NewDay
TREATMENT CENTER

Name__________________Patient ID___________Patient SSN____________Date__________Date of Birth__________

Biopsychosocial History

Presenting Problems

Primary ____

Secondary ____

____

Current Symptom Checklist (Rate intensity of symptoms currently present)

Mild = Impacts quality of life, but no significant impairment of day-to-day functioning
Moderate = Significant impact on quality of life and/or day-to-day functioning
Severe = Profound impact on quality of life and/or day-to-day functioning

Symptom	Impact				Symptom	Impact			
	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
Aggressive Behaviors	☐	☐	☐	☐	Laxative/Diuretic Abuse	☐	☐	☐	☐
Agitation	☐	☐	☐	☐	Loose Associations	☐	☐	☐	☐
Anorexia	☐	☐	☐	☐	Mood Swings	☐	☐	☐	☐
Appetite Disturbance	☐	☐	☐	☐	Obsessions/Compulsions	☐	☐	☐	☐
Bingeing/Purging	☐	☐	☐	☐	Oppositional Behavior	☐	☐	☐	☐
Circumstantial Symptoms	☐	☐	☐	☐	Panic Attacks	☐	☐	☐	☐
Concomitant Medical Condition	☐	☐	☐	☐	Paranoid Ideation	☐	☐	☐	☐
Conduct Problems	☐	☐	☐	☐	Phobias	☐	☐	☐	☐
Delusions	☐	☐	☐	☐	Physical Trauma Perpetrator	☐	☐	☐	☐
Depressed Mood	☐	☐	☐	☐	Physical Trauma Victim	☐	☐	☐	☐
Dissociative States	☐	☐	☐	☐	Poor Concentration	☐	☐	☐	☐
Elevated Mood	☐	☐	☐	☐	Poor Grooming	☐	☐	☐	☐
Elimination Disturbance	☐	☐	☐	☐	Psychomotor Retardation	☐	☐	☐	☐
Emotional Trauma Perpetrator	☐	☐	☐	☐	Self-Mutilation	☐	☐	☐	☐
Emotional Trauma Victim	☐	☐	☐	☐	Sexual Dysfunction	☐	☐	☐	☐
Emotionality	☐	☐	☐	☐	Sexual Trauma Perpetrator	☐	☐	☐	☐
Fatigue/Low Energy	☐	☐	☐	☐	Sexual Trauma Victim	☐	☐	☐	☐
Generalized Anxiety	☐	☐	☐	☐	Significant Weight Gain/Loss	☐	☐	☐	☐
Grief	☐	☐	☐	☐	Sleep Disturbance	☐	☐	☐	☐
Guilt	☐	☐	☐	☐	Social Isolation	☐	☐	☐	☐
Hallucinations	☐	☐	☐	☐	Somatic Complaints	☐	☐	☐	☐
Hopelessness	☐	☐	☐	☐	Substance Abuse	☐	☐	☐	☐
Hyperactivity	☐	☐	☐	☐	Worthlessness	☐	☐	☐	☐
Irritability	☐	☐	☐	☐	Other	☐	☐	☐	☐

Emotional/Psychiatric History

☐ No ☐ Yes **Prior outpatient psychotherapy?**

If yes, on____occasions. Longest treatment by__________________for____sessions from_____/______to_____/______

Provider Name | Month/Year | Month/Year

Prior provider name	City	State	Diagnosis	Intervention/Modality	Beneficial?

☐ No ☐ Yes **Has any family member had outpatient psychotherapy?**

If yes, who/why (list all):

____

____

☐ No ☐ Yes **Prior inpatient treatment for a psychiatric, emotional, or substance use disorder?**

If yes, on____occasions. Longest treatment at__________________________from______/______to_____/_____

Name of facility | Month/Year | Month/Year

Inpatient facility name	City	State	Diagnosis	Intervention/Modality	Beneficial?

