General Information

What are your preferred gender pronouns? like his, her, them _____

Name _____

Address _____

_____

State _____

Date of Birth _____

Email _____

Home Phone _____

Mobile Phone _____

Work Phone _____

What phone number would you prefer the Center Holistic Mental Health and Sexual Therapy to contact you?
- Mobile Phone ☐
- Home Phone ☐
- Work Phone ☐

Would it be ok you leave a voice message?
- Yes ☐
- No ☐

If so, on what phone number could we leave a voice mail message?
- Mobile Phone ☐
- Home Phone ☐
- Work Phone ☐

Email is not a 100 % secure form of communication, but we at the Center Holistic Mental Health and Sexual Therapy take all necessary precautions to minimize that risk. Would it be ok to email you?
- Yes ☐
- No ☐

What method of communication do you prefer Center Holistic Mental Health and Sexual Therapy contact you by?
- Text ☐
- Phone ☐
- Email ☐

How did you hear about our practice?
- Website ☐
- Internet Search ☐
- Social Media ☐
- CHMHST Newsletter ☐
- Medical professional ☐ Please specify _____
- Mental Health ☐ Please specify _____
- Other ☐ Please specify _____

Please provide your credit card to hold your session time. You may change or cancel a session up to 24 hours from the session time without being charged for the session. If given less then 24-hour notice of a cancelation and the slot is not filled, you will be charged the full session amount. We take Visa, Master Card, American Express, and Discover
We are proud member of the Cigna and Blue Cross/Blue Shield Provider Networks.

Name on Card _____

Card Number _____

Expiration Date _____

Billing Address _____

_____

_____

Code
On back of the card _____

Insurance Company
Cigna ☐
BCBS ☐
Private Pay ☐

Member ID _____

Group ID _____

Phone Number
on the back of insurance
Card _____

Signature Print Name Date

Historical Data
Mental Health and Medical History

What are the concerns and issues that have you made seek therapy?

How long have the issues and concerns you are seeking treatment for been an issue?

Have you tried to or thought about ending your life? If so, when was your last attempt?

If you think you may be a threat for suicide please call 911, go straight to the emergency room, or call the suicide hotline 1-800-273-8255.

Have you thought about ending your life in the last 6 months? If so on scale of 1-10, 1 being no thoughts 10 being I think

If you think you may be a threat for suicide please call 911, go straight to the emergency room, or call the suicide hotline 1-800-273-8255.

Have attempted or thought about ending your life in the past? If so How old where you and what happen?

In the past, have you sought psychological treatment?

Has anyone else in your family sought psych treatment? If, so for what reason and for how long? What age where they whey they sought treatment?

Please list all medication including over the counter medications you take on a regular basis and Cannabis?

Have you been hospitalized for any mental health reasons?
If so when? For what reason? And for how long?

Have you been DX with Cancer if so, what kind of cancer and are you still being treated or are you in remission? How long ago where diagnosis and what stage?

Please list any medical procedure especially on any part of the reproductive system?

Overall how do you describe your everyday health

Do you experience any of these symptoms and medical conditions? Please check as many as apply.

Hallucinations	☐	Restlessness	☐	Poor personal Hygiene	☐	Trouble getting or maintaining an Erection	☐
Low Energy	☐	Relationship/ Marital conflict	☐	black out or "lost time"	☐	Excessive Gambling	☐
Depressed Mood	☐	TMJ	☐	Difficulty with long-term memory	☐	Asthma	☐
Lack of sleep	☐	Anger	☐	Feel like you can't focus on tasks	☐	Trouble getting or maintaining an Erection	☐
Increased sex drive	☐	Difficulty falling asleep	☐	Forgetting things	☐	Inability to Orgasm	☐
Decreased sex drive	☐	Difficulty staying asleep	☐	Difficulty with short-term memory	☐	Vaginal Dryness even when aroused	☐
Headaches or Migraines	☐	Premature Ejaculation	☐	Difficulty with long-term memory	☐	Woke up with no idea how you got there.	☐
Hearing Voices	☐	Muscular tension	☐	Lost interest in things you once enjoyed	☐	Vulva/Vaginal Pain	☐
Irritability	☐	Feeling Isolated	☐	Felling Anxiety when in social encounters	☐	Panic Attacks	☐
Heart Attack	☐	High Blood Pressure	☐	Semen Allergy	☐	Peyronie's Disease	☐
Traumatic Brain Injury	☐	Diabetes	☐	Low-Testosterone	☐	Low-Estrogen	☐
Hay Fever Allergies	☐	Seizures	☐	Sleep Apnea	☐	Weaken Immune system	☐
Irritable Bowl/Crones Diseases/	☐	Infertile Issues	☐	Endometriosis	☐	Eating disorder	☐

