

PATRICIA LEE, LLC
Licensed Mental Health Counselor
2153 Chuckwagon Road, Suite 202
Colorado Springs, CO 80919
719-268-6882

Adult ADHD Evaluation

Evaluation for Adult Attention-Deficit/Hyperactivity Disorder requires collecting information through questionnaires, talking to at least one adult who knew you growing up, talking to your spouse, partner or good friend, and an extensive personal interview to collect your emotional, school, social, family and work history. You may be asked to complete cognitive and academic testing if you suspect you also have a learning disability and it is interfering with your success in school, on the job or with future life plans.

Please answer ALL questions. Use additional space if needed but remember you may expand on your answers during our interview. Collecting information from your parents, when possible, especially your mother if she was the adult who had primary caretaking responsibilities when you were very young, is extremely important. If at all possible, please talk to a parent or other adult who knew you well as you were growing up BEFORE coming to your appointment.

If you have questions please call my office.

Adult Registration

Date _____

Patient Information

Name _____ Home Phone _____

Address _____
Street City State Zip

Birthdate _____ Age _____ SS # _____

Place of Work _____ Work Phone _____ Cell _____

Email (optional) _____ Gives permission to send appointment reminders and information pertinent to your counseling and mental health. *Your email address will NEVER be shared.*

Spouse/Partner Information

Name _____ Home Phone _____

Place of Work _____ Work Phone _____ Cell _____

Are you married? _____ For how long? _____ Have you been divorced? _____ How many times? _____

List names of children in the family, their ages and who they live with if other than parents. Also list others who live in the home.

_____	_____
_____	_____
_____	_____

Have you experienced any deaths of family members or others close to you in the past three years? Briefly describe.

Primary Care Physician _____ Last time seen _____

List any medications you are presently taking _____

Have you been hospitalized in the last four years? _____ If yes please describe reason and date of hospitalization.

Have you gained or lost more than 5 pounds in last six months? _____ Do you smoke? _____ How many packs per day? _____ How much alcohol do you consume on a daily basis? _____

On a weekly basis? _____ Do you consider yourself an alcoholic? _____

How many cups of coffee do you drink on a daily basis? _____ Have you ever used illegal drugs? _____

How many jobs have you held in the past 5 years? _____ Have you ever been suicidal? _____

If you have been to counseling before briefly describe when, who the counselor was and the reason for counseling.

How did you learn of my services?

May I send a verbal or written thank you to this individual or organization?

Have you ever felt you ought to cut down on your drinking or drug use?

Yes No

Have people annoyed you by criticizing your drinking or drug use?

Yes No

Have you ever felt bad or guilty about your drinking or drug use?

Yes No

Have you ever had a drink or used drugs first thing in the morning as an eye opener to steady your nerves or get rid of a hangover?

Yes No

Adult ADHD Evaluation

Name of Person being Evaluated _____

Date _____

You may use the back of this page if you need additional space to answer these questions.

What problems or behaviors concern you NOW? These may include what others say about you.

Why do you believe you may have ADHD?

When did you first become aware of being different or wonder what was wrong with you?

Tell a little about your interests, strengths, talents, hobbies.

What previous counseling experiences have you had? Tell when and who your counselor was.

What do you want your life to be like one year from now?

What do you want your life to be like five years from now?

Wender Utah Rating Scale for Adults Self Rating Form

Name _____ Date _____

Answer all items even though you may not be sure. Just answer the best your memory allows.

As a child I was (or had):	Not at all or very slightly	Mildly	Moderately	Quite a bit	Very much
Concentration problems, easily distracted					
Anxious, worrying					
Nervous, fidgety					
Poor attention, daydreaming					
Hot or short-tempered, low boiling point					
Temper outbursts, tantrums					
Trouble with stick-to-it-tiveness					
Stubborn, strong-willed					
Sad or blue, depressed, unhappy					
Disobedient, rebellious, sassy					
Low opinion of myself					
Irritable					
Moody, ups and downs					
Angry					
Trouble seeing things from someone else's point of view					
Acting without thinking, impulsive					
Tendency to be immature					
Guilty feelings, regretting what I did or said					
Losing control of myself					
Tendency to be or act irrational, not to make sense					
Unpopular with other students					
Trouble with authorities, trouble with school, visits to principal's office					
As a child in school, I was (or had):					
Overall a poor student, slow learner					
Trouble with mathematics or numbers					
Not achieving up to potential					

Please note anything else that stands out in your mind relating to your childhood.