☐ No ☐ Yes **Has any family member had inpatient treatment for a psychiatric, emotional, or substance use disorder?**

If yes, who/why (list all):

____

____

☐ No ☐ Yes **Prior or current psychotropic medication usage?** If yes:

Medication	Dosage	Frequency	Start Date	End Date	Physician

☐ No ☐ Yes **Has any family member used psychotropic medications?** If yes, who/what/why (list all):

____

____

Family History

Family of Origin

Present during childhood

	Present entire childhood	Present part of childhood	Not Present at all
mother	☐	☐	☐
father	☐	☐	☐
stepmother	☐	☐	☐
stepfather	☐	☐	☐
brother(s)	☐	☐	☐
sister(s)	☐	☐	☐
other	☐	☐	☐

Describe parents

	Father	Mother
full name	______________________	______________________
occupation	______________________	______________________
education	______________________	______________________
general health	______________________	______________________

Parents' current marital status

- ☐ married to each other
- ☐ separated for_____years
- ☐ divorced for ____ years
- ☐ mother remarried ____ times
- ☐ father remarried_____times
- ☐ mother involved with someone
- ☐ father involved with someone
- ☐ mother deceased for_____years
  - age of patient at mother's death _____
- ☐ father deceased for_____years
  - age of patient at father's death _____

Describe childhood family experience

- ☐ outstanding home environment
- ☐ normal home environment
- ☐ chaotic home environment
- ☐ witnessed physical/verbal/sexual abuse toward others
- ☐ experienced physical/verbal/sexual abuse from others

Age of emancipation from home: ________

Circumstances that contribute to emancipation

____

____

____

Special circumstances in childhood

____

____

____

Immediate Family

Marital status

- ☐ single, never married
- ☐ engaged________months
- ☐ married for______years
- ☐ divorced for______years
- ☐ separated for____years
- ☐ divorce in process_______months
- ☐ live-in for_______years
- ☐ _______ prior marriages (self)
- ☐ _______prior marriages (partner)

Intimate relationship

- ☐ never been in a serious relationship
- ☐ not currently in relationship
- ☐ currently in a serious relationship

Relationship satisfaction

- ☐ very satisfied with relationship
- ☐ satisfied with relationship
- ☐ somewhat satisfied with relationship
- ☐ dissatisfied with relationship
- ☐ very dissatisfied with relationship

List all persons currently living in patient's household

Name	Age	Sex	Relationship to Patient

List biological / adopted children not living in same household as patient

Name	Age	Sex	Relationship to Patient

Frequency of visitation of above: ________________________

Describe any past or current significant issues in intimate relationships ____

____

____

Describe any past or current significant issues in other immediate family relationships ____________________________

____

____

Medical History (check all that apply for patient)

Describe current physical health ☐ Good ☐ Fair ☐ Poor

____

____

List name of primary care physician

Name ____ Phone ________________________________

List name of psychiatrist (if any):

Name ____ Phone ________________________________

List any non-psychiatric medications currently being taken (give dosage and reason)

____

____

List any known allergies

____

____

Is there a history of any of the following in the family

- ☐ tuberculosis
- ☐ birth defects
- ☐ emotional problems
- ☐ behavior problems
- ☐ thyroid problems
- ☐ cancer
- ☐ mental retardation
- ☐ heart disease
- ☐ high blood pressure
- ☐ alcoholism
- ☐ drug abuse
- ☐ diabetes
- ☐ Alzheimer's disease/dementia
- ☐ stroke
- ☐ other chronic or serious health problems ______________________________

Describe any serious hospitalization or accidents

Year	Age	Reason
________	_____	______________________________
________	_____	______________________________
________	_____	______________________________

List any abnormal lab test results

Year	Result
________	______________________________________
________	______________________________________
________	______________________________________

Substance Use History (check all that apply for patient)

Family alcohol/drug abuse history

- ☐ father
- ☐ mother
- ☐ grandparent(s)
- ☐ sibling(s)
- ☐ stepparent/live-in
- ☐ uncle(s)/aunt(s)
- ☐ spouse/significant other
- ☐ children
- ☐ other ____

Substance use status

- ☐ no history of abuse
- ☐ active abuse
- ☐ early full remission
- ☐ early partial remission
- ☐ sustained full remission
- ☐ sustained partial remission

