LIFE MANAGEMENT ASSOCIATES, LLC

LMA

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600 Dewey Blvd., Suite B, Butte, MT 59701
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Phone: 406-782-4778
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Welcome and thank you for your interest in receiving services at Life Management Associates, LLC.

Your appointment is scheduled on _____, _____/_____/_____, at ____: _____AM / PM, with
Day Date Time

☐ Jeffrey A. Watson, M.Ed., LCPC, LMFT, FAPA
☐ Mary L. Watson, MS, LCPC, LMFT
☐ Sarah M. Frazer, MS, LAC, LCPC
☐ Laura L. Watson, MSW, LCSW
☐ Kathleen J. Chavis, MS, LAC, LCPC
☐ Katherine R. Moore, MA, LCPC, MHPP

In: ☐ Butte or ☐ Deer Lodge

It is important that we start our relationship with good communication. One way to establish the open communication necessary to make the services you receive successful is to gather the necessary important information. Attached you will find our new client intake packet. Please take the time to read through, complete, and sign these documents. Without this information, we may not be able to provide the service you are requesting. If you find yourself unsure of how to complete the documents, please feel free to call and ask questions. If you are unable to complete the documents before your first session, please call our office or the individual with whom you are scheduled to seek approval to meet without the completed documents. Individuals who arrive without the completed documents may be rescheduled or denied services.

Life Management Associates, LLC is a private practice group of professionals who work with a variety of individual, couple, and family issues. We provide evaluations and treatment for the full spectrum of life issues and potential problems. Our evaluation and treatment services cover children, adolescents, and adults. We believe that our group can meet your needs.

Our HIPAA privacy policy is posted in our office waiting room. You may request a copy of this policy from any of our staff at any time. This notice explains how Life Management Associates, LLC follows all laws and regulations to safeguard your healthcare information. If you have any questions, call (406) 782-4778 and ask to speak with Jeffrey Watson.

Mission Statement

> *The mission of Life Management Associates, LLC is to be the leader in providing the most comprehensive and the highest quality healthcare services to the members of the communities we serve. We provide professional mental health services through progressive, integrated care within a private practice setting. With compassion and excellence,* LMA, LLC *strives to promote wellness, relieve suffering, and restore health.*

Feel free to ask questions at any time. Please direct all billing inquiries to our office staff at (406) 782-4778. We will be more than willing to help in any manner we can.

Jeffrey, Mary, Sarah, Laura, Kathy & Katie

Navigating Life's Obstacles…….Choose LMA

LIFE MANAGEMENT ASSOCIATES, LLC

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INFORMED CONSENT, MENTAL HEALTH AND/OR THERAPY SERVICES

CLIENT NAME(S)_____ ☐ **BUTTE OFFICE** ☐ **DEER LODGE OFFICE**

Welcome to Life Management Associates, LLC. We are pleased that you selected this practice for your mental health and/or therapy services, and we're sincerely looking forward to assisting you. This document is designed to inform you about what you can expect from us, policies regarding confidentiality, emergencies, and several other details regarding your treatment here at Life Management Associates, LLC. Although providing this document is part of an ethical obligation to our profession, more importantly, it is part of our commitment to you, to keep you fully informed of every part of your therapeutic experience. Please know that your relationship with us is a collaborative one, and we welcome any questions, comments, or suggestions regarding your course of mental health and/or therapy services at any time.

BENEFITS & RISKS OF PSYCHOTHERAPY

Participation in therapy can result in many benefits to you, including improved interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits requires effort on your part. Psychotherapy requires your active involvement, honesty, and openness to change your thoughts, feelings, and/or behavior. We will ask for your feedback and views on your therapy and its progress. Sometimes more than one approach can be helpful.

During the initial evaluation or the course of therapy, remembering unpleasant events, feelings, or thoughts may result in your experiencing considerable discomfort, strong feelings, anxiety, depression, insomnia, etc. We may challenge some of your assumptions or perceptions or propose different ways of thinking about or handling situations that may cause you to feel upset, angry, or disappointed. Attempting to resolve issues that brought you into therapy may result in changes that were not originally intended. Psychotherapy may result in decisions to change behaviors, employment, substance use, schooling, housing, or relationships. Change can sometimes be quick and easy, but more often it can be gradual and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results.

TERMINATION AND FOLLOW-UP

Deciding when to stop our work together is meant to be a mutual process. Before we stop, we will discuss how you will know if or when to come back or whether a regularly scheduled "check-in" might work best for you. If it is not possible for you to phase out of mental health and/or therapy services, we recommend that we have closure on the mental health and/or therapy services process with at least one termination session.

Noncompliance with treatment recommendations may necessitate early termination of services. We will look at your issues with you and exercise our educated judgment about what treatment will be in your best interest.

Your responsibility is to make a good faith effort to fulfill the treatment recommendations to which you have agreed. If you have concerns or reservations about our treatment recommendations, we strongly encourage you to express them, so that we can resolve any possible differences or misunderstandings.

If, during our work together, we assess that we are not effective in helping you reach your therapeutic goals, we are obliged to discuss this with you and if appropriate, terminate treatment and give you referrals that may be of help to you. If you request it and authorize it in writing, we may talk to the psychotherapist of your choice (with your permission only) to help with the transition. If at any time you want another professional's opinion or wish to consult with another therapist, we will assist you in finding someone qualified. You have the right to terminate treatment at any time. If you choose to do so, we will offer to provide you with names of other qualified professionals whose services you might prefer.

If you commit violence to, verbally or physically threaten or harass us, the office, or our families, we reserve the right to terminate your treatment unilaterally and immediately. Failure or refusal to pay for services after a reasonable time is another condition for termination of services. Please contact us to make payment arrangements any time your financial situation changes.

