Karen Mahan, LCSW
DBA Transitions Equine LLC
Corrales, NM 87048

Therapist________________________

Diagnosis:_______________________

CLIENT INFORMATION *Confidential*

Date:_________ Referral Source: ______________________________________

Client Name:____
Last First Middle initial

Address:_________________________ City:_____________ State:_____ Zip:___________

Home Phone:_____________________ Work:_____________ Cell:_____________________

Email address:_______________________________________ Marital Status:____ Sex:___

DOB:____________ Age:_____ Social Security No.:_______________________________

Employer Name/Address:____

Emergency Contact:_________________________ Phone:____________________________

Person Financially Responsible:______________________________ Birth Date:_________________

Relationship to Client:_______________________ Employer__________________________________

Address:______________________________ City:____________________ State:___ Zip:__________

Home Phone:___________________ Work Phone:______________ Cell:______________________

Please Provide Insurance Card(s) Ins. Name/Address/Ph:_________________________________

____

Member ID____

Dependent Children:

Name_____________Birth Date______________________Name___________Birth Date_________

Primary Care Physician's Name:_______________________________ Phone: ___________________

Address:____State_____ Zip_____________________

Karen Mahan, LCSW
DBA Transitions Equine LLC

Patient Assignment of Insurance Benefits and Authorization to Release Information

I acknowledge that I have received a copy of the patient bill of rights and the informed consent for treatment form. I hereby agree to treatment and understand that if I have questions, I will contact my therapist ..

I hereby authorize any insurance carrier to make payment directly to Karen Mahan, LCSW of any benefits otherwise payable to me for services provided by Karen Mahan, LCSW or Transitions Equine LLC staff. I understand that I am financially responsible for all charges whether or not paid by my insurance company (s).

I authorize Karen Mahan, LCSW to release to my insurance company(s) any information from my record which may be necessary to determine benefits payable under my policy. This information may include, but is not limited to diagnosis, treatment procedure and/or photocopies of all or part of my record.

Confidentiality will be strictly maintained under the guidelines of professional ethics and the procedures defined by my insurance program.

____
Patient Guardian Signature

____
Therapist Signature

____
Date

Karen A. Mahan, LCSW
DBA Transitions Equine LLC

____
NAME

Health History Questionnaire

1. Please list all current medications you are taking for either physical or emotional difficulties:

____

____

2. Allergy (Medications): ____
3. Current Medical/Emotional Conditions (please check):

___Anxiety ___ Diabetes ___Sleep Disturbance
___Allergies ___Epilepsy/Seizure Disorder ___Stomach Problems
___Asthma ___Frequent Constipation ___Skin Problems
___Arthritis ___Frequent Headaches ___Sexually Transmitted Disease
___Back Trouble ___Fatigue ___Vision Problems
___High Blood Pressure ___Hay Fever ___Weight Loss/Gain
___Cancer ___Heart Problems ___Smoker/Amount per day___
___Depression ___Irritable Bowels ___Other__________________

Is there any family history of the above conditions?_________________________________

4. Medical Doctor___________________________Last Physical Exam__________________

   Currently being treated?_____________Problem:____________Date Last Seen:_________

5. Have you ever previously been seen for outpatient therapy? (list previous therapists/reasons)

____

____

Have you been previously hospitalized for emotional difficulties? (list previous hospitals/dates)

____

Have you previously been treated for chemical dependency? (List hospitals/dates)

____

6. Do any family members have chemical dependency, alcoholism or emotional problems?
   List:____

7. Do you use sedatives, alcohol, tobacco, laxative, caffeine? Type and amount per day:.
   List:____

8. Are you having problems in your sexual relationship? ______________________________

Karen Mahan, LCSW DBA Transitions Equine LLC
Informed Consent for Treatment

I want you to be aware of your rights as a client and ask for your informed consent to receive treatment. Please be aware of my practice regarding confidentiality of your health information. Your rights as a patient are shown below.

