Gwen E. Rock, Psy.D., LPC, Counseling Services, LLC

Name of Client: _____
Last First Middle Name you wish to be called by

Age: ____ Date of Birth: ____/____/____ Telephone: Home: _____ Work: _____
Month /Day /Year

Address: _____ Cell: _____ Email: _____
Street/P O Box

_____ Gender: ____Male ___ Female
City State Zip

Referred By: _____ Today's Date: ____/____/____
Name Relationship Month/Day/Year

Relationship Status: ___Single ___Married ___Divorced ___Separated ___Widowed ___Significant Other

Occupation: _____ Employed By: _____

Insurance Name and ID # _____ Work Address: _____

Social Security Number: _____ _____

Family Information:	**Name**	**Age**	**Occupation**	**Deceased Date**	**Education**	**Health Status**
Father:				___/___/___		
Mother:				___/___/___		
Step-Father:				___/___/___		
Step-Mother:				___/___/___		
Brothers/Sisters: (circle gender)						
M F				___/___/___.		
M F				___/___/___.		
M F				___/___/___.		
M F				___/___/___.		
M F				___/___/___.		
M F				___/___/___.		
Spouse/Partner:						
M F				___/___/___.		
Sons/Daughters:						
M F				___/___/___.		
M F				___/___/___.		
M F				___/___/___.		
M F				___/___/___.		
M F				___/___/___.		

Education/Training/Work Experience: _____

_____

_____

_____(Please complete next page)

Health:

Describe your health_____

What medication, if any are you currently taking?

Name	Dosage	Condition

Date of last physical exam: ___/___/____ Name of physician: _____Telephone No: _____

Address:_____
Street City State Zip

Please note any noteworthy physical problems: _____

Brief (1-2 Sentences) description of problem for which you are seeking help: _____

Previous Psychotherapy/Counseling/Psychological Assessment:

Therapist Name: _____ Telephone Number: _____ ___ Individual ___Family ___Couples
(Mark all that apply)

Address: _____
Street City State Zip

Duration of Treatment: From: ___/___/____ to ___/___/____ Session Frequency: ____ Weekly Monthly (circle one)

Outcome and helpfulness: _____

Previous Psychotherapy/Counseling/Psychological Assessment:

Therapist Name: _____ Telephone Number: _____ ___ Individual ___Family ___Couples
(Mark all that apply)

Address: _____
Street City State Zip

Duration of Treatment: From: ___/___/____ to ___/___/____ Session Frequency: ____ Weekly Monthly (circle one)

Outcome and helpfulness: _____

Special Interests/Hobbies: _____

Patient Name _____ Date _____

BRIEF PATIENT HEALTH QUESTIONNAIRE tm (PHQ-Brief)

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability unless you are requested to skip a question.

1. Over the **LAST 2 WEEKS** how often have you been bothered by any of the following problems?

		Not at all	Several days	More than half the days	Nearly every day
a.	Little interest or pleasure in doing things	☐	☐	☐	☐
b.	Feeling down, depressed or hopeless	☐	☐	☐	☐
c.	Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
d.	Feeling tired or having little energy	☐	☐	☐	☐
e.	Poor appetite or overeating	☐	☐	☐	☐
f.	Feeling bad about yourself, or that you are a failure, or have let yourself or your family down	☐	☐	☐	☐
g.	Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
h.	Moving or speaking so slowly that other people could have noticed. Or the opposite, being so fidgety or restless that you have been moving around a lot than usual	☐	☐	☐	☐
i.	Thoughts that you would be better off dead, or hurting yourself in some way	☐	☐	☐	☐

2. **Questions about anxiety.**

		NO	YES
a.	In the **LAST 4 WEEKS** have you had an anxiety attack – suddenly feeling fear or panic?	☐	☐

IF YOU CHECKED "NO", GO TO QUESTION #3

b.	Has this ever happened before	☐	☐
c.	Do some of these attacks come suddenly out of the blue – that is, in situations where you don't expect To be nervous or uncomfortable?	☐	☐
d.	Do these attacks bother you a lot or are you worried about having another attack?	☐	☐
e.	During your last bad anxiety attack, did you have symptoms like shortness of breath, sweating, your heart racing or pounding, dizziness or faintness, tingling or numbness, or nausea or upset stomach?	☐	☐

3. If you checked off **ANY** problems on this questionnaire so far, how **DIFFICULT** have these problems made it for you to do your work, take care of things at home, or get along with people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Patient Name _____ Date _____