INFORMED CONSENT, MENTAL HEALTH AND/OR THERAPY SERVICES

DUAL RELATIONSHIPS

Mental health and/or therapy services never involve sexual, business, or any other dual relationships that could impair our objectivity, clinical judgment or therapeutic effectiveness or could be exploitive in nature. It is possible that during your treatment, we may become aware of other preexisting relationships that may affect our work together, and we will do our best to resolve these situations ethically, but this may entail our needing to stop working together, depending upon the type of conflict. Please discuss this with us if you have questions or concerns.

CONFIDENTIALITY & RECORDS

As a mental health and/or therapy services client, you have privileged communication. This means that your relationship with us as a client, all information disclosed in our sessions, and the written and electronic health records of those sessions are confidential and may not be revealed to anyone without your written permission, except where law requires disclosure. Most of the provisions explaining when the law requires disclosure are described in our Notice of Privacy Practices.

When Disclosure Is Required by Law: Disclosure is required when there is a reasonable suspicion of child, dependent adult, or elder maltreatment (abuse or neglect), when a client presents a danger to self or to others, or is gravely disabled. If a judge issues a court order for psychotherapy records and/or my testimony, I will be required by law to disclose this information.

When Disclosure May Be Required: Disclosure may be required in a legal proceeding. If you place your mental status at issue in litigation that you initiate, the defendant may have the right to obtain your psychotherapy records and/or my testimony. If you have not paid your bill for treatment for a long period of time, your name, payment record, and last known address may be sent to a collection agency or small claims court.

Couples or Relationship Therapy: In couples or relationship therapy or when different family members are seen individually, as a part of the couples or family therapy, confidentiality and privilege do not apply between the couple or among family members. Please see our attached, separate No Secrets Policy.

Emergencies: If there is an emergency during our work together in which we become concerned about your personal safety, the possibility of you injuring someone else, or about you receiving psychiatric care, we will do whatever we can within the limits of the law to prevent you from injuring yourself or another and to ensure that you receive appropriate medical care. For this purpose, we may contact the Emergency Contact whose name and information you have provided on your Client Questionnaire.

Health Insurance and Confidentiality of Records: Your health insurance carrier may require disclosure of confidential information to process claims. Only the minimum necessary information will be communicated to your insurance carrier, including diagnosis, the date and length of our appointments, and what services were provided. Often the billing statement and your company's claim form are sufficient. Sometimes treatment summaries or progress toward goals are also required.

Confidentiality of E-mail, Voice Mail, and Fax Communication: E-mail, voice mail, and fax communication can be accessed by unauthorized people, compromising the privacy and confidentiality of such communication. LMA cannot guarantee confidentiality of e-mail, voice mail, and fax communication. If you choose to communicate confidential information with LMA via e-mail, voice mail, and fax communication, LMA will assume that you have made an informed decision and LMA will view it as your agreement to take the risk that e-mail, voice mail, and fax communication may be intercepted.

Life Management Associates, LLC utilizes TherapyNotes, a HIPAA-compliant, web-based mental health practice management program for client scheduling, electronic-medical records, and integrated billing.

Please initial that you have read this page (for couples, two sets of initials are required) _____

INFORMED CONSENT, MENTAL HEALTH AND/OR THERAPY SERVICES

Consultation: We consult regularly with other professionals regarding our clients to provide you with the best possible service. Names or other identifying information are never mentioned; client identity remains completely anonymous and your confidentiality will be fully maintained. If, for some reason, we believe it is important to consult with another professional in-depth, and we believe identifying information about you may be shared, we will have you sign a release of information allowing us to share this information. Without such a release, we will not consult with another professional providing information that might lead another person to be able to identify you.

Release of Information: Considering all the above exclusions, upon your request and with your written consent, we may release limited information to any person/agency you specify, unless we conclude that releasing such information might be harmful to you. If we reach that conclusion, we will explain the reason for denying your request.

TECHNOLOGY STATEMENT

In our ever-changing technological society, there are several ways we could potentially communicate and/or follow each other electronically. It is of utmost importance to us that we maintain your confidentiality, respect boundaries, and ascertain that your relationship with us remains therapeutic and professional. Therefore, Life Management Associates, LLC has developed the following policies:

Cell phones: It is important for you to know that cell phones may not be completely secure and confidential. However, we realize that most people have and utilize a cell phone. Your therapist may also use a cell phone to contact you. If this is a concern for any reason, please feel free to discuss this with your therapist.

Electronic Communications (Email & Text Messages): We cannot ensure the confidentiality of any form of communication through electronic media, including text messages. You are also advised that any email sent to us via computer in a work-place environment is legally accessible by an employer. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, we will do so. While we may try to return messages in a timely manner, we cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

We are ethically and legally obligated to maintain records of each time we meet, or correspond via electronic communication such as email or text messaging. These records include a brief synopsis of the conversation along with any observations or plans for the next meeting. A judge can order release of your records for a variety of reasons, and if this happens, we must comply.

Social Networking: It is our policy not to 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. You are welcome to follow Life Management Associates, LLC Facebook site. However, please do so only if you are comfortable with the public knowing your name is attached to Life Management Associates, LLC. If you have questions about this, please bring them up when we meet and we can talk more about it.

Internet Searches: While our present or potential clients might conduct online searches about the practice and/or us, we do not search my clients with Google, Facebook, or other search engines unless there is a clinical need to do so, as in the case of a crisis or to assure your physical wellbeing. If clients ask us to conduct such searches or review their websites or profiles and we deem that it might be helpful, we will consider it on a case by case basis and only after discussing possible impacts to our professional relationship and your privacy.

In summary, technology is constantly changing, and there are implications to all the above that we may not realize now. Please feel free to ask questions and know that we are open to any feelings or thoughts you have about these and other modalities of communication.

