

Mind Body Medicine Network, LLC &
Ed Glauser, M.Ed., N.C.C., LPC

NEW CLIENT INFORMATION PACKET

Ed Glauser, M.Ed., N.C.C., LPC is a Licensed Professional Counselor and provides Mind Body Medicine, Clinical Hypnosis, Mindfulness-Based Cognitive Psychotherapy and other Integrative Counseling services, consultations, and workshops in person or by telephone through the Mind Body Medicine Network, LLC. As a Licensed Professional Counselor in the State of Georgia, Mr. Glauser can give you an appropriate diagnosis for the service rendered so you can seek possible reimbursement from your insurance provider. The number of sessions needed is highly individualized and will be determined by both you and Mr. Glauser as your work together progresses.

In-Person Services

Your initial appointment with Mr. Glauser will begin with an in-depth discussion in which you explore the issues that bring you to see him as well as the personal and life circumstances that are the context in which your symptoms present themselves. The second part of the initial session is devoted to exploring the most appropriate mind body medicine modalities that are most appropriate for your presenting condition. The cost of each clinical session is \$100 and is payable in full at the end of each session.

Telephone Services

If it is difficult for you to schedule a session with Mr. Glauser in person, you may choose to have a telephone appointment. In most instances, an appointment by telephone is cost and time effective, appropriate and effective. Before the initial telephone session, Mr. Glauser has the intake client forms on his web site at www.edglausercounseling.com and at www.mindbodymedicinenetwork.com. You can then fax, scan or send the forms to his business address so it can be received and assessed before your intake session. Mr. Glauser will call you for each telephone session.

Payment

Please make arrangements for payment prior to your sessions so payment method is clear before entering into the counseling relationship. Mr. Glauser accepts cash, personal checks as well as Visa and MasterCard. If you are using a credit or debit card, please give Mr. Glauser your credit card information before your session.

NEW CLIENT INFORMATION FORM

The decision to enter into counseling or psychotherapy is undoubtedly an important one arrived at after considerable thought. Whether you were referred by your physician, clergy, family or friends, or came because of problems and feelings only you know about, the decision to participate must ultimately be yours. The following document contains information that is meant to make your psychotherapy experience more rewarding. It also contains information about HIPAA (Health Insurance Portability and Accountability Act) and requirements that must be met by both you and your therapist.

RESPONSIBILITIES AND PURPOSES

Our purpose is to help you resolve problem areas in your life. Although no one can solve your problems for you, we are trained to help people cope more effectively with their difficulties. We will do our best to understand you as a unique individual and to help you work through your difficulties. It is our function to listen, to understand and to be helpful to the fullest extent of our professional training and experience. It is your responsibility to help us understand your life situation, thoughts and feelings and to have the courage to try to work on your problem areas. You as a patient have the following rights:

- To receive respectful treatment that will be helpful to you
- To have a safe treatment setting, free from sexual, physical, and emotional abuse
- To report immoral and illegal behavior by your therapist
- To ask for and receive information about our qualifications, including licensure, education, training, experience, membership in professional organizations, specific areas of practice, and limits on practice
- To have written information, before therapy, about fees, method of payment, insurance coverage, number of sessions that may be needed, substitute (backup) therapists used in case of vacations and emergencies, and cancellation policies
- To refuse audio or video recording of sessions (but you may ask for this if you wish)
- To refuse to answer any question or give any information you choose not to answer or give
- To know if your case will be discussed with others (for instance, supervisors or consultants) and what information will be shared
- To ask about your progress
- To discuss your therapy with anyone you choose
- To have any therapy procedure, including pros and cons of its use, explained to you before it is used
- To refuse any test, evaluation or therapy of any kind and to be advised of any possible problems that might come from such refusal
- To end treatment at any time (However, please schedule at least one session with your therapist before terminating treatment.)
- To review your Clinical Record and to have certain elements of your records sent to other professionals you designate. Your therapist's Psychotherapy Notes, however, may not always be open for your perusal.

