White River HEALTH

Caring Beyond Healthcare

LYON COLLEGE

Welcome to the Lyon College Counseling Center! We are glad you are here. If you have any questions about the paperwork, just leave it blank and ask when you come to your session.

Name:
Appointment:

Insurance is not required for therapy appointments. Please fill out this packet to the best of your ability and bring it with you to your next therapy session.

Our office number is 870.307.7277 or 870.307.7284

For information please email Victoria, the Lyon Therapist at victoria.hutcheson@lyon.edu or counseling@lyon.edu

Your time and cooperation is greatly appreciated! Please reach out with any questions. Thank you!

Lyon College Counseling Center
First Floor of Edwards Commons Building
2300 Highland Rd. Batesville, AR. 72501
Office Phone:870.307.7277 or 870.307.7284

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

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**
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 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 overeating	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 fidgety 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 in some way	0	1	2	3

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	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

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

Scale:
INSTRUCTIONS: Indicate how often each of the statements below is descriptive of you.

O indicates "I often feel this way"
S indicates "I sometimes feel this way"
R indicates "I rarely feel this way"
N indicates "I never feel this way"

1. I am unhappy doing so many things alone	O S R N
2. I have nobody to talk to	O S R N
3. I cannot tolerate being so alone	O S R N
4. I lack companionship	O S R N
5. I feel as if nobody really understands me	O S R N
6. I find myself waiting for people to call or write	O S R N
7. There is no one I can turn to	O S R N
8. I am no longer close to anyone	O S R N
9. My interests and ideas are not shared by those around me	O S R N
10. I feel left out	O S R N
11. I feel completely alone	O S R N
12. I am unable to reach out and communicate with those around me	O S R N
13. My social relationships are superficial	O S R N
14. I feel starved for company	O S R N
15. No one really knows me well	O S R N
16. I feel isolated from others	O S R N
17. I am unhappy being so withdrawn	O S R N
18. It is difficult for me to make friends	O S R N
19. I feel shut out and excluded by others	O S R N
20. People are around me but not with me	O S R N

Client Information Sheet

Client's Name_____ Date of Birth_____

Address_____ City, State & Zip_____

Social Security # _____ Cell Phone #_____

Sex: _____ Race:_____ Ethnicity: _____

Preferred Gender Identity: Female Male Non-Binary Other:_____

Preferred Pronouns: She/Her He/Him They/Them Other:_____

Marital Status: Unmarried Married

Primary Language_____ Religion_____

Email:_____

Would you like to sign up for our patient portal? Yes No

Employer(If applicable)_____

Primary Care Physician_____ Location:_____

Name of Pharmacy and Location_____

Name of Primary Insurance Card Holder_____

Name of Insurance _____

ID #_____ Group #_____

Card Holder DOB:_____ SSN_____

Emergency Contact_____ Relationship to you_____

Phone # of Emergency Contact_____ Address_____

Signed_____ Date_____

Confidentiality Policy

PLEASE READ CAREFULLY AND KEEP FOR FUTURE REFERENCE

Confidentiality Agreement

All interactions which take place in the setting of therapy are considered confidential. This includes requests by telephone, all interactions with this counselor, any scheduling or appointment notes, all session content records and any progress notes that I take during your sessions. I will not even verify that you are a client. You may choose to give me permission in writing to release any or specific information about you to any person or agency that you designate**.**

Limits to this agreement

1. In some legal proceedings a judge may issue a court order. This would require this counselor to testify in court.

2. If I learn of or believe that there is physical or sexual abuse or neglect of any person under 18 years of age, I must report this information to county child protection services.

3. If I learn of or believe that an elderly person, or disabled person is being abused or neglected, I must file a report with the appropriate state agency that handles elder abuse.

4. If I learn of or believe that you are threatening serious harm to another person, I am obligated to report this. This can be in the form of telling the person who you have threatened, contacting the police or placing you into hospitalization.

