input type="checkbox"/> Breastfed	<input type="checkbox"/> Milk allergies	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Bottle fed	<input type="checkbox"/> Rashes	<input type="checkbox"/> Colic	<input type="checkbox"/> Constipation
<input type="checkbox"/> Not cuddly	<input type="checkbox"/> Cried often	<input type="checkbox"/> Rarely cried	<input type="checkbox"/> Overactive
<input type="checkbox"/> Resisted solid food	<input type="checkbox"/> Trouble sleeping	<input type="checkbox"/> Irritable when awakened	<input type="checkbox"/> Lethargic

Developmental History Please note the age at which the following behaviors took place:

Sat alone: _____ Dressed self: _____

Took 1st steps: _____ Tied shoelaces: _____

Spoke words: _____ Rode two-wheeled bike: _____

Spoke sentences: _____ Toilet trained: _____

Weaned: _____ Dry during day: _____

Fed self: _____ Dry during night: _____

The child's development was: slow average fast

Age for following developments (fill in where applicable)

Began puberty: _____ Menstruation: _____

Voice change: _____ Convulsions: _____

Breast development: _____ Injuries or hospitalization: _____

Issues that affected child's development (e.g., physical/sexual abuse, inadequate nutrition, neglect, etc.)

Education

Current school: _____ School phone number: _____
 Type of school: Public Private Home schooled Other (specify): _____
 Grade: _____ Teacher: _____ School Counselor: _____
 In special education? Yes No If Yes, describe: _____
 In gifted program? Yes No If Yes, describe: _____
 Has child ever been held back in school? Yes No If Yes, describe: _____
 Which subjects does the child enjoy in school? _____
 Which subjects does the child dislike in school? _____
 What grades does the child usually receive in school? _____
 Have there been any recent changes in the child's grades? Yes No
 If Yes, describe: _____
 Has the child ever undergone psychological testing? Yes No
 If Yes, describe: _____
 Check the descriptions which specifically relate to your child.

Feelings about School Work:

Anxious Passive Enthusiastic Fearful
 Eager No expression Bored Rebellious
 Other (describe): _____

Approach to School Work:

Organized Industrious Responsible Interested
 Self-directed No initiative Refuses Does only what is expected
 Sloppy Disorganized Cooperative Doesn't complete assignments
 Other (describe): _____

Performance in School (Parent's Opinion):

Satisfactory Underachiever Overachiever
 Other (describe): _____

Child's Peer Relationships:

Spontaneous Follower Leader Difficulty making friends
 Makes friends easily Long-time friends Shares easily
 Other (describe): _____

Who handles responsibility for your child in the following areas?

School: Mother Father Shared Other (specify): _____
 Health: Mother Father Shared Other (specify): _____
 Problem behavior: Mother Father Shared Other (specify): _____

If the child is involved in a vocational program or works a job, please fill in the following:

What is the child's attitude toward work? Poor Average Good Excellent
 Current employer: _____ Position: _____ Hours per week: _____
 How have the child's grades in school been affected since working? Lower Same Higher
 How many previous jobs or placements has the child had? _____
 Usual length of employment: _____ Usual reason for leaving: _____

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, school activities, scouts, etc.)

Activity	How often now?	How often in the past?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical/Physical Health

- | | | |
|--|---|---|
| <input type="checkbox"/> Abortion | <input type="checkbox"/> Hayfever | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Blackouts | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hives | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Influenza | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Lead poisoning | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Congenital problems | <input type="checkbox"/> Measles | <input type="checkbox"/> Severe colds |
| <input type="checkbox"/> Croup | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Severe head injury |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Thyroid disorders |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Mumps | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Ear aches | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Wearing glasses |
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Whooping cough |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Other skin rashes | <input type="checkbox"/> Other |
| <input type="checkbox"/> Encephalitis | <input type="checkbox"/> Paralysis | _____ |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Pleurisy | _____ |

List any current health concerns: _____

List any recent health or physical changes: _____

Nutrition

Meal	How often (times per week)	Typical foods eaten	Typical amount eaten			
Breakfast	___ / week	_____	<input type="checkbox"/> No	<input type="checkbox"/> Low	<input type="checkbox"/> Med	<input type="checkbox"/> High
Lunch	___ / week	_____	<input type="checkbox"/> No	<input type="checkbox"/> Low	<input type="checkbox"/> Med	<input type="checkbox"/> High
Dinner	___ / week	_____	<input type="checkbox"/> No	<input type="checkbox"/> Low	<input type="checkbox"/> Med	<input type="checkbox"/> High
Snacks	___ / week	_____	<input type="checkbox"/> No	<input type="checkbox"/> Low	<input type="checkbox"/> Med	<input type="checkbox"/> High
Comments: _____						