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INFORMED CONSENT, MENTAL HEALTH AND/OR THERAPY SERVICES

MENTAL HEALTH EMERGENCIES

We are outpatient therapists, and we are set up to accommodate individuals who are reasonably safe and resourceful. We do not carry beepers, nor are we available always. If at any time this does not feel like sufficient support, please inform us, and we can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. Generally, we will return phone calls within 24-48 hours. If you have a mental health emergency, we urge you NOT to wait for a call back, but to do one or more of the following:

- Call 911.
- Call St. James Healthcare at (406) 723-2500 or Western Montana Mental Health's Crisis Hotline at (406) 497-9069.
- Go to your nearest emergency room.

We are requesting and consenting to the following services:

☐ Mental health evaluation, interpretation of results, & preparation of reports
☐ Counseling/Psychotherapy (individual, couples, family, or group)
☐ Substance abuse/addiction evaluation and interpretation of results
☐ Family systems evaluation, interpretation of results, & preparation of reports
☐ Child custody evaluation, interpretation of results, & preparation of reports
☐ GAL, guardian ad litem services
☐ Other services: _____

If you have any questions about any part of this document, please ask. Please sign and date below indicating that you have read and understand the contents of this form, that you agree to the policies of your relationship with us, and that you consent to the professional services of Life Management Associates, LLC.

_____ ____/____/____
Client Signature Date

_____ ____/____/____
Client/Partner Signature Date

_____ ____/____/____
Parent/Legal Guardian Signature mandatory *if client is a minor* Date

_____ ____/____/____
Therapist/Representative of Life Management Associates, LLC Date

600 Dewey Blvd., Suite B • Butte, MT 59701 • 302 Missouri Ave., Deer Lodge, MT 59722
Phone: 406-782-4778 • Fax: 406-782-1318

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INFORMED CONSENT, MENTAL HEALTH AND/OR THERAPY SERVICES

I acknowledge the receipt of Life Management Associates, LLC Notice of Privacy Practices. I understand that this notice may be made available to me on Life Management Associates, LLC website, but that I may always request a printed copy if I am unable to access it.

_____ ____/____/____

Client Signature Date

_____ ____/____/____

Client/Partner Signature Date

_____ ____/____/____

Parent/Legal Guardian Signature mandatory if client is a minor Date

_____ ____/____/____

Therapist/Representative of Life Management Associates, LLC Date

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INFORMED CONSENT, MENTAL HEALTH AND/OR THERAPY SERVICES

NO SECRETS POLICY: (If you are participating in individual treatment, you do not need to complete this section)

This written policy is intended to inform you, the participants in therapy, that when we/Life Management Associates, LLC, and the therapist agree to treat a couple or a family, we consider that couple or family (the treatment unit) to be the patient. For instance, if there is a request for the treatment records of the couple or the family, we will seek the authorization of all members of the treatment unit before we release confidential information to third parties. Also, if our records are subpoenaed, we will assert the psychotherapist-patient privilege on behalf of the patient (treatment unit). A judge may issue a court order that would override this psychotherapist-patient privilege in some cases.

During our work with a couple or a family, we may see a smaller part of the treatment unit (i.e., an individual or two siblings) for one or more sessions. These sessions should be seen by you as a part of the work that we are doing with the family or the couple, unless otherwise indicated. If you are involved in one or more of such sessions with us, please understand that generally these sessions are confidential in the sense that we will not release any confidential information to a third party unless we are required by law to do so or unless we have your written authorization. In fact, since those sessions can and should be considered a part of the treatment of the couple or family, we would also seek the authorization of the other individuals in the treatment unit before releasing confidential information to a third party.

However, we may need to share information learned in an individual session (or a session with only a portion of the treatment unit being present) with the entire treatment unit – that is, the family or the couple, if we are to effectively serve the unit being treated. We will use our best judgment as to whether, when, and to what extent we will make disclosures to the treatment unit and will also, if appropriate, first give the individual or the smaller part of the treatment unit being seen, the opportunity to make the disclosure. Thus, if you feel it necessary to talk about matters that you absolutely want to be shared with no one, you might want to consult with an individual therapist who can treat you individually.

This “no secrets” policy is intended to allow the therapist to continue to treat the couple or family by preventing, to the extent possible, a conflict of interest to arise where an individual’s interests may not be consistent with the interests of the unit being treated. For instance, information learned during an individual session may be relevant or even essential to the proper treatment of the couple or the family. If we are not free to exercise our clinical judgment regarding the need to bring this information to the family or the couple during their therapy, we might be placed in a situation where we will have to terminate treatment of the couple or the family. This policy is intended to prevent the need for such a termination.

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INFORMED CONSENT, MENTAL HEALTH AND/OR THERAPY SERVICES

PARTICIPATING FAMILY MEMBERS

_____		_____	
Name	*please print*	Name	*please print*
_____		_____	
Name	*please print*	Name	*please print*
_____		_____	
Name	*please print*	Name	*please print*
_____		_____	
Name	*please print*	Name	*please print*

We, the members of the couple/family/other unit being seen, acknowledge by our signatures below, that each of us has read this policy, that we understand it, that we have had an opportunity to discuss its contents with the therapist or representative of Life Management Associates, LLC, and that we enter couple/family therapy in agreement with this policy.

_____	_____/_____/_____
Client Signature	Date
_____	_____/_____/_____
Client Signature	Date
_____	_____/_____/_____
Parent/Legal Guardian Signature *mandatory if client is a minor*	Date
_____	_____/_____/_____
Therapist/Representative of Life Management Associates, LLC	Date

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CLIENT FINANCIAL INFORMATION, FINANCIAL AGREEMENT & INSURANCE COMPANY RELEASE

NEW CLIENT FINANCIAL INFORMATION: *In order to fill out the form completely, you will need to have a copy of your insurance card(s), the subscriber's date of birth, and the subscriber's social security number. The client's social security number and date of birth are also required regardless of age, for insurance company identification purposes. For your protection, we are requiring photo ID for the client, parent or guardian at the time of the initial appointment.*

Client Name (First) _____ (MI) _____ (Last) _____

Address: _____ City: _____ State: _____ Zip: _____

SS#: _____-_____-_____ DOB: _____/_____/_____ Gender M___ F___

Home #: (_____) _____-_____ Work #: (_____) _____-_____ Cell #: (_____) _____-_____

If you do not have or you do not wish to use insurance coverage, please skip to the Responsible Party for Payment section.