5. If there is evidence that you are a danger to yourself and I believe that you are likely to kill yourself unless protective measures are taken, I may be obligated to seek hospitalization for you or to contact family members or others who can help provide protection

6. There may be times when I consult with outside sources about cases. In these cases, no personally identifiable information will be used to discuss this case. However, discussion topics will be used in order to ensure that I am getting and giving the best assistance possible. The persons with whom I discuss cases are legally bound to keep information confidential.

Signature_____ Date:_____

Emergency Care Policy

The Lyon College Counseling Center is open Monday through Friday 8:00 am to 5:00 pm. We are closed on weekends and most holidays. Please call our office during business hours for non-emergency issues. **If you have an emergency, please call campus safety, call 911 or go directly to the nearest emergency room.**

Our office does not provide coverage for provider absences due to illness, cavation, or personal emergency. Every effort will be made to keep you informed/notified of schedule changes in a timely manner.

_____ _____

Client Signature Date

No Show Policy

We reserve this time specifically for you and we will be unable to offer this time to someone else in a timely manner. Three no shows with no communication of absence may result in termination and referral of your provider/patient relationship. Please notify the Lyon Counseling Center 24 hours before if unable to make the appointment

_____ _____

Client Signature Date

CONSENT FOR TREATMENT ACKNOWLEDGEMENT OF RECEIPT OF OFFICE POLICIES

I understand and agree to the following as evidenced by my initials:

1. _____ Confidentiality form
2. _____ Emergency Care Policy
3. _____ No Show Policy

By my signature below, I hereby authorize treatment from WRHS/Lyon College Counseling Center and its providers. I acknowledge that I have received a copy of the White River Health Systems Notice of Privacy Practices

_____ _____

Client Signature Date

Consent to Treat: I voluntarily consent to receive medical and health care services - these services may include diagnostic procedures, examinations,blood work and treatment.

Authorization to release insurance information: I hereby authorize release of medical information to give my insurance company or company's any insurance information they require concerning my case.

Authorization of Assignment of medical payments: I hereby authorize payment of any medical benefits to WRHS Behavioral Health Clinic.

The undersigned hereby authorizes White River Medical Center and the attending or consulting physician to photograph or permit other person to photograph while under the care of the above medical organization, and agree that they may use or permit other persons to use the negative, prints, digital, and/or video prepared there for such purposes and in such a manner as may be deemed necessary to provide medical care.

☐ yes ☐ use of picture declined

Authorization of Access to RX History Information: I hereby authorize WRHS Behavioral Health Clinic to access my historical prescription drug information

☐ yes ☐ declined

I have received a copy of the notice of privacy practices written acknowledgement form.

_____ _____ Date:_____

Signature of Client or Personal Representative Relationship to Patient (parent, self etc.)

Contact Preferences

Please fill in circle for preferred contact method

- ◯ Home Phone _____
- ◯ Cell Phone _____
- ◯ Work Phone _____
- ◯ Email _____

Please Indicate by check mark your approval to leave the following information on voicemail:

- ☐ Appointment Date and Time Reminder
- ☐ Lab/Test Results/Medication Changes
- ☐ DO NOT LEAVE ANY MESSAGES

The following people are allowed to receive information regarding my care and/or have my permission to consent for care of my child.

_____
Name and Relationship to Client

_____
Name and Relationship to Client

_____
Name and Relationship to Client

_____
Name and Relationship to Client

For Office Use Only

_____ _____ _____ Witness

MRN Date of Signing

INTAKE DATA (PLEASE COMPLETE ALL PAGES)

Name:_____ DOB:_____

Cell Phone Number: _____

Can we call your cell number if needed?

Can we text your cell number for appointment reminders?

Who referred you to the counseling center? _____

Do you want the therapist (Victoria Hutcheson) to have permission to notify this person you attended your first session? No other information will be provided. Yes No

Name of Primary Care Physician: _____

Please state in your own words why you decided to come for counseling.

_____

_____

_____

_____

Do you have thoughts of self harm, suicidal thoughts or thoughts of harming someone else?