Patient Treatment history

- ☐ outpatient (age[s]) ______
- ☐ Inpatient (age[s]) ______
- ☐ 12-step program (age[s]) ______
- ☐ stopped on own (age[s]) ______
- ☐ other (age[s]) ______ ____________________

Substances used	First use age	Last use age	Current Use	Frequency	Amount
☐ alcohol	_____	_____	☐	______________	________________________
☐ amphetamines/speed	_____	_____	☐	______________	________________________
☐ barbiturates/owners	_____	_____	☐	______________	________________________
☐ cocaine	_____	_____	☐	______________	________________________
☐ crack cocaine	_____	_____	☐	______________	________________________
☐ hallucinogens (e.g., LSD)	_____	_____	☐	______________	________________________
☐ inhalants (e.g., glue, gas)	_____	_____	☐	______________	________________________
☐ marijuana or hashish	_____	_____	☐	______________	________________________
☐ opioids	_____	_____	☐	______________	________________________
☐ PCP	_____	_____	☐	______________	________________________
☐ prescription	_____	_____	☐	______________	________________________
☐ other	_____	_____	☐	______________	________________________

Consequences of substance abuse

- ☐ hangovers
- ☐ seizures
- ☐ blackouts
- ☐ Accidental overdose
- ☐ binges
- ☐ withdrawal symptoms
- ☐ medical conditions
- ☐ Increase in tolerance
- ☐ loss of control over amount used
- ☐ job loss
- ☐ sleep disturbance
- ☐ assaults
- ☐ suicide attempts
- ☐ suicidal impulse/thoughts
- ☐ relationship conflicts
- ☐ arrests
- ☐ other ____

Developmental History (check all that apply for child/adolescent patient)

Problems during mother's pregnancy

- ☐ none
- ☐ high blood pressure
- ☐ kidney infection
- ☐ German measles
- ☐ emotional stress
- ☐ bleeding
- ☐ alcohol use
- ☐ drug use
- ☐ cigarette use
- ☐ other

Birth

- ☐ normal delivery
- ☐ difficult delivery
- ☐ cesarean delivery
- ☐ Complications

____

____

birth weight________lbs_______oz.

Infancy Problems

- ☐ none
- ☐ feeding problems
- ☐ sleep problems
- ☐ toilet training problems

Childhood health

- ☐ chickenpox (age) ______
- ☐ German measles (age) ______
- ☐ red measles (age) ______
- ☐ rheumatic fever (age) ______
- ☐ whooping cough (age) ______
- ☐ scarlet fever (age) ______
- ☐ autism
- ☐ ear infections
- ☐ lead poisoning (age) ______
- ☐ mumps (age) ______
- ☐ diphtheria (age) ______
- ☐ poliomyelitis (age) ______
- ☐ pneumonia (age) ______
- ☐ tuberculosis (age) ______
- ☐ mental retardation
- ☐ asthma
- ☐ allergies to ____
- ☐ significant injuries ____
- ☐ chronic, serious health problems ____

Delayed developmental milestones (check only those milestones that did not occur at expected age):

- ☐ sitting
- ☐ rolling over
- ☐ standing
- ☐ walking
- ☐ feeding self
- ☐ speaking words
- ☐ speaking sentences
- ☐ controlling bladder
- ☐ controlling bowels
- ☐ sleeping alone
- ☐ dressing self
- ☐ engaging peers
- ☐ tolerating separation
- ☐ playing cooperatively
- ☐ riding tricycle
- ☐ riding bicycle
- ☐ other ____

Emotional / behavior problems (check all that apply):

- ☐ none
- ☐ drug use
- ☐ alcohol abuse
- ☐ chronic lying
- ☐ stealing
- ☐ violent temper
- ☐ fire-setting
- ☐ hyperactive
- ☐ animal cruelty
- ☐ assaults others
- ☐ disobedient
- ☐ repeats words of others
- ☐ not trustworthy
- ☐ hostile/angry mood
- ☐ indecisive
- ☐ immature
- ☐ bizarre behavior
- ☐ self-injurious threats
- ☐ frequently tearful
- ☐ lack of attachment
- ☐ distrustful
- ☐ extreme worrier
- ☐ self-injurious acts
- ☐ impulsive
- ☐ easily distracted
- ☐ poor concentration
- ☐ often sad
- ☐ breaks things in anger
- ☐ other ____

