



22605 SE 56th Street Suite 150,
Issaquah, WA 98029
p: (425) 686-9509 f: (425) 686-7260
office@ohanabehavioralhealth.com
www.ohanabehavioralhealth.com

NEW CLIENT INFORMATION

Today's Date: _____ SSN/Driver's License: _____

Name: _____ Preferred Name: _____

DOB: __/__/__ Age: __ Legal Gender: _____ Gender Identity: _____ Pronouns: _____

Sexual Orientation: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____ Work: _____ Email: _____

Occupation: _____ Employer: _____

Education (circle last year completed): Grade school 1 2 3 4 5 6 7 8 9 10 11 12 University 1 2 3 4 5 6+

Religious Affiliation: _____

How may we contact you? Home Cell Work Email Okay to leave message Yes No

Email: _____ May we email you? Yes No

Email is used primarily for billing purposes but can sometimes be used for scheduling. All invoice/statements will be sent electronically unless otherwise discussed.

Marital/Partner Status: Single Divorced Married Living together Separated Widowed

Children? YES NO

If yes, please list:

Name	Biological, Adopted, or Step	Current Age	Gender
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

EMERGENCY CONTACT

Name of contact: _____ Phone Number: _____

Relationship to client: _____



22605 SE 56th Street Suite 150,
Issaquah, WA 98029
p: (425) 686-9509 f: (425) 686-7260
office@ohanabehavioralhealth.com
www.ohanabehavioralhealth.com

HEALTH CARE INFORMATION

Rate your physical health: Excellent Good Average Declining

Primary care physician: _____ Phone number: _____

Are you now under doctor's care? YES NO Reason for care? _____

Currently taking any medications? YES NO If yes, please specify: _____

Substance Use? YES NO If yes, please specify _____

Have you, or a family member, even been diagnosed with a mental health disorder? YES NO

If yes, please specify _____

Please answer the following questions:

What brings you to counseling?

Any previous Therapy/ Counseling Yes No If yes, describe where, when, how long, and what for?

What do you hope to get out of counseling?

Give 3 adjectives to describe yourself:

Is there any other information I should know about you?

How did you hear about us? Relative Friend School Doctor/clinic Internet Other _____



22605 SE 56th Street Suite 150,
Issaquah, WA 98029
p: (425) 686-9509 f: (425) 686-7260
office@ohanabehavioralhealth.com
www.ohanabehavioralhealth.com

FINANCIAL RESPONSIBILITY INFORMATION

Name of Patient: _____ DOB Patient ____ / ____ / ____ Gender: _____
Address: _____ City _____ State _____ Zip code _____
Home Phone: _____ Mobile Phone: _____
**Email: _____

Primary Insurance Information:

Subscriber Name: _____ Subscriber Date of Birth: ____ / ____ / ____ Gender: ____
Full Address: _____ City _____ State ____ Zip code _____
Home Phone: _____ Cell: _____ Email: _____
Client Relationship to Subscriber: _____
Name of Insurance Company: _____
Subscriber's ID# _____ Group # _____
Co-pay amount: _____ Customer Service Phone # _____

Secondary Insurance Information:

Subscriber Name: _____ Subscriber Date of Birth: ____ / ____ / ____ Gender: ____ Full
Address: _____ City _____ State ____ Zip code _____
Home Phone: _____ Cell: _____ Email: _____
Client Relationship to Subscriber: _____
Name of Insurance Company: _____
Subscriber's ID# _____ Group # _____
Co-pay amount: _____ Customer Service Phone # _____

Financially Responsible Party Signature X _____

Date: _____

Fees for Clinicians (and Professional Associates) at Ohana Behavioral Health apply as follows: Initial session (55 mins) is billed at \$250; Subsequent sessions (50 mins) are billed at \$200 (PA \$100) for individuals and \$225 (PA \$125) for families. Standard fees apply for 3rd party reports at \$200 per 1/4 hour. The rate for cash paying clients for Clinicians is \$160 per session. Longer sessions may occasionally be called for with fees prorated accordingly. Payment is due the same day of service and may be paid by cash, card, or online using the payment option on client portal. Cancellation Policy: If you are unable to keep an appointment, please let us know at least 48 hours in advance of your appointment. Otherwise, there will be \$100 late cancelation/no-show fee. Managed Care: Payments made in part of in full by a managed care organization (MCO) require compliance to the regulations of your plan. As your policy is a contract between you and your carrier, it is your responsibility to check with your insurance provider to confirm terms and limitations of coverage. If your insurance fails to pay, for whatever reason, you are responsible for the full-billed amount.

PATIENT HEALTH QUESTIONNAIRE (PHQ-SADS)

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability

A. During the last 4 weeks, how much have you been bothered by any of the following problems?

	Not bothered (0)	Bothered a little (1)	Bothered a lot (2)
1. Stomach pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Back pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Pain in your arms, legs, or joints (knees, hips, etc.)...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Feeling tired or having little energy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Menstrual cramps or other problems with your periods.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Pain or problems during sexual intercourse.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Headaches.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Chest pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Dizziness.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Fainting spells.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Feeling your heart pound or race.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Shortness of breath.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Constipation, loose bowels, or diarrhea.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Nausea, gas, or indigestion.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PHQ-15 Score = +

B. Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
1. Feeling nervous anxiety or on edge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Not being able to stop or control worrying.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Worrying too much about different things.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Trouble relaxing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Being so restless that it is hard to sit still.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Becoming easily annoyed or irritable.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Feeling afraid as if something awful might happen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

GAD-7 Score = + +

C. Questions about anxiety attacks.

a. In the last 4 weeks, have you had an anxiety attack — suddenly feeling fear or panic?.....

NO **YES**

If you checked "NO", go to question E.

	<input type="checkbox"/>	<input type="checkbox"/>
b. Has this ever happened before?.....	<input type="checkbox"/>	<input type="checkbox"/>
c. Do some of these attacks come <u>suddenly out of the blue</u> — that is, in situations where you don't expect to be nervous or uncomfortable?.....	<input type="checkbox"/>	<input type="checkbox"/>
d. Do these attacks bother you a lot or are you worried about having another attack?.....	<input type="checkbox"/>	<input type="checkbox"/>
e. During your last bad anxiety attack, did you have symptoms like shortness of breath, sweating, or your heart racing, pounding or skipping?.....	<input type="checkbox"/>	<input type="checkbox"/>

D. Over the last 2 weeks, how often have you been bothered by any of the following problems?

Not at all **Several** **More** **Nearly**
(0) **days** **than half** **every**
(1) **the days** **day**
(2) **(3)**

1. Little interest or pleasure in doing things.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Feeling down, depressed, or hopeless.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Trouble falling or staying asleep, or sleeping too much.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Feeling tired or having little energy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Poor appetite or overeating.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Trouble concentrating on things, such as reading the newspaper or watching television.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Thoughts that you would be better off dead or of hurting yourself in some way.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PHQ-9 Score = + +

E. If you checked off any problems on this questionnaire, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult
at all

Somewhat
difficult

Very
difficult

Extremely
difficult