Meredith Glick Brinegar, PhD, LLC
Licensed Clinical Psychologist
7071 Corporate Way, Suite 110
Dayton, OH 45459
Phone: 937-259-8594

ADULT PERSONAL DATA FORM

Name: _____ Date:_____

Home (local) address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Work phone: _____ Cell: _____

May I leave a message at: ☐ home phone ☐ work phone ☐ cell phone

Date of birth: _____ Age: _____ Social Security No: _____

Gender: _____ Sexual Orientation: _____ Marital Status: _____

Ethnicity: _____ Education: _____

Occupation: _____ Employer: _____

Health Insurance Carrier_____ Policy # _____

Name of Insured: _____ Date of birth of insured: _____

How did you find out about my practice? _____

Chief Concern

Please describe the main difficulty that has brought you here: _____

_____

_____

_____

_____

_____

When did this difficulty begin? _____

_____

What solutions or efforts have you tried to solve the problems that bring you here? _____

_____

How effective have these efforts been? _____

_____

Please use the back of this page if necessary to fully complete your responses to these questions.

Treatment

Have you ever been in counseling/psychotherapy before? ☐Yes ☐ No
If yes, please indicate:

When?	*Provider?*	*For what?*	*With what results?*

Have you ever taken, or are you now taking, medications for psychiatric or emotional problems? ☐Yes ☐ No
If yes, please indicate:

When?	*Prescribed by?*	*Name of medication*	*For what?*	*With what results?*

Other medications you are currently taking:

Name	*Condition*	*Prescribed by*

From whom or where do you get your medical care?

Name	*Specialty*	*Address*	*Phone*	*Date of last visit*

Please list any medial conditions or injuries:

Age	*Illness/Diagnosis*	*Treatment received*	*Result*

Height: _____ Weight: _____

Alcohol/Drug Use

Average number of alcoholic drinks per week: ☐0 – 2 ☐ 2-5 ☐5-10 ☐More than 10

Use of recreational drugs (including tobacco):

Name of drug	*Frequency*	*Amount per use*

Family

Immediate Family (Spouse/partner, children, etc.) and/or current living situation (roommates, etc.)

Name	*Relationship*	*Age*	*Occupation*	*Currently Living w/ you?*	*Year Deceased*

Family-of-origin (Parents, siblings, etc. – who you grew up with)

Name	*Relationship*	*Age*	*Occupation*	*Currently Living w/ you?*	*Year Deceased*

Emergency Information

If some kind of emergency arises and I cannot reach you directly, or I need to reach someone close to you, whom should I call?

Name: _____ Relationship: _____

Address: _____

_____ Phone: _____

Other Information

What do you consider to be some of your strengths?

_____

_____

Do you consider yourself to be spiritual or religious?_____ If yes, describe your faith or belief:

_____

_____

What would you like to accomplish during your time in therapy?

_____

_____

_____

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Licensed Clinical Psychologist **Dayton, OH 45459**

Policies, Procedures, and Therapy Agreement

Credentials and Contact Information

Meredith Glick Brinegar, Ph.D.
Licensed Clinical Psychologist (OH License #6749)
Phone: 937-259-8594
Fax: 844-374-9964
Email: dr.brinegar@gmail.com
Website: www.dr-brinegar.com

I provide individual and group psychotherapy for adults and adolescents. I do not prescribe medications or provide psychological testing services. I am not always available to answer the telephone. In that instance, please leave a detailed message—I am notified in real-time of new messages. If you wish to contact me by email or text, please read and sign the section below.

Information About Therapy

Participating in therapy has a variety of risks and benefits. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings, such as sadness, anger, and helplessness. On the other hand, psychotherapy can result in benefits to you, including a better understanding of your personal goals and values, a resolution of the specific concerns that led you to seek therapy, improved interpersonal relationships, and significant reductions in feelings of distress.

The first few sessions of therapy involve an evaluation of your needs. During this time, we can both decide if I am the best person to provide you the services you need. By the end of the evaluation, I will be able to offer you some impressions of what our work could include, and we can negotiate a plan for our work together. I am available now and throughout therapy to answer your questions regarding these matters and to help you make an informed decision about choosing therapy.

I abide by the Ethical Principles of the American Psychological Association (APA) and the Laws and Rules Governing the Practice of Psychology under the state of Ohio (Ohio Revised Code, Chapter 4732: Psychologists).

Confidentiality and Release of Information

Any information that you provide during the course of evaluation/treatment is strictly confidential and legally protected as "privileged communication." As such, I will not reveal information to any other person or agency without your written permission, except under the following circumstances:

1. By law I must report to any suspicion of abuse against a child or dependent adult to the appropriate authorities.

2. I am permitted by law to take action to protect you if you become an imminent, life-threatening danger to yourself. Action in this situation may include calling emergency personnel or the police and/or psychiatric hospitalization.

3. By law, if in my opinion you are a serious (life-threatening) and imminent threat to another person/group, I have a duty to take action to protect others from such harm. Such action may include notifying others of such a threat.

4. If I am ordered by a judge in a court of law to reveal information, I must comply.

5. I may consult with other clinicians in order to provide you with the best possible care. I will omit personally identifying information during such consultations.

6. If an insurance or managed care company is paying for part or all of your therapy services, they will be provided with a report if requested and other information necessary (e.g., diagnosis) to secure payment.

7. I use a billing specialist to verify benefits and submit insurance claims. She is an independent contractor, and has been given training about protecting your privacy and has agreed not to release any information outside of my practice.

