Pamela M. Hayes, Art Therapist

Licensed Marriage and Family Therapist

(818) 836-1239

26540 Agoura Road, Suite 100 Calabasas, CA 91302

hayesarttherapy@gmail.com

Thank you for scheduling your appointment with Pamela Hayes.

Attached is the new patient paperwork to ﬁll out and bring to your ﬁrst session. A Release of

Information consent form may also be completed if applicable. Contact information and a map

to the ofﬁce are attached as well.

Additional information about Pamela Hayes and Hayes Art Therapy can be found online: [www.HayesArtTherapy.com](http://www.HayesArtTherapy.com)

I look forward to working together.

Sincerely

 

**Pamela M Hayes**

Licensed Marriage and Family Therapist

Registered and Board Certified Art Therapist

**Demographics**

Contact information

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthdate \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone numbers (please circle your preferred number)

Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ OK to leave message?

Home \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ OK to leave message?

Work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ OK to leave message?

Emergency contact

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Questionnaire**

*Background*

Today’s date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary care physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

With whom do you live? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital status \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Questions*

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

2) What symptoms or problems are most concerning?

3) When did you ﬁrst notice the problem? How often does it occur?

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

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

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

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

8) Do you have any known medication allergies?

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

10) Have you ever had any legal problems?

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

12) Please indicate if you are/have experienced any of the following symptoms:

☐ Headaches ☐ Crying often ☐ Fears of losing self control

☐ Dizziness ☐ Unable to enjoy anything ☐ Unwanted thoughts

☐ Bowel trouble ☐ Restlessness ☐ Always worried

☐ Pain ☐ Decreased need for sleep ☐ Concentration problems

☐ Tremors or tics ☐ Mood swings ☐ Hearing voices

☐ Drug/alcohol cravings ☐ Excess energy ☐ Seeing things others do not

☐ Eating problems ☐ Confusion ☐ Strange experiences

☐ Binge eating ☐ Elated/euphoric mood ☐ Feel others are against you

☐ Sleep problems ☐ Excessive spending ☐ Constant suspicion/distrust

☐ Weight loss ☐ Racing thoughts ☐ Unusual thoughts

☐ Weight gain ☐ Irritability ☐ Violent behavior

☐ Loss of appetite ☐ Impulsive behavior ☐ Thoughts to harm others

☐ Feeling apart from others ☐ Grandiose thoughts/plans ☐ Physical abuse

☐ Low energy ☐ Anger/explosiveness ☐ Sexual abuse

☐ Feeling worthless ☐ Panic attacks ☐ Sexual problems

☐ Memory problems ☐ Anxiety ☐ Relationship problems

☐ Thoughts of suicide ☐ Fears ☐ Financial problems

☐ Feeling depressed ☐ Nightmares ☐ Work problems

Conﬁdentiality

**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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**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 OR 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.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT SIGNATURE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF AUTHORIZATION