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Before Your First Appointment

Hello, and welcome to therapy. Before we begin, I would like to get to know a little about you and the questions and concerns you will bring to therapy. I must also give you information about me and my practice so that you can make an informed decision about engaging in therapy with me. I have created this packet of materials so that you may complete these forms and review the necessary information in advance of our first meeting, so that we can use our time talking and beginning the work of therapy and not filling out paperwork.

Please return the following:

__ Client Information Questionnaire
__ Current Symptoms
__ Informed Consent for Treatment – please sign the second page
__ Schedule with preferred times marked

First and Ongoing Appointments

My office is currently open four days each week, with some evening and weekend hours by special appointment. If we have not already scheduled a first meeting, you may call me to set up an appointment at 503-421-1597. Please leave your name and number and the best times to reach you in your message.

I look forward to seeing you soon,

Siri Hoogen
Licensed Clinical Psychologist

TEEN INFORMATION QUESTIONNAIRE

Welcome to my practice. Please complete the following questionnaire to help me plan therapy services for you. You may need to ask a parent for assistance in filling out this form. Please ask them to use a different colored pen so that I will know which are your answers and which are theirs. If you need clarification on any question, please do not hesitate to call me. All information gathered here is held in strictest confidence.

CLIENT INFORMATION

Full Name: ________________________________ Today's Date: ______________________

Street Address: ____

City: ____ Zip: _________________________

Phone: Home__________________________ Cell ___________________________________

Which number do you prefer I call 1st ____________ Email: __________________________

Age: ________ Birth Date: ______________________________

School: ________________________________ Grade Level: _________________________

PARENT OR GUARDIAN INFORMATION

Name: ______________________________ Name: ___________________________________

Address: ____________________________ Address: ________________________________

City: _________________Zip: ___________ City: ____________________Zip: ___________

Phone: Home __________ Cell __________ Phone: Home ____________ Cell ___________

Work #: _______________ Fax __________ Work #: _______________ Fax _____________

Employer: ___________________________ Employer: _______________________________

DOB: _________ DOB: ___________

Please list members of your family and all others living in your home:

Name	Age	Relationship	Occupation

Name of person to contact in case of emergency: __________________________________

Phone: _____________________________ Address: _________________________________

Have you ever received psychiatric or psychological help of any kind before? yes no

Therapist name	Dates	Purpose	Was it helpful?
			yes no
			yes no
			yes no

Are you choosing to come now because you want to, your parents want you to, or both?

__ I choose __Parents want me to __We both/all think it would be helpful

Who is your primary care physician?______________________________

Address: ______________________________

Phone: ____________________ Fax: ____________________

Date of your last physical:______________________________

When possible, I like to coordinate care with your physician, psychiatrist, or other health care provider. May I notify your physician about the issues for which you are seeking psychotherapy? yes no Please initial here: ________

List any health concerns for which you are currently receiving treatment:

____

____

____

Allergies or adverse reactions to medication or treatment: ____________________

List any medications you are currently taking:

Name of medication	Dosage	Frequency	Prescribed by	Start Date

Briefly describe your reason for seeking help: ____________________

____

____

____

____

____

Current Symptoms

Please **circle the number** to indicate the degree to which the following feelings and behaviors are troubling your current life. Also, **in the blank,** indicate **how long** these problems have affected you. Please rate all symptoms.

Scale **1 = extremely big problem for me** **6 = little or no concern to me**

Symptom	Rating	How long	Symptom	Rating	How long
MOOD	1 2 3 4 5 6	______	Pregnancy loss	1 2 3 4 5 6	______
Tiredness	1 2 3 4 5 6	______	Chronic disease	1 2 3 4 5 6	______
Inferiority Feelings	1 2 3 4 5 6	______	Terminal condition	1 2 3 4 5 6	______
Concentration	1 2 3 4 5 6	______	THOUGHTS	1 2 3 4 5 6	______
Appetite	1 2 3 4 5 6	______	Making Decisions	1 2 3 4 5 6	______
Weight Gain/Loss	1 2 3 4 5 6	______	Memory	1 2 3 4 5 6	______
amount in last month		______	Confusion	1 2 3 4 5 6	______
Sleep	1 2 3 4 5 6	______	Communicating	1 2 3 4 5 6	______
Nightmares	1 2 3 4 5 6	______	IMPULSE Control	1 2 3 4 5 6	______
Insomnia	1 2 3 4 5 6	______	Anger	1 2 3 4 5 6	______
Ambition	1 2 3 4 5 6	______	Temper	1 2 3 4 5 6	______
Unhappiness	1 2 3 4 5 6	______	Hurting others	1 2 3 4 5 6	______
Irritability	1 2 3 4 5 6	______	Hurting self	1 2 3 4 5 6	______
Depression	1 2 3 4 5 6	______	Food management	1 2 3 4 5 6	______
Manic Behavior	1 2 3 4 5 6	______	Dangerous behavior	1 2 3 4 5 6	______
Suicidal Thoughts	1 2 3 4 5 6	______	Attention Deficit	1 2 3 4 5 6	______
ANXIETY	1 2 3 4 5 6	______	Medication ______________________		
Nervousness	1 2 3 4 5 6	______	SUBSTANCE USE	1 2 3 4 5 6	______
Panic Attacks	1 2 3 4 5 6	______	Alcohol	1 2 3 4 5 6	______
Compulsive Behavior	1 2 3 4 5 6	______	Drinks/week		______
Obsessive Thoughts	1 2 3 4 5 6	______	Drugs	1 2 3 4 5 6	______
Fears	1 2 3 4 5 6	______	Substance(s) used ________________		
Specific phobia	1 2 3 4 5 6	______	Caffeine	1 2 3 4 5 6	______
HEALTH	1 2 3 4 5 6	______	Drinks/week		______
Bowel Troubles	1 2 3 4 5 6	______	Tobacco	1 2 3 4 5 6	______
Headaches	1 2 3 4 5 6	______	Packs/week		______
Stomach Trouble	1 2 3 4 5 6	______	RELATIONSHIPS	1 2 3 4 5 6	______
Binging/Purging	1 2 3 4 5 6	______	Problems with friends	1 2 3 4 5 6	______
Infertility	1 2 3 4 5 6	______	Problems with partner	1 2 3 4 5 6	______