A. The benefits of being a recipient of services may include, but are not limited to, being better able to meet your personal needs: improved communications skills, clearer thought process, and more stable mood.
B. Services provided may include psychiatric assessment, case management., group, individual, family and couples therapy. If medication is part of your treatment program, the purpose of the medications will be discussed with you by your psychiatrist.
C. The risks of receiving services may include feelings of anxiety, depression, frustration, loneliness, helplessness or other intense emotions when you discuss life problems or experience with your treatment providers. Certain medications may have common side effects that will be discussed with you at the time that you see the psychiatrist for a medication evaluations. It is your right, unless under court order, to decide whether or not you want to take any medication.
D. If you disengage from services or elect not to participate, it is possible your problems may not be addressed or may become worse than they are at the present time.
E. The treatment staff may suggest alternate treatment modes and will make referrals to other services when appropriate or necessary.
F. You may be discharged from treatment for failure to follow through with treatment recommendations, failure to show up for appointments or abuse of medication.
G. Services never involve sexual contact between therapist and client; this is unethical and against the law.
H. The is informed consent will be in effect no longer than fifteen months from the time that consent is given.
I. You have a right to withdraw this informed consent, in writing, at any time.

Denial of Patient Rights

Your rights may only be denied in certain circumstances such as:

1) When there is a danger to life or health of the client or potential harm to others.
2) Suspected cases of child abuse or neglect (s.48.98)
3) A lawful order of the court to which you must comply.

By by signature below, I attest that my rights as a patient have been explained to me and I give my consent for treatment.My signature below also confirms this information provided to you:

____

Client /Guardian Signature Date

____

Client's Name (print) Date of Birth

____

Witness Date

____

*If client doesn't sign, please document reason:______________________

Karen Mahan, LCSW DBA Transitions Equine LLC
Client Intake Form

Last Name:______________________________ First Name:____________________________

Date of Birth:____________________________ Date of Assessment:____________________

Circle the number that best describes problems you have in the following areas. If not applicable, leave blank:

3=Severe **2=Moderate** **1=Minimal**

Depression	3 2 1	Financial Problems	3 2 1	Excessive Spending	3 2 1
Anger	3 2 1	Sexual Problems	3 2 1	Grief Issues	3 2 1
Anxiety	3 2 1	Sexual Orientation Issues	3 2 1	Marital	3 2 1
Withdrawn	3 2 1	Alcohol/Drug Use (self)	3 2 1	Other Relationships	3 2 1
Suicidal Thoughts	3 2 1	Alcohol/Drug Use (others)	3 2 1	Parenting Problems	3 2 1
Suicidal Attempts	3 2 1	Gambling	3 2 1	Physical Abuse	3 2 1
Job Problems	3 2 1	Excessive Eating	3 2 1	Sexual Abuse	3 2 1
Legal Problems	3 2 1	Excessive Dieting	3 2 1	Domestic Violence	3 2 1

How long has problem existed? ____weeks ____months ____years

In the past six months, have you experienced the following? (Please check all that apply)
Physical Reactions:

____Rapid Heart Rate ____Dizziness ____Lightheaded ____Headaches
____Stomach Aches ____Nausea ____Chest pain/Pressure ____Sweating
____Shaking ____Impaired Sleep ____Fatigue ____Muscle Tension
____Neck or Back Pain ____Other______________________________

Mental Reactions:
____Nightmares ____Flashbacks ____Intrusive Images ____Homicidal Plans
____Suicidal Thoughts ____Suicidal Plans ____Homicidal Thoughts ____ Obsessive thoughts
____Paranoia ____Delusions ____Hallucinations
____Compulsive Behavior ____Phobias ____Short-term memory ____Long-term memory
Other:____

Emotional Reactions:

____Fears ____Feeling Unsafe ____Sadness ____Grief
____Mood Swings ____Anxiety ____Depression ____Anger
____Irritability ____Fatigue ____Guilt ____Shame
____Blaming(self/others) ____Difficulty trusting others ____Emotional Numbness ____Sensitive
____Isolating ____Poor Memory ____Poor concentration
____Worthlessness
____Lack of Sexual Desire ____Crying Spells ____Hopelessness ____Lack of Motivation

Other____

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Behavioral Reactions:

