Salmaan Toor, PhD
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10421 Hickory Path Way
Suite 101
Knoxville, TN 37922

Adult Information Form

Today's date: ____________________________

Identification

Patient's name:___________________________________ Date of Birth: ___________________ Age: _____

Home street address: ____ Apt.: _______________

City: ____ State: ______________ Zip: ________________

Home/evening phone: ____________________________ email: __________________________________

Please indicate any restrictions on calls or emails: ____

____

____

Emergency Contact Information

Name: ____ Phone: ________________________________

Address: ____

Relationship to you: ____

Chief Concern

Please describe the main difficulty that has brought you to see me: _________________________________

____

____

____

Treatment Goals

Please describe what you hope to gain from psychotherapy: _______________________________________

____

____

____

____

Medical Care (From whom or where do you get your medical care?)

Clinic name: ______________________________________ Phone: ________________________________

Doctor's name: ____

Significant Medical Conditions: ____

____

____

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? ❑ Yes ❑ No

Current employer

Employer: ____

Occupation: ____

Family History

If you have children, please list their names, ages, and place of residence, school:

Name	Age	Residence	School

Family history of mental illness or addictions:____

____

____

____

Past Psychological/Psychiatric Treatment

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services? Please include both inpatient and outpatient treatment. ❑ No ❑ Yes

If yes, please indicate:

When	From Whom	For What	Results

Have you ever taken medications for psychiatric or emotional problems? ❑ No ❑ Yes

If yes, please indicate:

When	From Whom	Medication	For What	Results

Alcohol Use

Do you use alcohol?____________________________If yes, how much and how frequently do you drink?

Amount:____

Frequency:____

Recreational Drug Use

Do you recreationally use prescription or illegal drugs?_______________If yes, what type and how much?

Type: ____________________________________Amount:____________________________________

Frequency:____

Current Problems and Symptoms

Please indicate the degree to which the following items are a problem for you in the past two weeks by placing the appropriate number next to the problem.

1 – No Difficulty 2 – Mild Difficulty 3 – Great Difficulty 4 – Overwhelmed

_____ Job _____ School _____ Alcohol _____ Partner/Relationship

_____ Financial _____ Family _____ Drug Use _____ Sexual Activity

Other problems and/or symptoms:____

____

Rate each problem 0-4 (0 = no problem and 4 = major problem) and CIRCLE all words in parenthesis that pertain to you.

_____ Anxiety (worry, fear, scared feelings, excessive guilt)

_____ Depression (unhappiness, hopelessness, lack of motivation, loss of enjoyment, poor concentration)

_____ Thinking (poor concentration, procrastination, poor memory, intrusive thoughts, obsessive thoughts)

_____ Physical Symptoms (pain, headaches, fatigue, stomach aches)

_____ Self Control (uncontrolled anger, overpowering sexual desires, compulsive/addictive behavior)

_____ Emotions (change quickly, hard to control, emotionally overwhelmed)

_____ Relationships with others (friend, co-worker, partner)

_____ Sleep (difficulty falling asleep, difficulty staying asleep, sleeping too little, too much)

_____ Appetite/Eating (lack of appetite, recent weight gain, recent weight loss)

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Salmaan Toor, PhD
Licensed Clinical Psychologist

Our Psychotherapy Agreement

Informed consent to treatment: I, the patient (or his or her parent or guardian), understand that I have the right to not sign this form. My signature below indicates that I have read, discussed, and received a copy of the Notice of Privacy and Psychotherapy Information forms. My signature does not indicate that I am waiving any of my rights. I also understand that any of the points in the Notice of Privacy and Psychotherapy Information forms can be discussed and may be changed by mutual agreement at any time. I understand my rights to privacy and any exceptions to my rights to privacy, and that there are risks associated with treatment. I have read, or had read to me the Notice of Privacy and Psychotherapy Information forms. I have discussed those points I did not understand, and have had questions, if any, fully answered. I agree to the points in this document and enter into therapy with this therapist as shown by my signature here.

____ ____________________

Signature of patient (or person acting for patient) Date

____

Printed name

Relationship to client: ❑ Self ❑ Parent ❑ Legal guardian

Consent to Use and Disclose Your Health Information

When I examine, test, diagnose, treat, or refer you, I will be collecting what the law calls "protected health information" (PHI) about you. I need to use this information in my office to decide on what treatment is best for you and to provide actual treatment to you. I may also share this information with others to arrange payment for your treatment, to help carry out certain business functions, or to help provide other treatment to you.

By signing this form, you are also agreeing to let me use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have received the notice of privacy practices, which explains in more details what your rights are and how I can use and share your information. After you have signed this consent, you have the right to revoke it by providing me a request in writing.

____ ____________________

Signature of patient (or person acting for patient) Date

____

Printed name

Relationship to patient: ❑ Self ❑ Parent ❑ Legal guardian