Most recent examinations

Type of examination	Date of most recent visit	Results
Physical examination	_____	_____
Dental examination	_____	_____
Vision examination	_____	_____
Hearing examination	_____	_____

Current prescribed medications	Dose	Dates	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Current over-the-counter meds	Dose	Dates	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Chemical Use History

Does the child/adolescent use or have a problem with alcohol or drugs? Yes No

If Yes, describe: _____

Counseling/Prior Treatment History

Information about child/adolescent (past and present):

	Yes	No	When	Where	Reaction or overall experience
Counseling/Psychiatric treatment	_____	_____	_____	_____	_____
Suicidal thoughts/attempts	_____	_____	_____	_____	_____
Drug/alcohol treatment	_____	_____	_____	_____	_____
Hospitalizations	_____	_____	_____	_____	_____

Behavioral/Emotional

Please check any of the following that are typical for your child:

- | | | |
|---|---|---|
| <input type="checkbox"/> Affectionate | <input type="checkbox"/> Frustrated easily | <input type="checkbox"/> Sad |
| <input type="checkbox"/> Aggressive | <input type="checkbox"/> Gambling | <input type="checkbox"/> Selfish |
| <input type="checkbox"/> Alcohol problems | <input type="checkbox"/> Generous | <input type="checkbox"/> Separation anxiety |
| <input type="checkbox"/> Angry | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Sets fires |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Head banging | <input type="checkbox"/> Sexual addiction |
| <input type="checkbox"/> Attachment to dolls | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Sexual acting out |
| <input type="checkbox"/> Avoids adults | <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Shares |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Hurts animals | <input type="checkbox"/> Sick often |
| <input type="checkbox"/> Blinking, jerking | <input type="checkbox"/> Imaginary friends | <input type="checkbox"/> Short attention span |
| <input type="checkbox"/> Bizarre behavior | <input type="checkbox"/> Impulsive | <input type="checkbox"/> Shy, timid |
| <input type="checkbox"/> Bullies, threatens | <input type="checkbox"/> Irritable | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Careless, reckless | <input type="checkbox"/> Lazy | <input type="checkbox"/> Slow moving |
| <input type="checkbox"/> Chest pains | <input type="checkbox"/> Learning problems | <input type="checkbox"/> Soiling |
| <input type="checkbox"/> Clumsy | <input type="checkbox"/> Lies frequently | <input type="checkbox"/> Speech problems |
| <input type="checkbox"/> Confident | <input type="checkbox"/> Listens to reason | <input type="checkbox"/> Steals |
| <input type="checkbox"/> Cooperative | <input type="checkbox"/> Loner | <input type="checkbox"/> Stomach aches |
| <input type="checkbox"/> Cyber addiction | <input type="checkbox"/> Low self-esteem | <input type="checkbox"/> Suicidal threats |
| <input type="checkbox"/> Defiant | <input type="checkbox"/> Messy | <input type="checkbox"/> Suicidal attempts |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Moody | <input type="checkbox"/> Talks back |
| <input type="checkbox"/> Destructive | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Teeth grinding |
| <input type="checkbox"/> Difficulty speaking | <input type="checkbox"/> Obedient | <input type="checkbox"/> Thumb sucking |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Often sick | <input type="checkbox"/> Tics or twitching |
| <input type="checkbox"/> Drugs dependence | <input type="checkbox"/> Oppositional | <input type="checkbox"/> Unsafe behaviors |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Over active | <input type="checkbox"/> Unusual thinking |
| <input type="checkbox"/> Enthusiastic | <input type="checkbox"/> Overweight | <input type="checkbox"/> Weight loss |
| <input type="checkbox"/> Excessive masturbation | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Withdrawn |
| <input type="checkbox"/> Expects failure | <input type="checkbox"/> Phobias | <input type="checkbox"/> Worries excessively |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Fearful | <input type="checkbox"/> Psychiatric problems | _____ |
| <input type="checkbox"/> Frequent injuries | <input type="checkbox"/> Quarrels | _____ |

Please describe any of the above (or other) concerns: _____

How are problem behaviors generally handled? _____

What are the family's favorite activities? _____

What does the child/adolescent do with unstructured time? _____

Has the child/adolescent experienced death? (friends, family pets, other) ___ Yes ___ No

At what age? _____ If Yes, describe the child's/adolescent's reaction: _____

Have there been any other significant changes or events in your child's life? (family, moving, fire, etc.)