_____

Have you ever taken any action on these thoughts?

If yes, please explain. _____

Past Medical History (please check all that apply):

- ☐ AIDS/HIV
- ☐ Allergies
- ☐ Arteriosclerosis (artery disease)
- ☐ Arthritis
- ☐ Blood Disorder
- ☐ Brain Disease or Infection
- ☐ Cancer or Chemotherapy
- ☐ Chronic Pain
- ☐ Concussion
- ☐ Dementia
- ☐ Diabetes
- ☐ Head Injury
- ☐ Heart Disease
- ☐ Huntington's Disease
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Loss of Consciousness
- ☐ Lung (respiratory) disease
- ☐ Meningitis
- ☐ Multiple Sclerosis
- ☐ Obesity
- ☐ Parkinson's Disease
- ☐ Seizure Disorder

Other Past Medical History Not Listed Above: _____

_____

DRUG ALLERGIES _____

_____

Currently Prescribed Medications (list name and dosage):

_____

_____

_____

Current over the counter medications, vitamins or health supplements you take (list name and dosage):_____

_____

If you circled Chronic Pain above, please answer the following questions.

Where is your pain located? _____

Have you been given a diagnosis or treatment plan for your pain? If so, please describe

_____

Rate your pain on a 0-10 scale (0 no pain, 10 worst pain imaginable)

Current:_____ Highest:_____ Lowest:_____ Average:_____

What helps your pain?_____

What makes your pain worse?_____

What treatments have worked for your pain management? _____

_____

Psychiatric History

Are you currently in psychotherapy or under psychiatric care?

Have you ever been seen by a psychiatrist, psychologist, counselor or therapist for a mental health condition?

If yes, why, where, when and how long?_____

_____

Past Psychiatric Medications:_____

_____

Past Psychiatric Hospitalizations (when, where, how long, psychiatrist's name)

_____

_____

Have you had a prior psychological evaluation or neuropsychological evaluation?

☐ yes, please list provider _____ ☐ no

Have you ever been diagnosed with the following conditions? (Check all that apply)

☐ Schizophrenia ☐ Depression ☐ Anxiety
☐ Mental Retardation ☐ Learning Disability ☐ Bipolar DIsorder
☐ Explosive Disorder ☐ Dissociative Identity Disorder ☐ Anorexia/Bulimia
☐ Borderline Personality Disorder ☐ Obsessive Compulsive Disorder
☐ Antisocial Personality Disorder ☐ Post Traumatic Stress Disorder

Other:_____

Do you presently have Depression?

If yes, how long and please describe:_____

_____

Describe any past Depression_____

_____

Do you presently have anxiety/nervousness?

If yes, how long and please describe:_____

_____

Is your sleep Good Fair Poor How many hours per night? _____

Is your appetite Good Fair Poor

Have you ☐ lost some weight, ☐ gained some weight. If so, how much in what period of time?

_____

Is your energy Good Fair Poor Since when? _____

Please list any mental illness/psychiatric problems or alcohol/drug abuse in the family:

_____

_____

_____

Has anything happened recently to change your situation?	☐ yes	☐ no
Are you a “hyper” person who worries about everything?	☐ yes	☐ no
Do you have a depressed mood?	☐ yes	☐ no
Do you have problems doing everyday chores/activities?	☐ yes	☐ no
Have you lost interest in your normal activities?	☐ yes	☐ no
Do you have a loss of interest in your normal activities?	☐ yes	☐ no
Do you have a loss of feelings for relatives or friends?	☐ yes	☐ no
Do you have problems with memory or concentration?	☐ yes	☐ no