____Suicide Attempts ____Agitation ____Loss of Interests ____Easily Distracted
____Confrontational ____Aggressiveness ____Withdrawn ____Procrastination
____Easily Startled ____Overeating ____Under eating ____Anorexia
____Binging ____Purging ____Bulimia ____Gambling
____Increased alcohol use ____Alcohol Dependence
____Sexually Inactive ____Sexually Overactive ____Other Substance Use

Other____

Do you physically harm yourself? How so?____
____
____

What are your current stressors?____
____
____

Are you having financial/legal difficulties?______________________________________
____
____

What do you do to cope?____
____
____

Have you had any significant losses (relatives, friends, jobs, pets, etc.)?_____________________
____
____

Military History

Branch of Service______________________________________ Dates_______________
Combat Experience______________________________________ Dates_______________
Combat Trauma____ Dates_______________
Psychiatric Inpatient/Outpatient Treatment______________________ Dates_______________

Veteran Support Group____Dates__________________

Educational History

Karen Mahan, LCSW
DBA Transitions Equine LLC

Names of Schools______________________________________ Dates_____________________

____

Highest Academic Level_________________________________ Dates______________________

Other Job Training______________________________________ Dates_______________________

Job History

Current Place of Employment _____________________________ How long?___________________

Previous Employment____________________________________ Dates_______________________

____

What do you do for leisure?

____

____

Do you have a regular exercise program?____

Church/Spiritual Affiliation____

Any other information that would be helpful for your therapist?_______________________________

____

____

____ ______________________________

Client Date

Reviewed by:

____ ________________________________

Therapist Date

Karen Mahan, LCSW
DBA Transitions Equine LLC

Financial Policy and Agreement

Regarding Insurance and Managed Care

Insurance benefits assignment may be accepted. If you are covered by insurance it will be billed if you provide insurance information. Your insurance policy is a contract between you and your insurance company. I am not a party to that contract. In the event that I accept assignment of benefits, I will give you credit for the amount covered by insurance. If your insurance company has not paid your account in full within 60 days, the balance will automatically be transferred to you. Please be aware that thee cost of the services provided will become your responsibility if covered in part or not at all by your insurance company. **In addition, you are expected to pay the difference between the amount covered and amount owed each time you come for an appointment**. All co-pays and deductibles are due at the time of treatment. If you are a subscriber to a managed care policy, it is your responsibility to ensure that the first session is authorized by your insurance company. I also request that you understand the requirements of you insurance carrier and inform me of what procedures I must comply with to ensure payment. **While I may be a member of several managed care networks, it is your responsibility to ensure that I am a provider for your individual policy.**

Monthly Statements

All monthly statements are due in full upon receipt unless other arrangements have been made. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Missed Appointments

Unless cancelled at least 24 hours in advance, you may be charged for missed appointments at the rate of **$50** per session. Insurance carriers will not pay for missed or canceled appointments. Please help me serve you better by keeping scheduled appointments.

Treatment Plan

I am responsible for informing you of a tentative treatment plan regarding your therapy. Together, you and I can modify or alter this plan as treatment continues.

Fee Agreement

The agreed upon fee for professional services is:

$______________________ for initial session and $__________________per 45-minute session.

I agree to pay a minimum of $_____________toward the professional fees at each session. This includes any co-payment or deductible of which I am aware.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns. I have read the financial policy. I understand and agree to this policy. I also hereby authorize my insurance benefits to be paid directly to Karen Mahan, LCSW DBA Transitions Equine LLC and acknowledge that I am financially responsible for any unpaid balance.

