Serenity Therapeutics LLC
753 North Main St, Suite B5, Cottonwood AZ 86326
928-899-0723 info@SerenityTherapeuticsLLC.com

ADULT INTAKE
(18 year old and older)

Today's Date _____

Name _____

Date of Birth_____ Age _____

Address _____

_____

City State Zip

Home Phone _____ Cell Phone_____Text Y / N

E-mail _____

Permission to leave a message by phone, email or text: **Yes** _____ or **No** _____

Marital Status: _____ Married _____ Divorced _____ Separated _____ Widow/Widower

Occupation _____ Employer _____

Person to contact in case of emergency: _____Phone _____

Relationship to you _____

Whom may we thank for referring you? _____

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*** Please fill out following pages in detail. Some of this information may be upsetting or painful to fill out, however, this will help determine if Neurofeedback is right for you. All information is confidential and will not be shared.**

Reason for evaluation_____

_____

Have you been previously treated with Neurofeedback? _____ If yes, where/when/location? _____

_____

Number of sessions? _____ Reason for stopping treatment _____

_____

Have you been diagnosed with disorder: **Y** or **N** Date of diagnosis _____

Person who diagnosed: _____Place (City/State): _____

Diagnosis: _____

Does anyone else in the family have a problem similar to you? _____ Relationship _____

Describe your strengths _____

Describe your weaknesses _____

What are your current concerns? _____

How long has this been an issue?_____

How often does this happen? _____

How does this impact your daily living? _____

What have you done to address the issues? _____

What do you think are the causes of the issues? _____

Please describe in detail your personality and how you feel about yourself _____

_____

_____

_____

Do you have sensory issues? (e.g., food, texture, hot/cold, wet, sticky, etc.)_____

_____

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Describe your typical day during the week: _____

_____

_____

Describe your typical day during the weekend: _____

_____

_____

Do you ever feel overwhelmed or stressed? ____ No ____ Yes If yes, describe: _____

_____

How many friends do you have? _____ How many close friends do you have? _____

If married, how long together? _____ Prior Marriages? _____

Long-term partner (s)? _____ Name and number of years together _____

Things you like or admire about your spouse/partner? _____

_____

Things you don't like about your spouse/partner? _____

_____

Person closest to you _____ Relationship _____

Have you experienced (circle all that apply)

Death of a loved one separation from a loved one emotional trauma sexual abuse

Family conflict marital conflict physical abuse emotional abuse

Please explain _____

_____

Describe current living situation: _____

_____

Where were you born? _____ Where did you grow up? _____

Relationship to family: Are you? ____Biological ___ Adopted ____ Foster ____ Other

If adopted/foster/other, do you know about your biological family? ___ Yes ___ No

Are you in contact with them? ___Yes ___ No

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How do you feel about the situation? Explain: _____

_____

Do you have children? ____ Yes ____ No Biological / Adopted / Foster / Loss of child / Other

List children's names and ages: _____

_____

List any significant difficulties you have with your children: _____

_____

Please list parents, siblings, step-parents, grandparents, etc. related to you:

Name	Age	Relationship to you	Personality	How do you get along?

Describe the mood of your household while growing up? _____

_____

How were you treated as a child? Any abuse or neglect? _____

_____

As a minor, did you run away from home or get placed anywhere? ___ Yes ___ No

If so, what were the circumstances? _____

What important event(s) occurred during your teenage years? _____

_____

List past or current problems with parents, siblings, or other family members: _____

_____

_____

_____

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Please list you past several employers:

Employer	Date started/ended	Job Description	Reason for leaving

Have you served in the military? ___Yes ___ No If so, status? _____

What was your best job? _____ Worst? _____

Please list any career or work issues: _____

_____

How would your employer and colleagues describe you? _____

_____

What is the highest level of education that you have completed? _____

Where did you attend school? _____

What did you like about school? _____

What did you dislike about school? _____

Did you have trouble in any subjects? ___Yes ___No If yes, explain: _____

Current Medications:

Medication	For Condition	Dose	How long been on

Current Supplements:

Supplement	For Condition	Dose	How long been on

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Past Medications:

Medication	For Condition	Dose	How long been on

Past Supplements:

Supplement	For Condition	Dose	How long been on

Any current medical problems? _____

Are you receiving treatment for any health concerns? ____Yes ____ No If yes, explain _____

_____

If yes, who do you see for these concerns? _____

Please list any past health problems _____

Please list any treatment received for past health problems _____

_____

Maternal (Mother) Family History (circle all that are present; include parents, siblings, aunts, uncles, maternal and paternal grandparents):

Learning difficulties	Mental illness	Neurological illness	Seizures
Thyroid (Hyper/Hypo)	Psychiatric disorder	Schizophrenia Depression	Bipolar disorder
Migraine	Anxiety	Suicide	Alcoholism
Drug abuse	Sleep problems	Legal problems	Arrests
Personality disorder	Motor or Vocal Tics	Addictions	Speech problems
Attention problems	Asthma	Hyperactivity	Learning problems
Obsessive-compulsive disorder	Conduct problems or criminal behavior		Autism spectrum

Autoimmune disorders: Type 1, Type 2 Diabetes, Rheumatoid Arthritis, Lupus, MS, Scleroderma etc.

