ADULT INFORMED CONSENT FOR THERAPY SERVICES

Welcome to Flagstaff Counseling Center. These documents contain important information about our professional services and business policies. Please read them carefully and jot down any questions you might have so that you can discuss them with your therapist at your next meeting. When you sign these documents, they will represent an agreement between you and your therapist.

THERAPY SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and client, and the particular problems you hope to address. There are many different methods your therapist may use to deal with those problems. Psychotherapy calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things you and your therapist talk about both during your sessions and at home.

Psychotherapy can have benefits and risks. Because therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. There are no guarantees as to what you will experience.

Your first couple of sessions will involve an evaluation of your needs. Through this evaluation, your therapist will be able to offer you some first impressions of what your therapy will include and a treatment plan to follow. You should evaluate this information along with your own opinions about whether you feel comfortable working with your therapist. At the end of this evaluation, your therapist will notify you if they believe that they are not the right therapist for you and, if so, they will give you referrals to other therapists whom they believe are better suited to help you.

If you repeatedly miss your appointments or cancel your appointments, then your therapist may discontinue your counseling sessions.

THERAPY SESSIONS

Your therapist will normally conduct an intake evaluation that will last 45 to 55 minutes. During this time, you can both decide if your therapist is the best person to provide the services you need in order to meet your treatment goals. If you agree to begin psychotherapy, then you will discuss how often you will meet for regular therapy sessions. Sessions typically last 45 to 55 minutes.

CONFIDENTIALITY FOR ADULT CLIENTS

In general, the privacy of all communications between a client and a therapist is protected by law, and your therapist can only release information about your therapy to others with your written permission. But there are a few exceptions.

In most legal proceedings, you have the right to prevent your therapist from providing any information about your treatment. In some legal proceedings, a judge may order testimony from your therapist if he/she determines that the issues demand it, and your therapist must comply with that court order.

There are some situations in which your therapist is legally obligated to take action to protect others from harm, even if your therapist has to reveal some information about a client's treatment. For example, if your therapist believes that a child (or other vulnerable person) is being abused or has been abused, your therapist is mandated by law to make a report to the appropriate state agency.

If your therapist believes that a client is threatening serious bodily harm to another, your therapist is required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. If the client threatens to harm himself/herself, your therapist may be

obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. If a similar situation occurs in the course of your therapy together, your therapist will attempt to fully discuss it with you before taking any action.

Your therapist may occasionally find it helpful to consult other professionals about a case. During a consultation, your therapist will make every effort to avoid revealing the identity of the client. The consultant is also legally bound to keep the information confidential. Ordinarily, your therapist will not tell you about these consultations unless they believe that it is important to your therapy together.

Although this written summary of exceptions to confidentiality is intended to inform you about potential issues that could arise, it is important that you discuss any questions or concerns that you may have at any time during your therapy with your therapist. Your therapist will be happy to discuss these issues with you and provide clarification when possible. However, if you need specific clarification or advice your therapist is unable to provide, formal legal advice may be needed, as the laws governing confidentiality are quite complex.

COUPLES AND FAMILY THERAPY

If this is couples therapy, either person participating in the therapy has the independent right to request and obtain a complete copy of the medical record, and this may contain information pertaining to both parties. In family therapy, all adult clients in the therapy shall have full access to the complete medical record.

PROFESSIONAL FEES

Your therapist accepts some insurance, some Employee Assistance Programs, and self-pay. Other professional services include report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, preparation of treatment summaries, and the time spent performing any other service you may request of your therapist. If you become involved in legal proceedings that require your therapist's participation, you will be expected to pay for any professional time your therapist spends on your legal matter, even if the request comes from another party. Your therapist charges $390 per hour for professional services they are asked or required to perform in relation to your legal matter.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless you agree otherwise or unless you have insurance coverage that requires another arrangement. Payment can be made in person with cash, check, or credit card. Payment can also be made online at **www.flagcounseling.com**

Payment schedules for other professional services will be agreed to when such services are requested.

Our office has a policy of charging **$50.00** for missed appointments or appointments that are cancelled with less than 24 hours' notice. This fee will be waived if you and your therapist agree that your missed appointment was due to circumstances beyond your control.

If your account has not been paid for more than 60 days, and arrangements for payment have not been agreed upon, your therapist has the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information your therapist will release regarding a client's treatment is his/her name, the dates, times, and nature of services provided, and the amount due.

