Gregory Devore, Ph.D
Professional Psychological Services

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Before Your First Appointment
Before we begin, I would like to get to know a little about you and the questions and concerns you will bring to therapy. I also provide information about me and my practice so that you can make an informed decision about engaging in therapy with me. I have created this packet of materials so that you may complete these forms and review the necessary information in advance of our first meeting. You are welcome to type or write your responses, but please sign all signature fields with blue or black ink.

Please return the following on the date of our first meeting:

__ Adult Information Questionnaire

__ Schedule with preferred times marked

__Credit card authorization form (if you prefer this option for payment)

__ Informed Consent for Treatment (please make sure it is signed)

First and Ongoing Appointments
My office is currently open four days each week, with some morning and evening hours. If we have not already scheduled a first meeting, you may call me to set up an appointment at 503-660-8549. Please leave your name and number and the best times to reach you in your message.

I look forward to seeing you soon,

Gregory Devore, Ph.D
Licensed Psychologist

ADULT INFORMATION QUESTIONNAIRE

Welcome to my practice. Please complete the following questionnaire to help me plan therapy services for you. If you need clarification on any question, please do not hesitate to call me. All information gathered here is held in strictest confidence.

Full Name: _____ Date: _____

Street Address: _____

City: _____ Zip: _____

Phone: Home_____ Work _____Cell _____

Best Number to Reach You? _____

Email: _____

Age: _____ Birth Date:_____

Occupation/Job Title: _____

Employer/School: _____

Your Education: _____

Ethnicity:_____

Religious/Spiritual Preference:_____ Active / Inactive

Relationship (circle one): Single / Married / Partnered / Separated / Divorced / Widowed

Relationship status satisfactory: Yes / No / It's complicated

Length of current relationship or longest previous relationship if single: _____

Partner's Name: _____

Partner's Employer: _____

Name of person to contact in case of emergency: _____

Phone: _____ Address: _____

Please list members of your family and all others living in your home:

Name / Age / Relationship / Occupation

_____

_____

_____

_____

_____

_____

Who can you count on for social support? (i.e., spouse, mother, father, friend, sibling, etc)

_____

Have you done military service? Yes / No If Yes, what branch?_____

Have you ever had a head injury? If yes, please explain: _____

_____

Do you have any current legal problems or a history of imprisonment? If yes, please explain:

_____

_____

_____

Name of primary care physician:_____

Address: _____

Phone: _____ Fax: _____

Date of your last physical:_____

When possible, I like to coordinate care with your physician, psychiatrist, or other health care provider. May I coordinate your care?

Yes / No Please initial here: _____

List any current health concerns impacting your life:

_____

_____

_____

Allergies or adverse reactions to medication or treatment: _____

List any medications you are currently taking:

Name of medication	Dosage	Frequency	Prescribed by	Start Date

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

Have you ever received psychiatric or psychological help of any kind before?_____yes / no

Therapist name / Dates / Purpose Was it helpful?

_____ yes / no

_____ yes / no

_____ yes / no

Have you ever been hospitalized for a psychiatric illness? _____yes / no

Does anyone in your immediate family have mental health issues?_____ yes / no

If yes, please describe: _____

Briefly describe your reason for seeking help:_____

_____

_____

_____

_____

_____

How long have you felt this way?_____

Have you felt this way at another time in your life?_____

What have you tried to help with the above problem(s)?_____

_____

_____

CURRENT SYMPTOMS

How much have the following problems bothered you *in the past week?* Please circle your answer.	Not at all	A little bit	Somewhat	Very much	Extremely
Fear of embarrassment makes me avoid activities or speaking to people.	0	1	2	3	4
I avoid activities where I am the center of attention.	0	1	2	3	4
Being embarrassed or looking stupid are my worst fears.	0	1	2	3	4
It scares me when I feel shaky.	0	1	2	3	4
It scares me when I feel faint.	0	1	2	3	4
It scares me when my heart beats rapidly.	0	1	2	3	4
It scares me when I become short of breath.	0	1	2	3	4
I avoid (or feel distress in) situations where I fear getting trapped ***or*** that I may experience panic.	0	1	2	3	4
I have phobias (excessive or unreasonable fears of specific situations or objects). If yes, describe your phobia(s):	0	1	2	3	4