Do you suffer from any other symptoms or condition not listed?

_____

_____

_____

_____

Sexual History

What age was your first experience with penetrative sex? _____

What age was your first sexual experience? _____

What age did you start masturbating? _____

What Form of birth control do you use? _____

Do you use male or female condoms? _____

When was the last time you had sex? _____

What is your HIV status? _____

How often do you and your partner have sex? _____

Have you been the victim of a sexual assault or abuse? If so at what age? How long did the abuse take place?

Have you been diagnosed with Sexual Transmitted Infection? If so, how long ago? What was the diagnosis? Have you been treated?

What is your gender?
Cis means you are the same gender as on your birth certificate

- Cis Female ☐
- Cis Male ☐
- Non-Binary/ Third Gender ☐
- Transgender Female ☐
- Transgendered Male ☐
- Prefer not to say ☐
- Prefer to self-describe _____ ☐

What is your Sexual Orientation?

- Straight/Heterosexual ☐
- Gay or Lesbian ☐
- Bisexual ☐
- Prefer to self-describe _____ ☐
- Prefer not to say ☐

Relationship History

If single please fill out this section about information about your most recent relationship

What is your relationship status?

- Long-term Relationship ☐
- Single ☐
- Married ☐
- Domestic partnership ☐
- Divorced ☐
- Separated ☐
- Widowed ☐

Tell me about your current relationship? How did you meet? How long have you been a couple? How long have you been married?

Has there been infidelity? If so, how many? how long did they last? Are they still going on? Does your partner know? Is the infidelity something you are willing to discuss in session as a couple?

On a scale of 1-10 1- meaning the lowest and 10 being the highest

How satisfied are you with relationship? _____

How much do you love your partner/s? _____

How mad are you at your partner/s currently? _____

How happy are you in the relationship? _____

How attracted are you to your partner/s? _____

How do you describe your sex life with your partner/s? _____

How Happy are you about your own sexual performance? _____

How satisfied are you with your sex life? _____

Substance Abuse History

Do you consume alcohol? If so, how much do you drink per day/month/year? _____

_____

Do you consume recreation cannabis? If so, how much do you drink per day/month/year? _____

_____

Do you consume any other drugs? If so, what drugs? How much do you drink per day/month/year? _____

_____

In your past what drugs have experimented with? _____

_____

When was the last time you got drunk?

How often do you get drunk? _____

Have you blacked out from drinking? If so, when? _____

When was the last time you were high?

How often do you get high? _____

Have you been to NA/AA/Alanon? If so, for how long have been going to meetings? _____

Have you been to a rehab program? If so, when and how many times? _____

Policies and Procedures

Welcome to the Center for Holistic Mental Health and Sexual Therapy, LLC (CHMHST). It's my goal to provide the highest quality mental health care possible, and to provide an atmosphere of mutual respect and trust. This document is designed to explain the rights and obligations for you, the client, and myself, the therapist. Maryland Law enforces some of these rights and laws; others are established herein by contractual agreement between you the client and CHMHST your care provider. Any concerns or questions regarding the matters stated herein should be discussed directly with me.