_____ _____

Client or Guardian Date

_____ _____

Second Client (Couples Therapy Only) Date

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your insurance company. Of course, your therapist will provide you with whatever information they can based on their experience and will be happy to help you in understanding the information you receive from your insurance company. You (not your insurance company) are responsible for full payment of all fees.

You should also be aware that most insurance companies require that your therapist provide them with your clinical diagnosis. Sometimes your therapist has to provide additional clinical information, such as treatment plans, progress notes or summaries, or copies of the entire medical record (in rare cases). This information will become part of the insurance company files. Though all insurance companies claim to keep such information confidential, your therapist has no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. Your therapist will provide you with a copy of any records they submit, if you request it. ***You understand that, by using your insurance, you authorize your therapist to release such information to your insurance company. Your therapist will try to keep that information limited to the minimum necessary.***

ELECTRONIC COMMUNICATIONS POLICY

The use of various types of electronic communications is common in our society, and many individuals believe this is the preferred method of communication with others, whether their relationships are social or professional. Many of these common modes of communication, however, put your privacy at risk and can be inconsistent with the law and with the standards of our profession. Consequently, this policy has been prepared to assure the security and confidentiality of your treatment and to assure that it is consistent with ethics and the law.

Email Communications

Therapists at FCC use email communication only with your permission and only for administrative purposes unless we have made another agreement. That means that email exchanges with our office should be limited to things like setting and changing appointments, billing matters, and other related issues. Please do not email your therapist about clinical matters because email is not secure communication, unless you have made a prior agreement with your therapist to discuss clinical matters via email. If you need to discuss a clinical matter with your therapist, please feel free to call your therapist directly so you can discuss it on the phone or wait so it can be discussed during your therapy session. The telephone or face-to-face is simply a much more secure mode of communication.

Text Messaging

Because text messaging is a very unsecure and impersonal mode of communication, therapists at FCC do not text message to, nor do we respond to, text messages from anyone in treatment with us. So, please do not text message us unless we have made other arrangements.

Social Media

Therapists at FCC do not communicate with, or contact, any of our clients through social media platforms like Twitter and Facebook. In addition, if your therapist discovers that they have accidentally established an online relationship with you, they will cancel that relationship. This is because these types of casual social contacts can create significant security risks for you.

EMAIL NOTIFICATIONS FOR APPOINTMENT DATES AND TIMES

You have the option to be notified via email as to your appointment times and dates. Flagstaff Counseling Center uses a secure and encrypted system. Please note that by electing to receive appointment reminders via email, Flagstaff Counseling Center does not become responsible for maintaining, deleting, encrypting, or otherwise securing your email account or your appointment reminder once it has been transmitted to your individual email account.

____*Yes, I would like to receive email notifications reminding me of my appointment dates and times.*
Please send my appointment reminders to this email address: _____

____*No, I decline receiving email reminders for my appointments.*

CONTACTING YOUR THERAPIST

Your therapist will not often be immediately available by telephone. Though your therapist is usually in the office during normal business hours they will not answer the phone when with a client. Your therapist will make every effort to return your call within one business day of the day you call, with the exception of weekends and holidays. If you are unable to reach your therapist and feel that you are in crisis and cannot wait for a return call, please call **TERROS Mobile Crisis at 1-877-756-4090**. If you are experiencing a life-threatening emergency, call 911 or go to the nearest hospital Emergency Department.

I have read and understood the above.

_____ _____
Client or Guardian Date

_____ _____
Second Client (Couples Therapy Only) Date

Flagstaff Counseling Center
408 N. Kendrick, Suite 4
Flagstaff, AZ 86001
(928) 774-6364 Phone (928) 556-0504 Fax

NOTICE OF PRIVACY PRACTICES

Health Insurance Portability and Accountability Act (HIPAA) for Protecting Client Behavioral Health Information

THIS NOTICE DESCRIBES HOW BEHAVORIAL HEALTH INFROMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures of your health information

FCC may use or disclose your protected health information (PHI) for treatment, payment, and health care operations purposes without your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your medical record that could identify you.
- "Treatment, Payment and Health Care Operations"
  – Treatment is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another therapist.
  – Payment is when we obtain reimbursement for your health care. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage. This does not apply to Employee Assistance Program billing.
  – Health Care Operations are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "Use" applies only to activities within FCC such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of FCC such as releasing, transferring, or providing access to information about you to other parties.

In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

II. Uses and Disclosures Requiring Authorization

FCC may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment or health care operations, we will obtain an authorization from you before releasing this information.