___ Yes ___ No If Yes, describe: _____

Are you (on behalf of your child) or your child involved in any legal proceedings? (custody, probation, etc.)

Any additional information that you believe would assist me in understanding your child/adolescent?

Any additional information that would assist me in understanding current concerns or problems?

What are your goals for the current consultation, evaluation, or therapy request? _____

What family involvement would you like to see? _____

Do you believe the child is suicidal at this time? ___ Yes ___ No

If Yes, explain: _____

(ONLY COMPLETE IF THE PATIENT IS OVER THE AGE OF 18, OTHERWISE LEAVE BLANK)

Patient History Form – Adult Version

Patient's name: _____ Date: _____

Gender: __ F __ M Date of birth: _____ Age: _____

Form completed by (if someone other than Patient): _____

If you need any more space for any of the questions please use the back of the sheet.

Primary reason(s) for seeking services:

- __ Anger management __ Anxiety __ Coping __ Depression
__ Eating disorder __ Fear/phobias __ Mental confusion __ Sexual concerns
__ Sleeping problems __ Addictive behaviors __ Alcohol/drugs __ Psychosis
__ Relationship problems
__ Other mental health concerns (specify): _____

Type of therapy seeking: __ Individual __ Couples __ Family __ Psychological Testing

If seeking couples or family therapy, please provide the following information for others that will be attending sessions:

Table with 4 columns: Name, Date of Birth, Gender, Insurance Carrier. Includes multiple blank rows for data entry.

Family Information

Table with 7 columns: Relationship, Name, Age, Living (Yes/No), Living with you (Yes/No). Rows for Mother, Father, Spouse, Children.

Significant others (e.g., brothers, sisters, grandparents, step-relatives, half-relatives. Please specify relationship.

Table with 7 columns: Relationship, Name, Age, Living (Yes/No), Living with you (Yes/No). Multiple blank rows for data entry.

Other cultural/ethnic information: _____

Spiritual/Religious

How important to you are spiritual matters? ___ Not ___ Little ___ Moderate ___ Much

Are you affiliated with a spiritual or religious group? ___ Yes ___ No

If Yes, describe: _____

Were you raised within a spiritual or religious group? ___ Yes ___ No

If Yes, describe: _____

Would you like your spiritual/religious beliefs incorporated into the counseling?

___ Yes ___ No

If Yes, describe: _____

Legal

Current Status

Are you involved in any active cases (traffic, civil, criminal)? ___ Yes ___ No

If Yes, please describe and indicate the court and hearing/trial dates and charges: _____

Are you presently on probation or parole? ___ Yes ___ No

If Yes, please describe: _____

Past History

Traffic violations: ___ Yes ___ No DWI, DUI, etc.: ___ Yes ___ No

Criminal involvement: ___ Yes ___ No

Civil involvement: ___ Yes ___ No

If you responded Yes to any of the above, please fill in the following information.

Charges	Date	Where (city)	Results
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Education

Fill in all that apply: Years of education: _____

Currently enrolled in school? ___ Yes ___ No

___ High school grad/GED

___ Vocational: Number of years: _____ Graduated: ___ Yes ___ No

Major: _____

___ College: Number of years: _____ Graduated: ___ Yes ___ No

Major: _____

___ Graduate: Number of years: _____ Graduated: ___ Yes ___ No

Major: _____

Other training: _____

Special circumstances (e.g., learning disabilities, gifted): _____

Employment

Begin with most recent job, list job history: _____

Employer	Dates	Title	Reason left the job	How often miss work?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Currently: FT PT Temp Laid-off Disabled Retired
 Social Security Student
 Other (describe): _____

Military

Military experience? Yes No Combat experience? Yes No
 Where: _____
 Branch: _____ Discharge date: _____
 Date drafted: _____ Type of discharge: _____
 Date enlisted: _____ Rank at discharge: _____

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

Activity	How often now?	How often in the past?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical/Physical Health