(please list if any): _____

Other: _____ Other: _____ Other: _____

Please explain: _____

_____

Does anyone else in the family have an issue similar to you? _____

_____

Paternal (Father) Family History (circle all that are present; include parents, siblings, aunts, uncles, maternal and paternal grandparents):

Learning difficulties	Mental illness	Neurological illness	Seizures
Thyroid (Hyper/Hypo)	Psychiatric disorder	Schizophrenia Depression	Bipolar disorder
Migraine	Anxiety	Suicide	Alcoholism
Drug abuse	Sleep problems	Legal problems	Arrests
Personality disorder	Motor or Vocal Tics	Addictions	Speech problems
Attention problems	Asthma	Hyperactivity	Learning problems
Obsessive-compulsive disorder	Conduct problems or criminal behavior		Autism spectrum

Autoimmune disorders: Type 1, Type 2 Diabetes, Rheumatoid Arthritis, Lupus, MS, Scleroderma etc.

(please list if any): _____

Please explain: _____

_____

Other: _____ Other: _____ Other: _____

Please explain: _____

_____

Does anyone else in the family have an issue similar to you? _____

_____

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Prior Psychological and Treatment History

Please include psychologists, social workers, psychiatrists, counselors, outpatient and inpatient treatment, cognitive evaluations, neuropsychological evaluations, psychological testing, etc.

Name/Occupation Dates Seen For What? Describe Progress

_____

_____

_____

_____

Please add any additional information you would like us to know in the space below: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

The information given is correct to the best of my knowledge.

Signature: _____ **Date:** _____

Print Name: _____ **Relationship to Client:** _____

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ADULT CHECKLIST OF CONCERNS

Client Name: _____ Date: _____

Please check all of the items below that apply.
You may add a note in the space next to the concerns checked.

	I have no problem or concern bringing me here
	Abuse-physical, sexual, emotional, neglect (of children or the elderly), cruelty to animals
	Aggression, violence
	Alcohol use (see also "Habits")
	Allergies, asthma, skin problems –dry/oily/itchy
	Anger, hostility, arguing, irritability
	Anxiety, nervousness
	Attention, concentration, distractibility
	Autism Spectrum, Asperger's Syndrome
	Auditory/olfactory- hearing loss, ringing in ears, auditory sensitivity
	Autoimmune Disorders: I Diabetes, II Diabetes, Rheumatoid Arthritis, Lupus, MS, Schleroderma, etc.
	Bed wetting, soiling
	Bipolar Disorder: Bipolar Depression, Seasonal Bipolar –spring, summer, fall, winter
	Bruxism (teeth grinding)
	Cardiovascular/Pulmonary: breathing problems, heart problems, hypertension, palpitations or tachycardia ***It is NOT recommended to be treated for Neurofeedback if you have a pacemaker or defibrillator. Serenity Therapeutics, LLC. will not be able to treat you.**
	Career concerns, goals and choice
	Cerebral Palsy
	Childhood issues (your own childhood)
	Conduct problems or criminal behavior
	Codependence
	Confusion
	Compulsions
	Custody of children
	Decision making, indecision, mixed feelings, putting off decisions
	Delusions (false ideas)
	Dependence
	Depression, low mood, sadness, crying, manic depression
	Divorce, separation, loss of spouse/other
	Down Syndrome
	Drug use-prescription medications, over-the-counter medications, street drugs, poison
	Eating problems, overeating, undereating, appetite, vomiting (see also "Weight & Diet Issues")
	Endocrine: appetite awareness, thirst, sugar sensitivity, diabetes, heat or cold sensitivity (see also "Thyroid Disorder")
	Eye problems- double vision, blurred vision, blind spots, eye pain, visual sensitivity
	Emptiness