Do you have long term feelings of guilt or low self worth? ☐ yes ☐ no
Are you thinking worse and worse about the future? ☐ yes ☐ no
Do you sometimes feel as if you would be better off dead? ☐ yes ☐ no
Does suicide seem like a better solution to you at times? ☐ yes ☐ no
Have you ever had thoughts or plans of death or suicide? ☐ yes ☐ no
Have you ever attempted suicide? ☐ yes ☐ no
If yes, please explain_____
Do you feel empty inside? ☐ yes ☐ no
Are you bored most of the time? ☐ yes ☐ no
Do you or have you ever cut or harmed yourself on purpose? ☐ yes ☐ no
Have you ever hurt other people because you are angry with them? ☐ yes ☐ no
Would you reveal to us your plans to hurt yourself or others? ☐ yes ☐ no
Do you or have you ever had any fits and lost control? ☐ yes ☐ no
Have you had multiple, intense, full of conflict relationships? ☐ yes ☐ no
Do you feel people are either good or bad with no in between? ☐ yes ☐ no
Are you angry most of the time? ☐ yes ☐ no
Do you hear voices other people don't? ☐ yes ☐ no
Do you have visions (see things other people don't see)? ☐ yes ☐ no
Do you think that some people, thing, or group is out to get you? ☐ yes ☐ no
Does your imagination play tricks on you? ☐ yes ☐ no
Does it seem as if someone/something is controlling your thoughts? ☐ yes ☐ no
Do you feel that you can read people's minds? ☐ yes ☐ no
Have you ever gone more than a couple days without sleeping? ☐ yes ☐ no
Have you ever experienced a traumatic event that still impacts you? ☐ yes ☐ no

Substance Use History:

I began drinking alcohol regularly at age:

☐ prior to age 10 ☐ 10-15 ☐ 16-18 ☐ 19-21 ☐ over 21

I drink alcohol:

☐ rarely or never ☐ 1-2 days/week ☐ 3-5 days/week ☐ daily

The usual number of drinks I have at one time: _____

I used to drink alcohol but stopped: _____ Date stopped:_____

I used to drink excessively ☐ yes ☐ no

Check all that apply

☐ I can drink more than most people my age and size before I get drunk.

☐ I sometimes get into trouble (fights, legal problems, conflicts, accidents etc) after drinking.

☐ I sometimes black out after drinking.

☐ I have had legal problems associated with drinking.

☐ I have been in alcohol treatment ☐ Past ☐ Current

Drug Use: ☐ Past ☐ Current ☐ Never

Please check all of the drugs you are now using or have used in the past

	Presently Using	Used in Past	Age Used
Amphetamines (including diet pills)	☐	☐	
Barbiturates (downers, etc)	☐	☐	
Cocaine or Crack	☐	☐	
Hallucinogenics (LSD, Acid, etc)	☐	☐	
Inhalants (glue, nitrous oxide etc)	☐	☐	
Marijuana	☐	☐	
Methamphetamines	☐	☐	
Opiate Narcotics (heroin, morphine, etc.)	☐	☐	
PCP (angel dust)	☐	☐	

Other drugs: _____

Do you consider yourself to be dependent on any of the above substances? ☐ yes ☐ no

Do you consider yourself to be dependent on any prescription medications? ☐ yes ☐ no

Have you had any drug or alcohol treatment? ☐ Past ☐ Current ☐ Never

Do you smoke or vape? ☐ no ☐ yes, amount per day _____

Do you drink caffeine? ☐ no ☐ yes, amount per day _____

Legal History:

Have you been court ordered to receive psychiatric treatment? ☐ yes ☐ no

Have you ever been to jail, prison or probation? ☐ yes ☐ no

If yes, please explain:

_____

_____

Are you presently in legal trouble? ☐ yes ☐ no

If yes, please explain: _____

Do you own a weapon? ☐ yes ☐ no

If yes, what type(s) and how many? _____

Social History:

Marital Status: ___ Single ___ Married ____ Partnered ____ Divorced ____ Widowed

How many children do you have (if any) and what are their ages?_____

How would you describe your performance as a student? What are your average grades?

