**Heart of Texas Trauma Recovery Network Client Information**

**Personal Information**

|  |  |
| --- | --- |
| Name:                | Date:     /     /      |
| Age:       | Date of Birth:     /     /       |
| Home Address:      |
| City:       | State:       | Zip:      |
| Primary Contact Phone *Please check number you can be reached* | [ ]  Home Phone #      -     -     *Leave Message* [ ] Yes [ ]  No | [ ]  Cell Phone #      -     -     *Leave Message* [ ] Yes [ ]  No |
| Email:       |

**Emergency Contact**

*If there is an emergency during our work together with concern for you personal safety, I am requited by law and the rules of my profession to contact someone close to you. Please identify an individual that we may contact in the event of an emergency.*

|  |  |
| --- | --- |
| Name:       | Relationship to you:       |
| Primary Contact Phone  | [ ]  Home Phone #      -     -     *Leave Message* [ ] Yes [ ]  No | [ ]  Cell Phone #      -     -     *Leave Message* [ ] Yes [ ]  No |

**Other Professionals Involved in Your Treatment**

|  |  |
| --- | --- |
| Medical Provider/Clinic Name:       | Address:       |
| Primary Contact Phone *May I have your permission to contact this person for continuity of care?* [ ] Yes [ ]  No | [ ]  Home Phone #      -     -     *Leave Message* [ ] Yes [ ]  No | [ ]  Cell Phone #      -     -     *Leave Message* [ ] Yes [ ]  No |
| Psychiatric Provider/Clinic Name:       | Address:       |
| Primary Contact Phone *May I have your permission to contact this person for continuity of care?* [ ] Yes [ ]  No | [ ]  Home Phone #      -     -     *Leave Message* [ ] Yes [ ]  No | [ ]  Cell Phone #      -     -     *Leave Message* [ ] Yes [ ]  No |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Employment Status:**  | [ ]  Full-time  | [ ]  Part-time | [ ]  Student | [ ]  Unemployed |
| **First Responder:** [ ]  Yes [ ]  No | Branch:       Rank:       | Length of Service:       |

**Personal Information continued pg2**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Client Initials:** **Date: / /** | Age  | Gender | EMDR Therapist | Bilingual need[ ] Yes [ ]  No |
| Assessed SI/HI?Ideation/Plan/Intent/ [ ] Yes [ ]  No | Informed Consent signed? [ ] Yes [ ]  No | History Reviewed? [ ] Yes [ ]  No |
| **Impressions/Diagnosis:** | ICD10:  | Need for higher level care? [ ] Yes [ ]  No |

|  |  |  |
| --- | --- | --- |
| **Ethnicity:**  | * [ ]  African/American
* [ ]  Anglo/American
* [ ]  Hispanic/Latino/American
* [ ]  Native Hawaiian/Pacific Islander
* [ ]  American Indian/Alaskan Indian
 | * [ ]  Multiracial/American
* [ ]  Asian/Indian
* [ ]  Asian/American
* [ ]  Middle Eastern
* [ ]  Other:
 |
| **Check All that Apply:**  | * [ ]  Poor pre-morbid adjustment
* [ ]  Single incident trauma
* [ ]  Multiple incident trauma
* [ ]  History of addiction-at risk/reactivate
* [ ]  Prior trauma-unresolved
* [ ]  Instability of current life circumstances
* [ ]  Possible secondary gain
* [ ]  Potential legal involvement
* [ ]  Potential medical issues
 | * [ ]  Able use positive resources
* [ ]  Window of tolerance high
* [ ]  History of addiction-resolved
* [ ]  Prior trauma-resolved
 |
| **Not candidate for EMDR**:  | * [ ]  Active addictions
* [ ]  Unable to change state/self-soothe
* [ ]  Cannot tolerate affect (+ or -)
* [ ]  Cannot maintain dual attention
* [ ]  Dissociative disorder (DID,DD-NOS)
* [ ]  Markedly unresolved prior trauma
 | * [ ]  Major depression
* [ ]  Possible neurological injury
* [ ]  Danger to self or others
* [ ]  Active psychosis
* [ ]  Other:
 |
| **Suggested EMDR Protocols:** | * Resource/ Stabilization
* ERP
* R-TEP
* IGTP
* EMDR-8 phase
 | * REP
* EMDR-PRECI
* G-TEP
* G-REP
* Flash
* Other:
 |