	Failure
	Fatigues, tiredness, low energy
	Fears, phobias
	Financial or money troubles, debt, impulsive spending, low income
	Friendships
	Gambling
	Gastrointestinal: nausea or vomiting, stomach pain, intestinal pain, chronic constipation, irritable bowl
	Grieving, mourning, deaths, losses, divorce
	Guilt
	Habits: alcohol use, coffee use, cigarette use, diet, drug use, tobacco use, other
	Headaches, seizures, migraines, tension, other kinds of pain, fainting (see also “Neurological”)
	Health, illness, medical concerns, physical problems
	Housework/chores-quality, schedules, sharing duties
	Inferiority feelings
	Interpersonal conflicts, impulsiveness, loss of control, outbursts
	Judgment problems, risk taking, irresponsibility
	Legal matters, charges, suits
	Loneliness
	Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments
	Memory problems, concentration, distractibility, forgetfulness
	Menstrual problems, PMS, menopause, postpartum depression
	Mood swings
	Motivation, laziness
	Neurological: headaches, fainting, seizures, speech problems, tremor or spasticity, weakness, balance, coordination, accident prone, motor or vocal tics
	Nervousness, tension
	Obsessions, compulsions (thoughts or actions that repeat themselves),
	Oversensitivity to rejection
	Pain-arthritis, joint, fibromyalgia, aches, chronic pain, low pain threshold, high pain tolerance, chronic aching pain, chronic nerve pain (burning or stabbing), other pains
	Panic or anxiety attacks, phobias, panic attacks,
	Parenting, child management, single parenthood
	Perfectionism
	Pessimism
	Procrastination, work inhibitions, laziness
	Relationship problems (with friends, with relatives, or work) School problems (see “Career Concerns”)
	Schizophrenia
	Self-centeredness
	Self-esteem
	Self-neglect, poor self-care
	Senses: sense of smell, sense of taste, sense of touch, etc.
	Sexual issues, dysfunctions, conflicts, desire differences, other (see also “Abuse”)
	Shyness, oversensitivity to criticism

	Sleep problems-too much, too little, insomnia, nightmares, sleepwalking, vivid dreams, talking in sleep, restless sleep, night terrors, night sweats
	Smoking and tobacco use
	Spina Bifida
	Spiritual, religious, moral, ethical issues
	Stress, relaxation, stress management, stress disorders, tension
	Suspiciousness
	Suicidal thoughts
	Temper problems, self-control, low frustration tolerance
	Thought disorganization and confusion
	Threats, violence
	Thyroid disorder: Hypothyroidism, Hyperthyroidism,
	Weight and diet issues
	Withdrawal, isolating
	Work problems

Any other concerns or issues: _____

_____

_____

_____

_____

_____

Please review the concerns you have checked off and choose the one that you most want help with. It is:

_____

_____

_____

*Some concerns may be treated together, others may need to be treated separately.

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Agreement to Pay for Professional Services

I request professional services to be provided to:

_____

Please initial each line to acknowledge and agree to the following:

____ I am responsible for the charges for services provided **at the time of service**. I agree to cancel or change appointments with **at least 2 business days' notice.** I am responsible for full payment of any missed appointments. It is considered a missed appointment to cancel with less than 2 full business days' notice.

____ I am responsible for filing insurance claims on my behalf and obtaining any prior authorization or pre-certification from my insurance company if I seek reimbursement. The Serenity Therapeutics, LLC. contractors are out-of-network providers and I may request a monthly superbill with services for submittal.

____ If I am late, my appointment will end at the scheduled time. If my appointment starts late due to my therapist, my appointment will last for the full appointment time. In rare cases, if my therapist is late and cannot accommodate this, I will receive an extended session.

____ If I miss a payment or if a payment is returned due to insufficient funds, my credit card will be charged for the services immediately. I agree to pay any assessed bank fees.

____ I authorize charges associated for treatment or assessment to be charged to the credit card on file.

____ Payments not made within 30 days are subject to a 5% late fee and every 30 days that will continue to accrue until payment is made. Late payments may be sent to a collection agency after 60 days, although I will be notified beforehand and will have an opportunity to pay for services at that time.

_____ _____

Signature of Client (or person acting for client) Printed Name

_____ _____ _____

Relationship to Client Date Time

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ARIZONA STATE LAW

I acknowledge that Arizona State Law requires (must) and designates all Behavioral Health Counselors, Case Managers, Clinicians, or Technicians, to report any suspected or reason to suspect cases of **domestic violence, abuse, neglect to include all ages (child or adult)**, to the proper authorities as deemed necessary in behalf of the interested persons to protect their legal rights.

