Thank you for taking the time to complete these forms. The information that you provide will allow for me to learn more about you and will help me to better assist you.

The following forms are included in this packet:

Confidentiality: Your Rights and Limitations

This document details your rights in regards to confidentiality and the various limitations to this confidentiality that exist under the law. It is important that you read each page carefully. Please sign the last page.

New Client Information

This document contains important information about my professional services and business policies. Please read each page and sign the last page.

Client Background Information and Preferences

This document will let me know the best ways to contact you and will provide a brief personal history about you. I may ask for you to complete a more comprehensive background information form as we progress.

Symptom Checklist

This document provides a general indication of issues that may be troubling you.

If you would like for me to share information about you with another person or agency, please download and print the **Authorization for Use or Disclosure of Protected Health Information** form from my website or the form can be provided in person.

Thank you for choosing me as your mental health care provider,

Jeff

JEFFREY ZOOK | DOCTOR OF CLINICAL PSYCHOLOGY
LICENSED CLINICAL PSYCHOLOGIST PSY.D. PSY 26522

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SUITE 150
SAN DIEGO, CA 92121

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FAX | 619-452-1250
JEFF@DOCTORZOOK.COM
WWW.DOCTORZOOK.COM

Confidentiality: Your Rights and Limitations

All information disclosed in our sessions together and the written records pertaining to these sessions are confidential, protected by law, and will not be revealed to anyone without your written permission or the written permission of your legal guardian if you are a minor.

There are some exceptions however, as in most cases, insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes kind of services, dates and times of services, diagnosis, treatment plans, progress of therapy, case notes and summaries.

If you are under 18 years of age, please be aware that the law may provide your parents or legal guardian the right to examine your records. It is my policy to request an agreement from your parents or legal guardian that they agree to not have access to your records. I will provide them only with general information about our work together, unless I become concerned that there is a high risk that you will harm yourself or someone else. In this case, I will notify them of my concern. I will also provide them with a summary of your treatment when it is complete. Before giving them any information, I will discuss this with you if possible, and I will do my best to handle any objections you may have with what I am prepared to discuss with them.

There are some situations in which I am legally obligated to take action to protect you and others from harm and where I may have to reveal some information about your treatment. Disclosure is required in the following circumstances:

(A) If it becomes clear to me that you are ready to commit a suicidal act or threaten serious bodily harm to yourself, I am required by law to contact your family members or others who can help provide protection, to seek hospitalization for you, or to contact the police. You can discuss any other aspect of suicide, such as thoughts and dreams, without this break in confidentiality.

(B) If it becomes clear to me that you have an intention to harm a specific person whom you have named or identified or you have a plan on how to harm a specific person, I am required by law to notify and warn the potential victim and to notify the police of your intent.

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(C) If you mention to me that you are currently abusing or have recently abused a child or vulnerable adult that relies on the care of others, or if you know the details of some current abuse of a child or vulnerable adult, I am required by law to file a report with the appropriate state agency. If you are a minor and mention to me that you were physically or sexually abused by an adult, or that you are in a sexual relationship with an adult, I am required by law to file a report with the appropriate state agency.

(D) Clinical records are occasionally subject to legal subpoena. I am not obligated to and will not produce the records without your express written consent. However, if your records are the subject of a legitimate court order, release of your records or a summary may be required whether or not consent is given.

(E) In the event that the services of an attorney or collection agency is required to pursue any past due fees.

These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action. Your signature below indicates that you have read and fully understand the aforementioned information.

_____ _____

Client signature Date

_____ _____

Parent or Guardian signature (if client is under 18 years) Date

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New Client Information: several important things to know

This document contains important information about my professional services and business policies. Please read it carefully and make note of any questions that you may have so that we may discuss them later.

Psychological Services

It is beneficial for you to obtain as much information as possible in order to make an informed decision regarding psychological services. To help you with this, I offer an initial consultation over the phone. During this time, I will work with you to determine your best treatment options and answer questions you may have.

