Olympia Therapy PLLC
1534 Bishop Rd SW
Tumwater, WA 98512
360.357.2370 office
360.357.2374 fax
info@olympiatherapy.com
www.olympiatherapy.com

Name: _____ Today's Date: _____
Age: _____ Date of Birth: _____Gender: _____ Social Security Number: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ May we leave a message? ☐YES ☐NO
Cell Phone: _____ May we leave a message? ☐YES ☐NO
Work Phone: _____ May we leave a message? ☐YES ☐NO
Email: _____ May we email you? ☐YES ☐NO

Occupation: _____ Employer: _____

Education (circle last year completed): Grade school 1 2 3 4 5 6 7 8 9 10 11 12 University 1 2 3 4 5 6+

Religious Affiliation: _____

Marital/Partner Status: ☐Single ☐Living together ☐ Married ☐Separated ☐ Divorced ☐ Widowed

Children? ☐YES ☐NO If yes, please list below

First Name	Biological, adopted, or step	Current age	Gender	Lives with you?

Please answer the following questions:

What brings you to counseling?

_____

_____

What do you hope to get out of counseling?

_____

_____

Give 3 adjectives to describe yourself:

_____

Health Information:

Primary care physician: _____ Phone number: _____

Rate your physical health: □Average □Good □Excellent □Declining

Likes/skills:_____

Dislikes/challenges:_____

Recreation/Hobbies:_____

Social: □Many Friends □Few Friends □Mostly Acquaintances □Introvert □Extrovert _____

Financial Health/Money handling □Poor □Average □Excellent _____

Legal Challenges: □YES □NO If yes: □Misdemeanor □Felony Explain: _____

_____

Are you currently or had history of thoughts about harming yourself or others? □YES □NO If yes, please explain:

_____

Do you have any current safety concerns/issues? _____

Current Domestic Violence? □YES □NO --- Verbal Abuse? □YES □NO --- Physical Abuse? □YES □NO

Family History of Domestic Violence? □YES □NO f yes, please explain: _____

_____

Have you, or a family member, even been diagnosed with a mental health disorder?□YES □NO If yes, please specify:

_____

Have you ever seen a mental health therapist is the past?□YES □NO If yes, when?_____

Any recent or history of hospitalization (mental, surgeries, truam): □YES □NO If yes, when and for what?

_____

_____

Currently taking an medications?:□YES □NO If yes, please specify: _____

Drug Use: □YES □NO If yes, please specify □Daily □Weekly □Monthly □Infrequent Type: _____

Alcohol Use? □YES □NO If yes, please specify □Daily □Weekly □Monthly □Infrequent _____

Any Issues/Problems Related to substance use (DUI, MIP, DV)? □YES □NO _____

Family History of Drug or Alcohol Use?_____

Is there any other information I should know about you?

_____

_____

_____

How did you hear about us? □Relative □Friend □School □Doctor/clinic □Internet □Other _____

BRIEF PATIENT HEALTH QUESTIONNAIRE (Brief PHQ)

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability unless you are requested to skip a question.

Name _____ **Age** _____ **Sex:** ☐ **Female** ☐ **Male** **Today's Date** _____

1. 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
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed or hopeless	☐	☐	☐	☐
c. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
h. 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	☐	☐	☐	☐
i. Thoughts that you would be better off dead, or of hurting yourself in some way	☐	☐	☐	☐

2. Questions about anxiety.

	NO	YES
a. In the last 4 weeks, have you had an anxiety attack suddenly feeling fear or panic? **If you checked "NO," go to question 3.**	☐	☐
b. Has this ever happened before?	☐	☐
c. Do some of these attacks come suddenly out of the blue—that is, in situations where you don't expect to be nervous or uncomfortable?	☐	☐
d. Do these attacks bother you a lot or are you worried about having another attack?	☐	☐
e. During your last bad anxiety attack, did you have symptoms like shortness of breath, sweating, your heart racing or pounding, dizziness or faintness, tingling or numbness, or nausea or upset stomach?	☐	☐

3. If you checked off any problems on this questionnaire so far, 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**

FOR OFFICE CODING: Maj Dep Syn if answer to #1a or b and five or more of #la-i are at least "More than half the days" (count #1i if present at all). Other Dep Syn if #1a or b and two, three, or four of #la-i are at least "More than half the days" (count #1i if present at all). Pan Syn if all of #2a-e are "YES."

Continued on the other side ➔

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4. In the last 4 weeks, how much have you been bothered by any of the following problems?

	Not bothered	Bothered a little	Bothered a lot
a. Worrying about your health	☐	☐	☐
b. Your weight or how you look	☐	☐	☐
c. Little or no sexual desire or pleasure during sex	☐	☐	☐
d. Difficulties with husband/wife, partner/lover, or boyfriend/girlfriend	☐	☐	☐
e. The stress of taking care of children, parents, or other family members	☐	☐	☐
f. Stress at work outside of the home or at school	☐	☐	☐
g. Financial problems or worries	☐	☐	☐
h. Having no one to turn to when you have a problem	☐	☐	☐
i. Something bad that happened recently	☐	☐	☐
j. Thinking or dreaming about something terrible that happened to you in the past—like your house being destroyed, a severe accident, being hit or assaulted, or being forced to commit a sexual act	☐	☐	☐

5. In the last year have you been hit, slapped, kicked, or otherwise physically hurt by someone, or has anyone forced you to have an unwanted sexual act? ☐ NO ☐ YES

6. What is the most stressful thing in your life right now?_____

7. Are you taking any medication for anxiety, depression, or stress? ☐ NO ☐ YES

8. FOR WOMEN ONLY: Questions about menstruation, pregnancy, and childbirth.

a. Which best describes your menstrual periods?