BRIEF PATIENT HEALTH QUESTIONNAIRE tm (PHQ-Brief)

4. In the **LAST 4 WEEKS**, how much have you been bothered by any of the following problems?

		Not bothered	Bothered a little	Bothered a lot
a.	Worrying about your health	☐	☐	☐
b.	Your weight or how you look	☐	☐	☐
c.	Little or no sexual desire or pleasure during sex	☐	☐	☐
d.	Difficulties with husband/wife, partner/lover, or boyfriend/girlfriend	☐	☐	☐
e.	The stress of taking care of children, parents or other family members	☐	☐	☐
f.	Stress at work outside of the home or at school	☐	☐	☐
g.	Financial problems or worries	☐	☐	☐
h.	Having no one to turn to when you have a problem	☐	☐	☐
i.	Something bad that happened recently	☐	☐	☐
j.	Thinking or dreaming about something terrible that happened to you in the past – like your house being destroyed, a severe accident, being hit or assaulted, or being forced to commit a sexual act	☐	☐	☐

5. In the **LAST YEAR**, have you been hit, slapped, kicked or otherwise physically hurt by someone, or has anyone forced you to have an unwanted sexual act? **NO** ☐ **YES** ☐

6. What is the most stressful thing in your life right now? _____

_____

7. Are you taking any medicine for anxiety, depression or stress? **NO** ☐ **YES** ☐

8. FOR WOMEN ONLY: Questions about menstruation, pregnancy and childbirth

a. Which describes your menstrual periods?

☐ Periods are unchanged

☐ No periods became pregnant or recently gave birth

☐ Periods have becoming irregular or changed in frequency, duration or amount

☐ No periods periods for at least a year

☐ Having periods because taking hormone replacement (estrogen) therapy or oral contraceptive

		NO	YES
b.	During the week before your period starts, do you have a serious problem with your mood – like depression, anxiety, irritability, anger or mood swings?	☐	☐
c.	If YES: Do these problems go away by the end of your period?	☐	☐
d.	Have you given birth within the last 6 months?	☐	☐
e.	Have you had a miscarriage within the last 6 months?	☐	☐
f.	Are you having difficulty getting pregnant?	☐	☐

Patient Name _____ Date _____

PATIENT HEALTH QUESTIONAIRE
(PHQ-9)

Over the **last 2 weeks**, how often have you been bothered by any of the following problems? Circle your best answer.	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or over-eating	0	1	2	3
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so figity or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself	0	1	2	3
ADD COLUMNS				
TOTAL				

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card)

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? Not Difficult At All _____ Some-What Difficult _____ Very Difficult _____ Extremely Difficult _____

Patient Name _____ Date _____

PATIENT HEALTH QUESTIONNAIRE 15-ITEM SOMATIC SYMPTOM SEVERITY SCALE (PHQ-15)

During the **past 4 weeks**, how much have you been bothered by any of the following problems?	**Not Bothered At All**	**Bothered a Little**	**Bothered a Lot**
a. Stomach pain	☐	☐	☐
b. Back pain	☐	☐	☐
c. Pain in your arms, legs, or joints (knees, hips, etc.)	☐	☐	☐
d. Menstrual cramps or other problems with your periods (Women only)	☐	☐	☐
e. Headaches	☐	☐	☐
f. Chest pain	☐	☐	☐
g. Dizziness	☐	☐	☐
h. Fainting spells	☐	☐	☐
i. Feeling your heart pound or race	☐	☐	☐
j. Shortness of breath	☐	☐	☐
k. Pain or problems during sexual intercourse	☐	☐	☐
l. Constipation, loose bowels, or diarrhea	☐	☐	☐
m. Nausea, gas, or indigestion	☐	☐	☐
n. Feeling tired or having low energy	☐	☐	☐
o. Trouble sleeping	☐	☐	☐

Patient Name _____ Date _____

BECK INVENTORY

On this questionnaire are groups of statements. Please read each group of statements carefully. Then pick out the statement in each group which best describes the way you have been feeling the past week (including today). Circle the number beside the statement you picked. If several statements in the group seem to apply equally, circle each one. Be sure to read all the statements in each group before making your choice.