Our first few sessions together will usually involve an evaluation of your needs. By the end of the evaluation, I will be able to offer an overview of what our work will include and provide a treatment plan for you. Therapy calls for an active effort on your part. In order for it to be most successful, you will have to consider the things we talk about both during and between our sessions. I find that for most situations, meeting weekly works well, although in some cases, it can be helpful to meet more often than that.

Brief therapy does work well for those who are dealing with a temporary crisis, or specific, well-defined issues. In those instances, change can come quickly. Brief therapy is not appropriate for all people however. It takes time to resolve deeper, more complex, long-standing issues. If you find that you do not feel satisfied with the results from just a few sessions, longer-term therapy may prove to be more helpful to you.

Professional Fees

I have a base fee of $200 per hour for most services. This rate may change based on the type of service you require and reduced fees may be available under certain circumstances. In all cases, fees will be stated explicitly and in writing before services are provided. I also meet with you for a full hour, rather than the standard 45-50 minute session.

Appointment scheduling will occur at the conclusion of each session, where we will reserve time set specifically for us. If you need to cancel an appointment, ***please inform me of your cancellation at least 24 hours in advance***. Otherwise, you will be charged for the session. I will make every effort to find another time to reschedule your appointment if one is available.

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Billing and Payment

I accept payment in the form of cash, check, credit or debit card. I would appreciate payment after each session, unless we make other arrangements. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, it is possible that I may be able to make a fee adjustment or develop a payment installment plan with you.

If your account has not been paid for more than 60 days and arrangements for payment have not been made, I may use legal means to secure the payment. If such action is necessary, these costs will be included in the claim. In most cases, the only information that I will release regarding your treatment is your name, the nature of the services provided, and the amount due. These steps would only be taken as my last remaining option and I would inform you of my actions ahead of time.

Insurance Reimbursement

I work indirectly with insurance companies as an out-of-network provider. I am able to provide you with an invoice that you may then use to seek an out-of-network reimbursement from your insurance company. Not all insurance plans offer out-of-network benefits to those they insure, so it is important to speak directly with the insurance company first.

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How to Contact Me

There are several ways that you may use to contact me or send correspondence to me.

My office phone number is 619-403-9399.

If I am unavailable to take your call, please leave a message with my receptionist or directly on my voicemail. When leaving a message, please let me know some of the best times to return your call and if it is ok to leave a message for you.

Another way to contact me is by sending an e-mail to: jeff@doctorzook.com

This can be one of the quickest ways to get a message to me if I happen to be away from the office. E-mail may not always be a trustworthy medium for confidential communication however. If you would prefer to have a discussion over the phone, please send an e-mail with your name and phone number, including some of the best times to call you. Please let me know if it is ok to leave a message for you at that number.

In all cases, I will do my best to return your message within the same day.

To fax correspondence to me, my fax number is 619-452-1250.

To send correspondence to me, my mailing address is:

9920 Pacific Heights Blvd.
Suite 150
San Diego, CA 92121

If you find yourself in an immediate crisis and you are unable to speak with me, please dial 9-1-1, or contact the nearest emergency facility in your area.

The laws and standards of my profession require that I keep treatment records and you are entitled to receive a summary copy of your records. Because these are professional records, there is the potential for misinterpretation to untrained readers. If you wish to see your records or receive a copy of your records, I do require written notice and I would recommend that you review them in my presence so that we may discuss the contents.

All information disclosed in our sessions together and the written records pertaining to these sessions are confidential, protected by law, and will not be revealed to anyone without your written permission or the written permission of your legal guardian if you are a minor; except where disclosure is required by law.

I have read the New Client Information document and I agree to the terms contained within.

_____ _____

Client signature Date

_____ _____

Parent or Guardian signature
(if client is under 18 years)

Date

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Client Background Information and Preferences for Children and Adolescents

Please know that the information you provide here is protected as confidential information. If you are unsure about a particular question, please leave it blank and we will discuss it later.

