Dennis Mendonça, MA, MFT
HI MFT License # 193
NPI # 1558511170

--------CLIENT INTAKE PART ONE: DEMOGRAPHIC INFORMATION---------

Client Name:		DOB:		1st Date of Service:	
Gender:		Marital Status:		Ct. #:	E-mail:

CONTACT INFORMATION

Address:		
Cell Phone:	Work Phone:	Home Phone:
OK to leave message: ☐ *No* ☐ Yes	*OK to leave message:* ☐ No ☐ Yes	OK to leave message: ☐ No ☐ Yes
Preferred Phone: Home ☐ Work ☐ Cell ☐		
Call in Case of Emergency		
Name:		
Phone:	Email:	
Relationship to client:		

CURRENT LIFE SITUATION

Who Referred You?

Name:	May I contact the referral to thank them? ☐ Yes ☐ No
Phone #:	Email:

Living situation

☐ alone ☐ w/ family ☐ rooming house ☐ group residence ☐ foster care ☐ other:

Household members and ages:

Culture

Race:

Language spoken at home:

Religion/Faith/Spirituality raised in if any:

Religion/Faith/Spirituality currently practice if any:

Social club/organization

☐ No ☐ Yes (*description*):

Other agencies or providers involved

☐ None ☐ Yes (*description*):

Developmental History *(birth, walking, talking, toilet training, etc.)*

☐ None ☐ Yes (*description*):

Education

Highest grade completed (K-12) or college/university (U1-U8):

☐ None ☐ Degree(s) Trades?:

Learning Disabilities ☐ No ☐ Yes (*explain*):

Additional Education ☐ No ☐ Yes (*explain*):

Further comments on above ☐ No ☐ Yes (*explain*):	

Legal Issues

☐ None ☐ Yes (*description*):	

Vocational *(Job/Career training and/or work experience)*

☐ None ☐ Yes (*description*):	

Military Service

☐ None ☐ Yes (*description*):	

RELEVENT MEDICAL HISTORY

PCP Name:			
Address:			
			Zip:
Phone:		**Fax:**	

Illnesses and Allergies

☐ None ☐ the following:

Type of Illness or Allergy	Date or Age of Onset	Medications	Relevant Information	Severity

Mental Health History

Psychiatrist Name:			
Address:			
			Zip:
Phone:		**Fax:**	

Current Psychiatric Medication/s

☐ None to report ☐ the following is of note (past present)

Medication	Dosage	Prescriber	Date Started/Stopped	Side Effects

Previous Psychiatric Hospitalizations, Individual and/or Group Treatment

☐ None reported ☐ the following is of note:

Dates or Age	Therapist or Hospital	Type of TX	Reason/Symptoms/Medications	Outcome

Current Presenting Problem

Why are you seeking services:

If you need additional space please use backside of page and check box here: ☐

Dates or Age of Onset	Symptoms	Behavioral Example of Symptom	Severity mild, moderate, severe, extreme	Duration	Medication

Mental Health History Biological Family	Mother	Father	Sister/s	Brother/s	Grdmother	Grdfather	Aunt/Uncle
Depression	☐	☐	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐	☐	☐
Panic	☐	☐	☐	☐	☐	☐	☐
Alcohol/drug abuse (specify):	☐	☐	☐	☐	☐	☐	☐
Eating D.O. (specify):	☐	☐	☐	☐	☐	☐	☐
Bipolar D.O.	☐	☐	☐	☐	☐	☐	☐
Mania	☐	☐	☐	☐	☐	☐	☐
Schizophrenia	☐	☐	☐	☐	☐	☐	☐
Paranoia	☐	☐	☐	☐	☐	☐	☐
Learning Disability (specify):	☐	☐	☐	☐	☐	☐	☐
ADHD	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐

Mental Health History Adopted or Foster Family	Mother	Father	Sister/s	Brother/s	Grdmother	Grdfather	Aunt/Uncle
Depression	❑	❑	❑	❑	❑	❑	❑
Anxiety	❑	❑	❑	❑	❑	❑	❑
Panic	❑	❑	❑	❑	❑	❑	❑
Alcohol/drug abuse (specify)	❑	❑	❑	❑	❑	❑	❑
Eating D.O. (specify):	❑	❑	❑	❑	❑	❑	❑
Bipolar D.O.	❑	❑	❑	❑	❑	❑	❑
Mania	❑	❑	❑	❑	❑	❑	❑
Schizophrenia	❑	❑	❑	❑	❑	❑	❑
Paranoia	❑	❑	❑	❑	❑	❑	❑
Learning Disability (specify):	❑	❑	❑	❑	❑	❑	❑
ADHD	❑	❑	❑	❑	❑	❑	❑
Other:	❑	❑	❑	❑	❑	❑	❑

Other Relevant Family History (*Relevant loss/separation, significant illness, traumatic events, domestic violence, substance abuse, abuse/neglect, etc. of parents/care-givers, siblings)*

❑ None ❑ The following was reported

Date or Age	Description

TRAUMA HISTORY

Physical/Sexual/Emotional Abuse and/or Neglect of Client

❑ None ❑ The following was reported:

Intimate Partner Violence

❑ None ❑ The following was reported:

Additional Trauma Info:

SUBSTANCE ABUSE HISTORY

☐ None reported ☐ The following was reported

Date &/or Age	Type of Substance	Describe *(frequency, intensity, duration)*	Follow-up or Result

SELF HARM

Past Suicide Attempts (SA) &/or Suicidal Ideation (SI)

☐ None reported ☐ the following was reported

Date &/or Age	Relevant Information	Follow-up or Result

Please List: Siblings by birth order, Marital status & # of children, Level of Closeness Now

PLEASE ADD ANYTHING YOU WOULD LIKE YOUR THERAPIST TO KNOW, SIGN AND DATE AT THE BOTTOM: THANK YOU FOR GETTING THROUGH THIS FORM!

NAME:_____

DATE: _____

Therapist Signature: _____ **Licensure:** HI MFT # 193 **Date:** _____

Name: **DOB:** **Date:**

Note: To put a check in the box electronically, use cursur to highlight box then strike "x" key!

Client Symptom Checklist

Please check off all that apply.

In the past month...

	1 (never) – 5 (often)
1. Do you feel sad, blue or empty, crying for no reason?	☐ ☐ ☐ ☐ ☐
2. Have you lost or gained a lot of weight recently?	☐ ☐ ☐ ☐ ☐
3. Do you have a hard time falling asleep, staying asleep or wake frequently?	☐ ☐ ☐ ☐ ☐
4. Do you feel fatigued or have loss of energy nearly every day?	☐ ☐ ☐ ☐ ☐
5. Do you feel a sense of guilt for things in the past?	☐ ☐ ☐ ☐ ☐
6. Do you feel that you don't have anything to look forward to?	☐ ☐ ☐ ☐ ☐
7. Do you have difficulty concentrating or making decisions?	☐ ☐ ☐ ☐ ☐
	1 (never) – 5 (often)
8. Do you have a lot of energy after getting very little sleep?	☐ ☐ ☐ ☐ ☐
9. Do you have angry outbursts that are difficult to control?	☐ ☐ ☐ ☐ ☐
10. Do you have a pounding heart or racing thoughts, feel shaky, tremble for apparent reason?	☐ ☐ ☐ ☐ ☐
	1 (never) – 5 (often)
11. Do you have a difficult time leaving the house, taking public transportation, riding in elevators, etc.?	☐ ☐ ☐ ☐ ☐
	1 (never) – 5 (often)
12. Do you have repetitive thoughts you can't put out of your mind?	☐ ☐ ☐ ☐ ☐
13. Do you have rituals like checking if the stove is turned off, hand washing, counting, or repeating words silently?	☐ ☐ ☐ ☐ ☐
	1 (never) – 5 (often)
14. Has anyone hurt or touched you in ways you didn't want or have you witnessed someone being hurt?	☐ ☐ ☐ ☐ ☐
15. Do you have nightmares?	☐ ☐ ☐ ☐ ☐
16. Are you having difficulty at home?	☐ ☐ ☐ ☐ ☐
17. Are you having difficulty at work or school?	☐ ☐ ☐ ☐ ☐
18. If someone unexpectedly tapped you on the shoulder from behind, would you be startled or surprised?	☐ ☐ ☐ ☐ ☐
19. Did you lose a parent or caretaker before the age of 21?	☐ ☐ ☐ ☐ ☐
20. Do you feel disconnected from your feelings?	☐ ☐ ☐ ☐ ☐
	1 (never) – 5 (often)
21. In the past month, have you ever thought you should cut down on your drinking or drug use?	☐ ☐ ☐ ☐ ☐
22. Do you use alcohol or drugs even though you know that it makes you depressed?	☐ ☐ ☐ ☐ ☐
	1 (never) – 5 (often)
23. Do you eat a large amount of food in a short amount of time or "graze" all day?	☐ ☐ ☐ ☐ ☐
24. Do you restrict what you eat or yo-yo diet?	☐ ☐ ☐ ☐ ☐
25. Does how much you weigh dictate how you feel about yourself?	☐ ☐ ☐ ☐ ☐

