Beverly Hawpe and Associates
Patient Information

Name_____Social Security #_____DOB_____

Address_____City_____State____Zip Code_____

Sex: M F Race_____Marital Status_____

Home #_____Cell #_____Work #_____

May we call you at home? Y N May we call you at work? Y N

Employer_____Occupation_____

Name of primary physician_____Office #_____

Insurance Company_____ID #_____

Emergency Contact_____Phone #_____

Referred By_____

Underline any of the following that apply to you:

Headaches
Fainting
Dizziness
Memory Problems
Irritability
Restlessness
Anxiety
Thoughts Racing
Depression
Fatigue
Frequent Worries
Poor Appetite
Overeating
Weight Change
Vomiting
Insomnia
Excessive Sleep
Nightmares
Inferiority Feelings
Homicidal Ideas
Suicidal Ideas
Past Suicide Attempts
Guilt
Difficulty Making Decisions
Unwanted Thoughts
Brooding
Preoccupations
Poor Church/Religious Support

Allergies
Compulsions
Heart Palpitations
Problems Concentrating
Difficulty Relaxing
Stomach Trouble
Bowel Problems
Unusual Experiences
Hallucinations
Difficulty Trusting People
Paranoid Thoughts/Feelings
Marked Mood Changes
Loneliness
Past Court Involvement
Employment Problems
Inadequate Income
Eating Disorder
School Problems
Problems With Anger
Victim of Child Abuse (physical, verbal, sexual)
Drinking Too Much
Past Drug/Alcohol Problems
Drug Problem
Family Problems
Sexual Problems
Difficulty Making Friends
Difficulty Keeping Friends
Loss of Important Relationship

Other Concerns that brought you to this office_____

_____

_____

Spouse (including common-law)_____

Ex-Spouses_____

Length of Courship_____

Date of Marriage/Living Arrangement_____

Date of Divorce or Separation_____

Spouse's Age_____ Spouse's Education_____ Spouse's Occupation_____

Father's Name_____ Age_____

Occupation_____ Cause of death if deceased_____

Mother's Name_____ Age_____

Occupation_____ Cause of death if deceased_____

Your Brothers and Sisters

Name_____Age_____Marital Status_____

Name_____Age_____Marital Status_____

Name_____Age_____Marital Status_____

With whom are you now living

Name_____ Age_____

Relationship_____ Occupation, School/Grade_____

Name_____ Age_____

Relationship_____ Occupation, School/Grade_____

Name_____ Age_____

Relationship_____ Occupation, School/Grade_____

Your children living away from home

Name_____ Age_____ Living where/with whom_____

Name_____ Age_____ Living where/with whom_____

Name_____ Age_____ Living where/with whom_____

How many years of school have you completed? _____ Degrees held_____

Name of primary physician_____Date of last exam_____

Average daily amounts used:

Colas_____ Tea_____ Chocolate_____ Coffee_____ Tobacco_____

Type and frequency of exercise_____

Leisure time activities/hobbies_____

Yes	No	
☐	☐	Are you taking any medication(s)? If yes, list name and dosage information:_____
☐	☐	Do you have current health problems? If yes, list and include duration:
☐	☐	Describe past medical problems:_____
☐	☐	List major surgeries and dates:_____
☐	☐	Have you ever had treatment for alcoholism/drug use? If yes, explain:
☐	☐	Have you ever taken medicine for your nerves? If yes, specify names and dates of use:_____
☐	☐	Have you ever been admitted to a psychiatric hospital? If yes, specify names and dates:_____
☐	☐	Have you ever been in psychotherapy before? If yes, list therapist, dates and reason: _____
☐	☐	Have you ever attended AA, NA, CA? If yes, when:_____

Women Only

Yes	No		
☐	☐	Are you pregnant? Due date:_____	# of pregnancies_____
☐	☐	Do you have irregular periods?	# of live births_____
☐	☐	Do you have severe menstrual cramps?	# of abortions_____

Family Health History

Yes	No		Yes	No	
☐	☐	Alcoholism	☐	☐	Heart/High Blood Pressure/Stroke
☐	☐	Drug Addiction	☐	☐	Thyroid/Diabetes
☐	☐	Depression	☐	☐	Cancer
☐	☐	Suicide	☐	☐	Mental Illness
☐	☐	Epilepsy/Retardation	☐	☐	Other Diseases _____

Important, non-blood relatives with mental illness, suicide/homicide (i.e. step parents or spouse):

_____

Drinking/Drug History (Information will be held confidential)

1. Complete the following about drug use:

Alcohol
Y N
Date of 1st Use_____ Years Used_____ How much Used_____ Last Use_____

Marijuana/Hashish
Y N
Date of 1st Use_____ Years Used_____ How much Used_____ Last Use_____