PRIMARY INSURANCE
We must have a copy of this insurance card, or we may not be able to bill the insurance carrier properly.

Name of Insurance: _____ Phone #: (_____) _____-_____

Address: _____ City: _____ State: _____ Zip: _____

Subscriber's Name (First) _____ (MI) _____ (Last) _____

SS#: _____-_____-_____ DOB: _____/_____/_____

Relationship to Client: Self ☐ Spouse ☐ Parent/Legal Guardian ☐ Other ☐ *specify:* _____

Insured Through: Self ☐ EAP ☐ EAP Name: _____ Employer ☐ Employers Name: _____

ID Number: _____ Group Number: _____

SECONDARY INSURANCE
We must have a copy of this insurance card, or we may not be able to bill the insurance carrier properly.

Name of Insurance: _____ Phone #: (_____) _____-_____

Address: _____ City: _____ State: _____ Zip: _____

Subscriber's Name (First) _____ (MI) _____ (Last) _____

SS#: _____-_____-_____ DOB: _____/_____/_____

Relationship to Client: Self ☐ Spouse ☐ Parent/Legal Guardian ☐ Other ☐ *specify:* _____

Insured Through: Self ☐ Employer ☐ Employers Name: _____

ID Number: _____ Group Number: _____

RESPONSIBLE PARTY FOR PAYMENT
If different from client

Client Name (First) _____ (MI) _____ (Last) _____

Address: _____ City: _____ State: _____ Zip: _____

SS#: _____-_____-_____ DOB: _____/_____/_____

Home #: (_____) _____-_____ Work #: (_____) _____-_____ Cell #: (_____) _____-_____

Relationship to Client: Spouse ☐ Parent/Legal Guardian ☐ Other ☐ *specify:* _____

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CLIENT FINANCIAL INFORMATION, FINANCIAL AGREEMENT & INSURANCE COMPANY RELEASE

FINANCIAL AGREEMENT

To make sure we are operating on the same agreement regarding sessions, we have defined the following guidelines. Once you have agreed upon an appointment time, you are responsible for that time. **If you foresee that you cannot keep the appointment time, you will need to give us at least a 24-hour cancellation notice or you will be charged for the time.** Medical emergencies are acceptable for short notice (please call our office and leave a message if you have a medical emergency cancellation).

Our fees are fair and competitive. Here are our standard rates:

- Initial Evaluation: $225.00
- Individual Psychotherapy, 38-52 minutes: $150.00
- Individual Psychotherapy, 53+ minutes: $225.00
- Couples or Family Psychotherapy, 38-52 minutes: $150.00
- Couples or Family Psychotherapy, 53+ minutes: $225.00
- Group Psychotherapy, 38-52 minutes: $75.00

Full payment is due at the time of service, unless we are a participating member with your insurance plan. Insurance coverage is a contract between you and your insurance company. It is your responsibility to know and understand the limitations on your plan's coverage. In some cases, we may be a party to this contract. Please ask if we are a participating member with your insurance plan. If we are not, reduced benefits, in addition to deductibles and copays may apply. Your copayment is due at the beginning of each session. Fees will vary with the type of services provided. Cash, credit card, or check is accepted. Please make checks payable to Life Management Associates, LLC. Our service charge for returned items is $55. We will handle your claim according to our agreement with your insurance company. You must notify us of any changes in your coverage within 15 days of the change. We will not become involved in disputes between you and your insurance company (i.e., deductibles, co-payments, coverage changes, secondary insurance) other than to supply factual information as necessary. You are responsible for all non-contractual fees unpaid by your insurance company.

IMPORTANT INSURANCE QUESTIONS

- Is this referral through an EAP? No ☐ Yes ☐
- Does your company use an employee assistance program EAP? No ☐ Yes ☐
- Does your policy cover individual counseling? No ☐ Yes ☐
- Does your policy cover family counseling? No ☐ Yes ☐
- Does your policy cover couples counseling? No ☐ Yes ☐
- Do you have to get prior authorization for counseling? No ☐ Yes ☐
  - *If so, how do I go about getting authorization?*
- Are there a maximum number of sessions covered per year? No ☐ Yes ☐
  - *If yes, what is the limit?* _____
- Does your counselor have to be a provider with your company in order for your sessions to be covered? No ☐ Yes ☐
- Do you have to get a referral from your primary care physician for counseling? No ☐ Yes ☐
- How much of your deductible have you met at this time? $_____ of $_____
- What is your benefit year? Calendar Year ☐ Fiscal Year ☐
- What is your financial responsibility (i.e., co-pay, co-insurance) after your deductible has been met? $_____/per session.

COLLECTION

Timely payment is expected. In the event that your balance goes unpaid, for 120 days, we will turn your account over to a collection agency. Any fees incurred by us to collect on your bill will be your added responsibility. Please direct all billing inquiries to our billing staff at (406) 782-4778.

AUTHORIZATION & INSURANCE COMPANY RELEASE OF INFORMATION

I/We hereby authorize Life Management Associates, LLC to disclose to my/our insurance company(s), listed above, only the following information: patient name, date(s) of service, service(s) provided, and diagnosis, to be used for the purpose of insurance evaluation and reimbursement, unless otherwise specified in a separate authorization to disclose additional clinical information.