If your life, have you ever had any experience that was so frightening, horrible, or upsetting that *in the past month* you had any of the following problems?					
I have had nightmares about the event or thought about it when I did not want to.	0	1	2	3	4
I tried hard to not think about it or went out of my way to avoid situations that reminded me of the event.	0	1	2	3	4
I have been constantly on guard, watchful, or easily startled.	0	1	2	3	4

Please rate how much you agree with each item. **Please circle your answer.**	Not at all	A little bit	Somewhat	Very much	Extremely
I have felt numb or detached from others, activities, or my surroundings.	0	1	2	3	4
Rate any: I am bothered by ideas, images, or impulses that seem silly, weird, nasty, or horrible and I have trouble getting rid of them; ***or*** I fear doing something impulsively that might cause embarrassment or harm.	0	1	2	3	4
I check things too much (e.g., locks, doors, the stove) ***or*** do mental acts or calculations repeatedly.	0	1	2	3	4
Rate any: I need to do things in a ritualized way or have things exactly symmetrical or repeat actions until it feels "just right."	0	1	2	3	4
I engage in behaviors that harm my body (e.g., cutting, hitting, or scratching self).	0	1	2	3	4
I have intense feelings of anger that I have difficulty controlling.	0	1	2	3	4
I react impulsively in ways that are either self-damaging or damaging of my relationships.	0	1	2	3	4
I have headaches.	0	1	2	3	4
I have stomach problems ***or*** sometimes I feel an urgent need to use the toilet, especially in stressful settings.	0	1	2	3	4
I have muscle or join pains.	0	1	2	3	4
I have had periods of time with excessive energy, little or no sleep, and have not felt tired.	0	1	2	3	4
I have had periods of time with euphoria or irritability where my thoughts raced and I could not slow my thinking down.	0	1	2	3	4
I have had trouble with grandiose plans, spending sprees, sexual acting out, or other impulsive behavior.	0	1	2	3	4
I have been impaired much of my life by difficulty finishing projects that I have started.	0	1	2	3	4
I have been impaired much of my life by a lack of organization.	0	1	2	3	4
I have been impaired much of my life by problems focusing on tasks.	0	1	2	3	4
I have been impaired much of my life by poor time management.	0	1	2	3	4
I engage in compulsive/binge eating (i.e., eating more than twice what others might eat in a single sitting).	0	1	2	3	4
I purge, use laxatives, or do extreme exercises to control my weight.	0	1	2	3	4
I have a history of not eating with excessive weight loss.	0	1	2	3	4
I avoid specific foods I consider unhealthy because I fear they are harmful.	0	1	2	3	4
I believe that others can put thoughts into my head.	0	1	2	3	4

Please rate how much you agree with each item. **Please circle your answer.**	Not at all	A little bit	Somewhat	Very much	Extremely
I hear voices talking to me or calling my name when no one is around.	0	1	2	3	4
Sometimes I receive messages from objects (such as the TV or radio) that are specifically directed at me.	0	1	2	3	4
Sometimes I think it would be easier to not be here, or it wouldn't be that bad if something fatal happened to me.	0	1	2	3	4
I have thoughts of suicide.	0	1	2	3	4
I have a specific plan to commit suicide.	0	1	2	3	4
I have access to guns: Yes / No (please circle one)					
I have attempted suicide in the past: Yes / No (please circle one)					
I have thoughts of harming others: Yes / No (please circle one)					
In your current relationship, has there been any hitting, insulting, threatening to harm, or screaming?	0	1	2	3	4
I do not feel safe in my own home.	0	1	2	3	4

Please add any useful details about your checked items above: _____

_____

_____

_____

Adult Outcomes Questionnaire 1.4

Name_____ **Date**_____

PHQ-9 Over the last two weeks, how often have you been bothered by any of the following problems? (Circle only one number per line)		Not at all	Several Days	More than half the days	Nearly every day
1.	Little interest or pleasure in doing things	0	1	2	3
2.	Feeling down depressed or hopeless	0	1	2	3
3.	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4.	Feeling tired or having little energy	0	1	2	3
5.	Poor appetite or overeating	0	1	2	3
6.	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7.	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8.	Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9.	Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

Add the circled numbers in each column, then add the sums: 0 + ☐ ☐ ☐ = ☐ **A**

10.	Feeling nervous, anxious or on edge	0	1	2	3
11.	Not being able to stop or control worrying	0	1	2	3
12.	Feeling unproductive at work or other daily activities	0	1	2	3
13.	Having trouble focusing on achieving your goals	0	1	2	3