- | | | |
|---|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Nose bleeds |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Drug abuse | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Abortion | <input type="checkbox"/> Ear infections | <input type="checkbox"/> STD's |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Eating problems | <input type="checkbox"/> Sleeping disorders |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches | <input type="checkbox"/> Smallpox |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sexual problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Measles | <input type="checkbox"/> Toothache |
| <input type="checkbox"/> Colds/Coughs | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Thyroid problems |

- Constipation Mumps Vision problems
- Chicken Pox Menstrual pain Vomiting
- Dental problems Miscarriages Whooping cough
- Diabetes Neurological disorders Other (describe): _____
- Diarrhea Nausea

List any current health concerns: _____

List any recent health or physical changes: _____

Nutrition

Meal	How often (times per week)	Typical foods eaten	Typical amount eaten			
Breakfast	___ / week	_____	___ No	___ Low	___ Med	___ High
Lunch	___ / week	_____	___ No	___ Low	___ Med	___ High
Dinner	___ / week	_____	___ No	___ Low	___ Med	___ High
Snacks	___ / week	_____	___ No	___ Low	___ Med	___ High

Comments: _____

Current prescribed medications	Dose	Dates	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Current over-the-counter meds	Dose	Dates	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Are you allergic to any medications or drugs? ___ Yes _____ No

If Yes, describe: _____

	Date	Reason	Results
Last physical exam	_____	_____	_____
Last doctor's visit	_____	_____	_____
Last dental exam	_____	_____	_____
Most recent surgery	_____	_____	_____
Other surgery	_____	_____	_____
Upcoming surgery	_____	_____	_____

Family history of medical problems: _____

Please check if there have been any recent changes in the following:

- Sleep patterns Eating patterns Behavior Energy level
- Physical activity level General disposition Weight Nervousness/tension

Describe changes in areas in which you checked above: _____

Chemical Use History

	Method of use and amount	Frequency of use	Age of first use	Age of last use	Used in last 48 hours		Used in last 30 days	
					Yes	No	Yes	No
Alcohol	_____	_____	_____	_____	_____	_____	_____	_____
Barbiturates	_____	_____	_____	_____	_____	_____	_____	_____
Valium/Librium	_____	_____	_____	_____	_____	_____	_____	_____
Cocaine/Crack	_____	_____	_____	_____	_____	_____	_____	_____
Heroin/Opiates	_____	_____	_____	_____	_____	_____	_____	_____
Marijuana	_____	_____	_____	_____	_____	_____	_____	_____
PCP/LSD/Mescaline	_____	_____	_____	_____	_____	_____	_____	_____
Inhalants	_____	_____	_____	_____	_____	_____	_____	_____
Caffeine	_____	_____	_____	_____	_____	_____	_____	_____
Nicotine	_____	_____	_____	_____	_____	_____	_____	_____
Over the counter	_____	_____	_____	_____	_____	_____	_____	_____
Prescription drugs	_____	_____	_____	_____	_____	_____	_____	_____
Other drugs	_____	_____	_____	_____	_____	_____	_____	_____

Substance of preference

- 1. _____ 3. _____
- 2. _____ 4. _____

Substance Abuse Questions

Describe when and where you typically use substances: _____

Describe any changes in your use patterns: _____

Describe how your use has affected your family or friends (include their perceptions of your use): _____

Reason(s) for use:

- Addicted Build confidence Escape Self-medication
- Socialization Taste Other (specify): _____

How do you believe your substance use affects your life? _____

Who or what has helped you in stopping or limiting your use? _____

Does/Has someone in your family present/past have/had a problem with drugs or alcohol?

Yes No If Yes, describe: _____

Have you had withdrawal symptoms when trying to stop using drugs or alcohol? Yes No

If Yes, describe: _____

Have you had adverse reactions or overdose to drugs or alcohol? (describe): _____

Have drugs or alcohol created a problem for your job? ___ Yes ___ No

If Yes, describe: _____

Counseling/Prior Treatment History

Information about Patient (past and present):

	Yes	No	When	Where	Your reaction to overall experience
Counseling/Psychiatric treatment	___	___	_____	_____	_____
Suicidal thoughts/attempts	___	___	_____	_____	_____
Drug/alcohol treatment	___	___	_____	_____	_____
Hospitalizations	___	___	_____	_____	_____
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	___	___	_____	_____	_____