This information will be disclosed to the above insurance company from records whose confidentiality is protected by Montana and/or federal law. These regulations prohibit the above insurance company from making any further disclosure of this information without prior written consent. I/We understand that I/we have no obligation whatsoever to disclose any information from my/our record. I/We understand that I/we may revoke this consent at any time by notifying Life Management Associates, LLC or the above-noted person, organization, or agency, in writing and/or by specifying an event or condition upon which my/our consent will expire without revocation. I/We have read or had this form read and explained to me and I/we understand its contents.

I/We have completed the above to the best of my/our ability and fully understand the importance of this relationship. I/We have reviewed the terms in the document, and agree to abide by the terms as outlined for services provided by Life Management Associates, LLC. With my/our signature I/we give my/our consent to Life Management Associates, LLC, to provide the necessary information for any and all billing of the services rendered.

_____ _____/_____/_____

Responsible Party for Payment Signature Date

_____ _____/_____/_____

Parent/Legal Guardian Signature *mandatory if client is a minor* Date

_____ _____/_____/_____

Representative of Life Management Associates, LLC Date

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NEW CLIENT QUESTIONNAIRE

INSTRUCTIONS: Please answer these questions to help assist us in understanding the client's needs and concerns. If you need additional space to answer any question, please feel free to add additional sheets of paper. If you retain any documents concerning prior treatment, testing, reports, etc. please attach those to this new client questionnaire. When we agree to treat a couple or a family, we consider that couple or family to be the client. We would like each individual included in individual, and couple therapy to complete this form prior to the intake appointment, so that the therapist has background information on all participants. For the purpose of family therapy, we may require new client questionnaires on each individual family member.

Sources of Data Provided Below

☐ Client self-report for all ☐ Client's parent/guardian ☐ A variety of sources: _____

Please check the category below that best matches the client's treatment request.

☐ Individual Adult Issues
☐ Child/Adolescent Issues
☐ Couple/Marriage Issues
☐ Family Issues
☐ Mental Health Evaluation
☐ Substance Abuse/Addiction Evaluation
☐ GAL, Guardian Ad Litem Services

CLIENT INFORMATION

Client Name (First) _____ (MI) _____ (Last) _____

Address _____

City _____ State _____ Zip _____

Phone #s (Hm) (____) _____ (Wk) (____) _____ (Cell) (____) _____

Email_____

Age _____ Date of Birth ____/____/____

Ethnicity: ☐ Asian ☐ African-American ☐ Native American ☐ White/Caucasian ☐ Other, specify _____

Marital Status: ☐ Single - Never Married ☐ Engaged ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Live in Partner

Sex: F ☐ M ☐ Who was the client referred by? _____

EMERGENCY CONTACT: Name: (Last) _____ (First) _____ (MI) ____

Release Signed? Yes: ☐ No: ☐ , if other than parent/legal guardian.

Cell #: (_____) _____-_____ Home #: (_____) _____-_____ Work #: (_____) _____-_____

Relationship: Spouse ☐ Parent/Legal Guardian ☐ Other ☐ *specify*_____

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Cultural/spiritual/religious history

Describe the client's cultural identity (e.g., religion, nationality, family traditions, etc.)

_____

_____

Describe any cultural/spiritual/religious issues that contribute to current problem and/or should be taken into account during treatment

_____

- ☐ currently active in community/recreational activities?
- ☐ formerly active in community/recreational activities?
- ☐ currently engage in hobbies?
- ☐ currently participate in spiritual activities?

If answered "yes" to any of above, describe

_____

_____

PARTNER OR PARENT/LEGAL GUARDIAN INFORMATION

If minor is in state custody, the state representative must complete the appropriate questions within this section.

Name (First) _____ (MI) _____ (Last) _____

Address _____

City _____ State _____ Zip _____

Phone #s (Hm) (____) _____ (Wk) (____) _____ (Cell) (____) _____

Marital Status, ☐ Single– Never Married ☐ Engaged ☐ Married ☐ Divorced ☐ Separated ☐ Live in Partner ☐ Widowed

Sex: F ☐ M ☐ Age _____ Date of Birth ____/____/____

Relationship: Spouse ☐ Parent/Legal Guardian ☐ Other ☐ *specify*_____

OTHER PARTICIPATING FAMILY MEMBERS (List Names and Age)

_____

_____

_____

Presenting Problems

Primary _____

Secondary _____

Current Symptom Checklist (Rate intensity of symptoms currently present)

Mild = Impacts quality of life, but no significant impairment of day-to-day functioning
Moderate = Significant impact on quality of life and/or day-to-day functioning
Severe = Profound impact on quality of life and/or day-to-day functioning

Symptom	Impact				Symptom	Impact			
	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
Aggressive Behaviors	☐	☐	☐	☐	Laxative/Diuretic Abuse	☐	☐	☐	☐
Agitation	☐	☐	☐	☐	Loose Associations	☐	☐	☐	☐
Anorexia	☐	☐	☐	☐	Mood Swings	☐	☐	☐	☐
Appetite Disturbance	☐	☐	☐	☐	Obsessions/Compulsions	☐	☐	☐	☐
Bingeing/Purging	☐	☐	☐	☐	Oppositional Behavior	☐	☐	☐	☐
Circumstantial Symptoms	☐	☐	☐	☐	Panic Attacks	☐	☐	☐	☐
Concomitant Medical Condition	☐	☐	☐	☐	Paranoid Ideation	☐	☐	☐	☐
Conduct Problems	☐	☐	☐	☐	Phobias	☐	☐	☐	☐
Delusions	☐	☐	☐	☐	Physical Trauma Perpetrator	☐	☐	☐	☐
Depressed Mood	☐	☐	☐	☐	Physical Trauma Victim	☐	☐	☐	☐
Dissociative States	☐	☐	☐	☐	Poor Concentration	☐	☐	☐	☐
Elevated Mood	☐	☐	☐	☐	Poor Grooming	☐	☐	☐	☐
Elimination Disturbance	☐	☐	☐	☐	Psychomotor Retardation	☐	☐	☐	☐
Emotional Trauma Perpetrator	☐	☐	☐	☐	Self-Mutilation	☐	☐	☐	☐
Emotional Trauma Victim	☐	☐	☐	☐	Sexual Dysfunction	☐	☐	☐	☐
Emotionality	☐	☐	☐	☐	Sexual Trauma Perpetrator	☐	☐	☐	☐
Fatigue/Low Energy	☐	☐	☐	☐	Sexual Trauma Victim	☐	☐	☐	☐
Generalized Anxiety	☐	☐	☐	☐	Significant Weight Gain/Loss	☐	☐	☐	☐
Grief	☐	☐	☐	☐	Sleep Disturbance	☐	☐	☐	☐
Guilt	☐	☐	☐	☐	Social Isolation	☐	☐	☐	☐
Hallucinations	☐	☐	☐	☐	Somatic Complaints	☐	☐	☐	☐
Hopelessness	☐	☐	☐	☐	Substance Abuse	☐	☐	☐	☐
Hyperactivity	☐	☐	☐	☐	Worthlessness	☐	☐	☐	☐
Irritability	☐	☐	☐	☐	Other	☐	☐	☐	☐

