12641 World Plaza Lane, Building 56
Fort Myers, FL 33907
Tel: 239-247-1756 **Fax:** 239-690-2438 (fax)
www.katzpsychology.com

Informed Consent

I ______________________ voluntarily give my consent to Katz Counseling and Educational Psychology for the purposes of providing psychological and mental health services. (*If applicable:* This consent also includes psychological and mental health services for my child/children ______________________________________). These services may include but are not limited to: psychological assessment, counseling, consultation, parent training, and study skills enhancement. I understand that psychological and mental health services are confidential with the exception of the following scenarios: (A) knowledge or reasonable suspicion of harm to self or others, (B) knowledge or reasonable suspicion of child or elder abuse, and (C) court order of information regarding your case. I understand that if an individual accompanies me to my session(s), I am consenting to their participation in my services, including the sharing of my protected health information. I understand that if my child(ren), family members or other individuals participate in services with me, they may have rights to privacy and my access to their disclosures may be limited. Additionally, it is understood that minor children or dependents benefit therapeutically from privacy being respected by their parents or guardians. As such, the provider reserves the right to provide a treatment summary in lieu of extensive progress notes to assist with maintaining therapeutic rapport and alliance with the minor child or dependent adult client. If applicable, I agree to make a reasonable attempt to obtain consent for services from any and all medical decision making parent(s)/guardian(s) regarding the individual clients' services.

Psychological and mental health services are intended to be beneficial in the improvement of mental health or academic concerns; however, none of these benefits are guaranteed. You may disagree with the opinions offered to you and emotional distress may result from sensitive matters which are addressed during the course of psychological services. Alternative referrals to another health care provider will be given if desired.

Katz Counseling and Educational Psychology provides only outpatient mental health services and does not guarantee emergency intervention, particularly if it is necessary after business hours. If you should require emergency services after business hours, please call 911 or SalusCare (239) 275-3222.

By signing below, I confirm that I have read this form in its entirety or it was read to me, and I understood and agree with the information included in it. I have no additional questions and I have clarified any information with which I disagree. I concur that my consent is voluntary and can be revoked at any time.

____

Name of client

____ ____________________

Signature of adult client or parent/guardian of client Date

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Patient Consent for Use and Disclosure of Protected Health Information (HIPAA Acknowledgement)

I hereby give my consent for Katz Counseling & Educational Psychology to use and disclose protected health information (PHI) about me to carry out psychological services (evaluation or treatment), payment and health care operations (TPO). (The Notice of Privacy Practices-Updated 9/23/13 provided by Katz Counseling & Educational Psychology describes such uses and disclosures more completely.) Any uses or disclosures of personal information not described in this Privacy Notice require a signed Authorization before PHI can be released. We are required to provide notification if there is a breach of insecure PHI.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Katz Counseling & Educational Psychology reserves the right to revise its Notice of Privacy Practices at any time. An up-to-date Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Sheba Katz (239) 247-1756.

With this consent, Katz Counseling & Educational Psychology may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including test results, among others.

With this consent, Katz Counseling & Educational Psychology may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, services availability and patient billing statements and medical records.

With this consent, Katz Counseling & Educational Psychology may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, , such as appointment reminder cards, services availability and patient billing statements and medical records. I have the right to request that Katz Counseling & Educational Psychology restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Katz Counseling & Educational Psychology to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Katz Counseling & Educational Psychology may decline to provide services to me.

______________________________ ______________________
Signature of Patient or Legal Guardian Date

______________________________ ______________________________
Print Patient's Name Print Name of Legal Guardian, if applicable

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Financial Responsibility and Guarantee of Payment for Services

We are glad that you have chosen Katz Counseling and Educational Psychology (KCEP) to work with you or your family. We hope that you find your experience with us helpful. The aim of this notice is to clarify the financial arrangements before services begin.