_____

_____

_____

Have you experienced any abuse? ____ Physical ____ Sexual _____ Psychological

If so, what ages? _____

What do you like to do in your spare time? _____

_____

Have you ever been in the military? ____ yes _____ no

If yes, what branch? _____ Type of Discharge:_____

Major Duties in the Military: _____

_____

Please add any helpful comments. _____

_____

_____

_____

Do you have any questions at this time? _____

_____

_____

_____ _____

Client Signature Date

Review of Systems

Client Name: _____ Date: _____

Please check if present

Constitutional
- ☐ Chills or fever
- ☐ Fainting Spells
- ☐ Night Sweats
- ☐ Swollen glands
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Other

Skin
- ☐ Change in moles
- ☐ Itching
- ☐ Psoriasis
- ☐ Rashes
- ☐ Bumps
- ☐ Other

Head
- ☐ Cataracts
- ☐ Double Vision
- ☐ Glaucoma
- ☐ Headaches
- ☐ Hearing Loss
- ☐ Ringing in Ears
- ☐ Hearing Aid

- ☐ Sore throat
- ☐ Bleeding Gums
- ☐ Dentures
- ☐ Loose Teeth
- ☐ Removal Bridge
- ☐ Frequent Colds
- ☐ Nosebleeds

Cardiovascular
- ☐ Artificial Valve
- ☐ Chest Pain
- ☐ Fainting Spells
- ☐ Heart Attack in Past
- ☐ Heart Disease
- ☐ Heart murmur
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Irregular Heartbeat
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Rheumatic Fever (hx)
- ☐ Swollen Ankles

Respiratory
- ☐ Asthma or wheezing
- ☐ Can't breath when flat
- ☐ Chest Colds
- ☐ Cough up Blood
- ☐ Frequent Cough
- ☐ Shortness of Breath
- ☐ Other

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Appetite loss
- ☐ Blood/tarry stools
- ☐ Changes in bowels
- ☐ Colon Cancer in past
- ☐ Constipation/diarrhea
- ☐ Nausea/Vomiting
- ☐ Frequent heartburn
- ☐ Gallbladder trouble/ulcers
- ☐ Hemorrhoids
- ☐ Hiatal Hernia
- ☐ Jaundice/liver trouble
- ☐ Swallowing difficulties

Exposure to:
- ☐ Gonorrhea
- ☐ Herpes
- ☐ AIDS
- ☐ Syphilis
- ☐ Hepatitis
- ☐ Blood trans.
- ☐ TB

Genitourinary
- ☐ Bladder control prob.
- ☐ Blood in urine
- ☐ Frequent Urination
- ☐ Kidney Disease
- ☐ Night Urination
- ☐ Painful Urination
- ☐ Stones
- ☐ Other

(Men Only)
- ☐ Discharge - penis
- ☐ Erection problems
- ☐ Impotence
- ☐ Lump in testicles
- ☐ Other

(Women Only)
- ☐ Breast lump or mass
- ☐ Change in periods
- ☐ Discharge - nipple
- ☐ Endometriosis
- ☐ Hot Flashes
- ☐ Painful Periods
- ☐ Vaginal Discharge
- ☐ Menopause

Endocrine
- ☐ Diabetes
- ☐ Excessive thirst
- ☐ Fatigue
- ☐ Swollen Glands
- ☐ Intol. to heat/cold

Accidents or Injuries

Musculoskeletal
- ☐ Arthritis
- ☐ Back Pain
- ☐ Muscle Cramps
- ☐ Muscle Weakness
- ☐ Numbness/tingling
- ☐ Walking Problems
- ☐ Other

Neurological
- ☐ Dizzy Spells
- ☐ Headaches
- ☐ Memory Loss
- ☐ Paralysis
- ☐ Seizure/Epilepsy
- ☐ Shakiness/weakness
- ☐ Stroke
- ☐ Other

Psychological
- ☐ Anxious
- ☐ Depression
- ☐ Family Problems
- ☐ Fatigue
- ☐ Insomnia
- ☐ Marital Problems
- ☐ Stress
- ☐ Other