Adult ADHD Evaluation Parent Form

Name of Person Completing Form _____

Relationship to Person Being Evaluated _____

Describe anything unusual about your child's eating, sleeping, toilet training, activity or childhood behavior. For example, did he/she walk, talk, toilet train at an appropriate age?

Tell about any significant health problems or surgeries your child had.

Did your child ever experience a significant trauma such as sexual or physical abuse, violence in the home, or traumatic events such as a tornado or earthquake? Briefly describe and tell when it occurred.

What significant deaths or losses did your child experience? When?

Was your child ever removed from the home or did he/she live with someone else? Briefly describe.

Is there a history of learning, attention or emotional problems on either the father's or mother's side of the family? Describe.

Tell me anything else that may be helpful to my evaluation.

Wender Utah Rating Scale For Adults Parent Form

Note: Parent input is helpful but not required. You can interview your parent or primary caregiver and fill in the form accordingly if that works better. You can also interview siblings, grandparents or others who knew you as a child.

As a child, she (he) recalled that you (were/had):	Not at all	Just a little	Pretty much	Not at all
Restless (overactive), couldn't sit still				
Excitable, impulsive				
Disturbed other children				
Failed to finish things started (short attention span)				
Fidgeted, hands always busy				
Didn't pay attention, easily distracted when talked to				
Demands to be met immediately, got frustrated				
Cried a lot				
Mood and feelings changed quickly				
Temper outbursts (explosive & unpredictable behavior)				

Other remarks made by your parent as you were asking about the above behaviors that might be related to symptoms of childhood ADHD.

Name of Person Interviewed _____ Date contacted _____

Now living in (city, state) _____ Her/his age _____

Highest grade she/he completed _____

What symptoms of ADHD do you think your mother/father had?

Patricia A Lee, M.A., M.Ed.

Licensed Professional Counselor, Colorado License #587

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Your Rights as a Client

The practice of both licensed and unlicensed persons in the field of psychotherapy including psychological testing is regulated by the Colorado State Department of Regulatory Agencies. Any questions, concerns or complaints regarding the practice of mental health counseling may be directed to the State Grievance Board, 1560 Broadway, Suite 1340, Denver, CO 80202; (303) 894-7766.

You are entitled to receive information from me about my methods of therapy, techniques I use, duration of therapy, if I can determine it, and my fee structure. Please ask if you would like to receive this information. You may seek a second opinion from another therapist or may terminate therapy at any time.

You should know that in a professional relationship, sexual intimacy between a therapist and a client is never appropriate. If sexual intimacy occurs, it should be reported to the State Grievance Board.

Information provided by a client during therapy sessions is legally confidential except for certain legal exceptions which include: 1) I am required to report suspected child abuse or neglect to the appropriate law enforcement agency; 2) If I receive information from a client concerning a serious threat of imminent physical violence against a specific person, I must inform that person of the threat, and also notify law enforcement authorities; 3) I am required to initiate a mental health evaluation of a client who is dangerous to self or others due to a mental disorder. You should be aware that legal confidentiality does not apply in a criminal or delinquency proceeding. You should also be aware that confidentiality does not apply if I become aware that you are physically or sexually abusing another individual, that you plan to hurt yourself or someone else or that you plan to commit suicide.

I am licensed to practice psychotherapy in the state of Colorado as a Licensed Professional Counselor, Colorado (License #587) and in Indiana as a Licensed Mental Health Counselor (License # 39001913A). I have a Master of Arts in Counseling from the University of Colorado (1989) and a Master of Education Degree from Trenton State College (1975). You should be aware that it is usual and customary for mental health professionals to seek peer consultation on cases and this is done in a manner that protects the confidentiality of the client. You should also be aware that when you sign your request for reimbursement from your insurance company that you give permission for them to obtain information about your diagnosis and the progress of your therapy. In addition, you should understand that if either one of us uses cellular or portable telephones (I use both from time to time), information transmitted by one or both of us may be intercepted by a third party.

Also, you authorize with your signature below that in the event of my death or grave disability, one or more of my selected colleagues may review confidential information I have collected about you or your child in order to advise you of options for the continuity of treatment.