By signing below, you agree to be charged for direct and indirect services that we provide. Direct services are face-to-face services, such as psychotherapy, assessment, consultation, and observation. Indirect services, are services that are provided when the client is not physically present, which may include but are not limited to: review of records, school visits, collaboration between providers, advocacy, test scoring and interpretation, documentation, report writing, and phone calls. While some of these services are covered by insurance, others may not be deemed as medically necessary. Specifically, services designed to inform legal, educational or vocational needs may be outside the scope of medical insurance coverage. Additionally, insurance often has standard time allocations for services and may not cover extended professional time given to provide high-quality, comprehensive services. When insurance does not cover a service, you will be billed at the standard (45-55 minute) rate of $200/Hour. However, if eligible, a sliding scale rate based on income can also be calculated.

The standard forensic hourly rate is $250 which may include, but is not limited to, court-involved or court-ordered psychological services, consultation with attorneys, producing reports or summaries for the courts, preparation for court, depositions and court testimony. If at any time your case becomes court-involved, or for use in legal proceedings, your fee will be switched to the forensic rate and cannot be billed to insurance by the practice.

Assessment services involve billing for actual hours spent testing and time spent scoring, interpreting, and writing up results. **A brief summary of the results of testing is included in evaluation fees; however, a comprehensive report can be prepared at the cost of the hourly rate. Comprehensive reports generally require between 3 to 6 hours and insurance companies may not cover this service.**

Appointments are specifically held for the client and it is important that you give a 24 hour notice if you intend to cancel or not attend. If we do not receive notification within that time frame, we will charge you a $100 per hour fee for the late cancellation or no show. Additionally, if two doctors' time has been reserved for the appointment a $200 per hour fee will be applied. This cannot be billed to insurance. For returned checks, you are expected to pay the bank fee and the full charge for those services in cash or cashier's check. Client will be responsible for all costs of collections.

By signing this form, you are also consenting to allow KCEP to contact your insurance company regarding payment for services. It is your responsibility to understand your insurance plan. Any precertification which is required by your insurance company must be done prior to your appointment. The precertification for services should be submitted to Katz Counseling and Educational Psychology before services are rendered. ***It is difficult to understand all of the caveats of each insurance***

company and you will be responsible for payments which are not covered by your insurance company. Any issues with reimbursement are the responsibility of the client, not Katz Counseling and Educational Psychology.

Please provide the credit card information below. ***We do not accept American Express***:

VISA MASTERCARD DISCOVER

Full name on card ____

Credit Card #____

Expiration Date____________ Security Code _____________

If we are in-network with your insurance and your carrier does not pay within 30 days and you are notified by phone/email, you will be given an additional 10 days to settle the balance. If not, your card will be automatically charged for the unpaid balance.

If you are a self-paying client, your card will be automatically charged for any unpaid balance after services are rendered.

By signing below, you authorize Katz Counseling and Educational Psychology to charge your card for any unpaid balance after services have been rendered.

____
Name of client

____ __________________
Signature of adult client or parent/guardian of client Date

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Adult Client Information Form

Full Name:

Primary Address: (street/city/state/zip)

Date of Birth: Age: SS#:

Relationship to Primary Insured:

Contact Information:

Email Address:

Home Phone:

Cell Phone:

Emergency Contact Name and Relation:

Emergency Contact Phone Number:

Name of Current Primary Care Physician Phone #

Days/Times that you are available for an appointment:

How did you hear about us?

Reason for Referral:

Insurance Information for Primary Insurance

Insurance Company:	Insurance Phone Number:
Subscriber’s Name:	Subscriber’s Birthdate:
Subscriber’s Social Security #	Subscriber’s Employer:
Subscriber’s Address:	
Member ID#	Group#
Specialist Copay:	Specialist Coinsurance:

Insurance Information for Secondary Insurance (if applicable)

Insurance Company:	Insurance Phone Number:
Subscriber’s Name:	Subscriber’s Birthdate:
Subscriber’s Social Security #	Subscriber’s Employer:
Subscriber’s Address:	
Member ID#	Group#
Specialist Copay:	Specialist Coinsurance:

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Adult Background History

Name	
Who completed this form?	
Birthdate	
Age	
Date of Appointment	
Gender	
Ethnicity	
Languages Spoken	

Are there any recent life changes that may be affecting you right now? Yes No

If so, please describe:

Social History:

Where were you born?

Please list all of the different cities in which you have lived since birth.

