STEFANIE M. BROWN, JD MA LMFT CACI
LICENSED MARRIAGE & FAMILY THERAPIST
CERTIFIED ADDICTION COUNSELOR I

PTSD TRAUMA TREATMENT CENTER
TRADITIONAL AND EQUINE ASSISTED PSYCHOTHERAPY
422 E. VERMIJO AVENUE, SUITE 201
COLORADO SPRINGS, COLORADO 80903
TEL (719) 432-8175 ⧫ (719) 213-2322 FAX
www.OperationNewNormal.com
Stefanie@OperationNewNormal.com

Client's Contact Information & Release

Client:_____ Age: _____ Date of Birth:_____

Gender: Male ____ Female ____ Other _____ Height: _____ Weight: _____

Phone: (H) _____ (W) _____ (C) _____ Text okay? Yes___ No___

Street: _____City:_____ State: _____ Zip:_____

Email address (*if consent is given to contact through email*): _____

Psychiatrist: _____ Phone: _____ Consent to Contact? _____*

Previous Therapist: _____ Phone: _____ Consent to Contact? _____*

Previous Therapist: _____ Phone: _____ Consent to Contact? _____*

** If consent to contact is "yes," please fill out separate form: Consent to Release Confidential Information.*

In case of emergency: Contact:_____Phone:_____

Contact:_____Phone:_____

Parent/Guardian Name (*if any*)_____

Address/Phone (of Guardian, *if any*)_____

School or institution presently attending (*if any*): _____

RELEASE/PERMISSION TO CONTACT

I grant Stefanie Brown, or someone acting on her behalf, permission to contact me at the above listed numbers—including permission to leave a message, text (if permission checked above)—and/or email address. I understand that her license information and/or the name of the counseling facility may be in the signature line where others who have access to my email, texts, mail or voicemail may see it or hear it: YES___ NO___. If NO, please contact me only at this phone # or email address: _____

I also grant permission to Stefanie Brown, or someone acting on her behalf, to send an invoice for amounts due from me through PayPal to my email address: YES ___ NO ___.
(If no, then an invoice will be mailed.)

_____ ***Date:*** _____
Signature of Client

_____ ***Date:*** _____
Signature of Client (if more than one clt)

Name: _____

Therapeutic and Safety Issues

Check and describe applicable issues (indicate whether current "C" or past "P" issue):

___ inattention
___ hyperactivity
___ lack of concentration
___ learning disabilities
___ developmentally delayed
___ mentally challenged
___ boundary issues
___ social skills problems
___ problem with peers
___ separation anxiety
___ anxiety
___ phobias
___ aggressive
___ history of assaulting others
___ manipulative
___ unpredictable or dangerous behavior
___ sensory impairment
___ hypersensitivity
___ behavioral or physical tics
___ psychosomatic symptoms
____ other _____
____ other _____

___ medical issues
___ self-injurious behavior
___ suicidal ideations
___ history of runaway
___ issues of parental support
___ issues of family support
___ sexual abuse/acting out
___ history of physical abuse
___ history of emotional abuse
___ hallucinations
___ delusions
___ illusions
___ dissociations
___ substance abuse problems
___ legal problems
___ school problems
___ history of animal abuse
___ history of fire setting
___ possible medication side effects
___ seizure disorder
____ other _____
____ other _____

Why Are You Seeking Counseling Now? _____

_____

_____

_____

Diagnosis (DSM-IV-TR) *(if previously provided)*

Axis I _____

Axis II _____

Axis III _____

Axis IV _____

Axis V _____

Name: _____

Current Medications

Drug Dose Route Time Purpose

_____

_____

_____

_____

_____

Mental Health Treatment History

	When	Where	Diagnosis
<u>Current Therapy</u>: **Outpatient and/or Inpatient Therapy** **(*indicate which*)**			
<u>Past Therapy</u>: **Outpatient and/or Inpatient Therapy** **(*indicate which*)**			

Please describe your / your child's **current health status**, particularly regarding the physical and/or emotional demands mental health and/or equine program. *Specify if there are issues with fitness, cardiac, respiratory, bone or joint function, recent hospitalizations or surgeries, phobias or fears of large animals:*

_____

_____

_____

Allergies: Medications, Food, Environmental (e.g. bees, horses, hay, grasses):

_____

_____

_____

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Participant's Authorization for Emergency Medical Treatment

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while on the property of Stefanie M. Brown, I authorize her to:

___ Secure and retain medical treatment and transportation if needed.

___ Release participant records upon request to the authorized individual or agency involved in the medical emergency treatment at my expense.

I agree to hold Stefanie M. Brown harmless for any expenses incurred on my behalf.

Name:_____ Phone:_____

Address:_____

Emergency Contact: _____ Phone: _____

Physician's Name and Phone:_____

Preferred Medical Facility: _____

Health Insurance Co.: _____ Phone: _____

Policy #: _____ Group #: _____

Consent Plan (for Medical Treatment)

This authorization includes x-ray, surgery, hospitalization, medication, and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the person above is incapacitated.

Consent & Hold Harmless Signature:_____ Date: _____
(Participant or Parent/Legal Guardian)

Non-Consent Plan – IF YOU DO NOT WANT EMERGENCY MEDICAL TREATMENT

I do **not** give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services from, or while on the property of, Stefanie M. Brown. ***Rather, in the event emergency treatment/aid is required, I wish the following procedure to take place:*** _____
_____

Non-Consent Signature:_____ Date: _____
(Participant or Parent/Legal Guardian)