Ronya Hemenway, LCSW, Certified EMDR Therapist
P:208-953-1109
F: 208-953-3001

RH Counseling & Therapy, LLC
PO Box 249 Fruitland ID 83619
Fruitland Office: 2405 N. Whitley Dr Fruitland ID 83619
Nampa Office: 5700 E. Franklin Rd STE 220-G Nampa ID 83687

Please fill out the following as completely as possible. This information is part of your confidential file.

Today's Date: **How did you hear about me?**

Personal Information

First Name: Middle: Last:

Birthdate: Age: Male ☐ Female ☐

Address:

City/St/Zip:

Ethnicity: Religious Preference:

Home Phone:
☐ I give permission to leave a message at this number
☐ I DO NOT give permission to leave a message at this number.

Cell Phone:
☐ I give permission to leave a message/text at this number
☐ I DO NOT give permission to leave a message at this number.

Email:
☐ I give permission to be contacted by email (my email is confidential)
☐ I DO NOT give permission to be contacted by email.

Employment

Employer: Work Phone:

Employer Address:

Emergency Contact Information

Name: Relationship:

Home Phone: Cell Phone:

Insurance Information

Insurance Provider: **Phone Number**

Member ID: Group Number:

Policy Holders Name: DOB:

Policy Holders Address: Phone Number:

Client's Relationship to Policy Holder: Employer:

Copay **Coinsurance** **Deductible**

SECONDARY Insurance Provider: **Phone Number**

Member ID: Group Number:

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Policy Holders Name: DOB:

Policy Holders Address: Phone Number:

Client's Relationship to Policy Holder: Employer:

Copay **Coinsurance** **Deductible**

Others in The Home

Relationship Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Other

Please describe your relationship history:

How old were you when your first child was born? If you have had a miscarriage before, how many? _____

For immediate family members (spouse, significant others, children, and step-children/ parents, siblings), please list name, gender, age, relationship to you, and current residence (same as you or different).

Name	Gender	Age	Relationship to you	Residence if different

If any member(s) of your family (spouse, children, parents, brothers, sisters) is/are deceased, please list below.

Name	Relationship	Age at Death	Date of Death	Cause of Death

Education: Do you have (check all that apply)?

High School Diploma _____ GED _____ What grade did you complete in school? _____

Associate's Degree in _____ Bachelor's Degree in _____ Master's Degree in _____

Military Service: Were you in the military? ☐ No ☐ Yes – What branch? _____

What year did you discharged? _____ What type of discharge? _____

Please check your present state of health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Have you experienced the following during the past six months?

☐	Severe Headaches	☐	Frequent tiredness	☐	Severe backaches
☐	Frequent trouble sleeping	☐	Stomach Problems	☐	Dizziness or Fainting

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☐	Eating Problems	☐	Large Weight Loss	☐	Seizures
☐	Hearing Voices	☐	Hallucinating	☐	Fearfulness
☐	Excessive Worry	☐	Nervous	☐	Sadness
☐	Loss of interest in Sex	☐	Feeling Guilty	☐	Discouragement
☐	Large Weight Gain	☐	Anger	☐	Hurting Self
☐	Physically hurting Others	☐	Trouble Concentrating	☐	Speeding/racing Thoughts
☐	Trouble with the law	☐	Asthma or other respiratory problem	☐	Panic Attacks

Other problems not listed (please specify)

Are you currently taking any medications? If yes, please list below.

Medication	**Prescribing Doctor**	**Reason for taking**

Do you smoke?	How many a day?	Have you tried to quit?
How old were you when you started smoking?		
Do you drink alcohol? What age did you start?	If yes, when was your last drink?	
How much do you drink?	How many drinks do you have per week?	Have you ever tried to quit drinking?
Do you use illegal drugs?		How often?
If yes, please list drugs you are using:		
When was the last time you used an illegal substance?		What age did you start?

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Have you had legal problems as a result of drugs/alcohol? Please explain.

Have you ever been hospitalized for mental health or substance abuse reasons? ☐ Yes ☐ No

If yes, when?

Please describe.

Have you ever attempted suicide? If yes, when?

If yes, please explain.

Have you ever been in counseling before? ☐ Yes ☐ No When?

Who was your counselor?

Why did you stop?

Are you currently attending other therapy? ☐ Yes ☐ No Who are you seeing?

For what reason are you in therapy?

Do you have any close family members (spouse, children, parents, grandparents, siblings, aunts, uncles) who have had or now have depression, bipolar disorder, anxiety disorder, obsessive compulsive disorder, ADHD, substance abuse problems, suicide, trouble with the law, developmental disorders, or any other mental condition? If yes, please list.