You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage. The law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following limited circumstances:

- Child Abuse – We are required to report PHI to the appropriate authorities when we have reasonable grounds to believe that a minor is or has been the victim of neglect or physical and/or sexual abuse.
- Adult and Domestic Abuse – If you have the responsibility for the care of an incapacitated or vulnerable adult, we are required to disclose PHI when we have a reasonable basis to believe that abuse or neglect of the adult has occurred or that exploitation of the adult's property has occurred.
- Health Oversight Activities – If various Arizona Boards overseeing mental health services are conducting an investigation, then we are required to disclose PHI upon receipt of a request for medical records from a Board.
- Judicial and Administrative Proceedings – If you are involved in a court proceeding and a request is made for information about the professional services we provided you, such information is privileged under state law, and we will not release information without the written authorization of you or your legally appointed representative or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- Deceased Clients—We may disclose PHI regarding deceased clients as mandated by state law. A release of information regarding deceased clients may be limited to an executor or administrator of a deceased person's estate.
- Medical Emergencies—We may disclose your PHI in a medical emergency to medical personnel in order to prevent serious harm.
- Family Members involved in your care--We may disclose information to family members directly involved in your treatment based on your consent or as necessary to prevent serious harm.
- Law Enforcement—We may disclose PHI to a law enforcement official as required by law, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime or deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.
- Specialized Government Functions—We may review requests from US military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons, and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws, and the need to prevent serious harm.
- Research—PHI may only be disclosed after a special approval process.
- Serious Threat to Health or Safety – If you communicate to us an explicit threat of imminent serious physical harm or death to a clearly identified or identifiable victim(s) and we believe you have the intent and ability to carry out such a threat, we have a duty to take reasonable precautions to prevent the harm from occurring, including disclosing information to the potential victim and the police, and in order to initiate hospitalization procedures. If we believe there is an imminent risk that you will inflict serious harm on yourself, we may disclose information in order to protect you.
- Worker's Compensation – We may disclose PHI as authorized by, and to the extent necessary, to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness.

IV. Client's Rights

Client's Rights:

- Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of protected health information. However, we are not required to agree to a restriction you request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. For example, you may not want a family member to know that you are seeing us. On your request, we will send your bills to another address.
- Right to Inspect and Copy – You have the right to inspect or obtain a paper or electronic copy (or both) of PHI in our mental health and billing records, and any other records used to make decisions about you, for as long as the PHI is maintained in the Medical record. We may deny your access to PHI only where there is compelling evidence that access would cause serious harm to you.
  On your request, we will discuss with you the details of the request and denial process.
- Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the medical record. We may deny your request. You have the right to file a statement of disagreement with us, and we may prepare a rebuttal to your statement.
- Right to an Accounting of Disclosures– You generally have the right to receive an accounting of disclosures of your PHI. On your request, we will discuss with you the details of the accounting process.
- Breach Notification – If there is a breach of unsecured protected health information concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.

V. Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your medical records, you may contact this office. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, SW Washington, DC 20201. We will not retaliate against you for filing a complaint.

VI. Changes to Privacy Policy

- We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide you with a copy of the revised practices by posting a copy on our website or providing one to you at your next appointment.

_____ _____

Signature Date

ADULT CLIENT INFORMATION FORM

CLIENT INFORMATION:

LEGAL NAME_____

DATE: _____

MAILING ADDRESS_____

CITY/STATE_____ZIP_____

CELL PHONE_____

WORK PHONE _____

HOME PHONE _____

EMPLOYER _____

DATE OF BIRTH_____

SOCIAL SECURITY # _____

MARITAL/PARTNERSHIP STATUS_____

EDUCATION LEVEL_____

EMERGENCY CONTACT:

FULL NAME_____

TELEPHONE_____

RELATIONSHIP TO CLIENT_____

INSURANCE INFORMATION:

PRIMARY POLICY HOLDER _____

IF NOT SELF, HOW ARE YOU RELATED TO THE INSURED?_____

DATE OF BIRTH_____

INSURANCE NAME_____

ADDRESS _____

CITY/STATE_____ZIP_____

INSURANCE ID#_____

GROUP # _____ CO-PAY_____

DEDUCTIBLE AMOUNT_____

EFFECTIVE DATE _____

IS THERE A SECONDARY POLICY? ___YES ___NO

IF YES, NAME OF INSURED _____

SECONDARY INSURANCE COMPANY _____

FINANCIALLY RESPONSIBLE PARTY:

FULL NAME_____

MAILING ADDRESS_____

CITY/STATE_____ ZIP_____

TELEPHONE_____

SPOUSE/PARTNER (IF APPLICABLE):