I have been informed of my counselor’s degrees, credentials and licenses. I have also read the preceding information and understand my rights as a client.

Client Signature (Parent or guardian for minor)

Date

Patricia Lee, M.A, M.Ed.

Date

Patricia A. Lee, M.A., M.Ed.

Licensed Professional Counselor

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FEE AGREEMENT

In recent years, the confidentiality of psychotherapy has been undermined by medical insurance companies that require therapists to submit information about their patients. People who use their medical insurance or disability insurance to pay for psychotherapy waive some of their rights to confidentiality. When you use your insurance, a psychiatric diagnosis must be assigned and transmitted to your insurance company, detailed clinical information often must be provided by your therapist, and in the case of “in-network-benefits”, total access to patient files often must be provided to insurance company employees. Further, insurance companies often attempt to influence the methods or course of treatment so as to save money. That means treatment decisions are taken away from you and your therapist, the two people in the best position to make such decisions. Finally, psychiatric diagnoses may affect your ability to obtain future health or life insurance at a reasonable cost.

There is no way to ensure that confidential information will be treated as private once it is transmitted to an insurance company. For example, employers sometimes are able to obtain personal information from insurance records. In order to protect my client’s confidentiality and to provide ethical treatment I encourage you to pay out-of-pocket for your psychotherapy. I am happy to provide you with a simple billing statement that you may submit for “out-of-network” insurance reimbursement and/or tax purposes.

My standard fee is \$125 for a full session (50 minutes) and \$65 for a short session (25 minutes). Payment is due at the time of service by cash, check or Visa/Mastercard. If you pay by check please have your check written in advance to make best use of our time together. You also have the option of prepaying four sessions at the reduced rate of \$450. Sessions purchased in advance may be transferred to another member of the same family, are not refundable and must be used within three months. No shows and late cancellations will be deducted from pre-paid sessions. Telephone time or time spent on written correspondence or a report requested by you or professionals working with you is billed by the minute based on a fee of \$125 per 50-minute hour. Time spent with attorneys, court time or any written correspondence or tasks related to legal matters will be billed at \$250 per hour.

While psychotherapy may vastly improve the quality of your life, it is also an expensive process. The duration of therapy is affected by the nature of your concerns and what your goals are. It is very important that you feel you are benefiting from treatment. If at any time you feel you are not getting what you want or need out of therapy, I urge you to discuss this with me so that we can find a solution for your concerns.

Appointment Cancellations: My fees are based on the time I commit to work with you in sessions. Any scheduled session not cancelled 24 hours in advance will be charged at the full established fee including pre-paid appointments.

Emergencies: I do not interrupt client sessions and business appointments to answer calls. If your needs are immediate and of a crisis nature you should do one of the following: call Cedar Springs Hospital at 633-4114; call the Pikes Peak Mental Health Crisis Center at 635-7000; visit your nearest emergency room; or call 911. If your needs can wait call me at 719-268-6882, state that your message is urgent, and leave a number where you can be reached in the next few hours. I check my messages on a regular basis during the work day but do not check them on weekends. If you have caller ID on your phone and I am returning your call from my home you should be aware that I will not temporarily unblock my residence phone line to return your call. It is your responsibility to change your caller ID to accept a call from a blocked line. If you have caller ID and do not hear from me within a reasonable time you should use one of the emergency measures listed above. You should also be aware that calls made from cell phones and portable phones may not be secure and confidential.

Financial Contract:

I understand and agree to the professional fees and attendance policy described above. If for some reason charges accrue resulting in an overdue account and attempts to resolve nonpayment are unsuccessful any overdue account may be referred to an attorney or collection agency for collection. I understand that interest will accrue at the rate of 18 percent per year or 1 1/2 percent each month on any unpaid balance. Signature on this agreement indicates acceptance of such referral and responsibility for all costs of collection, including a reasonable attorney fee. I am ultimately responsible for all charges including those denied by my insurance provider. In the unlikely event that check funds are dishonored, I am aware that I will be charged a \$25 (or legal limit) processing fee. I agree that, in signing this Fee Agreement, I have read and fully understand the terms contained herein.

Name of Client _____

_____ Date

Signature of Responsible Party _____

