Robin Kahler, L.M.S.W., A.C.S.W.
1817 W. Stadium, Ste I, Ann Arbor, MI 48103
(734) 645-0580

History Form for Adults

Your Name: _____ Age: _____

What are you wanting from therapy?_____
_____
_____

What are you experiencing (please circle)?

Hopelessness	Anxiety	Mood Swings
Crying spells	Panic attacks	Lots of energy
Loneliness	Shortness of breath	Confusion
Emptiness	Fear of dying	Spending problems
Worthlessness	Phobias	Gambling problems
Difficulty concentrating	Racing thoughts	Worry about what others think
Depressed mood	Job Stress	Hearing Voices
Suicidal thoughts	Nightmares	Seeing things others don't
Loss of appetite	Flashbacks	Feeling controlled
Sleeping _____hrs	Relationship problems	Unusual thoughts
Decreased activity	Sexual problems	Homicidal thoughts
Decreased self care	Screaming/yelling	Increased alcohol use
Loss of weight _____lb	Hitting	Increased drug use
Weight gain _____lb	Food Binging	Blackouts
Guilt / Shame	Food purging	Withdrawal symptoms

Other _____

Have you been in therapy before? _____
When were you in therapy? _____
Where were you in therapy?_____
How long did you stay in therapy?_____
How many times have you been in therapy? _____

Employment
Are you employed?_____ Full time _____/ Part-time_____
What type of work do you do?_____
Where?_____
Have you ever been fired from your job?_____ How many times?_____
For what reasons?_____
Do you have any work problems now?_____
If so, what_____
Do you have any Financial Problems:_____

Family

Who do you live with?

Name	Age	Relationship to you

Current Marital / Relationship Status:_____ Age first married_____
times married _____# times divorced _____# times widowed_____

Who were you raised by _____

Suicide / Homicide Risk

Are you thinking about suicide now?_____
Have you ever thought about suicide?_____
Have you ever attempted suicide? _____
If so, when?_____
What did you do?_____
How did others react?_____
What help did you get?_____

Are you thinking about homicide now? _____
Have you ever thought about homicide? _____
Have you ever attempted homicide? _____
If so, when?_____
What did you do?_____
How did others react?_____
What help did you get?_____

Have you ever been hospitalized for emotional reasons?_____
If so, when?_____ Where? _____
For how long?_____ How many times? _____
What event brought you to the hospitalization? _____

Abuse Issues
Have you ever been in a controlling relationship? _____
Have you ever been in a physically abusive relationship?_____

Have you ever been in an emotionally abusive relationship?_____

Are you afraid of your partner?_____
Is your partner afraid of you?_____
Do you get into physical fights with your partner? _____

How do you discipline your children?_____
How does your partner discipline the children?_____
Has protective services ever been called?_____
If so, when_____ How many times have they been called?_____
For what reason_____
Is Protective Services involved now?_____

Have you had any traumatic experiences (any event that you feel was traumatic for you)
Please list events with the age you were at the time
_____
_____
_____
_____
_____
_____
_____
_____

Have you ever been a victim of:
Physical abuse?_____ by whom_____ at what ages_____
Emotional abuse?_____ by whom _____at what ages _____
Sexual abuse?_____ by whom _____at what ages _____

Legal Involvement
Are you in any legal trouble?_____ If so, for what?_____
Are you on probation?_____
If so, who is your probation officer? _____
Address:_____
Phone #:_____

Did you have any legal trouble in the past?_____
If so, please list:

Crime:_____ Date: _____ Outcome: _____

Crime: _____ Date: _____ Outcome: _____

Crime: _____ Date: _____ Outcome: _____

Crime: _____ Date: _____ Outcome: _____

Military
Have you ever been in the Military? _____If so, When?_____
Type of Discharge?_____ Combat experience?_____

Are you having any problems now because of your military experience?_____ if so, please explain

_____
_____
_____

Education

Last grade completed?_____ Degree: _____
Are you in School now?_____
If so, where _____
What are you studying? _____
Do you have a learning disability?_____