Professional Records

Law and ethical practice standards require that I keep treatment records. These records are kept under lock and key and are treated as confidential. If you wish to review your records at any time, please let me know and we can discuss the process.

Fee Policies

Fees are to be paid in full at the time of your session. I accept cash, check, and credit (Visa, Master Card, Discover Card, American Express). This includes insurance co-pays and deductible amounts. If using out-of-network benefits, you will be responsible for the entire session fee, a portion of which will be reimbursed by your insurance company, according to your insurance benefits, after you submit your claim.

If you have to cancel an appointment for any reason, please contact me by phone or email 24 hours in advance of your session. I recognize that this is not always possible and that there will be times when you have to cancel and cannot provide such notice. However, please be aware that a fee of $25 will be assessed for last minute cancellations or missed appointments. Insurance companies will not pay for late cancellations or missed sessions, so, in the event that this occurs, you would be charged directly.

Initial Evaluation (55-60 Minutes)	$200
Individual Psychotherapy (55-60 Minutes)	$150
Group Psychotherapy (90 Minutes)	$50
Late Cancellation/Missed Appointment Fee	$25

Email and Texting

Email and texting are convenient forms of communication. However, they can also have drawbacks. I take all reasonable precautions to keep your communications private, but I cannot guarantee that your email and texts will remain confidential. There are several ways that these messages can be intercepted. Therefore, if you are concerned in any way about the content of your email or text being read by someone other than myself, you should rely on alternate ways of communicating with me.

I will try to respond to emails or texts within 24 hours. Because I may not be able to respond immediately, they should not be used to communicate emergencies. In case of emergency, please contact me by phone.

Your signature below signifies that you have been informed of the limits of confidentiality pertaining to the use of email and texting.

Texting __ YES __ NO Cell phone: _____

Email __ YES __ NO Email: _____

_____ _____

Signature of client or legal guardian Date

Emergency Procedures

If you are experiencing a clinical emergency and need to speak with me on an urgent basis, please call my office phone at 937-259-8594 and leave a detailed message, indicating the nature of the emergency and the best way to reach you. Messages are forwarded to me in real-time. I will make every effort to return your call as soon as possible. If you are having thoughts of harming yourself or someone else, and cannot wait for a return call, please call Crisis Care at 937-224-4646 or go to the nearest emergency room.

Termination of Therapy

Your participation in this therapy is completely voluntary. Either of us may terminate our work together if we believe it is in your best interest. I ask that we meet for at least one session after an agreement to terminate. That session allows us to review our work together, your goals and accomplishments, any further work to be done, and your options for further treatment.

Patient Rights

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. The Notice Form of my Policies and Practices to protect the privacy of your health information is printed on my website at **www.dr-brinegar.com.** You have the right to request a paper copy if you wish. I am happy to discuss any of these rights with you.

Your signature below signifies that you have read and understand the preceding information and your questions have been answered to your satisfaction.

_____ _____

Signature of client or legal guardian Date

_____

Printed name of client or legal guardian

Symptom Checklist for Adults

x	Please check all that apply	x		x	
	Mood		**Sleep**		**Anxiety**
	Sadness		Can't fall asleep		Worry/nervousness
	Loss of interest/pleasure		Can't stay asleep		Shaking
	Hopelessness		Waking up too early		Sweating
	Guilt		Feeling tired all day		Feeling hot/cold
	Feeling worthless		Need less sleep than usual		Feeling faint/dizzy
	Low energy		Need alcohol/drugs to sleep		Things feel unreal
	Concentration problems		Other:		Feeling detached
	Low self esteem				Nausea
	Mood swings		**Eating**		Chest pain
	Wanting to die		Decreased appetite		Numbness/tingling
	Wanting to cut myself		Increased appetite		Pounding heart
			Weight loss		Fear of dying
	Feeling extra happy		Weight gain		Fear of going crazy
	Too much energy		Making myself throw up		Fear of leaving house
	Unusually talkative		Restricting food intake		Muscle tension
	Racing thoughts		Binge eating		Pulling hair/eyelashes
	Distractibility		Emotional eating		Counting/washing
	Irritability		Excessive exercise		Shyness
	Anger		Using laxatives		Social anxiety
	Reckless/risky behavior		Body image concerns		Nightmares
	Other:		Other:		Flashbacks
					Easily startled
					Fears of:_____

	Physical		**Sexual**		**Risk factors**
	Headache		Decreased desire		Impulsive behavior
	Stomachache		Increased desire		Binge drinking
	Vomiting		Inability to orgasm		Drug use
	Muscle pain		Erectile difficulties		I think about suicide
	Joint pain		Unwanted sexual thoughts		I have a plan for suicide
	Back/neck pain		Pain during intercourse		I intend to kill myself
	Other:		Survivor of sexual abuse		I think about hurting someone
			Other:		I have a plan for hurting someone
					I intend to hurt someone
	Unusual experiences		**Relationship concerns**		**These problems affect my:**
	I hear voices		Hard to get along w/others		Relationships
	I see things that aren't there		Wish I had more friends		Work/school performance
	I believe things others don't		Avoiding people		Health
	I am being followed/watched		Recent breakup/divorce		Other:
	Someone is trying to hurt me		Relationship violence/abuse		
	I'm not sure what's real		Parenting concerns		
	I can't remember things		Family of origin concerns		
	Other:		Death of loved one		
			Communication problems		
			Other:		