**Intake Assessment Notes pg3**

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| --- | --- | --- | --- | --- |
| **Client Initials:** **Date: / /** | Age  | Gender | EMDR Therapist | Bilingual need[ ] Yes [ ]  No |

**Notes:**

**Therapist Name (print)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature License #**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HOT TRN Consent for Treatment pg4**

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| --- | --- | --- | --- | --- |
| **Client Initials:** **Date: / /** | Age  | Gender | EMDR Therapist | Bilingual need[ ] Yes [ ]  No |

\_\_\_\_\_\_\_\_(initial) When you work with a Texas licensed therapist from the Heart of Texas Trauma Recovery Network (HOT TRN), you will receive brief, symptom-informed single incident trauma treatment only. In the first meeting, you and your therapist will discuss what you need and how best to meet those needs. Part of your treatment might include the use of Eye Movement Desensitization and Reprocessing (EMDR). EMDR therapy involves recalling a stressful past event and “reprocessing” the memory using bilateral stimulation (eye movements, tones or tapping) to facilitate this process. All EMDR-related procedures or specialty protocols will be fully explained to you prior to beginning treatment. If it is determined that you could benefit from a more comprehensive treatment program or referral for a more intensive psychiatric treatment, your HOT TRN therapist will provide you with recommendations and treatment options.

\_\_\_\_\_\_\_(initial) If you have any medical issues that might impair your ability to take part fully in treatment, you should contact your medical provider to get clearance for participating in EMDR. If you have any legal issues that might be impacted by your treatment, you should contact your attorney to discuss this form of treatment and get clearance for participating in EMDR therapy.

\_\_\_\_\_\_\_\_(initial) You understand that, if available by your therapist, you may receive up to six (6) therapy sessions of 60-90 minutes to be conducted in the therapist’s office, or designated location. These sessions will be conducted on dates and at times consistent with the therapist’s schedule of appointments, and availability, at no charge whatsoever. Once you reach the final or 6th session, you understand that if you choose to continue after these sessions with the therapist, you will be expected to pay the therapist at the beginning of each session $\_\_\_\_\_\_\_\_\_\_.

\_\_\_\_\_\_\_\_(initial) HOT TRN can refer you to a therapist for continuation of treatment. Any referrals will be provided at your last meeting or today. If you do wish to continue your treatment, with your therapist a signature of private practice consent to treatment form will be provided.

\_\_\_\_\_\_\_\_(initial) I understand that the HOT TRN is a volunteer network of therapists who practice independently. You have been provided with a copy of the therapist's Notice of Privacy Practices. If you have questions regarding the Privacy Notice or your privacy rights, you should speak to your therapist. You may obtain a summary of or copy of your records upon written request and payment for copying charges, if any.

\_\_\_\_\_\_\_\_(initial) I understand that the HOT TRN is a volunteer network of therapists who practice independently. I understand that this form and the information included may be shared with the volunteer TRN members to coordinate care and services. Your records will be maintained by the individual volunteer and not by the HOT TRN.

Your signature below will indicate that you understand and accept the terms of this agreement.

**NOTICE TO THE RECIPIENT OF THE INFORMATION**

*NOTICE: The information contained in this document transmission may contain privileged and confidential information, including patient information protected by federal and state privacy laws. It is intended only for the use of the person(s) named above. If you are not the intended recipient, you are hereby notified that any review, dissemination, distribution, or duplication of this communication is strictly prohibited. If you are not the intended recipient, please contact the sender by reply email and destroy all copies of the original message.*

|  |  |
| --- | --- |
| **Client Name**  | **Therapist Name** |
| **Client Signature Date**  | **Therapist Signature Date** |