What is your **ethnic/cultural** background?_____
Any concerns?_____

What is your **religious/spiritual** involvement?_____
Any concerns?_____

What is your **sexuality**? _____
Any concerns? _____

Health

How is your physical health currently? _____
What problems do you have medically (please explain in detail)_____
_____
_____
_____
_____
_____
_____
_____
_____

Have you had any surgeries (please explain in detail)

_____
_____
_____

Primary Doctor:_____

Phone Number: _____

Address:_____

_____

What medications are you on for (list dosage and frequency)

Medication Dosage/freq Prescribed by Helps with

_____
_____
_____
_____
_____
_____
_____

For Women:
Pregnancies _____# Abortions _____# Miscarriages _____
Stillbirths _____# Live births _____

Do you have a normal menstrual cycle? _____
Do you have Premenstrual syndrome ?_____
Menopause?_____ if so when?_____
Are you on hormonal replacement?_____

Alcohol Use
What alcohol do you drink?_____
How much do you drink?_____
How often do you drink?_____
Do you think your alcohol use is a problem for you?_____
Have you ever tried to cut down or stop?_____
What happened?_____
Have you ever been in treatment for your alcohol use?_____
If so, where_____
When_____
How many times?_____
Has Alcohol ever been a problem for you in the past?_____

Drug Use
What drugs have you ever tried?_____
What drugs do you use now? _____
How much do you use?_____
How often do you use?_____
Do you think your drug use is a problem for you?_____
Have you ever tried to cut down or stop?_____
What happened?_____
Have you ever been in treatment for your drug use?_____
If so, where_____
When_____
How many times? _____
Has drugs ever been a problem for you in the past?_____

Does anyone in your immediate or extended family have a problem with:
Alcoholism_____ if so, whom _____
Drug use _____ if so, whom _____

Has anyone in your immediate or extended family ever:
Attempted suicide _____ if so, whom _____
Committed suicide _____ if so, whom _____
Attempted homicide _____ if so, whom _____
Committed homicide _____ if so, whom _____

Has anyone in your immediate or extended family have difficulties with:
Depression _____ if so, whom _____
Anxiety/panic attacks _____ if so, whom _____
Manic Depression/Bipolar _____ if so, whom _____
Other _____

Client Signature: _____ Date; _____

Therapist Signature: _____ Date: _____

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Therapeutic Approaches

General Psychotherapy

Robin Kahler, LMSW provides psychotherapy to children, teenagers and adults. Therapy might draw from a variety of therapeutic approaches including cognitive behavioral, marital, EMDR and Sensorimotor Psychotherapy.

EMDR

Eye Movement Desensitization Reprocessing is a trauma therapy involving bilateral stimulation, either by using eye movement, sound or sensation. This can help process trauma by stimulating the two brain hemispheres to work together, helping traumatic memory to be recalled and processed through. If you have had seizures, take anxiety medication, or wear progressive lenses, please discuss this first with the therapist. This treatment helps soften and release memories so they are not as painful. If you are to testify in court regarding a trauma, this treatment might make recalling details of the memory difficult and in that way may affect your court case. It is important to not schedule any important events involving decision making or driving following treatment sessions, until we know how these treatments affect you. As with any intervention there are possible risks involved. Here is a link on Web MD that describes the technique **http://www.webmd.com/mental-health/emdr-what-is-it#1**

Sensorimotor Psychotherapy

Sensorimotor Psychotherapy is a form of talking therapy that brings mindfulness to the body sensations, tensions, posture, movements and emotions. In doing so it is a body oriented psychotherapy for the treatment of trauma, attachment wounding and attachment trauma. Here is an article from one of the teachers, talking in depth about the process of Sensorimotor Psychotherapy **http://www.janinafisher.com/pdfs/trauma.pdf**

Trauma involves the body's nervous system to respond to a threat, causing a fight or flight response. This causes feelings of panic, rage or exhaustion. Incidents that can cause trauma include car accidents, house fires, being in combat, etc.

Attachment trauma also causes the nervous system to go into survival mode, but is complicated by the fact that the threat is coming from a significant attachment figure, like a parent. Examples might include physical, sexual abuse or neglect.