PTSD CheckList – Civilian Version (PCL-C)

Client's Name: _____

Instruction to patient: Below is a list of problems and complaints that veterans sometimes have in response to stressful life experiences. Please read each one carefully, put an "X" in the box to indicate how much you have been bothered by that problem *in the last month*.

No.	Response	Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
1.	Repeated, disturbing *memories, thoughts, or images* of a stressful experience from the past?					
2.	Repeated, disturbing *dreams* of a stressful experience from the past?					
3.	Suddenly *acting* or *feeling* as if a stressful experience *were happening* again (as if you were reliving it)?					
4.	Feeling *very upset* when *something reminded* you of a stressful experience from the past?					
5.	Having *physical reactions* (e.g., heart pounding, trouble breathing, or sweating) when *something reminded* you of a stressful experience from the past?					
6.	Avoid *thinking about* or *talking about* a stressful experience from the past or avoid *having feelings* related to it?					
7.	Avoid *activities* or *situations* because they *remind you* of a stressful experience from the past?					
8.	Trouble *remembering important parts* of a stressful experience from the past?					
9.	Loss of *interest in things that you used to enjoy?*					
10.	Feeling *distant* or *cut* off from other people?					
11.	Feeling *emotionally numb* or being unable to have loving feelings for those close to you?					
12.	Feeling as if your *future* will somehow be *cut short*?					
13.	Trouble *falling* or *staying asleep*?					
14.	Feeling *irritable* or having *angry outbursts*?					
15.	Having *difficulty concentrating*?					
16.	Being *"super alert"* or watchful on guard?					
17.	Feeling *jumpy* or easily startled?					

PCL-M for DSM-IV (11/1/94) Weathers, Litz, Huska, & Keane National Center for PTSD - Behavioral Science Division

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808-652-2505 dennism08@gmail.com

DENNIS MENDONÇA MFT

CONSENT FOR TREATMENT

Aloha,

I am a licensed Marriage & Family Therapist with a Master's Degree in Integral Counseling Psychology. What that means is that I am schooled in traditional psychology and counseling as well as having training in meditation, body awareness, Eastern Philosophy and Cultural Anthropology. I spent my 20's working in psychiatric hospitals, and have specialties in Domestic Violence, Couples Counseling, Individual Psychotherapy and in recent years have been studying EMDR- a highly specialized way of working with trauma. This consent will list your Rights & Responsibilities, fee's cancellation policy and insurance information where applicable.