Child's Name: _____ Date: _____

Birth Date: _____ Age: _____ Gender: ☐ Male ☐ Female

Your Name: _____

Your Relationship to child: _____

Address to which Dr. Zook may send correspondence:

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone numbers at which Dr. Zook may reach you:

Home: _____ Is it ok to leave a message at this number? ☐ Yes ☐ No

Work: _____ Is it ok to leave a message at this number? ☐ Yes ☐ No

Cell: _____ Is it ok to leave a message at this number? ☐ Yes ☐ No

E-mail address to which correspondence may be sent: _____
*Please know that e-mail correspondence is not considered to be a trustworthy medium for confidential communication.

Emergency contact: _____ Phone: _____

Relationship to client: _____

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How did you hear about Dr. Zook? _____

How would you briefly describe the main issues for which you are seeking help for your child?

_____

_____

_____

On the scale below, please estimate the severity of these issues:

☐ Not a problem for my child, only for other people.

☐ Mildly upsetting to my child.

☐ Moderately upsetting to my child.

☐ Severely upsetting to my child.

☐ Extremely upsetting to my child.

When did these issues begin? _____

How have you tried to resolve these issues? _____

_____

_____

Are you currently working with another therapist? ☐ Yes,Name: _____

☐ No

Has your child previously received any kind of mental health services? ☐ Yes ☐ No

If so, please provide the following information regarding these services:

Name of therapist Dates of therapy Issue(s) treated

_____

_____

_____

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Has your child ever been prescribed psychiatric medication? ☐ Yes ☐ No

If so, please provide the following information regarding these medications:

Medication Name	Dose	Date Medication Started	Stopped Medication

Is your child currently taking any medication for physical concerns? ☐ Yes ☐ No

If so, please provide the following information regarding these medications:

Medication Name	Dose	Date Medication Started

Any significant physical medical conditions in the past or presently? ☐ Yes ☐ No

If so, please provide the following information regarding these conditions:

Medical Condition	Date of Onset

What is the date of your child's last physical examination? _____

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How many times a week does your child exercise or is physically active in some way? _____

How would you rate your child's sleep each night? ☐ Poor ☐ Good ☐ Excellent

Has your child ever been treated in a psychiatric hospital or in-patient setting? ☐ Yes ☐ No

Has anyone in your family ever:

Suffered from depression? ☐ Yes, relation to child: _____
☐ No

Been diagnosed with bipolar disorder? ☐ Yes, relation to child: _____
☐ No

Threatened to commit suicide? ☐ Yes, relation to child: _____
☐ No

Committed suicide? ☐ Yes, relation to child: _____
☐ No

Had problems with drugs or alcohol? ☐ Yes, relation to child: _____
☐ No

Been diagnosed with schizophrenia? ☐ Yes, relation to child: _____
☐ No

Suffered from panic attacks? ☐ Yes, relation to child: _____
☐ No

Suffered from an eating disorder? ☐ Yes, relation to child: _____
☐ No

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Symptom Checklist

Client Name: _____ Date: _____

Please rate yourself on each question using the following scale. If you are unsure about a particular question, please leave it blank and we will discuss it later. For young children, it may not be practical to have them fill out the questionnaire, so please use your best judgment in rating your child's thoughts and behavior.

0 = Never

1 = Rarely

2 = Occasionally

3 = Often

4 = Very Often

___ 1. I am feeling depressed or I am in a sad mood.

___ 2. I do not have as much interest in things that are usually fun for me.

___ 3. I am experiencing a significant change in my weight or appetite.

___ 4. I have thoughts of death or suicide.

___ 5. I am experiencing changes in my sleep, such as a lack of sleep or a large increase in the amount of time I sleep.

___ 6. I have low energy or feel tired.

___ 7. I have feelings of being worthless, helpless, hopeless, or guilty.

___ 8. I do things alone or I feel socially withdrawn from other people.

___ 9. I can easily be made to cry.

___ 10. I think bad or negative thoughts.

___ 11. I am in an elevated, high, or an irritable mood.

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___ 12. I have very high self-esteem or I have big ideas.