Relationship to you	Condition	Current Mental Status

What is your reason for seeking therapy?

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How long has this been a problem?
What made you decide to seek therapy now?
How much do you feel you need counseling right now?

Please check any stressors that are a part of your life.

☐ Personal illness	☐ Health problem in family	☐ Money Problems
☐ Lack of employment	☐ Marital discord	☐ Death of a family member
☐ Divorce	☐ Marital separation	☐ Sexual Abuse
☐ Physical abuse	☐ Discrimination	☐ Death of a Friend
☐ Loneliness	☐ Unhappy childhood	☐ Retirement
☐ New baby	☐ New marriage	☐ Educational problems
☐ Job change	☐ Job dissatisfaction	☐ Homelessness
☐ Inadequate housing	☐ Lack of health care	☐ Discord with parents
☐ Victim of crime	☐ Trouble with children	☐ Legal problems
☐ Recent move	☐ Other	

What else do you think is important for me to know about you?

NAME: _____ DATE:_____

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Generalized Anxiety Disorder Screener (GAD-7)

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

Total Score _____

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? (Select response)	Not difficult at all	Somewhat difficult	Very difficult
	☐	☐	☐

When did the symptoms begin? _____

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PATIENT HEALTH QUESTIONNAIRE

PHQ-9 - Nine Symptom Checklist

Name: _____ Date:_____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Question	Not at all (0)	Several Days (1)	Almost all the Days (2)	Nearly every Day (3)
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
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 yoursel	☐	☐	☐	☐

2. If you checked off any problem 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 ☐

3. In the past two years, have you felt depressed or sad most days, even if you felt okay sometimes? ☐ Yes ☐ No

Total # Symptoms: _____ Total Score:_____

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PCL-5

Instructions: This questionnaire asks about problems you may have had after a very stressful experience involving *actual or threatened death, serious injury, or sexual violence*. It could be something that happened to you directly, something you witnessed, or something you learned happened to a close family member or close friend. Some examples are a *serious accident; fire; disaster such as a hurricane, tornado, or earthquake; physical or sexual attack or abuse; war; homicide; or suicide.*

First, please answer a few questions about your *worst event*, which for this questionnaire means the event that currently bothers you the most. This could be one of the examples above or some other very stressful experience. Also, it could be a single event (for example, a car crash) or multiple similar events (for example, multiple stressful events in a war-zone or repeated sexual abuse).

Briefly identify the worst event (if you feel comfortable doing so): _____

How long ago did it happen? _____ ***(please estimate if you are not sure)***

Did it involve actual or threatened death, serious injury, or sexual violence?

☐ Yes
☐ No

How did you experience it?

☐ It happened to me directly
☐ I witnessed it
☐ I learned about it happening to a close family member or close friend
☐ I was repeatedly exposed to details about it as part of my job (for example, paramedic, police, military, or other first responder)
☐ Other, please describe _____

If the event involved the death of a close family member or close friend, was it due to some kind of accident or violence, or was it due to natural causes?

☐ Accident or violence ☐ Natural Causes

☐ Not applicable (the event did not involve the death of a close family member or close friend)

Second, keeping this worst event in mind, read each of the problems on the next page and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by: (check box)	*Not at all*	*A little bit*	*Moderately*	*Quite a bit*	*Extremely*
1. Repeated, disturbing, and unwanted memories of the stressful experience?	☐	☐	☐	☐	☐
2. Repeated, disturbing dreams of the stressful experience?	☐	☐	☐	☐	☐

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3. Suddenly feeling or acting as if the stressful experience were actually happening again *(as if you were actually back there reliving it)*?	☐	☐	☐	☐	☐
4. Feeling very upset when something reminded you of the stressful experience?	☐	☐	☐	☐	☐
5. Having strong physical reactions when something reminded you of the stressful experience *(for example, heart pounding, trouble breathing, sweating)*?	☐	☐	☐	☐	☐
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	☐	☐	☐	☐	☐
7. Avoiding external reminders of the stressful experience *(for example, people, places, conversations, activities, objects, or situations)*?	☐	☐	☐	☐	☐
8. Trouble remembering important parts of the stressful experience?	☐	☐	☐	☐	☐
9. Having strong negative beliefs about yourself, other people, or the world *(for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)*?	☐	☐	☐	☐	☐
10. Blaming yourself or someone else for the stressful experience or what happened after it?	☐	☐	☐	☐	☐
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	☐	☐	☐	☐	☐
12. Loss of interest in activities that you used to enjoy?	☐	☐	☐	☐	☐
13. Feeling distant or cut off from other people?	☐	☐	☐	☐	☐
14. Trouble experiencing positive feelings *(for example, being unable to feel happiness or have loving feelings for people close to you)*?	☐	☐	☐	☐	☐
15. Irritable behavior, angry outbursts, or acting aggressively?	☐	☐	☐	☐	☐
16. Taking too many risks or doing things that could cause you harm?	☐	☐	☐	☐	☐
17. Being "super alert" or watchful or on guard?	☐	☐	☐	☐	☐
18. Feeling jumpy or easily startled?	☐	☐	☐	☐	☐
19. Having difficulty concentrating?	☐	☐	☐	☐	☐
20. Trouble falling or staying asleep?	☐	☐	☐	☐	☐