Attachment wounding can be emotionally painful, but does not cause our nervous system to go into a survival response. One may feel anxiety but it doesn't spike into panic for example. Attachment wounding might include things like feeling criticized, teased, or put down.

Sensorimotor Psychotherapy treatment might include physical touch as part of the therapy. This is always optional and your therapist will ask permission each time. There are risks involved with touch such as possibly activating old memories or increasing a longing for contact. If touch is considered appropriate part of your treatment, you will always have the right to decline without any fear of adverse consequences. An example of how touch might be included in therapy could be the therapist offering a little resistance to your hands as you explore the need to push something or someone away.

Client: I acknowledge and agree to:

I have read and understand risks are involved in the treatment of trauma, such as reactivation of memory and symptoms, and will discuss any concerns with the therapist ahead of time.

I understand that the therapist may use physical touch as part of the therapeutic approach, provided I give permission orally each time. I will ask questions concerning touch at any time during the course of my therapy. I also will agree to notify the therapist if I do not wish to use touch as part of treatment.

I understand with children or adolescents, all physical intervention, if at all, will be performed by the parent and/or with the parent in the room.

I understand that the use of touch might bring about increased longing for contact. I understand that sexual contact between therapist and client is never appropriate. I also understand that the therapist will hold appropriate boundaries, and will avoid dual relationships.

_____	_____
Client or Parent's Signature	Date
_____	_____
Client Name (Print)	Child's Name
_____	_____
Robin Kahler, LMSW	Date

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Consent for Therapy & Payment Agreement Form

I, _____ voluntarily consent to psychotherapy, and understand that I can discontinue from therapy at anytime. I also understand that it is my responsibility to pay for all therapy, either through insurance coverage or private pay and agree to pay at the time of each session. I agree to notify Robin Kahler, LMSW, if there are any changes in my insurance coverage, if there are multiple insurances or if my policy is terminated. In the event the insurance company does not pay for services, I agree to make payments in full. I understand that the therapy time is reserved for me and will make every effort to keep my appointments. In the event I need to cancel an appointment, I agree to do so at least 48 hrs. in advance, or will pay the full fee (which is not covered by insurance companies). Exceptions are made for emergencies. If you are using an Employee Assistance Program (EAP) then you will need to obtain authorization through the EAP.

initial_____ I also agree to provide credit card information and give permission to have it safely stored in Therapy Notes or their credit card associates as part of the electronic medical record. I understand and provide permission to have any missed appointments or other fees not paid at the time of service to automatically be charged to this credit card.

initial_____ I understand that Robin Kahler, LMSW reserves the right to send any outstanding balances that are exceeding 90 days to a collection agency.

initial_____ I understand that all clinical information is confidential and will not be disclosed, unless a signed release is authorizing disclosure. Exceptions are; you are threatening to harm yourself or another, there is suspicion of child abuse or neglect, when you are in a medical emergency, a court order

initial_____ I, understand that I can be terminated from therapy and referred elsewhere for the following reasons: Acting in a violent or hostile manner, carrying a weapon to sessions, attending sessions intoxicated, not paying the fees timely.

initial_____ I authorize Robin Kahler to submit bills and necessary clinical information to my insurance or EAP companies for the purpose of receiving reimbursement, authorization or audit reviews. I consent for electronic billing whenever possible, either through insurance/EAP websitesor through Therapy Notes, Inc and their clearing house. I understand these are HIPAA compliant companies. I also understand that Robin Kahler, LMSW might hire an individual or billing service to assist in billing.

initial_____ I also understand that my medical record will be kept electronically through Therapy Notes, a HIPAA compliant company. I understand that if any HIPAA breaches occur, I will be notified.

Initial_____ I consent permission to communicate with the therapist via technology and in doing so give consent for medical record information or personal health

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Consent for Therapy & Payment Agreement Form (pg 2)

information to be transmitted in this way. I understand the risks involved if I choose to send an email or text to the therapist and expect a reply.

By signing, I acknowledge that I have read and agree to the above statements.