Explanation onset, duration and frequency for any of the symptoms that you have listed above:

Client Emotional/Psychiatric History

☐ ☐ **Client, Prior outpatient psychotherapy?**
No Yes
If yes, on ____occasions. Longest treatment by _____ for ___ sessions from ____/_____ to _____/_____
Provider Name Month/Year Month/Year

Prior provider name	City	State	Diagnosis	Intervention/Modality	Beneficial?

☐ ☐ **Client, Prior inpatient treatment for a psychiatric, emotional, or substance use disorder?**
No Yes
If yes, on ____occasions. Longest treatment at _____from _____/_____ to _____/_____
Name of facility Month/Year Month/Year

Inpatient facility name	City	State	Diagnosis	Intervention/Modality	Beneficial?

☐ ☐ **Has the client had suicidal ideation and/or attempts?** If yes, explain suicidal ideation and/or attempts
No Yes

☐ ☐ **Has the client experienced a traumatic event?**
No Yes
If yes, the traumatic event occurred on _____/____
Month/Year

Please describe what occurred during the traumatic event _____

_____

_____

☐ ☐ **Has the client been previously treated for the traumatic event?**
No Yes
If yes, on ____occasions. Longest treatment by _____from _____/_____ to _____/_____
Name of Provider Month/Year Month/Year

Family Emotional/Psychiatric/Substance Abuse History

☐ ☐ **Does any family member have a history of mental illness and or substance abuse? If yes, list all**
No Yes

Name and relationship to client	**Diagnosis**	**Treatment** (e.g., outpatient psychotherapy, inpatient, medication, none)
_____	_____	_____
_____	_____	_____

Family alcohol/drug abuse history

☐ father
☐ mother
☐ grandparent(s)
☐ sibling(s)
☐ other _____
☐ stepparent/live-in
☐ uncle(s)/aunt(s)
☐ spouse/significant other
☐ children

Any other relevant family emotional/psychiatric/substance abuse information, please explain:

_____

_____

_____

_____

NEW CLIENT QUESTIONNAIRE

Medical History (check all that apply for client)

Describe the client's current physical health ☐ Good ☐ Fair ☐ Poor

description if relevant: _____

_____

List name of primary care physician for the client

Name _____ Phone _____

List name of psychiatrist for the client (if any):

Name _____ Phone _____

Is there a history of any of the following in the family

- ☐ tuberculosis
- ☐ birth defects
- ☐ emotional problems
- ☐ behavior problems
- ☐ thyroid problems
- ☐ cancer
- ☐ mental retardation
- ☐ heart disease
- ☐ high blood pressure
- ☐ alcoholism
- ☐ drug abuse
- ☐ diabetes
- ☐ Alzheimer's disease/dementia
- ☐ stroke
- ☐ other chronic or serious health problems _____

List any known allergies for the client

_____

Describe any serious hospitalization or accidents for the client

Year	Age	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

List any abnormal lab test results for the client

Year	Result
_____	_____
_____	_____
_____	_____

NEW CLIENT QUESTIONNAIRE

Clients Sexual history

- ☐ heterosexual orientation
- ☐ homosexual orientation
- ☐ bisexual orientation
- ☐ transgender
- ☐ other _____
- ☐ currently sexually active
- ☐ currently sexually satisfied
- ☐ currently sexually dissatisfied

age first sex experience _____
age first pregnancy/fatherhood _____
history of promiscuity age _____ to_____
history of unsafe sex age _____ to_____

Any additional information pertaining to the clients sexual history, including abuse, assault or perpetrating

_____
_____
_____
_____
_____

Client Mental Health and Other Prescribed Medications

☐ ☐ **Prior or current mental health medication usage? If yes, list below**
No Yes

Medication	Dosage	Frequency	Start Date	End Date	Physician

List any other medications currently being taken (give reason, including other prescribed medication and over-the-counter)

_____
_____
_____

Please provide any other relevant information, or adverse side effects concerning the use of medications:

_____
_____
_____
_____

NEW CLIENT QUESTIONNAIRE

Substance Use History (check all that apply for client)

Client Substance use status

- ☐ no history of abuse
- ☐ active abuse
- ☐ early full remission
- ☐ early partial remission
- ☐ sustained full remission
- ☐ sustained partial remission

Client Treatment history

- ☐ Outpatient (age[s]) _____
- ☐ Inpatient (age[s]) _____
- ☐ 12-step program (age[s]) _____
- ☐ stopped on own (age[s]) _____
- ☐ other (age[s]) _____ _____

