Sheryl L. Brickner PhD LPC LAC
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Demographic Information

Client name: _____ Entry Date:_____

Address: _____ City: _____

State: _____ Zip Code: _____

Contact Phone: _____ Date of Birth: _____

Social Security Number: _____ Gender: _____

Email: _____
I would like to receive the monthly health newsletter by e-mail ___yes ___no

Emergency Contact (Please list at least one name and phone number):

_____

Insurance holder's Name and Date of Birth

_____

Payment Information

New Patient Consultation, Psychotherapy, or Clinical Supervision	$95.00/hour
Continuing Consultation, Psychotherapy	$80.00/hour
NAET Initial Session (Includes 1st Treatment)	$95.00
NAET Treatment	$40.00
Late Cancellation / No Show	$40.00

Services available for nutritional consultation, psychotherapy, allergy correction and other Holistic therapies.

We accept cash, checks, or credit card payments. Payment required before session. 24-hour notice required for cancellation to avoid being charged for session. **We bill insurance but you are responsible for anything insurance doesn't pay.** Please provide copy of insurance card and call your company to get information on deductibles, co-pays, and preauthorization requirements.

****Senior and family discounts available upon request****

_____ _____
Signature of Responsible Party SSN / D.O.B. / Date

Health/Mental Health History

Height: _____ **Weight**: _____ **1 year ago**: _____ **5 years ago**: _____

Occupation: _____ **Full Time ❑ Part Time ❑**

Living situation: Alone ❑ Friends ❑ Partner/Spouse ❑ Parents ❑ Children ❑ Pets ❑

What are your major health/mental health concerns and intentions for your visit today?_____

_____

Please list any other health care providers or consultants you are currently working with:

_____

Please list any current health conditions diagnosed by a medical doctor:

_____

When was your last physical exam? _____

Please list all herbs, vitamins, and dietary supplements you are currently taking, including dosage and frequency:

_____

List all medications you are currently taking (including aspirin, antacids, etc.) indicating whether they are over the counter (OTC) or prescription, including dosage and frequency:

_____

List all medications, herbs, foods, environmental factors, to which you have a known allergy:

DIETARY INFORMATION

Describe below your typical meals. Please be as specific as possible. For example, instead of "oil" note the type of oil, such as olive, corn, etc. Instead of "bread" list whether it is white or whole grain, etc. Instead of "vegetables," list the type of vegetable, how it was prepared, whether canned, frozen, or fresh, etc. Please include the type and quantity of all beverages (two cups of orange juice, one cup of coffee, etc.).

Breakfast: _____

_____

Morning snack(s): _____

Lunch: _____

_____

Afternoon snack(s): _____

Dinner: _____

_____

Daily water consumption (number of glasses/day): _____ **Any recurring food cravings (such as salt, starch, sugar, chocolate, etc.)? Please list as many as applicable including time of day or month:**

_____

_____

MEDICAL HISTORY

List all major health problems including any operations:

PROBLEM **YEAR**

_____

_____

_____

GENERAL HEALTH

Cardiovascular
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Pain in heart
- ❑ Poor circulation
- ❑ Swelling
- ❑ Stroke/murmur

Skin
- ❑ Boils
- ❑ Bruises
- ❑ Dryness
- ❑ Itching
- ❑ Varicose veins
- ❑ Skin eruptions

Muscles/Joints
- ❑ Backache
- ❑ Broken bones
- ❑ Limited mobility
- ❑ Arthritis
- ❑ Bursitis
- ❑ Weakness

Respiratory
- ❑ Chest pain
- ❑ Difficulty breathing
- ❑ Cough
- ❑ Tuberculosis
- ❑ Congestion
- ❑ Itchy ears/eyes
- ❑ Asthma
- ❑ Coughing up blood

Urinary/Kidney
- ❑ Excessive urination
- ❑ Water retention
- ❑ Burning urine
- ❑ Kidney stones
- ❑ Lower back pain
- ❑ Wheezing
- ❑ Circles under eyes
- ❑ Blood in urine

Gastro-Intestinal
- ❑ Belching
- ❑ Colitis
- ❑ Constipation
- ❑ Abdominal pain
- ❑ Liver disorders
- ❑ Gallstones
- ❑ Ulcers
- ❑ Digestive troubles

Eyes, Ears, Nose and Throat

❑ Ear aches ❑ Eye pains ❑ Failing vision ❑ Hay fever
❑ Sinus infections ❑ Sinus congestion ❑ Sore throat ❑ Tonsils
❑ Hearing loss ❑ Canker sores ❑ Nosebleeds ❑ Difficulty breathing

General

❑ Fatigue ❑ Night sweats ❑ Fever ❑ Excessive thirst ❑ Irritability
❑ Loss of appetite ❑ Always hungry ❑ Difficulty sleeping ❑ Cold hands and feet