_____ _____
Client Signature or Parent Signature Date

_____
Childs name if client

_____ _____
Therapist/Witness Signature Date

(rev 3/2017) 2-6

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Client Name: _____ **Social Security _____**

Date of Birth: _____Age:_____

Address:_____

_____

Cell phone #: _____ **Home phone #: _____**

Email:_____

Emergency Contact: _____Relationship:_____

Phone#: _____

Insurance Company: _____ **Policy Holder's phone #: _____**

Policy holder Name: _____ **Date of birth: _____**

Contract #: _____ **Group #: _____**

Employer: _____

Deductable _____Copay _____

Secondary Insurance:_____ **Date of Birth:_____**

Policy holder Name:_____

Contract #:_____ **Group#: _____**

Employer: _____

Deductible: _____ **Copay: _____**

Who referred you: _____(revised 3/2017) 3/6

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Authorization for Release/Request of Client Information

I, _____(client/parent) whose date of birth is _____ hereby authorize
Robin Kahler LMSW, ACSW, 1817 W. Stadium, Suite I, Ann Arbor, MI 48103 to disclose to and or obtain client records from (write in Insurance company or EAP)
_____

I, authorize the following information to be released: assessment, intake paperwork, demographic information, diagnosis, psychosocial evaluation, psychological evaluation, treatment plan and updates, medication, participation in treatment, medical information, educational information, discharge summary, continuing care planning, progress in treatment, progress notes. For the purpose of:
(***please put your initials in **ONE)**
____ Insurance Communication to coordinate billing
____ EAP Communication to coordinate billing

I further understand that Robin Kahler, LMSW will not condition my treatment on whether I give authorization for the requested disclosure.
Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be re-disclosed by the recipient and the PHI will no longer be protected by the HIPAA privacy regulations, unless a State Law applies that is more strict than HIPAA and provides additional privacy protections.

This consent automatically ends when its purpose has been achieved, or 60 days after the date below, whichever is later.

_____ _____
Client Name Date

_____ _____
Parent Signature Date

_____ _____
Therapist Signature/Witness Date

****

(***DO NOT SIGN HERE UNLESS YOU ARE REVOKING THE RELEASE)**
I understand that I can revoke this release at anytime. By signing here, I am canceling this release. Signed_____ dated _____ updated release 3/2017 -4/6

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Authorization for Release/Request of Client Information

I, _____ whose date of birth is _____
hereby authorize Robin Kahler LMSW, ACSW, 1817 W. Stadium, Suite I, Ann Arbor, MI 48103 to Disclose to and or obtain client records from
Primary Doctor -_____
Doctor's Address_____
Doctor's Phone: _____ Fax:_____

I, authorize the following information to be released: assessment, intake paperwork, demographic information, diagnosis, psychosocial evaluation, psychological evaluation, treatment plan and updates, medication, participation in treatment, medical information, educational information, discharge summary, continuing care planning, progress in treatment, progress notes. This release is for or the purpose of communicating to coordinate treatment. I further understand that Robin Kahler, LMSW will not condition my treatment on whether I give authorization for the requested disclosure.

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be re-disclosed by the recipient and the PHI will no longer be protected by the HIPAA privacy regulations, unless a State Law applies that is more strict than HIPAA and provides additional privacy protections.

This consent automatically ends when its purpose has been achieved

_____ _____
Client Name Date

_____ _____
Client/Parent Signature Date

_____ _____
Therapist Signature/Witness Date

****

(***DO NOT SIGN HERE UNLESS YOU ARE REVOKING THE RELEASE)
I understand that I can revoke this release at anytime. By signing here, I am canceling this release. Signed_____ dated _____ updated release
(revised 3/2017) 5-6

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Notice of Privacy Practices Receipt and Acknowledgment of Notice

Patient/Client Name:_____

DOB: _____

SSN:_____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Robin Kahler, LMSW Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Robin Kahler, LMSW at (734) 645-0580.

_____

Signature of Patient/Client Date

_____

Signature or Parent, Guardian or Personal Representative * Date

_____

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

❑ **Patient/Client Refuses to Acknowledge Receipt**:

_____

Signature of Staff Member

(revised 9/2017) 6-6