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

- | | | |
|--|--|---|
| <input type="checkbox"/> Aggression | <input type="checkbox"/> Elevated mood | <input type="checkbox"/> Phobias/fears |
| <input type="checkbox"/> Alcohol dependence | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Recurring thoughts |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Gambling | <input type="checkbox"/> Sexual addiction |
| <input type="checkbox"/> Antisocial behavior | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Sexual difficulties |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Sick often |
| <input type="checkbox"/> Avoiding people | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Speech problems |
| <input type="checkbox"/> Cyber addiction | <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Irritability | <input type="checkbox"/> Thoughts disorganized |
| <input type="checkbox"/> Disorientation | <input type="checkbox"/> Judgment errors | <input type="checkbox"/> Trembling |
| <input type="checkbox"/> Distractibility | <input type="checkbox"/> Loneliness | <input type="checkbox"/> Withdrawing |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Memory impairment | <input type="checkbox"/> Worrying |
| <input type="checkbox"/> Drug dependence | <input type="checkbox"/> Mood shifts | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Panic attacks | _____ |

Briefly discuss how the above symptoms impair your ability to function effectively: _____

Any additional information that would assist me in understanding your concerns or problems:

What are your goals for therapy? _____

Do you feel suicidal at this time? ____ Yes _____ No

If Yes, explain: _____

IF you feel you need immediate care please call 911 or go directly to your nearest emergency room as we do not provide emergency care.

Privacy Policies Center for Professional Psychology

Janissa D. Jackson, Ph.D., PLLC Narissa R. Griffin, Ph.D. PLLC, Benjamin W. Storie, LPC-S, Danielle Wheeler, LMFT, LPC
Current Privacy Officer: Janissa D. Jackson, Ph.D.

This form describes the confidentiality of your medical records, how the information is used, your rights, and how you may obtain this information.

My Legal Duties

Uses and Disclosures for Treatment, Payment, and Health Care Operations

I 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 health record that could identify you.
- “Treatment, Payment and Health Care Operations”
 - *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
 - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I 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 my 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 care coordination.
- *Treatment is not* defined as reviewing prospective patient intake paperwork although this information is treated with the utmost care. If a patient is screened and not deemed appropriate for the services provided at the Center for Professional Psychology, the patient will then be given the option of retaining their intake paperwork or it will be shredded at that time with appropriate referrals provided “Use” applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- “Disclosure” applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

State and Federal laws require that I keep your medical records private. Such laws require that I provide you with this notice informing you of my privacy of information policies, your rights, and my duties. I am required to abide these policies until replaced or revised. I have the right to revise my privacy policies for all medical records, including records kept before policy changes were made. Any changes in this notice will be made available upon request before changes take place.

The contents of material disclosed to us in an evaluation, intake, or therapy session are covered by the law as private information. I respect the privacy of the information you provide us and I abide by ethical and legal requirements of confidentiality and privacy of records.

Use of Information

Information about you may be used by the personnel associated with my office for diagnosis, treatment planning, treatment, and continuity of care. I may disclose it to health care providers who provide you with treatment, such as doctors, nurses, mental health professionals, and mental health students and mental health professionals or business associates affiliated with my office such as billing, quality enhancement, training, and audits. In any disclosure, the minimum necessary will be disclosed in order to protect the privacy of the patient.

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 or personal representative. It is the policy of my office not to release any information about a patient without a signed release of information except in certain emergency situations or exceptions in which patient information can be disclosed to others without written consent. Some of these situations are noted below, and there may be other provisions provided by legal requirements.

Duty to Warn and Protect

When a patient discloses intentions or a plan to harm another person or persons, the health care professional is required to report this information to legal authorities and may need to seek hospitalization for the patient. In cases in which the patient discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the patient.

Public Safety

Health records may be released for the public interest and safety for public health activities, judicial and administrative proceedings, law enforcement purposes, serious threats to public safety, essential government functions, military, and when complying with

worker's compensation laws. This could include Health Oversight Activities such as receiving a subpoena from the Arkansas Board of Examiners in psychology.

Abuse

If a patient states 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, the health care professional is required to report this information to the appropriate social service and/or legal authorities. If a patient is the victim of abuse, neglect, violence, or a crime victim, and their safety appears to be at risk, I may share this information with law enforcement officials to help prevent future occurrences and capture the perpetrator. This applies to adult and domestic abuse as well..

For Operations

I may use and give information about you to make sure that the services and benefits you get are correct and of high quality. I may share your health information with business partners who perform work for my office and I require that my business partners use the same level of privacy and security as I do when handling your health information.