Social interaction

- ☐ normal social interaction
- ☐ isolates self
- ☐ very shy
- ☐ alienates self
- ☐ other ___________________
- ☐ inappropriate sex play
- ☐ dominates others
- ☐ associates with acting-out peers

Intellectual / academic functioning

- ☐ normal intelligence
- ☐ high intelligence
- ☐ learning problems
- ☐ authority conflicts
- ☐ attention problems
- ☐ underachieving
- ☐ mild retardation
- ☐ moderate retardation
- ☐ severe retardation

Current or highest education level _______________

Describe any other developmental problems or issues

____

____

Socio-Economic History

Living situation

- ☐ housing adequate
- ☐ homeless
- ☐ housing overcrowded
- ☐ dependent on others for housing
- ☐ housing dangerous/deteriorating
- ☐ living companions dysfunctional

Social support system

- ☐ supportive network
- ☐ few friends
- ☐ substance-use-based friends
- ☐ no friends
- ☐ distant from family of origin

Military

- ☐ never in military
- ☐ served in military - no incident
- ☐ served in military - with incident

Employment

- ☐ employed and satisfied
- ☐ employed but dissatisfied
- ☐ unemployed
- ☐ coworker conflicts
- ☐ supervisor conflicts
- ☐ unstable work history
- ☐ disabled:

Financial situation

- ☐ no current financial problems
- ☐ large indebtedness
- ☐ poverty or below-poverty income
- ☐ impulsive spending
- ☐ relationship conflicts over finances

Legal history

- ☐ no legal problems
- ☐ now on parole/probation
- ☐ arrest(s) not substance-related
- ☐ arrest(s) substance-related
- ☐ court ordered this treatment
- ☐ jail/prison______time(s)
  total time served: _______________

Describe last legal difficulty

____

____

Sexual history

- ☐ heterosexual orientation
- ☐ homosexual orientation
- ☐ bisexual orientation
- ☐ currently sexually active
- ☐ currently sexually satisfied
- ☐ currently sexually dissatisfied

age first sex experience _____

age first pregnancy/fatherhood _____

history of promiscuity age______to______

history of unsafe sex age______to______

Additional information

____

____

____

____

Cultural/spiritual/recreational history

cultural identity (e.g., ethnicity, religion)

____

____

Describe any cultural issues that contribute to current problem and/or should be taken into account during treatment planning

____

____

- ☐ currently active in community/recreational activities?
- ☐ formerly active in community/recreational activities?
- ☐ currently engage in hobbies?
- ☐ currently participate in spiritual activities?

If answered "yes" to any of above, describe

____

____

Sources of Data Provided Above

☐ Patient self-report for all ☐ A variety of sources

Presenting Problems/Symptoms

- ☐ patient self-report
- ☐ patient's parent/guardian
- ☐ other ____________________

Family History

- ☐ patient self-report
- ☐ patient's parent/guardian
- ☐ other ____________________

Developmental History

- ☐ patient self-report
- ☐ patient's parent/guardian
- ☐ other ____________________

Emotional/Psychiatric History

- ☐ patient self-report
- ☐ patient's parent/guardian
- ☐ other ____________________

Medical/Substance Use History

- ☐ patient self-report
- ☐ patient's parent/guardian
- ☐ other ____________________

Socioeconomic History

- ☐ patient self-report
- ☐ patient's parent/guardian
- ☐ other ____________________

