Scott P. Gregory L.M.F.T., A.T.R.
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(719) 574-6562, Fax (719) 570-0386

Disclosure Statement

Degrees: M.A. 1984, Art Therapy Masters/ Marriage, Family and Child Therapy College of Notre Dame, Belmont California.
B.A. 1980, Psychology, University of Colorado, Boulder Colorado.

License: Colorado License # 181, 1993, Marriage and Family Therapist
Registered Art Therapist, # 9135, 1991, The American Art Therapy Association

Confidentiality

I will Keep Confidential anything that you tell me with the exception of the following:

____ You direct me to disclose information and provide a signed release
____ I determine that you are behaving in ways that are dangerous to yourself or others
____ I am ordered by the court to disclose information
____ Any suspected child abuse

Your Rights

Involvement in counseling at this level is a voluntary process. Not all therapists are alike in their training, treatment philosophies or experience. I will discuss my training and philosophy with you in our first session. As a good consumer, you should determine if this seems to be a good fit for you. You have the right to a second opinion or to terminate the therapy process with this provider at any time. I ask that you please communicate any concerns or intent to terminate should this arise. I also have the right to terminate services with clients if I feel that the therapeutic process has been compromised or it is beyond the scope of my training or experience.

I understand that I am responsible for the payment of my treatment services. My signature verifies that I have read and understand the information above and gives Scott Gregory, or the Colorado Centers for Neuropsychiatry and Behavioral Care the permission to bill and accept insurance reimbursement for the services provided.

Regulation of Psychotherapists

The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Registrations. The regulatory boards can be reached at 1560 Broadway, Suite 1350, Denver, CO 80202, 303.894-7800. The Regulatory requirements for mental health professionals provide that a Licensed Clinical Social Worker, a Licensed Marriage and Family therapist, and a Licensed Professional Counselor must hold a master's degree in in their profession and have two years of post-master's supervision. A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision. A Licensed Social Worker must hold a master's degree in social work. A Psychologist Candidate, a Marriage and Family Therapist Candidate, and a Licensed Professional Counselor Candidate must hold the necessary licensing degree and be in the process of completing the required supervision for licensure. A Certified Addiction Counselor 1 (CAC I) must be a high school graduate, and complete required training hours and 1000 hours of supervised experience. A CAC II must complete additional required training hours and 2,000 hours of supervised experience. A CAC III must have a bachelor's degree in behavioral health, and complete additional required training hours and 2,000 hours of supervised experience. A Licensed Addiction Counselor must have a clinical master's degree and meet the CAC III requirements. A Registered Psychotherapist is listed in the State's Database and is authorized by law to practice psychotherapy in Colorado but is not licensed by the state and is not required to satisfy any standardized educational or testing requirements to obtain a registration from the state.

Disclosure Regarding Divorce and Custody Litigation

If you are involved in a divorce or custody litigation, my role as a therapist is not to make recommendations to the court concerning custody or parenting plans. By signing this Disclosure Statement, you agree not to subpoena me to court for testimony or for disclosure of treatment information in such litigation; you also agree not to request that I write any reports to the court or to your attorney regarding making recommendations concerning custody. The court can appoint professionals whose job is to conduct investigations or evaluations for the court concerning parental responsibilities or parenting time in the best interest of the family's children.

Patient Record Retention Policy

For the treatment of adults, records will be kept for seven (7) years after treatment ends or following our last session, but I may not retain them after seven years. For the treatment of minors, records will be kept for seven (7) years, commencing on the last date of treatment or for seven (7) years from the date when the minor reaches 18 years of age, whichever comes later. In no event am I required to keep these records for longer than 12 years.

Print name: _____

Signature: _____

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Colorado Center for Behavioral Care

Instructions: *Please complete all sections to the best of your ability. This will significantly help quicken the intake process. You may decline to answer any question, though this may inhibit your overall treatment process. All information herein is privileged under state and federal law. Please refer to your mandatory disclosure document for info on privilege and exceptions to privilege.*

Patient Name	Date of Birth	Age	Gender
Date	Referred by		

History of Presenting Problem

What brought you here today?

What led up to this decision?

Are there specific stressors/life events that may have triggered your situation?

How long has this lasted?

How bad or intense has it been?

Have you experienced this before? If so, when and how did you handle it?

Have you ever seen a therapist or psychiatrist before, either as an inpatient or outpatient client? If so, who, when, why, and did you feel it worked?

Have you ever taken psychotropic medications (medications to address mental health issues) before? If so, what, when, how much, and did you feel it worked?

Medical History

Date of last physical exam or visit to your physician?

Date of last physical exam or visit to your psychiatrist?

Are you on any current medications? If so, what, for how long, how much, why, and who prescribed them?

Are you allergic to any medications? If so, what?

Have you or anyone in your family ever had the following? If so, write their name and relationship to you (e.g., Grandfather on Mom's side).