Judicial and 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 I will not release information without the written authorization of you or your legally appointed representative or a court order. The privilege does not apply when you are being evaluated by a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

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 their child's or spouse's 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.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor patients or patients of any age having a legal guardian, the legal guardian retains the right to access the patient's records. Appropriate procedures to ensure the authority of that legal guardian will be made such as requesting court documentation.

Worker's Compensation/Specialized Government Functions

In the event that an employer seeks treatment on behalf of a patient, certain information is typically required to be reported to that employer. The patient must review and choose to authorize this information if it is required for payment. This does not apply to any psychotherapy notes. Furthermore, at times release of information is required by government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

Other Provisions

When payment for services are the responsibility of the patient, or a person who has agreed to providing payment, and payment has not been made in a timely manner, collection agencies may be utilized in collecting unpaid debts or I may elect to pursue small claims court. The specific content of the services (e.g., diagnosis, treatment plan, progress notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the patient's credit report may state the amount owed, the time-frame, and the name of the office or collection source.

Insurance companies, managed care, and other third-party payers are given information that they request regarding services to the patient. Information which may be requested includes type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, and summaries. The minimum necessary will be carefully determined by the treating psychologist.

Information may be disclosed to other entities that have a formal business associate contract with, in which they promise to maintain the confidentiality of this data except as is specifically allowed in the contract or otherwise specified by the law. If you wish, you may request and obtain a list of all current business associate contracts.

Information about patients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the patient, or any identifying information, is not disclosed. Clinical information about the patient is discussed.

In the event in which my office must telephone the patient for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please notify me in writing where I may reach you by phone and how you would like me to identify myself. For example, you might request that when I phone you at home or work, I do not say the name of my office or the nature of the call, but rather my first name only. If this information is not provided to me (see first page of new patient paperwork), I will adhere to the following procedure when making phone calls: First I will ask to speak to the patient (or guardian) without identifying my full name. If the person answering the phone asks for more identifying information I will say that it is a personal call. I will not identify my office (to protect confidentiality). If I reach an answering machine or voice mail I will follow the same guidelines.

Your Rights

You have the right to request to review or receive your medical files. The procedures for obtaining a copy of your medical information is as follows. You may request a copy of your records in writing with an original (not photocopied) signature. If your request is denied, you will receive a written explanation of the denial. Records for non-emancipated minors must be requested by their custodial parents or legal guardians. The charge for this service is \$.15 per page, plus postage or if requested electronically, only the cost of the appropriate jump drive device will be assessed.

You have the right to cancel a release of information by providing me with written notice. If you desire to have your information sent to a location different than the address on file, you must provide this information in writing.

You have the right to restrict which information might be disclosed to others.

You have the right to request an amendment to your records. This request will be considered and a response will be given to you in writing as well as an explanation of your additional rights if this amendment is denied by the psychologist.

You have the right to request that information about you be communicated by other means or to another location. This request must be made to me in writing.

You have the right to disagree with the medical records in my files. You may request that this information be changed. Although I might deny changing the record, you have the right to make a statement of disagreement, which will be placed in your file.

You have the right to restrict disclosure of PHI to a health plan if you pay out of pocket in full for the healthcare service.

You have the right to be notified if there is a breach of any unsecured Protected Health Information.

You have the right to know what information in your record has been provided to whom. Request this in writing.

You must sign an authorization before we can release your PHI for any uses or disclosures not described in this privacy notice.

You will be given a written copy of this notice.

Complaints

If you have any complaints or questions regarding these procedures, please contact your service provider directly or Dr. Jackson who serves as the privacy officer. We will get back to you in a timely manner. For psychologists, you can also contact the state psychological association and speak to the chairperson of the ethics committee. The number is (501) 614-6500. He or she can help clarify your concerns or tell you how to file a complaint. You may also contact the Arkansas Psychology Board (501-682-6167). For counselors, please contact the Arkansas Board of Examiners in Counseling (501-683-5800). These are the organizations that license those of us in the independent practice of psychology and professional counseling respectively. You may also submit a complaint to the Secretary of the U.S. Dept. of Health and Human Services(1-800-368-1019). If you file a complaint I will not retaliate in any way.

Private Practice Social Media Policy

This document outlines office policies related to use of Social Media. Please read it to understand how we at Center for Professional Psychology conduct ourselves on the Internet as mental health professionals and how you can expect us to respond to various interactions that may occur between us on the Internet.