CALLING YOUR THERAPIST

When you have a question or need to schedule or reschedule an appointment, please call our office. If you need to speak with us when we are in session, we cannot be disturbed unless you have an emergency. Please tell the receptionist right away if you have an emergency. Otherwise, if we are in session, our office staff will take your call and any message you wish to leave. We will return your call as soon as possible. We will post in advance any scheduled absences.

EMERGENCIES

If you are in immediate danger of harming yourself or someone else...it's an emergency

If someone you know is in immediate danger of harming him or herself or someone else...it's an emergency.

If you feel that you are losing touch with reality and you cannot control yourself...it's an emergency

If you are in immediate danger of being harmed by someone else...it's an emergency. Call 911 and request assistance immediately. Then, call your therapist.

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CLIENT REGISTRATION FORM

DATE _____

NAME _____

Last

First

Initial

Address _____

CITY, STATE, ZIP _____

PHONE _____ (Home/Work) _____ (Cell)

(Check phone number you prefer to be reached)

EMAIL _____

EMPLOYED BY _____ OCCUPATION _____

BIRTHDATE _____ AGE _____ SEX _____

EMERGENCY CONTACT INFO/RELATIONSHIP _____

REFERRED BY: _____

RECITAL

Mind Body Medicine, like biomedical science and psychology is an inexact science. Even in the best of hands, services rendered cannot guarantee the cessation of symptoms or an improvement in a condition or illness. Please understand that Mind Body Medicine is a complement to medical care, not a substitute for it. A substantial part of treatment will rest on your commitment to following through on treatment recommendations and self-care.

MBMN, LLC IS COMPLIANT WITH HIPAA

Essentially, a HIPAA covered entity (MBMN, LLC) cannot use or disclose protected health information for any purpose other than treatment, payment, or health care operations without either the authorization of the individual or under an exception in the HIPAA regulations.

AGREEMENT

I understand all of the above information and accept responsibility for maintaining my own health and for asking questions of Mr. Glauser about any care, concern, information or policy which I do not understand.

SIGNATURE: _____ DATE _____

PERSONAL INFORMATION FORM

Please provide the following information. It will be kept as a confidential part of your psychotherapy notes.

Your Name _____ Birthday _____

Have you ever been to a counselor, social worker, psychologist or psychiatrist or been admitted to a psychiatric hospital? yes no

If yes, please indicate when, for what purpose (s) and name of provider(s): _____

What level of education have you received? _____

Do you have children? yes no

If yes, please list their names and ages:

_____	_____	_____
_____	_____	_____

Other people living in your home:

_____	_____	_____
_____	_____	_____

What is your religious preference? _____ Are you active in your religion? yes no

Do you smoke or use other tobacco products? yes no

If yes, what do you use and how much? _____

Do you or have you ever used drugs or alcohol? yes no

If yes, what did or do you use and how much? _____

Have you ever been in trouble with the law? yes no

If yes, please briefly explain: _____

Are you presently involved in any litigation? yes no

What are you experiencing that led you to come for assistance?

What would you like to accomplish in therapy? (How will you know that you are finished?)

Thank you for taking the time to fill out this form. It helps your therapist understand you and saves therapy time.

CLINICAL RECORD INFORMATION

Please provide the following information. It will be kept as a confidential part of your Protected Health Information clinical record.

Name _____ Birthday _____

Who is your primary physician? _____

What is her/address and phone number? _____

What medications do you take?

Medicine	Date started	Dosage	Prescribed by

Please list any over the counter medications, herbs or other supplements you take.

Do you have any allergies to medications? yes no If yes, please list them: _____

Whom can we contact in case of emergency?

Name _____ Number _____ Relationship _____

Do you have, or have you had, any significant or chronic health problems? yes no

If yes, please describe them _____

Thank you for taking the time to fill out this form. It helps your therapist understand you and saves therapy time.

PROBLEM CHECKLIST

Name _____ Birthday _____ Today's Date _____

Your Therapist's Name _____

The following questions are meant to help your therapist determine the types of difficulties you are experiencing. Answering these questions saves time in your therapy sessions which enables your therapist to work more efficiently. Please check the boxes to the right of each problem that you have experienced in the past month. If you have not experienced a problem listed, check the "None" box. Thanks.