Client Rights: You have the right to information regarding my training, the right to refuse treatment, the right to know that sometimes symptoms can get worse before they get better, as well as the right to confidentiality. The exceptions in confidentiality include: if you are a danger to self or others, unreported child or elder abuse, basic insurance information or Consultation needs. If the above conditions do exist you will be informed prior to disclosure. When consulting your name and identifying information will not be used. (Please see the accompanying Hippa handout for more information.)

Client Responsibilities: Your responsibilities include: showing up on time, engaging in good faith, pay in a timely manner (my standard fee is $150.00 for a 50-60 minute session, $200.00 for an 80-90 minute session). Fee's and co-pays should be paid at the **beginning** of sessions. Your co-pay is_____. **A 24-hour cancellation is required to avoid a $75 cancellation fee (unless an emergency occurs). Insurance companies cannot be billed for missed sessions.**

Initial:

_____ I grant permission for Dennis Mendonça to bill my insurance.

_____ I acknowledge receipt of the Hippa Notice **Today's Date:**_____

Insurance Information: Subscriber #: _____

Company:_____ Subscriber Name: _____

Onset of current illness:_____

Emergency Contact Person:

Name: _____ Phone:_____

I have read, understand and agree to the above information:

Name: _____Phone:_____**DOB:**_____

Address:_____ E-Mail:_____

HIPPA: Notice of Privacy Practices (Updated July 2019)

DENNIS MENDONÇA, MA, MFT

East Kauai Professional Building Suite 203, 4-1579 Kuhio Hwy, Kapaa, HI 96746
808-652-2505 dennism08@gmail.com

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATIONO ABOUT YOU MAY BE USED AND DISCLAOSED AND HOW YOU CAN GET ACCES TO THIS INFORMATION. PLEASE REVIEW THIS AT YOUR CONVENIENCE.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care service is referred to as Protected Health Information (PHI). This Notice of Privacy Practices describes how I may use and disclose your PHI in accordance with applicable law and professional code of ethics. It also describes your rights regarding how you may gain access to and control your PHI. I am required by law to maintain the privacy of PHI and to provide you with notice of my legal duties and privacy practices with respect to PHI. I am required to abide by the terms of this notice. I reserve the right to change the terms at any time. Any new Notice will be effective for all PHI that maintain at that time. I will provide you with a copy of the revised Notice by sending a copy to you in the mail upon request, or providing one to you at your next appointment.

HOW MAY I USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU FOR TREATMENT: Your PHI may be used and disclosed by those who are involved in your care for the purposes of providing, coordinating, or managing your health care treatment and related services. This may include consultation with clinical supervisors or other treatment team members. I may disclose PHI to any other consultant only with your authorization. **For Payments:** I may use and disclose PHI so that I can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes or legal action due to lack of payment for service, I will only disclose the minimum amount of PHI necessary for purposes of collection. **For Health Care Operations:** I may use or disclose, as needed, your PHI in order to support my business activities including but not limited to, quality assessment activities, licensing, and conducting or arranging for other business activities. For example, I may share your PHI with third parties that perform various business activities (e.g. billing, transcribing or typing services) provided I have a written contract with a business or an individual that requires them to safeguard the privacy of your PHI. For training or teaching purposes PHI will only be disclosed with your authorization.

As required by law: Under the law, I must make disclosure of your PHI to you upon your request. In addition, I must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of determining investigating my compliance with the requirements of the privacy rule. **Verbal Permission:** I may use or disclose your information to family members that are directly involved in your treatment with your verbal permission. **With authorization:** Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked. **Without Authorization:** Applicable law and ethical standards permit me to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are **Required by Law,** such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the licensing board). **Required by Court Order. For Safety Reasons,** such as to prevent suicide, homicide, assault or any other serious and imminent threat to anyone's health or safety. If, in my professional judgment, you are likely to harm yourself, I may notify a family member or a friend of yours to assist in maintaining your safety. If I have a reason to believe that you have intent to harm someone else or pose a health threat to the community, I may disclose information to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