Cocaine/Crack
Y N
Date of 1st Use_____ Years Used_____ How much Used_____ Last Use_____

Crystal Meth (Crank)
Y N
Date of 1st Use_____ Years Used_____ How much Used_____ Last Use_____

Heroin/Methadone
Y N
Date of 1st Use_____ Years Used_____ How much Used_____ Last Use_____

Opium
Y N
Date of 1st Use_____ Years Used_____ How much Used_____ Last Use_____

Morphine
Y N
Date of 1st Use_____ Years Used_____ How much Used_____ Last Use_____

Amphetamines (Speed)
Y N
Date of 1st Use_____ Years Used_____ How much Used_____ Last Use_____

Barbiturates
Y N
Date of 1st Use_____ Years Used_____ How much Used_____ Last Use_____

LSD
Y N
Date of 1st Use_____ Years Used_____ How much Used_____ Last Use_____

Inhalants
Y N
Date of 1st Use_____ Years Used_____ How much Used_____ Last Use_____

Valium
Y N
Date of 1st Use_____ Years Used_____ How much Used_____ Last Use_____

Xanax
Y N
Date of 1st Use_____ Years Used_____ How much Used_____ Last Use_____

Librium
Y N
Date of 1st Use_____ Years Used_____ How much Used_____ Last Use_____

Other:_____
Date of 1st Use_____ Years Used_____ How much Used_____ Last Use_____

2. Age at first drink_____ Age at first drug use_____

3. Age at regular alcohol use_____ Age at regular drug use_____

4. Do you think alcohol or drugs is a problem for you?_____

5. When was you last drink or drug use?_____

6. Describe your drinking and/or drug use:_____

_____

_____

7. Do you drink and/or use drugs alone or with a group?_____

   Describe:_____

8. What is you longest period of sobriety?_____

9. Do you have any arrests due to drinking and/or drug use?_____

   Explain:_____

10. Loss of employment due to alcohol and/or drug use:_____

    Explain:_____

11. Have you ever done something while drinking/using that you do not remember doing?_____

    If yes, how often has this occurred?_____

12. Have you ever had one of the following (please include dates):

Seizure	Y	N	Dates:_____
Hallucinations	Y	N	Dates:_____
DT's	Y	N	Dates:_____
Shakes	Y	N	Dates:_____

13. Describe your parents drinking and/or drug use:_____

_____

_____

14. Is any family member an alcoholic and/or drug addicted?_____

15. Describe how your family/friends react to your drinking/drug use:_____

_____

_____

16. Describe your ideas about managing your alcohol/drug problem:_____

_____

_____

Beverly Hawpe and Associates
Client Rights

In accordance with the Civil Rights Acts of 1964, treatment is offered to you without discrimination as to age, sex, race, creed or country of origin. You have the right to a confidential relationship with your therapist. One legal exception this is: "threat of serious harm to self or others", in the case of child abuse, suicide or grave disability. You have the right to receive the following in writing from your therapist: name, business address, business phone number and a list of all degrees, credentials and licenses. You are entitled to receive information from your therapist about the methods of therapy, the techniques used and the duration of therapy. You may seek a second opinion from another therapist or may terminate therapy at any time. Sex and intimacy is never appropriate in therapy and is illegal. Any such occurrence must be reported to the grievance board.

Furthermore, the confidentiality of alcohol and drug abuse records maintained by your therapist is protected by Federal Regulations. Generally, any information identifying a patient's participation in therapy may not be disclosed unless: 1. the patient consents in writing; 2. the disclosure is allowed by court order; 3. the disclosure is made to medical personnel in a medical emergency; or 4. the disclosure is made to qualified personnel for research, audit or evaluation purposes. The signature of a parent or legal guardian must accompany signatures of minors under the age of 15.

Violation of these Federal Laws and Regulations is a crime. Such violations may be reported to appropriate authorities in accordance with Federal Regulations. Federal Law and Regulations do not protect any information about crimes committed by a client or any threats to commit a crime. Federal Laws do not protect any information about suspected child abuse or neglect from being reported under State Law to appropriate agencies or local authorities. Should you have any questions or complaints regarding any aspect of your treatment and are unable to resolve these concerns with your therapist, a meeting will be arranged for you and your therapist with a Clinical Supervisor.

Payment of fees is required as outlined in the fee arrangement. Non-payment of fees shall be cause for immediate termination of therapy.

The practice of both licensed and unlicensed psychotherapists is regulated by the Department of Regulatory Agencies. You may contact them at: 1525 Sherman Street, Room 128, Denver, CO 80202 or 303-866-3248.

I have read and understand my rights as a client.