Location	Ages or Dates

About your parents:

Name of Parent	Job	Mental Health difficulties?	Relationship with you?	Health?
		Yes No	Poor Fair Good	Poor Fair Good Deceased
		Yes No	Poor Fair Good	Poor Fair Good Deceased

Are your parents married to each other or together? Yes No Never Married

If not, how old were you when they divorced/separated?

If divorced /separated, did your parents remarry? Yes No

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Please complete this table for any step-parents:

Name of Parent	Job	Mental Health difficulties?	Relationship?	Health?
		Yes No	Poor Fair Good	Poor Fair Good Deceased
		Yes No	Poor Fair Good	Poor Fair Good Deceased

If your parents were divorced, which parent did you live with? Mom Dad Both Other:

Custody Schedule: Full Time: _________ 50/50 Split:___________
Weekends:___________No Contact: ______________ Other:___________________

How many sisters do you have? _____ How many brothers do you have? ____

Please complete this table for your brothers and sisters:

Name	Age	Learning problems?	Mental Health difficulties?	Relationship?
		Yes No	Yes No	Poor Fair Good
		Yes No	Yes No	Poor Fair Good
		Yes No	Yes No	Poor Fair Good
		Yes No	Yes No	Poor Fair Good
		Yes No	Yes No	Poor Fair Good

Circle any of the following that have been present in **your immediate/extended family** members:

Heart Disease/Attack	Stroke	Cancer	Intellectual Impairment
Learning Problems	Anxiety	Depression	Social Difficulties
ADHD	Autism/Asperger's	Alcoholism	Drug Addiction/Abuse
Bipolar Disorder	Personality Disorders	Jail/Prison	Probation
Suicide	Extended Unemployment	Eating Disorder	Developmental Delays
Tic Disorders	OCD	Schizophrenia	PTSD
Sleep Disorders	Sexual Disorders	Other:	Other:

Has how you were treated and raised as a child had more of a positive or negative effect on your personality? Positive Negative

If you circled negative, please explain:

At home, did you often or very often feel (Circle all that apply):

Unloved	Unsupported	Unimportant
Unprotected	Unsafe	Lonely

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History of Trauma (circle all that apply):

Serious Illness in Family	Serious Illness in Child	Poverty
Homeless	Foster Care/Adopted	Multiple Caregivers
Unsafe Neighborhood	Exposure to Domestic Violence	Child Abuse/Neglect
Emotional Abuse	Sexual Abuse	Attempted Sexual Assault
Victim of a Crime	Victim of Violence	Attempted Physical Assault
Threatened with Violence	Threatened with a Weapon	Been Afraid for your Life

Was the Department of Children and Families (DCF), ever involved with your family as a child?

Yes No

Do you attend a religious organization regularly? Yes No
Where___________________________

Do you feel emotionally supported by friends and family? Yes No

Were you ever abused or mistreated? Yes No

As a child, was there enough food to eat in your home? Yes No Sometimes

Presently, is there enough food to eat in your home? Yes No Sometimes

Current Family History:

Who do you currently live with?
____

Have you ever lived with someone who had a problem with alcoholism or drugs? Yes No

Have you ever been in a serious relationship? Yes No

Are you currently in a romantic relationship? Yes No How long? _______________

Have you ever been married? Yes No How many times? ____

Spouse Name	Date Married	Date Separated/Divorced

Circle any problems in your romantic relationships:

Communication	Trust	Commitment	Affair/Cheating	Anger	Control
Physical fights	Yelling	Insults	Affection	Intimacy	Empathy

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Making time	Disagree about Money	Disagree about Religion	Disagree about childrearing	Romance	Alcohol/Drug Abuse

Do you have difficulty making friends? Yes No

Do you have difficulty keeping friends? Yes No

Circle any problems in your relationships with friends.