If you have any questions about anything within this document, we encourage you to bring them up during your next visit. As new technology develops and the Internet changes, there may be times when we need to update this policy. If we do so, we will notify you in writing of any policy changes and make sure you have a copy of the updated policy.

FRIENDING

We do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). We believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

FOLLOWING

Our primary concern is your privacy. If you share this concern, there are more private ways to follow us on Twitter (such as using an RSS feed or a locked Twitter list), which would eliminate your having a public link to our content. You are welcome to use your own discretion in choosing whether to follow us.

Note that we will not follow you back. We do not follow current or former clients on blogs or Twitter. Our reasoning is that we believe casual viewing of clients' online content outside of the therapy hour can create confusion in regard to whether it's being done as a part of your treatment or to satisfy our personal curiosity. In addition, viewing your online activities without your consent and without our explicit arrangement towards a specific purpose could potentially have a negative influence on our working relationship. If there are things from your online life that you wish to share with us, please bring them into your sessions where we can view and explore them together, during the therapy hour.

INTERACTING

Please do not use SMS (mobile phone text messaging) or messaging on Social Networking sites such as Twitter, Facebook, or LinkedIn to contact us. These sites are not secure and we may not read these messages in a timely fashion. Do not use Wall postings, @replies, or other means of engaging with us in public online if we have an already established client/therapist relationship. Engaging with us this way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart.

If you need to contact us between sessions, the best way to do so is by phone.

USE OF SEARCH ENGINES

It is NOT a regular part of our practice to search for clients on Google or Facebook or other search engines. Extremely rare exceptions *may* be made during times of crisis. If we have a reason to suspect that you are in danger and you have not been in touch with us via our usual means (coming to appointments, phone, or email) there *might* be an instance in which using a search engine (to find you, find someone close to you, or to check on your recent status updates) becomes necessary as part of ensuring your welfare. These are unusual situations and if we ever resort to such means, we will fully document it and discuss it with you at your next appointment.

GOOGLE READER

We do not follow current or former clients on Google Reader and we do not use Google Reader to share articles. If there are things you want to share with us that you feel are relevant to your treatment whether they are news items or things you have created, we encourage you to bring these items of interest into our sessions.

BUSINESS REVIEW SITES

You may find our psychology practice on sites such as Yelp, Healthgrades, Yahoo Local, Bing, or other places which list businesses. Some of these sites include forums in which users rate their providers and add reviews. Many of these sites comb search engines for business listings and automatically add listings regardless of whether the business has added itself to the site. If you should find our listing on any of these sites, please know that our listing is NOT a request for a testimonial, rating, or endorsement from you as our client.

The American Psychological Association's Ethics Code states under Principle 5.05 that it is unethical for psychologists to solicit testimonials: "Psychologists do not solicit testimonials from current therapy clients/patients or other persons who because of their particular circumstances are vulnerable to undue influence."

Of course, you have a right to express yourself on any site you wish. But due to confidentiality, we cannot respond to any review on any of these sites whether it is positive or negative. We urge you to take your own privacy as seriously as we take our commitment of confidentiality to you. You should also be aware that if you are using these sites to communicate indirectly with us about your feelings about our work, there is a good possibility that we may never see it.

If we are working together, we hope that you will bring your feelings and reactions to our work directly into the therapy process. This can be an important part of therapy, even if you decide we are not a good fit. None of this is meant to keep you from sharing that you are in therapy with us wherever and with whomever you like. Confidentiality means that we cannot tell people that you are our client and our Ethics Code prohibits us from requesting testimonials. But you are more than welcome to tell anyone you wish that you see a therapist here, or how you feel about the treatment we have provided to you, in any forum of your choosing.

If you do choose to write something on a business review site, we hope you will keep in mind that you may be sharing personally revealing information in a public forum. We urge you to create a pseudonym that is not linked to your regular email address or friend networks for your own privacy and protections.

LOCATION-BASED SERVICES

If you use location-based services on your mobile phone, you may wish to be aware of the privacy issues related to using these services. We do not place our practice as a check-in location on various sites such as Foursquare, Gowalla, Loopt, etc. However, if you have GPS tracking enabled on your device, it is possible that others may surmise that you are a therapy client due to regular check-ins at our office on a weekly basis. Please be aware of this risk if you are intentionally "checking-in" from our office or if you have a passive LBS app enabled on your phone.

REFERENCE

Keely Kolmes, Psy.D. – Social Media Policy – 4/26/10