Consent for Treatment and Confidentiality Statement

COUNSELING SERVICE OVERVIEW—NATURE OF COUNSELING

- NewDay Center is a place to promote, for those who are willing, the continuous journey to be transformed into the image of Christ. I have made a voluntary choice to seek counseling at NewDay Center with a licensed mental health professional (each a "Counselor"). I understand counseling is a cooperative effort between myself and my Counselor. I understand that I may withdraw this Consent for Treatment and Confidentiality Statement ("Consent") in writing and terminate counseling at any time.
- NewDay Center is a Christian organization that approaches the subject of addiction and mental health from the point of view of Christian theology. NewDay Center offers individual and group counseling that is provided by Counselors, Counselors in training and ordained clergy. I understand that counseling often involves talking about and expressing intense and possibly painful emotions, facing and dealing with difficult situations in the present, or recalling frightening or challenging parts of my personal history. Therefore, it may get harder before it gets easier. I understand that while attempting to resolve unpleasant current and past situations, I may have moments of discomfort and temporary increases in emotional pain. I understand that I may discuss any questions or concerns I have about the possible risks and benefits of counseling with my Counselor, Pastor, Counseling Training Student and I agree to work with my Counselor, Pastor, Counseling Training Student training in order to process and/or resolve my symptoms or concerns.
- If a situation comes up during the therapeutic process where I am uncomfortable, in any way, I should immediately notify NewDay Center or my Counselor, Pastor, Counseling Training Student so that the situation can be discussed at that time. It is essential to have trust in this relationship. I understand that I have a right to decline counseling against professional advice at any time.
- I understand that I must sign this Consent before counseling begins. **If I am under the age of 18 years**, I must have a parent or legal guardian sign this Consent before counseling begins.

COUNSELING FORUM

- I understand my sessions may occur face-to-face with my Counselor, Pastor, Counseling Training Student or through online technology called "teletherapy." Teletherapy differs from in-person services in that it uses interactive technology (audio, video, or other electronic communications) between my Counselor, Pastor, Counseling Training Student and myself when we are not in the same physical location. I understand that any exchange of information or paperwork during a teletherapy session will likely be through electronic means.
- I understand that during teletherapy, the electronic systems used by my Counselor, Pastor, Counseling Training Student will incorporate network and software security protocols to help protect the privacy and security of health information and any imaging data and will include reasonable measures to safeguard the data to ensure its integrity against intentional or unintentional corruption. I further understand that I will need access to, and have familiarity with, the appropriate technology in order to participate in teletherapy, and will advise my Counselor, Pastor, Counseling Training Student if such technology becomes unavailable to me.
- I understand that teletherapy is to be utilized for regularly scheduled sessions only. **I understand and agree that if I am in crisis or having an emergency, I will utilize 911 or other emergency services in my area.**
- I understand that the laws and professional standards of care that apply to in-person counseling apply equally to teletherapy.
- I further understand that if my Counselor, Pastor, Counseling Training Student and I use teletherapy, we will reassess its appropriateness regularly. If at any time I choose to decline further teletherapy sessions, I can do so without jeopardizing my access to future care or services at NewDay Center.

CONFIDENTIALITY

- I understand my treatment will be kept in confidence and is protected by state and federal laws and regulations. A release of information to others can only occur with my informed and signed consent. Exceptions to that are disclosures allowed by law, including but not limited to: suspected child abuse/neglect (which will be reported to appropriate state or local authorities), danger to self or others, a court order, and release of treatment information regarding minors to parents and/or legal guardians (except minors being treated for substance abuse). I also understand my appointments may be discussed by my Counselor internally and privately within NewDay Center with a licensed supervisor or during regular staffing check-ins. Counselors in training consult with supervisors and

with fellow students in a structured classroom setting and in individual supervision about clients' progress. All supervisors hold a master's degree in a field of counseling and are licensed by the state of Indiana as Mental Health Counselors, Marriage and Family Therapists, or Clinical Addiction Counselors.