NAME_____

DATE OF BIRTH_____

MAILING ADDRESS_____

CITY/STATE_____ ZIP_____

PHONE _____

EAP BENEFIT INFORMATION:

EMPLOYEE'S FULL NAME_____

IF NOT SELF, HOW ARE YOU RELATED TO THE EAP EMPLOYEE? _____

EMPLOYER_____

YEARS AT THE COMPANY _____

HAS THE EAP BENEFIT BEEN USED BY YOU OR A FAMILY MEMBER THIS YEAR? ___YES ___NO

IF YOU WERE REFERRED TO OUR OFFICE, WHO REFERRED YOU?_____

CHILDREN & OTHER FAMILY MEMBERS

NAME	RELATION	SEX	DOB	AGE	GRADE	SCHOOL/ EMPLOYER

CLIENT INFORMATION FOR ADULT CLIENTS

Family Physician(s)_____ Allergies_____ __
Medications _____
_____ _____
How helpful are your medications? _____

Health and Wellness Concerns	**Self**	**Spouse/Partner**
Arthritis	_____	_____
Asthma	_____	_____
Breathing problems	_____	_____
Diabetes	_____	_____
Dizziness or fainting	_____	_____
Heart problems	_____	_____
Head injury	_____	_____
High blood pressure	_____	_____
High cholesterol	_____	_____
Headaches	_____	_____
Lack of exercise	_____	_____
Low energy	_____	_____
Poor nutrition	_____	_____
Sleep problems	_____	_____
Smoker	_____	_____
Thyroid problems	_____	_____
Weight issues	_____	_____

In the last year, have you ever drank or used drugs more than you meant to? Y ___ N ___
Has your alcohol or drug use interfered with your job or family life? Y ___ N ___
Have you ever felt that you needed to cut down on your drinking or drug use? Y ___ N ___
Does anyone in your family have an alcohol or drug problem? Y ___ N ___

Other medical problems? _____
_____

Psychological Concerns	**Self**	**Spouse/Partner**
Agitated	_____	_____
Alcohol abuse	_____	_____
Angry	_____	_____
Anxious or nervous	_____	_____
Attention problems	_____	_____
Appetite change	_____	_____
Bad childhood	_____	_____
Career	_____	_____
Child abuse	_____	_____
Confidence	_____	_____
Depression	_____	_____
Disciplining children	_____	_____
Divorce	_____	_____
Domestic violence	_____	_____

CLIENT INFORMATION FOR ADULT CLIENTS

Psychological Problems	Self	Spouse/Partner
Drug abuse	_____	_____
Eating disorders	_____	_____
Elderly parents	_____	_____
Emotional abuse	_____	_____
Fears	_____	_____
Financial problems	_____	_____
Friendships	_____	_____
Gambling	_____	_____
Grieving	_____	_____
Hallucinations	_____	_____
Jealousy	_____	_____
Legal problems	_____	_____
Loneliness	_____	_____
Marriage/partnership	_____	_____
Memory problems	_____	_____
Mental illness	_____	_____
Mood swings	_____	_____
Nightmares	_____	_____
Obsessions/compulsions	_____	_____
Panic attacks	_____	_____
Parenting	_____	_____
Poor communication	_____	_____
Poor concentration	_____	_____
Problems with relatives	_____	_____
Pushing or hitting	_____	_____
Relationships	_____	_____
School problems	_____	_____
Self-esteem	_____	_____
Sexual affairs	_____	_____
Sexuality concerns	_____	_____
Shyness	_____	_____
Sibling conflicts	_____	_____
Stressed	_____	_____
Suicidal thoughts	_____	_____
Threats or use of weapons	_____	_____
Traumas	_____	_____
Violent thoughts	_____	_____
Work issues	_____	_____

Other psychological problems? _____

_____

Previous counseling? Yes_____ No_____ When_____Counselor(s)_____

Problems at that time?_____

Reason you are here today?_____ _____

_____ _____

YOU ONLY NEED TO COMPLETE THIS FORM IF YOU WOULD LIKE YOUR THERAPIST TO CONSULT WITH YOUR PHYSICIAN OR PSYCHIATRIST

Flagstaff Counseling Center
408 N. Kendrick, Suite 4
Flagstaff, AZ 86001
(928) 774-6364 Phone
(928) 556-0504 Fax

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION TO PHYSICIAN

Client Name_____ DOB_____

I hereby authorize the release of the medical information listed below which pertains to my history, mental or physical condition, or treatment, including information relating to my mental health diagnosis or treatment and/or substance abuse diagnosis and treatment to my physician:

_____
Physician Name

_____
Address

_____
Phone Number

I understand that the release of this information is to permit my physician to monitor my health status and to coordinate care. This authorization becomes effective on the date signed and may be revoked by me at any time. If not earlier revoked, this authorization shall terminate automatically within one year. I understand that the information may be provided to this recipient only with signed consent from me. I further understand that I have a right to receive a copy of this authorization upon my request.