Add the circled numbers in each column, then add the sums: 0 + ☐ ☐ ☐ = ☐ **B**

TOTAL (A + B) = ☐

If you have had a visit with Dr. Devore, please circle the number that BEST matches your feelings about your most recent visit.		Only a little or not at all	Sometimes	Quite a bit	Totally
1.	In the session, we discuss the things that are most important to me.	0	1	2	3
2.	I feel understood and respected by my clinician.	0	1	2	3
3.	I understand and agree with my treatment plan.	0	1	2	3

Goodness of Fit score: 0 + ____ ____ ____ = ☐ **F**

Gregory Devore, Ph.D
http://www.drdevorephd.com

Substance Use History

In the past 12 months, do you feel you have you abused alcohol or drugs? _____ yes / no

Do you feel you have a drug or alcohol problem?_____ yes / no

If you drink alcohol, please indicate current use (one drink equals one shot of liquor, one beer, or one glass of wine): __ 4 or more drinks per day __ 3 or fewer drinks per day
__ 1 drink per day __ less than 5 a week

Last drink (time and amount)? _____

Do you use drugs (including marijuana)?_____yes / no

If yes, what drugs?_____

How much?_____ How often?_____

When was the last time you used?_____ How much did you use?_____

Have you ever tried cutting down on drinking/drug use?_____yes / no

Have you ever felt angry/annoyed when asked about your drinking/drug use?_____yes / no

Have you ever felt guilty about your drinking/drug use?_____yes / no

Have you ever been arrested for a DUI?_____yes / no

Do you smoke cigarettes? yes / no If yes, how many per day?_____

Do you drink caffeine? yes / no If yes, how much per day?_____

List any other concerns you may have at this time: _____

_____

_____

_____

_____

OPTIONAL QUESTIONS

What do you do for relaxation and enjoyment? _____

_____

_____

_____

How much attention do you pay to your physical health? Please explain. _____

_____

_____

What do you value most in life? _____

_____

_____

If "everything were better" in your life, what would that look like? _____

_____

_____

_____

Schedule Information
Please return this page so I have an approximate idea of your schedule. This will assist me in making appointments with you and will also help me in the event that we need to reschedule a missed or canceled appointment.

Name _____ Date _____

Times I am available to schedule regular appointments:

Preferred times for appointments mark with ✔
Available times mark with ✗

Monday	Tuesday	Wednesday	Thursday	Friday
8:00 am	8:00 am	8:00 am	8:00 am	8:00 am
9:00 am	9:00 am	9:00 am	9:00 am	9:00 am
10:00 am	10:00 am	10:00 am	10:00 am	10:00 am
11:00 am	11:00 am	11:00 am	11:00 am	11:00 am
12:00 pm	12:00 pm	12:00 pm	12:00 pm	12:00 pm
1:00 pm	1:00 pm	1:00 pm	1:00 pm	1:00 pm
2:00 pm	2:00 pm	2:00 pm	2:00 pm	2:00 pm
3:00 pm	3:00 pm	3:00 pm	3:00 pm	3:00 pm
4:00 pm	4:00 pm	4:00 pm	4:00 pm	4:00 pm
5:00 pm	5:00 pm	5:00 pm	5:00 pm	5:00 pm
6:00 pm	6:00 pm	6:00 pm	6:00 pm	6:00 pm
7:00 pm	7:00 pm	7:00 pm	7:00 pm	7:00 pm

Credit Card Authorization Form

I, _____, authorize Gregory Devore, Ph.D., to charge my credit card for professional services.

- I understand, and agree, that my card will be charged per session rate (individual, couples, or group) or the value of a cancellation as was disclosed in the informed consent literature.
- I understand and agree that my card will be charged for balances of charges not paid by me within 45 days of due date.
- I understand this form is valid until my card's expiration date, or if my card account number changes, unless I cancel the authorization in writing.
- I will not dispute charges for sessions I have received, cancellations, or appointments I missed according to the aforementioned policies.

All billing information is securely stored

Cardholder Name: _____

Billing Address: _____

Credit Card Type (circle one): Visa MasterCard Discover Amex

Credit Card Number: _____

Expiration Date:_____

Card Security Code (last 3 digits located on the back of the card): _____

Print Name, Sign, and Date Below:

Name: _____ Date: _____

Signature: _____