HIPPA: Notice of Privacy Practices (Updated July 2019)

Medical Emergencies. I may use or disclose use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. I will try to provide you a copy of this information as soon as reasonably practicable after the resolution of the emergency. **For Military/National Security Reasons.** If you are or were a member of the armed forces, or part of the national security or intelligence communities, military command or other governmental authorities may require the release of health information about you. **Family Involvement in Care.** I may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm. **In the Event of Your Death.** When friends or family have been involved in providing or paying for your treatment, I may release your health information to them as it relates to billing or other practical matters related to death. A release of information regarding deceased clients may be limited to an executor or administrator of a deceased person's estate or the person identified as next of kin. **Health Oversight.** If required I may disclose PHI to a health oversight agency for activities required by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third party payers based on your prior consent) and peer review organizations performing utilization and quality control. **Law Enforcement.** I may disclose PHI to a law enforcement official as required by law, in compliance with subpoena (with your written consent), court order, administrative order or similar document. The purpose for this disclosure would be the identification of a suspect, material witness or missing person, in connection with the victim of a crime, a deceased person, the reporting of a crime in an emergency, or in a crime on the premises. **Public Health.** If required, I may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information or to a government agency with whom they are collaborating for the purpose of preventing or controlling disease, injury, or disability. **Research.** PHI may only be disclosed after a special approval process or with your authorization.

Your Rights Regarding Your PHI: You have the following rights regarding PHI I maintain about you. To exercise any of these rights, please submit your request to me in writing, **Right to Revoke Your Consent.** You have the right to revoke your consent at anytime by giving me written notice. Your revocation will be effective when I receive it, but it will not apply to any uses or disclosures that occurred prior to that time. **Right of Access To Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. I reserve the right to charge a reasonable, cost-based fee for copies. **Right to Amend.** If you feel the PHI I have about you is incorrect or incomplete, you may ask me to amend the information, although I am not required to agree to the amendment. **Right To An Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that I make of your PHI. I may charge you a reasonable fee if you request more than in any 12-month period. **Right To Notification of Any Accidental Breaches of Confidentiality.** If there is an accidental breach of PHI-for example, if my computer is stolen or an e-mail is sent to the wrong person-you have the right to be notified after a risk analysis is conducted. This analysis will take I into account: the nature and extent of the PHI involved including the sensitivity of the information from a financial or clinical perspective and the likelihood the information can be re-identified; the person who obtained the unauthorized access and whether that person has an independent obligation to protect the confidentiality of the information; whether the Phi was actually acquired or accessed, determined after conducting a forensic analysis; and the extent to which the risk has been mitigated, such as by obtaining a signed confidentiality agreement form the recipient. **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. I am not required to agree to your request. **Right to Request Confidential Communication.** You have the rig ht to request that I communicate with you about medical matters in a certain way or at a certain location. **Right to a Paper Copy of This Notice. Complaints.** If you believe I have violated your privacy rights, you have the right to file a complaint in writing with the Secretary of Health and human Services at 200 Independence Ave., SW, Washington, DC 20201 or by calling (202)-619-0257.

I will not retaliate against you for filing a complaint.

AUTHORIZATION TO OBTAIN/RELEASE INFORMATION

Dennis Mendonça MA, MFT
Hawaii License # 193
East Kauai Professional Bldg, Suite 203
4-1579 Kuhio Hwy
Kapaa, HI 96746
808-652-2505
dennism08@gmail.com

I _____ DOB:_____
authorize Dennis Mendonça MA, MFT to obtain and release information from

_____

for the purpose of assessment, treatment planning and for communicating progress in treatment.

I understand that this release is good for one year from the date of signature and that I may revoke this permission in writing at anytime.

Print Name: _____

Signature: _____

Date:_____