Annie Vance's Psychotherapy Check in

Name: _____ Appointment time: _____ Today's Date:_____

Parent's Name, if filled in for a child: _____ Responsible Party_____

All monies owed are due at the beginning of each session. **If an accurate co-payment or co insurance amount has not yet been determined, a standard fee of $40.00 is due – your account will be adjusted appropriately once a payment and EOB has been received from your Insurance Company.**

Blue Cross Patients **must pay the full fee, $150 Initial Session $125 for follow up sessions. Your insurance company will reimburse you directly depending on your plan coverage.**

My co-payment or agreed upon amount due today is: $_____.____

My Method of payment today is: CASH _____ CHECK : Number_____ VISA / MC / DEBIT **circle one**

---

1. **Rate your highest and lowest feelings in the last 7 days**.
2. On a scale of 0 – 10, 10 being the best you have ever felt, 0 being the worst, Low___ High ___
3. Today: 0 1 2 3 4 5 6 7 8 9 10

---

4. Please list medication you are currently taking

For:	Medication	Prescribing MD	Start Date	Effects
• sleep,	_____	_____	_____	_____
• pain,	_____	_____	_____	_____
• depression,	_____	_____	_____	_____
• anxiety	_____	_____	_____	_____
• moods	_____	_____	_____	_____
•	_____	_____	_____	_____

- Recently been evaluated by a Medical Professional or set an App. with one? Yes____ No_____
  When? _____ With who? _____ Auth. to Contact_____Initial

5. List the topic / issue / symptoms you most want to discuss today:

6. Accomplishments since my last session are:

7. My Goals for this session are:

8. Is there anything from our last session that we need to follow up on?

9. List the person, situation or place when you felt the most irritation, anger or annoyance in the last week:

	Circle Response	Comments
10. Do you or others have any concerns about your drug or alcohol use?	Y N	_____
11. Have you experienced a change in your habits or health?	Y N	_____
12. Do you feel we are making progress toward your goals?	Y N	_____
13. Are you unhappy with your self-care?	Y N	_____
14. Have you had changes in your primary support system or job?	Y N	_____
15. Is there any issue which you have been reluctant to bring up?	Y N	_____
16. Do you have any disturbing memories?	Y N	_____
17. Are you now or have you been suicidal in the past 30 days?	Yes____	No_____
18. If yes, do you feel safe now?	Yes____	No_____
19. If yes, have you and I agreed to a Safety Plan or 24 Hour Watch?	Yes____	No_____
20. Yes, I have now agreed to a safety plan. Signed: _____	Date: _____	

Complete Only if you have *a New Address*? _____ _____ _____

Or a *New Insurance Company?* _____ 1 800 _____

Date of Birth_____ Insurance ID #_____ SS # _____

Effective date ____/____/____to____/____/___ Card Copied? Y N Policy Holder_____

Therapist Notes: Rev2/28/2011

Mood/Affect: Unremarkable Depressed Anxious Euphoric Fearful Irritation Anger Labile Incongruent Flat Broad Blunted

Appearance: Appropriate Inappropriate Unkempt Dirty Unusual

Behavior: Unremarkable Cooperative Defiant Guarded Withdrawn Noncompliant Hyperactive Suspicious Hostile Dramatic Eccentric

Cognitions: Intact Loose Scattered Blocked Illogical Delusional Paranoid Hallucinations Grandiose Fragmented Somatic

Safety: Danger to self/Others Y N Suicidal Ideation Y N Homicidal Ideation Y N Other Risk Y N

Intervention: Safety Agreement 24 Hr Watch Hospitalization

Presenting symptoms:

Session Focus was on:

Intervention: Clarification Support Education Venting Cathartic Confrontation Other_____

Progress toward Goals:

Treatment Plan Progress: Worse Fair Average Good

Next Appointment:_____ at _____ Signature_____