Client Substances used	First use age	Last use age	Current Use	Frequency	Amount
☐ alcohol	_____	_____	☐	_____	_____
☐ amphetamines/speed	_____	_____	☐	_____	_____
☐ barbiturates/owners	_____	_____	☐	_____	_____
☐ cocaine	_____	_____	☐	_____	_____
☐ crack cocaine	_____	_____	☐	_____	_____
☐ hallucinogens (e.g., LSD)	_____	_____	☐	_____	_____
☐ inhalants (e.g., glue, gas)	_____	_____	☐	_____	_____
☐ marijuana or hashish	_____	_____	☐	_____	_____
☐ opioids	_____	_____	☐	_____	_____
☐ PCP	_____	_____	☐	_____	_____
☐ prescription	_____	_____	☐	_____	_____
☐ other	_____	_____	☐	_____	_____

Consequences of substance abuse

- ☐ hangovers
- ☐ seizures
- ☐ blackouts
- ☐ Accidental overdose
- ☐ binges
- ☐ withdrawal symptoms
- ☐ medical conditions
- ☐ Increase in tolerance
- ☐ loss of control over amount used
- ☐ job loss
- ☐ sleep disturbance
- ☐ assaults
- ☐ suicide attempts
- ☐ suicidal impulse/thoughts
- ☐ relationship conflicts
- ☐ arrests
- ☐ other _____

Client Family History

Client Family of Origin

Present during childhood

	Present entire childhood	Present part of childhood	Not Present at all
mother	☐	☐	☐
father	☐	☐	☐
stepmother	☐	☐	☐
stepfather	☐	☐	☐
brother(s)	☐	☐	☐
sister(s)	☐	☐	☐
other	☐	☐	☐

Client's Parents' current marital status

- ☐ married to each other
- ☐ separated for ____ years
- ☐ divorced for ____ years
- ☐ mother remarried ____ times
- ☐ father remarried ____ times
- ☐ mother involved with someone
- ☐ father involved with someone
- ☐ mother deceased for____ years
  age of client at mother's death ____
- ☐ father deceased for ____ years
  age of client at father's death ____

Describe childhood family experience for the client

- ☐ outstanding home environment
- ☐ normal home environment
- ☐ chaotic home environment
- ☐ witnessed physical/verbal/sexual abuse toward others
- ☐ experienced physical/verbal/sexual abuse from others

Client age of emancipation from home: _____, reason: _____

Client special circumstances in childhood [anything you believe is relevant about your childhood history]

_____

_____

_____

Client Immediate Family

Client marital status

- ☐ single, never married
- ☐ engaged _____ months
- ☐ married for _____ years
- ☐ divorced for _____ years
- ☐ separated for ___ years
- ☐ divorce in process _____ months
- ☐ spouse/partner deceased for ____ years
- ☐ live-in for _____ years
- ☐ _____ prior marriages (self)
- ☐ _____ prior marriages (partner)

Client relationship satisfaction

- ☐ very satisfied with relationship
- ☐ satisfied with relationship
- ☐ somewhat satisfied with relationship
- ☐ dissatisfied with relationship
- ☐ very dissatisfied with relationship

List all persons currently living in client's household

Name	Age	Sex	Relationship to Client

List biological/adopted children not living in same household as patient

Name	Age	Sex	Relationship to Client

Describe any past or current significant issues in intimate relationships, the client may have: _____

_____

_____

_____

Client Socio-Economic History (check all that apply)

Living situation
- ☐ housing adequate
- ☐ homeless
- ☐ housing overcrowded
- ☐ dependent on others for housing
- ☐ housing dangerous/deteriorating
- ☐ living companions dysfunctional

Social support system
- ☐ supportive network
- ☐ few friends
- ☐ substance-use-based friends
- ☐ no friends
- ☐ distant from family of origin

Military
- ☐ never in military
- ☐ served in military - no incident
- ☐ served in military - with incident

Client Developmental History (check all that apply for the client)

Client problems during mother's pregnancy
- ☐ none
- ☐ high blood pressure
- ☐ kidney infection
- ☐ German measles
- ☐ emotional stress
- ☐ bleeding
- ☐ alcohol use
- ☐ drug use
- ☐ cigarette use
- ☐ other

Client birth
- ☐ normal delivery
- ☐ difficult delivery
- ☐ cesarean delivery
- ☐ complications

_____

_____

birth weight _____ lbs. _____oz.

Client infancy problems
- ☐ none
- ☐ feeding problems
- ☐ sleep problems
- ☐ toilet training problems

Client delayed developmental milestones (check only those milestones that did not occur at expected age):
- ☐ sitting
- ☐ rolling over
- ☐ standing
- ☐ walking
- ☐ feeding self
- ☐ speaking words
- ☐ speaking sentences
- ☐ controlling bladder
- ☐ controlling bowels
- ☐ sleeping alone
- ☐ dressing self
- ☐ engaging peers
- ☐ tolerating separation
- ☐ playing cooperatively
- ☐ riding tricycle
- ☐ riding bicycle
- ☐ other _____

NEW CLIENT QUESTIONNAIRE

Client emotional / behavior problems during childhood (check all that apply):

- ☐ none
- ☐ drug use
- ☐ alcohol abuse
- ☐ chronic lying
- ☐ stealing
- ☐ violent temper
- ☐ fire-setting
- ☐ hyperactive
- ☐ animal cruelty
- ☐ assaults others
- ☐ disobedient
- ☐ other _____
- ☐ repeats words of others
- ☐ not trustworthy
- ☐ hostile/angry mood
- ☐ indecisive
- ☐ immature
- ☐ bizarre behavior
- ☐ self-injurious threats
- ☐ frequently tearful
- ☐ lack of attachment
- ☐ distrustful
- ☐ extreme worrier
- ☐ self-injurious acts
- ☐ impulsive
- ☐ easily distracted
- ☐ poor concentration
- ☐ often sad
- ☐ breaks things in anger
- ☐ Withdraws/avoids interactions with others

Client social interaction during childhood (check all that apply)

- ☐ normal social interaction
- ☐ isolates self
- ☐ very shy
- ☐ alienates self
- ☐ other _____
- ☐ inappropriate sex play
- ☐ dominates others
- ☐ associates with acting-out peers

Client intellectual / academic functioning

- ☐ normal intelligence
- ☐ high intelligence
- ☐ learning problems
- ☐ authority conflicts
- ☐ attention problems
- ☐ underachieving
- ☐ mild retardation
- ☐ moderate retardation
- ☐ severe retardation

Client's current or highest education level _____

Describe any other developmental [physical, emotional, behavioral, social, intellectual or academic] problems or issues, the client may have had during childhood.