Male Reproductive

❑ Burning/discharge ❑ Vasectomy ❑ Lumps/swelling of testicles ❑ Painful testicles

Female Reproductive

Age of first period: __ ❑ Irregular cycles ❑ Pre-menopausal ❑ Heavy bleeding
❑ Blood clots ❑ Menopause ❑ Vaginal discharge ❑ Vaginal itching
❑ Pains/cramps ❑ Painful intercourse ❑ Vaginal dryness ❑ Pelvic pain
❑ Breast pain ❑ Breast lumps ❑ Anemia ❑ Infertility
❑ Genital herpes ❑ Hot flashes ❑ Mood Swings ❑ PMS ❑ Not able to conceive

Contraceptive/Pregnancy History

❑ Birth Control Pills ❑ Rhythm-method ❑ I.U.D. ❑ Diaphragm ❑ Condoms
❑ Mucous-method ❑ Cervical Cap ❑ Spermicides ❑ Fertility lens

Please list each pregnancy you have had, including miscarriages:

_____

_____

CURRENT STATE OF EMOTIONS AND SPIRITUAL WELL-BEING

Please check all those that describe you:

- ❑ I am often stressed out and not able to cope properly.
- ❑ Even though I'm in a relationship, I often feel lonely.
- ❑ I often feel anxious and nervous for no good reason.
- ❑ I don't sleep well at night and have a hard time waking up in the morning.
- ❑ I often suffer from bad dreams and nightmares.
- ❑ There are many things I'd like to change in my life I just don't have the means.
- ❑ I have very low energy and often feel exhausted mentally and physically.
- ❑ I don't enjoy my work and would rather be doing something else.
- ❑ I find my children irritating and hard to relate to.
- ❑ I have very few hobbies.
- ❑ I often feel depressed for no reason.
- ❑ I often become angry with people and feel guilty about it later.
- ❑ I have a hard time letting go of the past.
- ❑ I don't look towards the future with much enthusiasm.
- ❑ I am not able to concentrate for extended periods of time.
- ❑ My outlook is more negative than positive.
- ❑ I spend a great deal of time worrying about what people think about me.
- ❑ I tend to see the good in people.
- ❑ I have a great sense of humor and love a good joke.
- ❑ I receive great joy from my family.
- ❑ My outlook on life is positive.
- ❑ I have plenty of energy to do all the things I want.
- ❑ I sleep well at night and feel rested in the morning.
- ❑ I can concentrate on the task at hand for as long as it takes.
- ❑ I have a strong spiritual faith.
- ❑ I am able to express anger constructively.
- ❑ I practice meditation or other relaxation techniques.
- ❑ I try to maintain peace of mind and tranquility.
- ❑ I have many close friends that I can always count on.
- ❑ I accept full responsibility for my actions.
- ❑ I trust my intuition and believe that things happen for a reason.
- ❑ I do not harbor any resentment from the past.
- ❑ I can feel completely fulfilled even if I'm alone.
- ❑ I have many hobbies and interests to keep me preoccupied.
- ❑ How I see myself is more important than how others see me.
- ❑ I often go out of my way to help others.

Please list approximate dates and describe the nature of any traumatic experiences you have had in the past 7 years (divorce, surgery, end of a relationship, loss of job, change of residence, injury, death of a loved one, etc.):

YEAR **EVENT**

_____

_____

_____

LIFESTYLE HABITS

Do you engage in regular physical activity? Yes ❑ No ❑
If yes, for how many minutes? _____ How often? _____

Do you smoke tobacco? Yes ❑ No ❑
If yes, how much? _____/day

Do you drink alcohol? Yes ❑ No ❑
If yes, how much? _____ How often? _____

Do you drink coffee and/or caffeinated beverages? Yes ❑ No ❑
If yes, how much? _____ How often? _____

How many hours of television do you watch in a week? _____

Do you use artificial sweeteners? Yes ❑ No ❑

Please use this space to add any other information about yourself that you think will be helpful:

INDIVIDUAL DISCLOSURE
OF
Sheryl L. Brickner PhD LPC LAC RPT/S

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Email: drbrickner@q.com

Colorado state law requires that I provide you, both verbally and in writing, with a disclosure statement outlining my credentials as a therapist and your rights as a client. The following statement covers the points on which you should be informed according to Colorado Revised Statue (C.R.S.) 12-43-218. If you have any questions about the material contained in this statement or about any aspect of your work with me, please do not hesitate to ask.