- I further understand that information regarding a positive COVID-19 diagnosis may be shared by my Counselor, Pastor, Counseling Training Student or NewDay Center staff as reasonably necessary, including to for purposes of facilitating contact tracing.
- We are also ethically and legally obligated to maintain records of each time we meet, whether in-person or through teletherapy. This also includes times you and your Counselor, Pastor, Counseling Training Student may talk on the phone or correspond via other technology such as email. These records include a brief synopsis of the conversation along with any observations or plans for the next meeting. A judge can subpoena your records for a variety of reasons, and if this happens, we must comply.
- Counseling records and individual documents are maintained electronically in accordance with HIPAA standards. Client records will be kept for *at least* seven (7) years after the date of the last contact with our office.
- I understand that teletherapy relies on technology, which can allow for greater convenience and flexibility in service delivery. However, there are risks in transmitting information with technology that include but are not limited to breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties.
- I also understand that, while using teletherapy, it is my responsibility to maintain privacy on my end of the communication. I understand that there is not a guarantee of confidentiality if I choose a public setting to conduct a teletherapy appointment.
- I understand that NewDay Center cannot absolutely ensure the confidentiality of any form of communication through electronic media, including text messages and emails. At my written request, however, NewDay Center will communicate via email regarding scheduling or cancellations.
- I understand that NewDay Center policy does not allow counselors to "*friend*" or "*follow*" current or recent clients on Facebook, Twitter, or other social media platforms. The NewDay Center feels that it is not in the best interest of our clients to engage with them on social media and puts the ability to maintain confidentiality at risk.

CLIENT'S RIGHTS AND RESPONSIBILITIES

- The length of therapy is greatly determined by each situation. The goal is to resolve the issues that brought you in as thoroughly and quickly as possible. Initially, most appointments are scheduled every week or every other week. It is your right to discontinue treatment any time you feel it is in your best interest to do so. It is the Counselor, Pastor, Counseling Training Students ethical responsibility to end counseling when it is reasonably clear that you are no longer benefiting from treatment.
- I understand that while I am physically at NewDay Center I will help maintain other people's privacy by refraining from taking pictures or making recordings of any kind. I will also silence my phone while in session. This will help me make the most of my session.
- I understand that after 60 consecutive days of not attending sessions of any type, my file will be closed. I understand that I am free at any point to contact NewDay Center to restart counseling and have the file reopened.
- I understand that, due to a number of factors, my Counselor, Pastor, Counseling Training Student may occasionally need to start my session a few minutes later than scheduled. If I have been waiting for 10 minutes, I am encouraged to check in with (if attending in-person) or call (if teletherapy) the Counseling Center receptionist.
- I understand that if I am more than 15 minutes late to my session, my Counselor, Pastor, Counseling Training Student may not be able to see me that day, and I will need to reschedule.
- I understand that if I transfer to a new counselor, Pastoral Counselor, or Counselor in Training, they will receive my old file.

PAYMENT

Payment by credit card is expected in full at the time of service. You may choose to keep a credit card on file that authorizes NewDay Center to charge this card for therapy sessions.

Name on Card: ____

Type of Card: __Visa __Mastercard __Discover __AmEx

By signing below, you are stating you are the holder of this card and have authorized NewDay Center to charge this card.

____

CANCELLATION POLICY
Appointments are to be kept at their scheduled time. If an appointment must be canceled, 24-hour notice is required. If the cancellation is given with less than 24-hour notice, half of the fee will be charged. If no cancellation takes place and you miss your appointment, the full fee will be charged. Late cancellations and missed appointments are not covered under any insurance. In the case of a serious emergency, inclement weather, or illness, notify NewDay Center immediately and we will reschedule your appointment without additional charge. If your credit card is on file, you will be charged automatically.

CONSENT AND AFFIRMATION OF UNDERSTANDING
I have read this Consent or have had it read to me if I am unable to do so. I fully understand its terms and sign it freely and voluntarily without inducement. I have been given the opportunity to ask any questions about the use of both face-to-face counseling and teletherapy sessions and understand the differences and risks associated with each. My questions have been answered to my full satisfaction, and, unless otherwise noted on this form, I am freely consenting to counseling using either means.

With my signature below, I voluntarily consent to counseling as described in this Consent. I will receive a copy of this Consent if I request one.

Client's Name (printed): ____ Date: _____________

Client's Signature: ____ Date: ______________

Counselor's Signature: ____ Date: ______________

Client's Parent/Legal Guardian Name and Signature (if Client is a minor):

__________________________________ __________________________________
Name Signature

__________________________________ _________________
Relationship to Client Date