____

Signature of Patient or Responsible Party **Date**

Karen Mahan, LCSW
DBA Transitions Equine LLC

Initial Treatment Plan
Confidential

Client Name:______________________________ Therapist: ______________________________

Primary Dx:______________________________ Secondary Dx:___________________________

Dates of Assessment____________________________

Treatment Modality: Individual __ Marriage Couples___
Family___ Group___
Play___ EMDR___
Relaxation___ Solution Focused___
Other___

Psychiatric Evaluation Yes:___ No:___ Psychiatrist/Physician____________________________

Medications:____

Treatment Goals:

1)____

2)____

3)____

4)____

5)____

Others involved in therapy:____

Prognosis, frequency, and expected length of treatment________________________________
____

____
Therapist Signature Date

I have participated in the formulation of this treatment plan:

____

Client Signature Date

Karen Mahan, LCSW
DBA Transitions Equine LLC

Psychosocial Assessment and Mental Status

Client Name: ____ Date:_____________________

Affect:

____Normal ____Restricted ____Anxious ____Sad/Depressed ___Angry

____Hostile ____Tearful ____Alert ____Lethargic ____Distracted

Orientation:

____Oriented in all spheres ____Oriented for person only

____Oriented for persons and place only ____Oriented for person and time only

Hygiene: ____Good ____Fair ____Poor ____Neglected

Gait: ____Normal ____Shuffling ____Poorly Coordinated ____Other

Thought Process – Note content of client's thoughts:

____Narcissism ____Negative ____Grandiose ____Indecisive ____Obsessive

____Tangential ____Paranoia _____Vague ____W/in Normal Limits

Family of Origin History:____
____
____
____

Relationship with Siblings (Past & Current):____
____
____
____

Members of Household (Current):____
____
____

History of Relationships____
____
____
____

Psychosocial Assessment Page Two

Karen Mahan, LCSW
DBA Transitions Equine LLC

Client Name:______________________

Family History of Psychiatric Emotional Problems____
____
____

Family History of Chemical Dependency:____
____
____

Alcohol/Substance and Other Addictive Behaviors:

Current Alcohol/Drug Use:____
____

Past Alcohol/Drug Use:____
____

Pattern of Alcohol/Ddrug Use:____
____

History of Alcohol/Drug Use:____
____

Inpatient Treatment (Dates):____
____

Outpatient Treatment (Dates):____
____

____Caffeine Use _________________Consumption per day (Cups)
____Cigarettes _________________Consumption per day/week, Pack/Carton
____Gambling

Other Addictive/Compulsive Behaviors (eating disorders, sex, gambling, etc.)
____
____

Treatment for Other Addictive Behaviors____
____

Have you been thinking of killing yourself?____
Have you been thinking of killing someone other than yourself?________________________________

Have you thought of a specific way of killing yourself?____________or others?__________________

____

Psychosocial Assessment Page Three **Karen Mahan LCSW**
DBA **Transitions Equine LLC**

Client Name______________________

Trauma History (i.e. physical or sexual assault, relationship w/perpetrator, combat, work injury, auto accident, natural disaster, sudden death, etc.)____

____

____

Multiple, repeated, prolonged events:____

____

Please assess the "severity" of current impairment in the following categories:

	Class 1	Class 2	Class 3	Class 4	Class 5
	No impairment	Mild impairment	Moderate impairment	Marked impairment	Extreme impairment
CATEGORIES	No impairments noted	Impairment levels compatible with most useful function	Impairment levels compatible with some but not all useful functions	Impairment levels significantly impede useful function	Impairment levels preclude useful function
Activities of Daily Living					
Social Functioning					
Concentration, persistence, pace, etc.					
Adaptation to stressful conditions:					

Insight: ____Excellent ____Good ____Fair ___ Poor
Memory (short term) ____Excellent ____Good ____Fair ____Poor
Memory (long term) ____Excellent ____Good ____Fair ____Poor
Judgment ____Excellent ____Good ____Fair ____Poor
Patient Appears: ____Motivated ____Ambivalent ____Non-Motivated
Estimated IQ (current):
____Below 85-Lower sixth of the population
____Between 85 and 115-Middle two-thirds of the population
____Above 115-Upper sixth of the population

Do you expect this individual's condition to:
____Improve ____Regress ____Remain the Same
Highest GAF in the past year_____ Current GAF____

Impressions: ____Cooperative ____Uncooperative ____Immature ____Withdrawn
Reliability: ____ Reliable ____Malingering ____Exaggerated ____Other

Diagnostic Impressions: Axis I _______________ Axis IV___________________
Axis II_______________ Axis V ___________________
Axis III______________

Provider___________________________________ Date_________________________