DEGREES & CERTIFICATIONS

MA from University of Northern Colorado in Psychology and Counseling 1979
PhD from Trinity Seminary in Biblical Counseling 1993
Licensed Professional Counselor #86 Licensed Addiction Counselor #8
Nutritional Consultant
Holistic Health Practitioner
NAET Practitioner (Nambutripad Allergy Elimination Technique)
Certified Mental Health/Addiction Nutrition Coach 2013

GENERAL DISCLOSURES

♦ The Colorado Department of Regulatory Agencies has the responsibility of regulating the practice of licensed psychologists, licensed social workers, licensed professional counselors, licensed marriage and family therapists, licensed school psychologists practicing outside the school setting, and all NON-LICENSED INDIVIDUALS WHO PRACTICE PSYCHOTHERAPY. The agencies within the Department that have specific responsibility:

STATE GRIEVANCE BOARD
1560 BROADWAY, STE 1350
DENVER, CO 80202
303-894-7766

♦ **Mental Health Regulation and Types of Licenses and Registration.** The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Registrations. The Colorado Board of Psychologist Examiners can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800. As to the regulatory requirements applicable to mental health professionals: a **Licensed Clinical Social Worker,** a **Licensed Marriage and Family Therapist**, and a **Licensed Professional Counselor** must hold a masters degree in their profession and have two years of post- masters supervision. A **Licensed Psychologist** must hold a degree in psychology and have one year of post- doctoral supervision. A **Licensed Social Worker** must hold a masters degree in social work. A **Psychologist Candidate**, a **Marriage and Family Therapist Candidate**, and a **Licensed Professional Counselor Candidate** must hold the necessary licensing degree and be in the process of completing the required supervision for licensure, A **Certified Addiction Counselor I** (CAC I) must be a high school graduate, and complete required training hours and 1,000 hours of supervised experience. A **CAC II** must complete additional required training hours and 2,000 hours of supervised experience. A **CAC III** must have a bachelor's degree in behavioral health, and complete additional required training hours and 2,000 hours of supervised experience. A **Licensed Addiction Counselor** must have a clinical master's degree and meet the CAC III requirements. A **Registered Psychotherapist** is registered with the State Board of Registered Psychotherapists, is not licensed or certified, and no degree, training or experience is required. **I am a Licensed Professional Counselor and a Licensed Addiction Counselor in the State's database and am authorized by law to practice psychotherapy in Colorado.**

♦ You, as my client, are entitled to receive information from me about my methods of therapy the

techniques I use, the duration of your therapy (if I can determine it), and my fee structure. Please ask me if you would like to receive this information.

YOU MAY SEEK A SECOND OPINION FROM ANOTHER THERAPIST OR TERMINATE THERAPY AT ANY TIME.

♦ In a professional relationship (such as ours), **SEXUAL INTIMACY BETWEEN A THERAPIST AND A CLIENT IS NEVER APPROPRIATE!** If such intimacy occurs, it should be immediately reported to the Department of Regulatory Agencies, Mental Health Section.

♦ Generally speaking, the information provided by and to a client during therapy sessions is legally confidential if the psychotherapist is a licensed marriage and family therapist, a licensed social worker, a licensed professional counselor, a licensed psychologist, or an unlicensed psychotherapist. If the information is legally confidential, the therapist cannot be forced to disclose the information without the client's consent. Information disclosed to a licensed or unlicensed therapist is privileged communication and cannot be disclosed in any court of competent jurisdiction in the State of Colorado without the consent of the person to whom the testimony sought relates.

- There are also exceptions to the general rules of confidentiality, some of which are listed in section 12-43-219 and in the Notice of Privacy Practices you were provided, particularly in the case of threat of harm to self or others, in child abuse issues, in some cases of child custody matters as well as in some criminal and delinquency proceedings (as provided in Colorado Statues, section C.R.S. 13-90-107). You will be informed if, in my judgment, any matter may need to be disclosed to proper authorities.

- I use prayer in therapy for those wishing to use that as a part of addressing spiritual health. If you want me to pray with you, please ask me to do so.

- Recommendation for nutrition, supplements, exercise and other healthcare suggestions, are not intended to replace medical advice and treatment from your primary care physician.

- In the case of insurance or other third party billing, It will become necessary to provide a diagnosis code in order to receive payment. These codes could be disclosed improperly by the insurance company and perhaps become a problem to you at a later date.

- Fees are collected at the time of service. **You are responsible for any fees not covered by your insurance.**

I understand that, consistent with the HIPPA requirements, consent to treatment and consent to release will expire after twelve months and I may revoke such consent at will, although revocation is **NOT retroactive**.

If you have any questions or would like additional information, please feel free to ask.

ATTESTING THAT I UNDERSTAND THE ABOVE AND AGREE TO THERAPY UNDER THE ABOVE LIST OF DISCLOSURES I HAVE SIGNED BELOW:

CLIENT SIGNATURE _____ DATE _____

SIGNATURE OF PARENT OR
GUARDIAN IF CLIENT IS A MINOR _____ DATE _____

THERAPIST _____ DATE _____