1. 0 I do not feel sad
   1 I feel sad
   2 I am sad all the time and can not snap out of it
   3 I am so sad or unhappy that I can not stand it

2. 0 I am not particularly discouraged about the future
   1 I am discouraged about the future
   2 I feel I have nothing to look forward to
   3 I feel that the future is hopeless and that things can not improve

3. 0 I do not feel like a failure
   1 I feel I have failed more than the average person
   2 As I look back on my life, all I can see is a lot of failures
   3 I feel I am a complete failure as a person

4. 0 I get as much satisfaction out of things as I used to
   1 I do not enjoy things the way I used to
   2 I do not get real satisfaction out of anything anymore
   3 I am dissatisfied or bored with everything

5. 0 I do not feel particularly guilty
   1 I feel guilty a good part of the time
   2 I feel quite guilty most of the time
   3 I feel guilty all the time

6. 0 I do not feel I am being punished
   1 I feel I may be punished
   2 I expect to be punished
   3 I feel I am being punished

7. 0 I do not feel disappointed in myself
   1 I am disappointed in myself
   2 I am disgusted with myself
   3 I hate myself

8. 0 I do not feel I am any worse than anybody else
   1 I am critical of myself for my weaknesses or mistakes
   2 I blame myself all the time for my faults
   3 I blame myself for everything bad that happens

Patient Name _____ Date _____

9. 0 I do not have any thoughts of killing myself
   1 I have thoughts of killing myself but I would not carry them out
   2 I would like to kill myself
   3 I would kill myself if I had the chance

10. 0 I do not cry any more than usual
   1 I cry more now than I used to
   2 I cry all the time
   3 I used to be able to cry but now I can not cry even though I want to

11. 0 I am no more irritated now than I ever am
   1 I get annoyed or irritated more easily than I used to
   2 I feel irritated all the time
   3 I do not get irritated at all by the things that used to irritate me

12. 0 I have not lost interest in other people
   1 I am less interested in other people than I used to be
   2 I have lost most of my interest in other people
   3 I have lost all of my interest in other people

13. 0 I make decisions about as well as I ever could
   1 I put off making decisions more than I used to
   2 I have greater difficulty in making decisions than before
   3 I can not make decisions anymore

14. 0 I do not feel I look any worse than I used to
   1 I am worried that I am looking old or unattractive
   2 I feel that there are more permanent changes in my appearance that make me look unattractive
   3 I believe I look ugly

15. 0 I can work about as well as before
   1 It takes an extra effort to get started at doing something
   2 I have to push myself very hard to do anything
   3 I can not do any work at all

16. 0 I can sleep as well as usual
   1 I do not sleep as well as I used to
   2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep
   3 I wake up several hours earlier than I used to and can not get back to sleep

17. 0 I do not get more tired than usual
   1 I get tired more easily than I used to
   2 I get tired from doing almost anything
   3 I am too tired to do anything

Patient Name _____ Date _____

18. 0 My appetite is no worse than usual
1 My appetite is not as good as it used to be
2 My appetite is much worse now
3 I have no appetite at all anymore

19. 0 I have not lost much weight
1 I have not lost more than five (5) pounds. I am purposely trying to lose.
2 I have lost more than ten (10) pounds. By eating less? ____ Yes ____ No
3 I have lost more than fifteen (15) pounds

20. 0 I am no more worse about my health than usual
1 I am worried about physical problems such as aches and pains/upset stomach/constipation
2 I am very worried about physical problems and it is hard to think of much else
3 I am so worried about my physical problems that I can not think of anything else

21. 0 I have not noticed any recent change in my interest in sex
1 I am less interested in sex than I used to be
2 I am much less interested in sex now
3 I have lost interest in sex completely