Don't keep in touch	Hard to think of things to say	Hard to meet people	Hard to open up	Too few friends	Respect
Gossiping	Don't like people	Trust	Empathy	Physical fights	Backstabbing
Making time	Arguments	Yelling	Insults	Can't count on them	Alcohol/Drug Abuse

Do you have any children? Yes No

Name	Age/Grade	Learning problems?	Mental Health difficulties?	Relationship?
		Yes No	Yes No	Poor Fair Good
		Yes No	Yes No	Poor Fair Good
		Yes No	Yes No	Poor Fair Good
		Yes No	Yes No	Poor Fair Good

Parent Time/Custody Schedule with your child(ren): Full Time:__________50/50
Split:____________ Weekends: ____________ No Contact:_______________
Other:_____________________

Has DCF been involved with your current family? Yes No

If yes,
explain:____

Are you a caregiver to your parent or parent in laws? Yes No

Developmental History:

Circle any of the following that were problems with your birth or delivery.

Premature	Low Birth Weight	Gestational Diabetes	Jaundice
C-Section	Mom drank alcohol	Mom smoked	Mom used illegal drugs

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To the best of your knowledge, did you met the following developmental milestones on time?
Talking? On time Delayed Walking? On time Delayed

Toilet Training? On time Delayed

Did you have any speech difficulties? Never As a child Currently

Did you ever receive speech therapy? Yes No If so, when?

Have you ever received occupational therapy? Yes No If so, when?

Have you ever received physical therapy? Yes No If so, when?

Medical History:

Place an “X” in the appropriate range if you have suffered from any of the following:

Medical Disorder	As a child/teenager	As an adult
Broken Bones		
Concussion		
Head Injury		
Seizure/Epilepsy		
Heart Attack		
High Blood Pressure		
Chronic Stomach Problems		
Chronic Ear Infections		
Chronic Fatigue Syndrome		
Chronic Pain/ fibromyalgia		
Genetic Disorder		
Multiple Sclerosis		
Thyroid Condition		
Asthma		
Diabetes		
Cancer		
HIV/AIDS		
Other		
Other		
Other		

Have you ever had surgery? Yes No
If Yes, explain

Any visual difficulties? Yes No If Yes, do you wear glasses or contacts?

Any hearing difficulties? Yes No If Yes, do you wear a hearing aid?

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Please list any prescription medications that you currently use:

Medication	For What?	Doctor Who Prescribed?

Circle any of the following that you often struggle with:

Headaches	Fainting	Shortness of breath	Sore throat
Tension	Hair pulling	Nail biting/picks skin	Teeth grinding
Feels shaky	Stomachaches	Eat too much	Eat too little/No appetite
Nausea	Vomiting	Diarrhea	Constipation
Heart racing	Chest pains	Excess sweating	Shallow breathing
Can't fall asleep	Can't stay asleep	Wake up too early	Don't need sleep/Stay up all night
Nightmares	Sleep talk	Sleepwalk	Sleep eat
Snoring	Sleep Apnea	Excessive weight loss	Excessive weight gain

Circle any motor difficulties that you have:

Clumsiness	Poor fine motor	Difficulty with balance
Difficulty throwing or catching	Not athletic	Difficulty coordinating movements
Poor Handwriting	Poor balance	Poor muscle tone

For Females Only:
At what age did your first period begin? __________

If you have suffered from any of the following, place an X next to the symptom on condition:

significant changes in mood before or around your period	
Premenstrual Dysphoric Disorder (PMDD)	
perinatal or postpartum depression	
polycystic ovarian syndrome (PCOS)	
difficulty with fertility/getting pregnant	

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used Intrauterine Insemination (IUI) or In Vitro Fertilization (IVF)	
Miscarriage(s)	
traumatic birthing experience	
Hysterectomy	
Menopause/Peri-menopause	
Pain during sex	
Endometriosis	
Hormonal supplements	
Other	
Other	
Other	

Mental Health History:

Circle any of the following which have been an issue for you over the past year:

Irritable	Sad most of the day	Excessively nervous	Unemotional or detached
Poor attention to detail	Paying attention for long periods	Poor organization	Easily distracted
Hard to repeat directions	Fail to finish work	Stressed	Forgetful
Loss of interest in normally enjoyable activities	Trouble getting to work or appts. on time	Frequent mood changes	Purposefully injure yourself or cut yourself
Mistrustful of others	Think about death	Low self-esteem	Think about suicide
Test anxiety	Impulsive	Social anxiety	Strong beliefs that are unsupported by reality
Sees or hears things that are not present	Fidgets	Restless	Obsessions
Break things	Physically aggressive	Phobia with ______________________________	
Flashback of bad memories	Nightmares	Seeing reminders of bad experiences everywhere	Poor concentration
Excessive energy	Hyper	No sex drive	Hyper sexual
Overwhelmed	Difficulty remaining quiet	Interrupt others while they are talking	Hostile
Hard to sit still	Ritual/unusual routines	Lack motivation	Withdrawn