_____ _____
Signature of Client or Legal Guardian Date

Dear Dr. _____,

In order to coordinate care, I wish to inform you that your patient _____

was referred to me for treatment on _____.

Presenting problems: _____
_____
_____

Diagnosis: _____

Treatment Plan: _____
_____

Additional Comments: _____
_____
_____

If you need additional information please contact me.

_____ _____
Therapist's Name Signature

EMPLOYEE ASSISTANCE PROGRAM (EAP/ASSIST) STATEMENT OF UNDERSTANDING

Employee assistance programs are provided by many employers who wish to offer their employees and family members' professional assessment, counseling and referral services.

This information is provided to you to help you better utilize available services.

FEES: Sessions within the EAP/ASSIST program are offered at no cost to the employee or family members. Your employer has already paid for the service.

If an employee or family member needs specialized counseling or treatment beyond the sessions offered by the company program, he or she can choose to remain with their FCC therapist or be assisted in referring you to another therapist outside the Employee Assistance Program.

SUPERVISORY REFERRAL: If a supervisor initiates the referral of an employee as the result of a performance discussion, or as a result of a positive substance abuse test, the supervisor will be notified of attendance at sessions, provided a proper release of information has been obtained.

PRIVACY: Information concerning the use of the EAP/ASSIST program will not be given to anyone outside the program without your permission unless required by law.

I have read and received a copy (if requested) of this information.

_____ _____

Signature Date

Gore Associate Assistance Program

Primary Client Name _____

Associate Name *(If different than the primary client)*:_____

Years at the company:_____

Information about the Primary Client:

Referred by:

Self ____

Human Resources ____

Supervisor/sponsor ____

Co-worker ____

Family member ____

Mental health professional ____

Medical professional ____

Other ____

Age: _____

Previous EAP Client:

Yes _____

No _____

Client Gender:

Female _____

Male _____

Other _____

Stressors: Please rate the level of the stress in your life on each of the following domains. Indicate the level of stress by making a mark on the number that best represents you with marks to the left representing low levels of stress and marks to the right representing high levels of stress. Write N/A next to any stressor that does not apply to you.

Alcohol or Drug Use

|————————————————————————————————————|

0 1 2 3 4 5 6 7 8 9 10

Child Behavior and Parenting

|————————————————————————————————————|

0 1 2 3 4 5 6 7 8 9 10

Finances

|————————————————————————————————————|

0 1 2 3 4 5 6 7 8 9 10

Health and Fitness

|————————————————————————————————————|

0 1 2 3 4 5 6 7 8 9 10

Marriage and Partnership Relationships

|————————————————————————————————————|

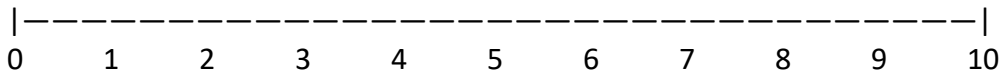
0 1 2 3 4 5 6 7 8 9 10

Mental Health

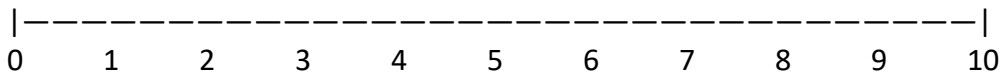
|————————————————————————————————————|

0 1 2 3 4 5 6 7 8 9 10

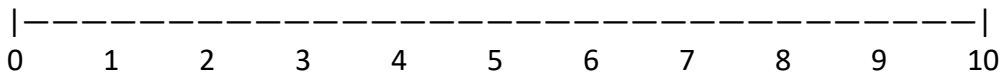
Self-Esteem



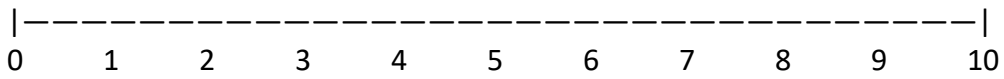
Social Life



Work



Education



Other Stressors:

Please list any other stressors that aren't listed above