Patient Name _____ Date _____

BURNS ANXIETY INVENTORY

Instructions: The following is a list of symptoms that people sometimes have. Check the box that best describes how much that symptom or problem has bothered you **during the past week.**	Not at all 0	Somewhat 1	Moderately 2	A Lot 3
CATEGORY I: ANXIOUS FEELINGS				
1. Anxiety, nervousness, worry or fear				
2. Feeling that things around you are strange, unreal or foggy				
3. Feeling detached from all or part of your body				
4. Sudden unexpected panic spells				
5. Apprehension or a sense of impending doom				
6. Feeling tense, stressed, "uptight", or on edge				
CATEGORY II: ANXIOUS THOUGHTS				
7. Difficulty concentrating				
8. Racing thoughts or having your mind jump from one thing to the next				
9. Frightening fantasies or daydreams				
10. Feeling that you're on the verge of losing control				
11. Fears of cracking up or going crazy				
12. Fears of fainting or passing out				
13. Fears of physical illnesses or heart attacks, or dying				
14. Concerns about looking foolish or inadequate in from of others				
15. Fears of being alone, isolated, or abandoned				
16. Fears of criticism or disapproval				
17. Fears that something terrible is about to happen				
CATEGORY III: ANXIOUS PHYSICAL SYMPTOMS				
18. Skipping, racing or pounding of the heart sometimes called, "palpitations".				
19. Pain, pressure, or tightness in the chest				
20. Tingling or numbness in the toes or fingers				
21. Butterflies or discomfort in the stomach				
22. Constipation or diarrhea				
23. Restlessness or jumpiness				
24. Tight, tense muscles				
25. Sweating not brought on by heat				
26. A lump in the throat				
27. Trembling or shaking				
28. Rubbery or "jelly" legs				
29. Feeling dizzy, lightheaded or off balance				
30. Choking or smothering sensations or difficulty breathing				
31. Headaches or pains in the neck or back				
32. Hot flashes or cold chills				
33. Feeling tired,, weak or easily exhausted				

Patient Name _____ Date _____

AUDIT QUESTIONNAIRE

Questions	0	1	2	3	4	Enter Score
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week	

If score to 1st question is zero, stop screening here.

2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have five or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

If the total score for Questions 1-3 is 5 points or higher for Men OR 4 points or higher for Women, then continue

	0	1	2	3	4	Enter Score
4. How often during the last year have you found that you were not able to stop drinking once you started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
10. Has a relative, friend, doctor or other healthcare worker been concerned about your drinking or suggested you cut down?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
					TOTAL SCORE	

Scores of 8 or more for men (up to age 60) or 4 or more for women, adolescents, and men over the age of 60 are considered positive results

Patient Name _____ Date _____

DAST-10

The following questions concern information about your potential involvement with drugs, excluding alcoholic beverages and tobacco, during the past 12 months. Carefully read each statement and decide if your answer is "Yes" or "No". Then circle the appropriate response beside the question.

When the words "drug abuse" are used, they mean the use of prescribed or over-the counter medications/drugs in excess of the directions and any non-medical use of drugs. The various classes of drugs may include cannabis (marijuana, hashish), solvents (e.g. paint thinner), tranquilizers (e.g. Valium), barbiturates, cocaine, stimulants (e.g. speed), hallucinogens (e.g. LSD), or narcotics (e.g. heroin). Remember that the questions do not include alcoholic beverages or tobacco.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right. You may choose to answer or not answer any of the questions in this section.

These Questions Refer to the Past 12 Months

1.	Have you used drugs other than those required for medical reasons?	YES	NO
2.	Do you abuse more than one drug at a time?	YES	NO
3.	Are you unable to stop using drugs when you want to?	YES	NO
4.	Have you ever had blackouts or flashbacks as a result of drug use?	YES	NO
5.	Do you ever feel bad or guilty about your drug use?	YES	NO
6.	Does your spouse (parents) ever complain about your involvement with drugs?	YES	NO
7.	Have you ever neglected your family because if your use of drugs?	YES	NO
8.	Have you engaged in illegal activities to obtain drugs?	YES	NO
9.	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	YES	NO
10.	Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	YES	NO

Interpretation (Each "Yes" response = 1) _____

In these statements, the term "drug abuse" refers to the use of medications at a level that exceeds the instructions, and/or any non-medical use of drugs. Patients receive 1 point for every "yes" answer with the exception of question #3, for which a "no" answer receives 1 point.

Score	Degree of Problems Related to Drug Abuse	Suggested Action
0	No Problems Reported	None At This Time
1-2	Low Level	Monitor, Reassess At A Later Date
3-5	Moderate Level	Further Investigation
6-8	Substantial Level	Intensive Assessment
9-10	Severe Level	Intensive Assessment

Patient Name _____ Date _____

Physical Stress Symptom Scale

In the space provided, indicate how often each of the following effect happens to you either when you are experiencing stress, or following exposures to a significant stressor. Respond to each item with a number between 0 and 5, using the scale below.