___ 13. I have a decreased need for sleep without feeling tired.

___ 14. I am more talkative than usual or I feel pressure to keep talking.

___ 15. I have fast thoughts or I am frequently jumping from one subject to another.

___ 16. I am easily distracted by things that are not important.

___ 17. I have had a large increase in my activity level and wanting to do things.

___ 18. I am angry, mean, or violent.

___ 19. I feel intensely anxious or nervous.

___ 20. I have trouble breathing or I feel like I am being smothered.

___ 21. I feel dizzy, faint, or unsteady on my feet.

___ 22. I feel like my heart is pounding, like I have a fast heart rate or chest pain.

___ 23. I tremble, shake, or sweat.

___ 24. I am nauseous, I have stomach discomfort, or feel like I am choking.

___ 25. I have an intense fear of dying.

___ 26. I lack confidence in my abilities.

___ 27. I need lots of reassurance.

___ 28. I need to be perfect.

___ 29. I feel fearful or anxious.

___ 30. I feel shy or hesitant.

___ 31. I am easily embarrassed.

___ 32. I am sensitive to criticism.

___ 33. I bite my fingernails or I chew on my clothing.

___ 34. I do not like to leave my house.

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___ 35. I have an excessive fear of interacting with other people.

___ 36. I have an excessive fear of (e.g. heights, closed spaces, specific animals, etc.)

Please list: _____

___ 37. I am very anxious when I am not around my family or friends.

___ 38. I have bothersome thoughts, ideas, or images that I try to ignore.

___ 39. I get "stuck" on certain thoughts, or I have the same thought over and over.

___ 40. I worry excessively or senselessly.

___ 41. Other people tell me that I worry too much or that I get "stuck" on the same thoughts.

___ 42. I have behaviors, such as excessive hand washing, cleaning, checking locks, or counting or spelling, that I must do or else I feel very anxious.

___ 43. I need to have things done a certain way or else I become very upset.

___ 44. I have reoccurring and upsetting thoughts of a past traumatic event.

___ 45. I have reoccurring and upsetting dreams of a past traumatic event.

___ 46. I have a sense of reliving a past traumatic event.

___ 47. I spend a lot of time and effort avoiding thoughts and feelings related to a past traumatic event.

___ 48. I feel like my future is limited.

___ 49. I feel jumpy or I am quick to startle.

___ 50. I feel like I am always watching out for bad things to happen.

___ 51. I do not keep my body weight above a level that most people would consider to be healthy.

___ 52. I have an intense fear of gaining weight or becoming fat, even though I am underweight.

___ 53. I have feelings of being fat, even though I am underweight.

___ 54. I repeatedly eat large and excessive amounts of food.

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___ 55. I feel that I lack control over my eating behavior.

___ 56. I engage in activities to eliminate excess food, such as self-induced vomiting, using laxatives, strict dieting, or strenuous exercise.

___ 57. I am overly concerned with my body shape and weight.

___ 58. I am experiencing involuntary physical movements and/or motor tics, such as eye blinking, shoulder shrugging, head jerking, or picking.

___ 59. I am experiencing involuntary vocal sounds and/or verbal tics, such as coughing, puffing, blowing, whistling, or swearing.

___ 60. I repeatedly perform physical movements, such as hand-shaking or waving, body-rocking, head-banging, mouthing of objects, self-biting, picking at skin or parts of my body, or hitting my own body, that interferes with normal activities or results in self-inflicted injury to my body.

___ 61. I am unable to speak in specific social situations in which there is an expectation for speaking (e.g. work or school) despite speaking in other situations.

___ 62. I am experiencing delusional or bizarre thoughts, such as thoughts I know that others would think are false.

___ 63. I am seeing objects and images that are not really there.

___ 64. I am hearing voices or noises that are not really there.

___ 65. I behave oddly or people tell me that I behave in an odd manner.

___ 66. I have poor personal hygiene.

___ 67. I have inappropriate moods for certain situations (e.g. laughing at sad events).

___ 68. I feel that someone or something is out to hurt me.

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