Thyroid Disease	Diabetes		Hypoglycemia	Traumatic Brain Injury		Other? (Please write in below)	
	Type 1	Type 2					
Major Depression	Bipolar Disorder	ADHD	Schizophrenia	Substance or Alcohol Abuse	Anxiety	Personality Issues	Traumatic Stressor

Other medical conditions or concerns?

Symptom Checklist for Patient

	Mark Selections that Apply						Comments		
Sleep Quality	○ Too Little		○ Just Right		○ Too Much		Average number of hours per night:		
Energy Level	○ Too Little		○ Just Right		○ Too Much				
Concentration/Focus	○ Too Little		○ Just Right		○ Too Much				
Memory	○ Poor/Worsened		○ Just Right		○ Excellent				
Appetite	○ Too Little		○ Just Right		○ Excellent				
Guilt	○ Too Little		○ Just Right		○ Too Much				
Body Movements	○ Couch Potato		○ Just Right		○ Fidgety/Hyper				
Hallucinations	☐ None	☐ See Things	☐ Hear Things	☐ Feel Things	☐ Taste Things	☐ Smell Things	They command me to do things like…		
Mood	☐ Sad	☐ Happy	☐ Up and Down	☐ Unpredictable	☐ Irritated	☐ Angry	☐ Anxious or Fearful	☐ Flat or Restricted	☐ Elated or Manic
Body Aches and Pain	☐ Headaches		☐ Stomach Aches	☐ Diarrhea	☐ Nausea	☐ Vomiting	☐ Rashes	☐ Other?	
Suicidal Thoughts and Actions	○ Never		○ In the past but not now		○ Wish I were dead but wouldn't do it		○ Pretty strong feelings	○ Scared for my own safety	
Homicidal Thoughts and Actions	○ Never		○ In the past but not now		○ Wish I were dead but wouldn't do it		○ Pretty strong feelings	○ Scared for my own safety	

Other symptoms that I should know about?

Therapist Observations or Comments (therapist to complete this section)

Family History

(May include family that raised you; current or past significant relationships; family history of physical, emotional abuse and alcohol or drug dependency; significant life events; marital issues; education; social support; interest/leisure activities; work; or other significant information.)

Developmental History

(May include any information from your past that is important. May be replaced by expanded developmental questionnaire if patient is a child or adolescent.)

Alcohol and Drug Abuse History

	Have you ever used this?	If so, how often over the past year?	How much at a time?	Age of first use?	Date of last use?	Have you ever experienced blackouts, hallucinations, shakes, or other issues from using?	Has using ever led to problems with the law, friends, your spouse, work, school, or the military?	If treatment was sought for this, what was it? (e.g., AA, therapy, rehab)
Alcohol								
Stimulants (e.g, meth)								
Cocaine								
Pain Pills								
Tranquilizers								
Narcotics								
Sleeping Pills								
Marijuana								
Hallucinogens								
“Downers”								
Huffing Agents								
Other:								

Strengths Based Approach

What are your strengths as a person?

What are your weaknesses or areas of improvement as a person?

What do you want to get from therapy?

Is there anything else I would benefit from knowing about you, your family, or your past?

Thank you for your openness and honesty completing this form. The questions are difficult, but very important to successful treatment.

PATIENT, PLEASE STOP HERE

Mental Status Screening

Appearance	☐ Well Groomed ☐ Disheveled ☐ Eccentric ☐ Inappropriate ☐ Dirty
Attitude	☐ Cooperative ☐ Uncooperative ☐ Guarded ☐ Suspicious ☐ Belligerent
Alertness	☐ Alert ☐ Drowsy ☐ Lethargic
Motor Activity	☐ Normal ☐ Increased ☐ Decreased
Mood	☐ Normal ☐ Euthymic ☐ Elevated ☐ Depressed
Affect	☐ Appropriate ☐ Positive ☐ Irritable ☐ Tearful ☐ Anxious ☐ Angry ☐ Blunt/Flat ☐ Labile ☐ Other:
Speech	☐ Normal ☐ Over talkative ☐ Under Talkative ☐ Loud ☐ Soft ☐ Pressured ☐ Slowed ☐ Slurred ☐ Other:
Thought Process	☐ Appropriate ☐ Delayed Responses ☐ Blocking ☐ Circumstantial ☐ Perseverative ☐ Loose ☐ Flight of Ideas ☐ Incoherent ☐ "Magical" Quality ☐ Other:
Thought Content	☐ Appropriate ☐ Ideas of Reference ☐ Grandiose ☐ Delusional ☐ Obsessive ☐ Paranoid ☐ "Magical" Quality ☐ Floridly Psychotic ☐ Other:
Hallucinations	☐ None ☐ Auditory ☐ Visual ☐ Tactile ☐ Olfactory ☐ Gustatory ☐ Command in Nature Comments:

Summary Statement or Conclusions of Therapist