Patient Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Signature: _____ Date: _____

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CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION PRIVACY INFORMATION

This form is an agreement between you and Serenity Therapeutics, LLC. When we use the word "you" below, it can mean you, your child, a relative or other person if you have written his/her name here

_____.

When we examine, test, diagnose, treat, or refer you, we will be collecting what the law calls Protected Healthcare Information (PHI) about you. This information is needed to decide which treatment should be provided to you in your best interests. We may also share this information with others who provide treatment to you or to those who need it to arrange payment for your treatment or for other business or government functions.

By signing this form, you are agreeing to permit us to use your information here and to send it to others as detailed below.

Serenity Therapeutics, LLC. is fully compliant with the Health Insurance Portability and Accountability Act of 1966 (HIPAA) regulations to protect the confidentiality of your information. You have a right to fully informed consent regarding handling of your privileged information. In general, unless you sign a written release of information, your information will not be released to a third party.

Exceptions are:

- Serenity Therapeutics, LLC. may be required to release your information if the withholding of this information could result in harm to either you or another person. This may apply if, for example, you indicate you intent to harm yourself or another person, or in cases of abuse or neglect of a child or a vulnerable adult.
- Serenity Therapeutics, LLC. may be required to release your information by court order or subpoena. An example would be if you were party to litigation and a judge decided this information was needed.
- Serenity Therapeutics, LLC. may be required to release your information to emergency treatment personnel or to your emergency contact if you require immediate medical attention while in session.
- Serenity Therapeutics, LLC. may release your information to another health care provider if you initiate contact with that provider. Your information may be released with your verbal consent to facilitate a referral. In most cases, a written release of information will be requested for this purpose.
- Serenity Therapeutics, LLC. may release your information to a consultant or supervisor for the purpose of insurance reimbursement, and to provide you with optimal care.
- Serenity Therapeutics, LLC. may release your information anonymously if brief consultation with professional colleagues is necessary to provide you with optimal care. An example might be a description of your situation (without identifying you by name) and asking a colleague for resources to provide you to assist you with your treatment.

- Serenity Therapeutics, LLC. generally will request a written release of information from you whenever possible. Your rights include: access to your records upon request, the safeguarding of your records at all times, and the keeping of accurate financial and clinical records.

If you do not sign this consent form agreeing to what is in this notice of privacy practices, we cannot treat you.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. Requests must be in writing and although we will try to respect your wishes, Serenity Therapeutics, LLC. is not required by law to agree to these limitations.

I, _____ have read and understand the above information.

All of my questions have been adequately addressed.

_____

Patient or Guardian Signature Date

Relationship to Patient: _____

I have discussed the issues contained herein with the client (and/or the person acting for the client). My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____

Witness Signature Date

_____

Signature of Practice Representative Date

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INFORMED CONSENT FOR TREATMENT

Treatment of emotional, behavioral and mental health disorders such as Attention Deficit Hyperactivity Disorder, depression and anxiety involves the active participation of the patient (and their family in most cases). There are many different approaches to treatment including counseling, behavior modification, family therapy, medication, skill training and EEG (biofeedback) neurofeedback. At Serenity Therapeutics, LLC. we will work with you to plan the treatment program that will best meet your needs.

If you choose to use EEG neurofeedback as part of your treatment, you need to be aware that there has been over 30 years of research since this was first developed. Although no guarantees or promises can be made that it will be effective, experienced clinicians are usually reporting 80% to 90% improvement rates. Many patients have been found to no longer require medication for their disorder. However, in 10% to 20% of cases people are unable to change their brainwave patterns in desired directions sufficiently to bring about adequate improvements.

Counseling and EEG neurofeedback can sometimes bring up painful memories. This can be part of the growth and healing process, however, it can, at times, be emotionally painful. Although side effects from neurofeedback are rare, they can occur. If they do occur they are usually redeemable relatively quickly.

QEEG Topographic Brain Maps are not intended to diagnose neurological disorders. If you suspect a seizure disorder or any other neurological disorder you are strongly encouraged to see a neurologist. EEG neurofeedback is usually a helpful adjunctive treatment for many neurological disorders (stroke, closed head injury, seizure disorders, Tourettes syndrome, etc.).

It is uncommon, but if following a treatment session you feel confused, disoriented or light headed, please inform a staff member and rest here until you feel normal again. Do not drive a vehicle until fully recovered.

I have read the above “Informed Consent for Treatment”. I understand that there are usually significant improvements but that some people do not improve, become worse before they become better, or may even, in very rare cases, find their problems have worsened. I hereby release Serenity Therapeutic, LLC. from any liability related to my treatment and to hold its staff harmless from any effects caused directly or indirectly from counseling or EEG neurofeedback.

_____

Patient or Responsible Party Signature Date