_____

_____

_____

NEW CLIENT QUESTIONNAIRE

Client Employment

- ☐ employed and satisfied
- ☐ employed but dissatisfied
- ☐ Employed full time
- ☐ Employed part time
- ☐ Disabled:

_____

Current Occupation

_____

Current Employer

_____

Location

_____

Client Financial Situation

- ☐ no current financial problems
- ☐ large indebtedness
- ☐ poverty or below-poverty income
- ☐ impulsive spending
- ☐ relationship conflicts over finances

- ☐ Coworker conflicts
- ☐ Supervisor conflicts
- ☐ Unstable work history

Client Legal History

- ☐ no legal problems
- ☐ now on parole/probation
- ☐ arrest(s) not substance-related
- ☐ arrest(s) substance-related
- ☐ court ordered this treatment
- ☐ jail/prison _____ time(s)

  total time served: _____

Describe Any Client Legal Difficulties

_____

_____

_____

_____

_____

_____

_____

NEW CLIENT QUESTIONNAIRE

Strengths: The client exhibits the following strengths, check all that apply?

- ☐ Accepts Guidance/Feedback
- ☐ Calm
- ☐ Capable of Independence
- ☐ Clear Thinking
- ☐ Confident
- ☐ Cooperative
- ☐ Expressive/Articulate
- ☐ Good Personal Care Habits
- ☐ Insightful
- ☐ Integrated Moral Values
- ☐ Intelligent
- ☐ Motivated for Change
- ☐ Physically Healthy
- ☐ Positive Support Network
- ☐ Reasonable Judgment
- ☐ Reliable
- ☐ Responsible
- ☐ Sociable
- ☐ Stable Living Environment
- ☐ Stable Work History
- ☐ Supportive Family
- ☐ Varied Interests

Other *explain*: _____

Limitations: The client exhibits the following limitations, check all that apply?

- ☐ Aggressive
- ☐ Chaotic Living
- ☐ Concrete Thinking
- ☐ Defensive
- ☐ Demanding
- ☐ Dependent
- ☐ Distrustful
- ☐ Easily Distracted
- ☐ Hostile
- ☐ Illiterate
- ☐ Impulsive
- ☐ Indecisive
- ☐ Intellectual Deficits
- ☐ Irresponsible
- ☐ Lacks Insight
- ☐ Lacks Moral/Ethical Values
- ☐ Lacks Social Skills
- ☐ Needs Close Supervision
- ☐ Negative Peer Group
- ☐ No Support Network
- ☐ Non-Supportive Family
- ☐ Not Motivated to Change
- ☐ Not Open/Articulate
- ☐ Poor Health
- ☐ Poor Hygiene/Grooming
- ☐ Poor Judgment
- ☐ Unreliable
- ☐ Unstable Employment History
- ☐ Very Narrow Interests

Other *explain:* _____

Does the client have any additional issues or concerns not previously identified by any of the prior questions?

If so, please explain below:

600 Dewey Blvd., Suite B • Butte, MT 59701 • 302 Missouri Ave., Deer Lodge, MT 59722
Phone: 406-782-4778 • Fax: 406-782-1318

LIFE MANAGEMENT ASSOCIATES, LLC

LMA

NEW CLIENT QUESTIONNAIRE

Confidentiality of E-mail, Voice Mail, and Fax Communication: E-mail, voice mail, and fax communication can be accessed by unauthorized people, compromising the privacy and confidentiality of such communication. LMA cannot guarantee confidentiality of e-mail, voice mail, and fax communication. If you choose to communicate confidential information with LMA via e-mail, voice mail, and fax communication, LMA will assume that you have made an informed decision and LMA will view it as your agreement to take the risk that e-mail, voice mail, and fax communication may be intercepted.

Understanding the above information, please indicate your communication preferences.

OK to send mail?	Yes ☐ No ☐	OK to send email?	Yes ☐ No ☐
OK to call cell?	Yes ☐ No ☐	OK to leave voicemail message on cell?	Yes ☐ No ☐
OK to call home?	Yes ☐ No ☐	OK to leave voicemail message at home?	Yes ☐ No ☐
OK to call work?	Yes ☐ No ☐	OK to leave voicemail message at work?	Yes ☐ No ☐
OK to text cell?	Yes ☐ No ☐		

CONSENT TO THE FOLLOWING SERVICES

The client/parent/legal guardian requests and consents to the following services:

☐ Mental Health Evaluation, Interpretation Of Results, & Preparation Of Reports

☐ Counseling/Psychotherapy (Individual, Couples, Family, Or Group)

☐ Family Systems Evaluation, Interpretation Of Results, & Preparation Of Reports

☐ Substance Abuse/Addiction Evaluation And Interpretation Of Results

☐ GAL, Guardian Ad Litem Services

☐ Other services: _____

I attest that the information provided in or attached to this questionnaire is complete, accurate, and true to the best of my knowledge.

_____ ____/____/____

Client Signature Date

_____ ____/____/____

Parent/Legal Guardian Signature [*mandatory if client is a minor*] Date

_____ ____/____/____

Therapist/Representative of Life Management Associates, LLC Date

600 Dewey Blvd., Suite B • Butte, MT 59701 • 302 Missouri Ave., Deer Lodge, MT 59722
Phone: 406-782-4778 • Fax: 406-782-1318