Separation/Divorce	1	2	3	4	5	6	______	Finances	1	2	3	4	5	6	______
Problems with family	1	2	3	4	5	6	______	Stress	1	2	3	4	5	6	______
Loss of someone	1	2	3	4	5	6	______	TRAUMA	1	2	3	4	5	6	______
Who? ______________________________								Vehicular accident	1	2	3	4	5	6	______
Shyness	1	2	3	4	5	6	______	Natural disaster	1	2	3	4	5	6	______
Loneliness	1	2	3	4	5	6	______	History of abuse	1	2	3	4	5	6	______
Fear of being alone	1	2	3	4	5	6	______	Physical	1	2	3	4	5	6	______
Distancing others	1	2	3	4	5	6	______	Emotional	1	2	3	4	5	6	______
SEXUAL Problems	1	2	3	4	5	6	______	Sexual	1	2	3	4	5	6	______
SELF CARE	1	2	3	4	5	6	______	Incest	1	2	3	4	5	6	______
Work	1	2	3	4	5	6	______	Physical assault	1	2	3	4	5	6	______
Career Choices	1	2	3	4	5	6	______	Sexual assault	1	2	3	4	5	6	______
Education	1	2	3	4	5	6	______	Current abuse	1	2	3	4	5	6	______
Legal Matter	1	2	3	4	5	6	______	Domestic violence	1	2	3	4	5	6	______

List any other concerns you may have at this time: ____________________________________

____

____

____

____

OPTIONAL QUESTIONS

What do you do for relaxation and enjoyment? ____

____

____

How much attention do you pay to your physical health? Please explain. ___________________

____

____

What do you value most in life? ____

____

____

If "everything were better" in your life, what would that look like? ________________________

____

____

____

INFORMED CONSENT FOR TREATMENT/ CONFIDENTIALITY

As a client, you have rights and responsibilities when you seek my consultation, including:

l. THE RIGHT OF CLIENTS TO REFUSE TREATMENT. You have the right to request a change of therapy, be referred to another therapist, or discontinue therapy at any time. If you are unhappy with therapy or have questions about the treatment, please speak with me about these concerns. If my services are not meeting your needs, I will be happy to refer you to another practitioner.

2. THE RESPONSIBILITY OF THE CLIENT FOR CHOOSING THE PROVIDER AND TREATMENT MODALITY WHICH BEST SUITS HER/HIS NEEDS. I will make an assessment and suggest possible treatment modes that may be helpful to you. However, the choice of treatment mode remains with you. If at any time you feel dissatisfied with the therapy, your questions and concerns must be addressed before we can continue.

3. THE EXTENT OF CONFIDENTIALITY PROVIDED BY LAW. Under Oregon state law psychologists have an obligation to honor client confidentiality. **Nothing you tell me can be told to anyone else without your permission**. HOWEVER, THERE ARE EXCEPTIONS, SOME OF WHICH ARE:

- CHILD ABUSE - I am required to report any known or suspected child abuse to the Department of Human Services.
- HARM TO ANOTHER - If I believe a client is about to harm another person, I have a duty to warn and, insofar as possible, to protect the intended victim.
- SUICIDE - If I believe someone is immediately likely to harm her/him self, I will try to protect the person by notifying a family member, the police, or the Mental Health Department.
- EVALUATIONS - If you meet with me for an evaluation requested by another professional (i.e. counselor, lawyer, or physician), I will routinely send a written report of my findings to that professional. I will obtain a written consent from you in advance authorizing me to make such a disclosure.
- COLLECTION PROBLEMS - If you do not pay for services rendered, I may refer your account to a collection agency or file a small claims court suit. Although no clinical information will be revealed, your name, address, dates and fees of service will be released, along with other information that may help make collection possible.