296/300.4	None	Minimal	Moderate	Severe
Depressed mood nearly all day				
Loss of self-esteem				
Loss of interest or pleasure in activities				
Decreased or increased appetite				
Difficulty sleeping or increased sleeping				
Loss of energy or fatigue				
Loss on interest in sex				
Loss of hope that life is worthwhile				
Feeling guilty or worthless				
Difficulty concentrating				
Recurrent thoughts of dying or death				
Thoughts of harming oneself				
Suicide plans				
Have you ever made a suicide attempt	__yes__no			

296.4x	None	Minimal	Moderate	Severe
Feeling "too good"				
Needing much less sleep				
Needing much less food				
Being more talkative than usual				
Having racing thoughts				
Feeling hyper-irritable				
Feeling speeded up				
Being impulsive in spending, sex, driving too fast, etc.				
Numerous periods of "up" moods for days				
Numerous periods of "down" moods for days				
Do friends say you seem extra irritable, impulsive, and too energetic?	__yes__no			

300.01	None	Minimal	Moderate	Severe
Brief anxiety "attacks" approx. 30 minutes)				
In these attacks, did any of the following occur?				
Shortness of breath				
Choking feeling				
Dizziness				
Rapid heart beat				
Nausea or abdominal distress				
Feelings of unreality				
Chest pains				
Powerful feelings of doom or imminent death				
Fear of going crazy or losing control				
Trembling				
Have you missed important events because of these attacks?-	<u> yes </u> <u> no </u>			

300.02	None	Minimal	Moderate	Severe
Unrealistic/excessive worry or anxiety about things in your life				
Tension, restlessness and fatigue				
Feeling keyed up and on edge				
Insomnia				
Mind going blank due to anxiety				
Irritability				

300.23, 300.29	None	Minimal	Moderate	Severe
Unreasonable fear over situations or objects				
Fear of social or performance situations				
Avoiding of fearful situations that significantly interferes with your responsibilities or pleasures				
Being fearful even though you know you shouldn't be				

303.x - 305.x	None	Minimal	Moderate	Severe
Using larger amounts of alcohol or drugs than intended				
Unsuccessfully trying to cut down on or control use of drug or alcohol				
Being criticized by others for using alcohol or drugs				
Feeling guilty about drug or alcohol use				
Using drugs or alcohol in the A.M. after heavy use the night before				

303.x-305.x CONT

Legal difficulties and/or problems with other authorities due to drug or alcohol use				
Giving up work, school, social or recreational activities due to drug or alcohol use				
Using large amounts of a drug or alcohol to get the same effect				
Drinking more than 2 caffeinated drinks per day				
Is there a history of drug or alcohol abuse in your family?	<input type="checkbox"/> yes <input type="checkbox"/> no			

307.x, 316

	None	Minimal	Moderate	Severe
Intense fear of gaining weight or becoming fat				
Loss of more than 5 pounds in the past year				
Feeling "fat" regardless of your weight				
Missing 3 or more consecutive periods (females)				
Using food to comfort oneself when emotionally upset				
Overeating, inducing vomiting or abusing laxatives				

314, 314.01

	None	Minimal	Moderate	Severe
Difficulty in sitting still, no fidgeting				
Being easily distracted, unable to keep your attention				
Often acting without thinking or impulsively				
Difficulty getting your work/studies done				
How long have you had these problems?	<input type="checkbox"/> Never	<input type="checkbox"/> One month	<input type="checkbox"/> One year	<input type="checkbox"/> Always

295, 297, 298, 300.15

	None	Minimal	Moderate	Severe
Knowing special secrets no-one else knows				
Hearing or seeing things others do not hear or see				
Being able to control other's thoughts				
Feeling there is a plot against you				
Being unable to remember periods of time (hours or days)				
Trouble controlling your anger				
Thoughts of harming others				
Difficulty relating to friends, family or co-workers				
Currently being sexually or physically abused				

Has there been an event or experience from which most of your problem dates? yes no

Are there any other problems you are experiencing that are not on the list? yes no

If yes, please write them down here:

Thanks for taking the time to complete this checklist!