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Agreements

Please read, initial each section, and sign

FINANCIAL POLICIES AND INFORMATION

I have read the financial policy. I understand and agree to comply with this financial policy. I have been given a copy of this policy. I agree to pay for all services rendered and any legal expenses incurred should my account be turned over to another party for collection. Initial _____

INFORMATION DISCLOSURE AND INFORMED CONSENT FORM

I have read and reviewed this informed consent. I understand and agree to all of the terms as they are written including fee schedule, no-show fee, children as minors, and court appearances. In addition, I have been offered a copy of this form for my own records. Initial _____

CLIENT RIGHTS

I have read, understand, and accept my rights as a client of regarding both privacy practices, and the scope of services available Initial _____

HIPAA AND YOUR PROTECTED HEALTH INFORMATION

I have read the HIPAA and Protected Health Information agreement and agree to its term. I acknowledge I have received this notice of privacy practices. Initial _____

THIRD PARTY INFORMATION

I authorize the release of any information necessary to process my claim to Third Party Payers that provide financial reimbursement for requested services of Ronya Hemenway, LCSW. I authorize direct payment to my service provider from my Third Party Payer. Initial _____

My signature signifies that I have read, I understand, and I accept these conditions and policies, and that I agree to enter therapy. I have been given a copy of these policies. I agree to pay for all services rendered and any legal expenses necessary for collection. I authorize and request that Ronya Hemenway, LCSW provide psychological assessments, treatment and/or diagnostic procedures which may now or during the course of my care as a client are advisable. The frequency and type of treatment will be decided between my counselor and me. I understand that the purpose of these procedures will be explained to me and be subject to my verbal agreement. I understand that there is an expectation that I will benefit from counseling but there is no guarantee that this will occur. I understand that maximum benefit will occur with consistent attendance and that at times I may feel conflicted about my therapy as the process can sometimes be uncomfortable. I have read and I fully understand this Informed Consent and Disclosure Form. By signing this, I am giving my consent for treatment.

CLIENT NAME (PRINTED):	**DATE:**

CLIENT OR PARENT/GUARDIAN SIGNATURE:

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Client Communication Policy Agreement

The following agreement is between you and RH Counseling & Therapy, LLC. The word "you" or "client" refers to you, your child, relative or other person who has written his or her name below.

The undersigned agrees to the following electronic documentation policies:

1. Ronya Hemenway, D.B.A RH Counseling & Therapy, LLC uses an Electronic Health Record (EHR) to document all sessions, client information and billing.

2. All information documented in the EHR is kept confidential and cannot be released to a third-party entity without expressed written consent by you.

3. In the event of a breach in the confidential EHR and your private information is compromised Ronya Hemenway will contact you and take all appropriate steps necessary to resolve the situation and ensure the information is secure.

The undersigned agrees to the following electronic communication policies:

1. Appointment dates and times can be communicated via phone, email, or text, as indicated on demographic form by you.
    a. Email and/or text should not be used for purposes other than scheduling/rescheduling appointments

2. No Personal Health Information (PHI) or symptoms should be communicated or exchanged via text.

3. When using text or email to communicate with Ronya Hemenway, the client understand that confidentiality is limited to the security and encryption options set on the phone or email accounts which is being used. Ronya Hemenway uses a secure email through GSuites.

4. In the event of a breach of PHI via text or email, Ronya Hemenway will contact you and take all appropriate steps necessary to resolve the situation and ensure the information is secured.

5. I (client) understand the risks of electronic communication via email or text and I agree to unencrypted methods of communication.

The undersigned agrees to the following Telehealth communication policies:

1. If Telehealth services are provided, Doxy.me/RonyaLCSW is the HIPPA compliant platform used.

2. All existing confidentiality protection under Federal and State laws apply to information disclosed in the Telehealth session.

3. You are responsible for ensuring your side of the Telehealth session is confidential, safe, secure and distraction free environment. Ronya Hemenway will ensure her side of the Telehealth session is secure and confidential.

_____ _____

Signature of Client or Personal Representative/Guardian Date