☐ **Periods are unchanged**

☐ **No periods because pregnant or recently gave birth**

☐ **Periods have become irregular or changed in frequency, duration, or amount**

☐ **No periods for at least a year**

☐ **Having periods because taking hormone replacement (estrogen) therapy or oral contraceptives**

	NO (or does not apply)	YES
b. During the week before your period starts, do you have a serious problem with your mood—like depression, anxiety, irritability, anger or mood swings?	☐	☐
c. If YES, do these problems go away by the end of your period?	☐	☐
d. Have you given birth within the last 6 months?	☐	☐
e. Have you had a miscarriage within the last 6 months?	☐	☐
f. Are you having difficulty getting pregnant?	☐	☐

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Appointment Reminders

As a courtesy service, Olympia Therapy offers appointment reminders. Although we offer this service, it is the patient's responsibility to know when appointments are scheduled. Missed appointments will incur a NO SHOW fee of $50. LAST MINUTE CANCELLATIONS under 24 hours will incur a fee of $50.

Notice of confidentiality:
These communications may contain information that is protected by Federal Confidentiality laws (42CFR, Part 2). When you choose to communicate Patient Identifiable Information by responding to these communication methods, you are consenting to the associated communication risks. Please note communication methods are not secure, and I cannot guarantee that information transmitted will remain confidential.

Patient's Name: _____

Please select ONE (1) of the following options:

☐ Phone Call Reminders: (10 Digit Phone Number): _____

☐ Text Reminders: (10 Digit Phone Number): _____
Mobile Carrier (Text message rates apply)

You may also select an email reminder in addition to a phone or text reminders:

☐ Email Reminders: (Email Address): _____

By signing this, you understand and agree to the above statement:

_____
Print

_____ _____
Sign Date

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Financial Responsibility Information:

Date: _____

Name of Patient:_____ DOB Patient_____/_____/_____ Male/Female

Address: _____ City _____State_____ Zip code _____

Home Phone: _____ Mobile Phone: _____

****Email:**_____

Primary Insurance Information:

Subscriber Name:_____ Subscriber Date of Birth: _____/_____/____ Male/Female

Full Address: _____ City _____State_____ Zip code _____

Home Phone: _____ Cell: _____ Email:_____

Patient Relationship to Subscriber: _____

Name of Insurance Company: _____

Subscriber's ID#_____ Group # _____

Co-pay amount: _____ Customer Service Phone # _____

Secondary Insurance Information:

Subscriber Name:_____ Subscriber Date of Birth: _____/_____/____ Male/Female

Full Address: _____ City _____State_____ Zip code _____

Home Phone: _____ Cell: _____ Email:_____

Patient Relationship to Subscriber: _____

Name of Insurance Company: _____

Subscriber's ID#_____ Group # _____

Co-pay amount: _____ Customer Service Phone # _____

Financially Responsible Party Signature: X_____

Fees for Senior Clinicians (and Professional Associates) at Olympia Therapy apply as follows: Initial session (1 hr) is billed at $200; Subsequent sessions (50 mins) are billed at $160 (PA $50) for individuals and $180 (PA $100) for couples or families. Standard fees apply for 3rd party reports at $70 per ½ hour. **Payment** is due the same day of service and may be paid by check, cash, card, or online using the payment option on our website. **Cancellation Policy:** If you are unable to keep an appointment, please let us know at least 24 hours in advance of your appointment. **Managed Care:** Payments made in part of in full by a managed care organization (MCO) require compliance to the regulations of your plan. As your policy is a contract between you and your carrier, it is your responsibility to check with your insurance provider to confirm terms and limitations of coverage. **If your insurance fails to pay, for whatever reason, you are responsible for the full-billed amount.**

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Credit Card Payment Authorization Form

Credit Card Information
Card Type: □ MasterCard □VISA □ Discover □ AMEX □ Other: _____
Cardholder Name (as shown on card): _____
Card Number: _____ - _____ - _____ - _____
Expiration Date (mm/yy): _____ - _____
CVC Code (3 digits - back of card): _____
Cardholder ZIP Code (from credit card billing address): _____

*Name of minor/family member patient (If Applicable): _____

I, _____, authorize Olympia Therapy PLLC to charge my credit card, listed above, for agreed upon purchases. I understand that my information will be saved on file for future transactions on my account.

□ Please check the box if you would like to enable Autopay on your account.
AutoPay will process the payment on the 1st day of the month for any outstanding balances.

_____ _____
Signature Date

_____
Printed Name

**Last Minute Cancellations (LMC) and No Shows (NS) will be charged a fee of $50 by the end of the week if Administration is not provided a reason for the cancelation within 48 hours.