CREATIVE
COGNITIVE
THERAPY
METHOD

Pamela Malkoff Hayes

Therapist and Marriage Family Therapist

818-836-1239

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CONFIDENTIAL CLIENT INFORMATION

Name: _____

Preferred Pronouns: _____ DOB: _____

Address:_____

_____

Email: _____

Phone numbers
Mobile: _____ Home:_____

_____ Single
_____ Married
_____ In a Relationship
_____ Polyamorous / Non Monogamous

Referred by: _____

Previous Therapist:_____

Primary care physician:_____

With whom do you live? _____

Occupation/Employer: _____

Questions

1) Summarize briefly why you are seeking treatment at this time.

2) What symptoms or problems are most concerning?

3) FIDO

Frequency of symptoms (days per week):
Intensity of symptoms (0-10):
Duration (how long the symptoms persist at highest level):
Onset of symptoms (months? years?):

4) Current Stressors (check all that apply):

_____ Social / Relational
_____ Health medical
_____ Vocational academic
_____ Financial
_____ Identity related
_____ Recent loss
_____ Life transition
_____ Experiences of discrimination racial trauma acculturative stress

5) Coping Skills / Strengths (check all that apply):

_____ Affect management skills
_____ Able to use social support
_____ Exercise or physical movement
_____ Monitoring or challenging automatic negative thoughts
_____ Journaling or writing
_____ Mindfulness or meditation
_____ Hobbies
_____ Faith or spiritual practices
_____ Attention to self care

6) Relevant Family or Social History:

7) Are you currently taking any medications (including over-the-counter or herbal supplements)?

8) Do you have any serious or chronic medical conditions (including past surgeries)?

9) Have you had any serious medical accidents, head injuries or seizures?

10) Have you had psychotherapy or psychiatric medications before? Hospitalizations?

11) Do you have any known medication allergies?

12) How much/often do you consume coffee or alcohol? Nicotine? Other substances?

13) Have you ever had any legal problems?
14) Do you currently have thoughts of dying/suicice/hurting yourself? If yes, explain:

15) Do you currently have thoughts of hurting others or property? If yes, explain:

16) Is there a family history of mental illness, substance abuse or suicide? Who?

Confidentiality

- The content of sessions is confidential except in the following situations: in cases where a patient may be a danger to self or others, in cases of suspected child or elder abuse, in cases where a patient may be incapable of taking care of him/herself, or certain legal proceedings when required by a judicial subpoena.
- Medical records are separately maintained, and no one else can have access to them without your specific, written permission.

Acknowledgement of Receipt for 'Notice of Privacy Practices' (HIPAA)

- I have received (paper or online version) the Notice of Privacy Practices and I have been provided an opportunity to review it.

My signature indicates that I have read the above office policies and consents, and agree to abide by these terms during our professional relationship.
The undersigned patient or responsible party (parent, legal guardian) consents to, and authorizes services, by Pamela Hayes or Hayes Art.

The undersigned understands that he/she has the right to:

- Be informed of and participate in the selection of treatment modalities.
- Receive a copy of this consent.
- Withdraw this consent at any time.

Signature _____

Print name _____

Date _____

Pamela Malkoff Hayes
Art Therapist and Marriage Family Therapist
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HayesArtTherapy@gmail.com

AUTHORIZATION TO RELEASE INFORMATION

I, _____, hereby authorize Pamela Hayes to exchange information with and/or release copies of my psychiatric and medical record(s) pertaining to my treatment to:

_____
NAME OF PERSON OR ORGANIZATION

_____
ADDRESS and PHONE

All relevant and timely information may be released.
Only the following information may be released:

- _____ Initial clinical summary
- _____ Laboratory results
- _____ Progress notes
- _____ Substance abuse treatment
- _____ Medication records
- _____ Psychological testing
- _____ Other_____

These records are required for the purpose of continuity of clinical care.
This release will expire one year from the date signed unless otherwise noted.
I certify that I have read this form and that I understand its contents.

SIGNATURE_____

DATE OF AUTHORIZATION _____