FEES--ADDITIONAL CHARGES—BILLINGS--OFFICE POLICIES

PROFESSIONAL FEES

My fees are based on the amount of professional time spent or reserved. The basic fee for a therapy hour (50 minutes) is $140 for individual psychotherapy and $140 for couples/family. Group psychotherapy (1 and 1/2 hours) is $75 a session. Additional time for phone calls, preparing letters, conferring with other professionals, etc. will be prorated at $140/hour. Psychological assessments, testing, and/or questionnaires are priced individually. Fees may increase during the course of treatment. If so, you will be notified in writing 30 days in advance.

ADDITIONAL CHARGES - You will also be charged for the following. Each charge is payable immediately upon demand.

- $15 for any check submitted to me to pay any sums for which you are obligated

and which check is dishonored.

- A delinquency fee of $25 in the event you fail to timely pay me any sum you owe and I elect to institute or turn your debt over to a collection agency for collection. If I initiate a collection action and prevail, I will also seek such reasonable attorney fees as the court allows.
- $140 should you fail to keep an appointment and fail to give me 24 hours advance notice that you will not keep such appointment.
- Phone sessions are available ($140) but insurance cannot be billed for this service.

BILLINGS - I request that you pay for your portion of services at the time of your session unless you request I bill you monthly, in which case the bill is due and is payable immediately upon demand. There is a $5 service fee for billing which I will add to your charges that I billed.

MISSED APPOINTMENTS - The time scheduled for you is reserved exclusively for you. If you do not keep the appointment, no one else will be able to use the time. Therefore, I ask that you please give me 24 hours notice if you need to cancel an appointment. In all events, please call as soon as you know that you will not be able to keep a scheduled appointment. My voice mail is accessible at all hours.

EMERGENCIES- Should you find yourself in need of emergency assistance during hours when my office is closed, call **my home office at 513-461-9727.** If I am not available, you may call the **Crisis Line at 503-988-4888** 24 hours a day or your local emergency room.

MY TRAINING, BACKGROUND AND ORIENTATION-

I earned my M.A. and Ph.D. in Clinical Psychology from Miami University in 2010. I am currently practicing as a Licensed Clinical Psychologist in the state of Oregon. To continue my growth and education, I complete a minimum of 25 hours a year of continuing education credit, as required by the Oregon Licensing Board. I operate from a mostly feminist constructivist theoretical orientation, which essentially means I am concerned with how people make sense of their lives and how they find the power to change the aspects of their lives that give them dissatisfaction or pain. Please do not hesitate to ask me about any of my policies, beliefs, or my psychological orientation.

I, ______________________________, HAVE READ AND UNDERSTOOD ALL THE FOREGOING AND AGREE TO BE BOUND TO ALL OF THE PROVISIONS REGARDING CONSENT, CONFIDENTIALITY, FEES, CHARGES AND BILLINGS.

____ _______________________

Signature of client or legal guardian Date

I have been offered a copy of this form: ___________________ _______________________

Client initials Date

Schedule Information

Please return this page so I can know your schedule. This will assist me in making a regular appointment time with you and will also help me in the event that we need to reschedule a missed or canceled appointment.

Name ____ Date _________________________

Times I am available to schedule regular appointments:

Preferred times for appointments mark with ✔

Available times mark with ✗

Monday	Tuesday	Wednesday	Thursday	Friday
__ 9:00 AM		__ 9:00 AM		__ 9:00 AM
__ 10:00 AM	__ 10:00 AM	__ 10:00 AM	__ 10:00 AM	__ 10:00 AM
__ 11:00 AM	__ 11:00 AM	__ 11:00 AM	__ 11:30 AM	__ 11:00 AM
__ 12:00 PM	__ 12:00 PM	__ 12:00 PM	__ 12:00 PM	__ 12:00 PM
__ 1:00 PM	__ 1:00 PM	__ 1:00 PM	__ 1:00 PM	__ 1:00 PM
__ 2:00 PM	__ 2:00 PM	__ 2:00 PM	__ 2:00 PM	__ 2:00 PM
__ 3:00 PM	__ 3:00 PM	__ 3:00 PM	__ 3:00 PM	__ 3:00 PM
__ 4:00 PM		__ 4:00 PM		

I also have some hours available on Monday, Tuesday, and Friday later afternoons and evenings and on Saturday mornings. Due to variation in my own schedule I am not scheduling regular or reoccurring appointments at these times, but I will make appointments during those hours as necessary on a week-by-week basis. Please let me know if you are interested in or limited to late afternoon, evening, or weekend hours and I will do my best to accommodate you.

Please also let me know if your schedule changes so that you need to arrange for a different regular meeting time.