0 = Never
1 = Once or twice a year
2 = Every few months
3 = Every few weeks
4 = Once or more each week
5 = Daily

Cardiovascular Symptoms
____ Heart pounding
____ Heart racing or beating erratically
____ Cold, sweaty hands
____ Headache (throbbing pain)
____ Subtotal

Respiratory Symptoms
____ Rapid, erratic or shallow breathing
____ Shortness of breath
____ Asthma attack
____ Difficulty in speaking because of poor breathing control
____ Subtotal

Gastrointestinal Symptoms
____ Upset stomach, nausea, or vomiting
____ Constipation
____ Diarrhea
____ Sharp abdominal pains
____ Subtotal

Muscular Symptoms
____ Headaches (steady pain)
____ Back or shoulder pains
____ Muscle tremors or hand shaking
____ Arthritis
____ Subtotal

Skin Symptoms
____ Acne
____ Dandruff
____ Perspiration
____ Excessive dryness of skin or hair
____ Subtotal

Immunity Symptoms
____ Allergy flare-up
____ Catching colds
____ Catching the flu
____ Skin rash
____ Subtotal

Metabolic Symptoms
____ Increased appetite
____ Increased craving for tobacco or sweets
____ Thoughts racing or difficulty sleeping
____ Feelings of crawling anxiety or nervousness
____ Subtotal

OVERALL SYMPTOM TOTAL = _____
(Add all seven subtotals)

From Allen, R: Progressive neuromuscular relaxation. Autumn Wind Press. College Park, Md., 1979

Patient Name _____ Today's Date _____

CURRENT SYMPTOM CHECKLIST

	None	Mild	Mod	Severe
depressed mood	☐	☐	☐	☐
appetite disturbance	☐	☐	☐	☐
sleep disturbance	☐	☐	☐	☐
elimination disturbance	☐	☐	☐	☐
fatigue/low energy	☐	☐	☐	☐
psychomotor retardation	☐	☐	☐	☐
poor concentration	☐	☐	☐	☐
poor grooming	☐	☐	☐	☐
mood swings	☐	☐	☐	☐
agitation	☐	☐	☐	☐
emotionality	☐	☐	☐	☐
irritability	☐	☐	☐	☐
generalized anxiety	☐	☐	☐	☐
panic attacks	☐	☐	☐	☐
phobias	☐	☐	☐	☐
obsessions/compulsions	☐	☐	☐	☐
bingeing/purging	☐	☐	☐	☐
laxative/diuretic abuse	☐	☐	☐	☐
anorexia	☐	☐	☐	☐
paranoid ideation	☐	☐	☐	☐
circumstantial symptoms	☐	☐	☐	☐
loose associations	☐	☐	☐	☐
delusions	☐	☐	☐	☐
hallucinations	☐	☐	☐	☐

	None	Mild	Mod	Severe
aggressive behavior	☐	☐	☐	☐
conduct problems	☐	☐	☐	☐
oppositional behavior	☐	☐	☐	☐
sexual dysfunction	☐	☐	☐	☐
grief	☐	☐	☐	☐
hopelessness	☐	☐	☐	☐
social isolation	☐	☐	☐	☐
worthlessness	☐	☐	☐	☐
guilt	☐	☐	☐	☐
elevated mood	☐	☐	☐	☐
hyperactivity	☐	☐	☐	☐
dissociative states	☐	☐	☐	☐
somatic complaints	☐	☐	☐	☐
self-mutilation	☐	☐	☐	☐
significant weight gain/loss	☐	☐	☐	☐
concomitant medical condition	☐	☐	☐	☐
emotional trauma victim	☐	☐	☐	☐
physical trauma victim	☐	☐	☐	☐
sexual trauma victim	☐	☐	☐	☐
emotional trauma perpetrator	☐	☐	☐	☐
physical trauma perpetrator	☐	☐	☐	☐
sexual trauma perpetrator	☐	☐	☐	☐
substance abuse	☐	☐	☐	☐

None = This symptom not preset at this time
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.

1) Date _____ No Changes _____ Initial _____ Doctor Initial _____
2) Date _____ No Changes _____ Initial _____ Doctor Initial _____
3) Date _____ No Changes _____ Initial _____ Doctor Initial _____
4) Date _____ No Changes _____ Initial _____ Doctor Initial _____
5) Date _____ No Changes _____ Initial _____ Doctor Initial _____

Treatment Goals

Circle four (4) of the following areas you would like to improve upon:

1. Increase involvement in outside interests and activities
2. Increase social activities
3. Spend more time with my family
4. Improve communication with spouse
5. Decrease daily tension and anxiety
6. Develop greater self-worth
7. Learn to be less sensitive
8. Become more comfortable in a group
9. Modify feelings of anger and resentment
10. Learn to say what I really think and feel
11. Be a better listener
12. Appreciate the feelings of others more
13. Appreciate more how my behavior affects others
14. Gain more ability to be patient under stress
15. Learn some factual information about alcoholism/drug addiction
16. Become more trustful and candid in relationships
17. Understand and accept personal strengths and limitations
18. Deal more constructively with feelings of hostility
19. Be more self-assertive in relationships
20. Acknowledge past disappointments and failures
21. Set realistic working goals
22. Modify tendency to be too rigid and inflexible

Please complete the following sentence in your own words:

I have come to counseling because:

_____

_____

Patient Name _____ Date _____

Measure Your Stress Quotient

This stress rating chart, designed by Dr. Thomas H. Holmes, provides a measurement of the stress in your life. Check all the events that have happened to you in the **PAST YEAR** and then add up the total.

EVENT	VALUE
Death of Spouse	100
Divorce	73
Marital Separation	65
Jail Term	63
Death of Close Family Member	63
Personal Injury or Illness	53
Marriage	50
Fired from Work	47
Marital Reconciliation	45
Retirement	45
Change in Family Member's Health	44
Pregnancy	40
Sex Difficulties	39
Addition to Family	39
Business Readjustment	39
Change in Financial Status	38
Death of Close Friend	37
Change to Different Line of Work	36
Change in Number of Marital Arguments	35
Mortgage or Loan over $10,000	31
Foreclosure of Mortgage or Loan	30
Change in Work Responsibilities	29
Son or Daughter Leaving Home	29
Trouble with In-Laws	29
Outstanding Personal Achievement	28
Spouse Begins or Stops Work	26
Starting of Finishing School/College	26
Change in Living Conditions	25
Revision of Personal Habits	24
Trouble with Boss	23
Change in Work Hours, Conditions	20
Change in Residence	20
Change in Schools	20
Change in Recreation	19
Change in Church Activities	19
Change in Social Activities	18
Mortgage or Loan Under $10,000	17
Change in Sleeping Habits	16
Change in Number of Family Gatherings	15
Change in Eating Habits	15
Vacation	13
Christmas Season	12
Minor Violation of the Law	11
Total	_____

Holmes, T. and Rahe, R: The social readjustment rating scale. J Psychosom Res, 11:213, 1967

Gwen E Rock Psy.D, LPC Counseling Services, LLC
875 E. Main Street
Waynesboro, Pa 17268
717-762-4339/717-765-4345 (fax)

AUTHORIZATION FOR RELEASE OF INFORMATION TO INSURANCE COMPANY

I authorize Gwen E Rock Psy.D, LPC Counseling Services, LLC and all business partners to release billing information which may include client name, date and type of services, diagnoses codes, substance abuse information and/or treatment plans to my insurance company/ies for the purpose of: collecting insurance benefits or for the authorization of additional sessions for:

Patient Name	Date of Birth	Social Security Number

- I understand that I have the right to inspect the information released through this authorization and such an inspection will occur in a meeting with Gwen Rock.
- I understand that I may revoke this authorization by providing a written revocation.
- I also understand any information released prior to the revocation may be used for the purpose(s) listed above.
- A photocopy of this authorization shall have the same force as the original.
- This release shall be valid for one year following our last appointment, unless otherwise restricted.

Patient or Parent/Guardian Signed: _____ Date: _____

Witnessed: _____ Date: _____

Policy Holder Name, Date of Birth & Social Security Number	
Policy Holder Address	
Policy Holder's Employer's Name	
Insurance Company	
Policy Number, Member ID or FECA Number	
Group Number if Applicable	
Co-Pay listed on card	

** Gwen E Rock Psy.D, LPC, Counseling Services, LLC will need to photocopy your insurance card and photo ID at your first session, yearly or when you either change Insurance or your Photo ID has been updated**

Although your insurance MAY cover all your fees, ultimately it is your responsibility to cover all your costs. Some plans require preauthorization before your first visit. It is YOUR responsibility to obtain this authorization. Mental Health benefits may differ from your medical benefits so it is essential that you have researched your mental health benefits prior to your visit. If you have not done this prior to your visit, and/or your treatment is not a payable benefit, you will be responsible for the full cash payment at the time of service. Further if your insurance carrier determines that the services received are not medically necessary, you will be responsible for full payment of your accrued fees.