Confidentiality

All information and communication between you and me in the course and continuance of the psychotherapeutic relationship will be treated as strictly confidential. As the client, you control whether or not I may disclose confidential information. You have the power to choose to waive confidentiality with a written agreement. There are exceptions to confidentiality mandated by the State of Maryland Law. Under the following circumstances I am legally bound to breach confidentiality:

- When I have cause to suspect that a child, an elderly person or an individual with disability has been or may be abused.
- When I have reasonable cause to believe that a client poses an imminent risk of harming themselves or another person.
- When I am legally compelled to testify or surrender your records to a valid court order or warrant.
- For clients under the age of 18 your guardian has right to know limited information including session notes.

Information from a session where a member of a couple wants to see me 1 on 1 for a session, confidentiality will apply and only information with permission will be revealed to the partner in a couple's session.

Clients generally wish to establish certain limited waivers of confidentiality. Unless otherwise specified in writing you agree to the following limited waivers:

- **To the referral source**.-You agree that I may contact the individual or agency who referred you and may convey the following limited information:
    - The fact that you have been seen and evaluated by CHMHST.
    - The number of sessions you have attended or missed.
    - General comments regarding your prognosis, fitness for employment, and participation in treatment.

- **For medical consultation**-You agree that I may consult with your physician or physicians. You authorize the release of information from your physician to me and vice versa to facilitate such consultation.

- **For consultation-** with professional peers. From time to time, I may consult with my professional peers regarding a clinical matter. You authorize the release of information reasonably necessary to a consultation. It is understood that your name will not be released to the consulting clinician in such cases.

- **Referrals-** you and I may deem it appropriate to make a referral to another practitioner for specific services. I may know professionals in my field and in related fields and will gladly make any necessary arrangements. My knowledge as to their competence comes in part from reports from other clients, and thus, I cannot take personal responsibility for their competence.

Your session will start on time whether you are here or not. Arriving after our scheduled session starts, the time missed will be charged as if you were there and the full fee will be assessed.

Telephone Calls

When you call my office, I will answer the call unless I am in session or away from my desk. Please leave a message and I will do everything in my power to return your call within next 24 hours. **If you find yourself in an emergency situation and need to talk immediately, please hang up and dial 911 or go to your nearest emergency room or the suicide prevention hotline (800) 273-8255**

Payment

Each 60-minute session will cost 120 dollars. Payment is expected at the start of each session. Cash, personal checks, and most credit cards are acceptable forms of payment. If special circumstances exist that render it difficult for you to make payment as expected, please discuss it with me. If unable to pay for the session, a two session grace period after which if no payment is received for the outstanding balance, a third session will not be scheduled until the previous two sessions are paid in full.

Because of the vast number of insurance companies that have separate forms and procedures, I do not bill insurance companies for you unless you are covered by Cigna or Blue Cross/Blue Shield. I would be happy to issue you a “super bill” (receipt) that will provide all the information you will need for reimbursement from your insurance company for services rendered so you can submit directly to your insurance company.

Cancelation and No-Show Policy

A 24 hour notice of cancellation is required. Please recognize that when you make an appointment this time is being reserved for you. If you miss an appointment that is time that could have been scheduled for another client. Therefore, it is necessary to charge you the full session rate for any appointments missed without 24-hour notice of cancellation. If you do not, show without a 24-hour notice the credit card provided will be charged and an invoice will be mailed to you letting know you of the charge.

It is important for you to arrive on time for your scheduled appointment. Therefore, should you arrive late, your session will still end at the scheduled time, and you will be billed for the entire session.

Inclement weather is a concern in DC area, especially snow. My office will close if the Federal Government is closed for weather related reasons. Sessions will be considered canceled and no cancellation fee will be issued. If the government is open and you are unable to make the session due to weather, please contact me to make arrangements. If no contact is made, you will be charged for the session in full.

Consent to Treatment

I consent to psychotherapeutic evaluation and treatment. I have read the above information and agree with the terms stated therein.

Signature_____

Printed Name_____

Date _____