_____

Signature Date

_____

Signature of Guardian Date

Coordination of Care between Health Care Providers and Release of Information

Communications between behavioral providers and your primary care (PCP) is important to ensure that you receive comprehensive and quality health care. This form will allow your behavioral health provider to share protected health information (PHI) with your PCP. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plans, and progress if necessary.

Patient Rights

- You may end this authorization (permission to use or disclose information) any time by contacting the practitioner's office.
- If you make a request to end this authorization, it will not include information that may have already been used or disclosed based on your previous permission. For more information about this and your rights, please see the applicable Notice of Privacy Practices.
- You will not be required to sign form as a condition of treatment, payment, enrollment or eligibility for benefits.
- You have a right to a copy of this signed authorization.
- If you choose not to agree with this request, your benefits or services will not be affected.

Patient Authorization

I hereby authorize the name(s) or entities written below to release verbally or in writing information regarding any medical, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the following identified patient. I understand that these records are protected by Federal and State laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request. This consent expires in one (1) year from the date of my signature below unless otherwise stated herein.

_____ is authorized to release protected health information related
(provider name – please print)

to the evaluation and treatment of_____ _____/_____/_____
(member name) (date of birth-MM/DD/YYYY)

PCP Name:_____ PCP Phone:_____

PCP Address:_____
(street) (city) (state) (zip)

Disclosure may include the following verbal or written information: (check all that apply)

_____Face Sheet _____Psychosocial Assessment

_____Discharge Summary _____UA Results

_____Substance Abuse Treatment Plan _____All Records

_____ **I hereby refuse to give authorization for any release of information**

_____ _____
Signature of Patient, Parent, Guardian or Authorized Representative Date

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www.beverlyhawpeassociates.com

PERSONAL DISCLOSURE STATEMENT

BEVERLY HAWPE, LPC, CAC III, LAC, P.C.

C.6 QUALIFICATIONS/EXPERIENCE

I am licensed by Colorado as a Professional Counselor. In addition, I am certified by the Alcohol and Drug Abuse Division of Colorado as a Level III counselor and a Licensed Addictions Counselor. I am also certified as a level II specialist by the National Association of Alcohol/Drug Abuse. My counseling practice includes the treatment of both addictions and mental health issues.

I hold a Master's Degree in Counseling Psychology from Central State University, Edmond, Oklahoma. I have been a professional counselor since 1981.

I accept only clients in my practice who I believe have the capacity to resolve their own problems with my assistance. I believe that as people become more accepting of themselves, they are more capable of finding happiness and contentment in their lives.

a. During assessment, I will evaluate the treatment issues and discuss them with you, as well as your own expectations and goals to be accomplished during the therapeutic process. We will also discuss at that time, the expectations and cooperation from you to make therapy most effective as well as appropriate timelines for treatment. I utilize a cognitive behavioral approach to treatment. My belief is that the goal of therapy is to enhance the self-empowerment of my client, and to identify roadblocks that may interfere with your being able to utilize self-empowering behavior. You may terminate the counseling relationship at any point. I will be supportive of that decision. If counseling is successful, you should feel that you are able to face life's challenges in the future without my support or intervention.

b. Although our sessions may be very intimate emotionally and psychologically, it is important for you to realize that we have a professional relationship rather than a personal one, and that our relationship is exclusively within the professional context of our counseling session. Our sessions concentrate exclusively on your concerns; you will learn a great deal about me as we work together during your counseling experience; however, it is important for you to remember that you are experiencing me only in my professional role.

c. All of our communication becomes part of the clinical record, which is accessible to you on request. I will keep confidential anything you say to me, with the following exceptions: a) you direct me to tell someone else, b) I determine that you are a danger to yourself or others, or c) I am ordered by a court to disclose information. It is important to understand that if you choose to utilize insurance benefits for payment of sessions, your consent allows the insurance company access to any relevant information requested for case management and/or billing, and that it is necessary to submit a diagnosis of your condition for reimbursement. I will inform you of the diagnosis plan I

render before I submit it to the health insurance company. Any diagnosis will become part of your permanent insurance record.

d. If at any time for any reason you are dissatisfied with my services, please let me know. If I am not able to resolve your concerns, you may report your complaints to the following, in the order presented:

Connect Care
220 Ruskin Drive
Colorado Springs, CO 80910
(719) 550-0100

Alcohol and Drug Abuse Division
Colorado Department of Health
4055 South Lowell Boulevard
Denver, CO 80206
(303) 866-7480

Department of Regulatory Agencies
Mental Health Section
1560 Broadway, Suite 1370
Denver, CO 80202
(303) 849-7766

_____ _____

Signature Date

_____ _____

Beverly Hawpe, LPC, CAC III, LAC, P.C. Date