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Excessive spending	Risky or illegal behavior	Hoarding	Overly dramatic
Anger management	Poor coping	Inflated self-esteem	Panic attacks
Lying	Anxious	Bizarre thinking	Procrastination
Feeling on top of the world	Feeling invincible	Can't control worrying	Thoughts come too quickly to keep up
Can't get organized	Loses things easily	No energy/Fatigue	Excessive guilt/shame
Antsy	Can't focus	Have to do things a certain way	Don't like change
Hate emotions	Avoid emotions	Feel hopeless	Feel Helpless
Feel like I was born the wrong sex	Unusual sexual interests	Other:	Other:

Circle any of the following harmful eating behaviors that you struggle with:

Avoid eating in front of others	Induce vomiting after meals	Overly restrictive diet	Exercise right after meals
Use diet pills	Purposefully fasts	Binge eats	Overly picky eater

Circle any of the following communication or social skills which you struggle with:

Using eye contact to interact with others	Initiating interactions	Don't enjoy activities with other people	Understanding what people expect in a relationship
Relating to other people's feelings	Explaining experiences	Accepting criticism	Bossiness
Making inappropriate comments	Hard to share or take turns	Holding conversations	Bragging
Overly shy	Misinterprets others' intentions	Inflexible with routines/rules	Hard to adjust to change
Few close friends	Unusual interests	Hard time with social chit-chat	Don't seek comfort when upset
Don't talk with my hands	Using voice intonation to communicate meaning	Talking with your eyes	Insulting people
Yelling	Problems reading facial expressions	Using nonverbal gestures to convey meaning	Difficulty expressing self effectively
Stutter	Using facial expressions to communicate	Understanding personal space	Speaking too loud

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Speaking too softly	Speak too fast	Poor pronunciation of words	Verbal tics
Cannot find the right words to say in conversation	Use words that have no meaning or made up words	Difficulty describing emotions or how I feel	Curse excessively
Talk too much	Talk too little	Talking too much about one topic	Repeating myself often
Dependent on others	Hard to be alone	Loneliness	Practice Social Situations
Speak too slow	Stuck in my ways	Other:	Other:

Circle any sensory difficulties that you struggle with:

Irritation with certain fabrics	Sensitive to bright lights	Picky eater	Don't like to be touched
Motor tics	Overly sensitive to loud noises	Don't respond to loud noises	Bothered by low volume noise
Don't like foods with certain textures	Don't like foods with strong tastes	Irritation with tags in clothes	Finding eye contact uncomfortable

Circle any mental health disorder in which you have been diagnosed:

Depression	Learning Disability	Obsessive Compulsive Disorder	Bipolar Disorder
Gender Identity	Sexual Disorder	Alcoholic	PTSD
Schizophrenia	Intellectual Impairment	Substance Abuse	Autism/Aspergers
Manic	Oppositional Defiant	Attachment issues	Tic Disorder
Anxiety	Conduct Disorder	Personality Disorder	ADHD/ADD
Sleep Disorder	Speech/Language Issues	Developmental Delays	Eating Disorder
Other			

Have you been to counseling before? Yes No

If so, when?

Who was the therapist? What were you treated for?

Have you ever received inpatient hospitalization for a mental health issue? Yes No

Have you ever been involuntarily hospitalized or Baker Acted? Yes No

Have you ever attempted suicide? Yes No How many times? __________

Drug and Alcohol Use:

Please circle all substances you have used in the past:

Substance	Last Use	Substance	Last Use
Alcohol		Cocaine	

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PCP (angel dust)		crack cocaine	
marijuana		Hallucinogens (LSD, acid, mushrooms)	
amphetamines (speed)		Bath salts	
Spice/synthetic marijuana		Ecstasy/Molly	
methamphetamine (meth)		Opium	
heroin		sleeping pills	
pain killers		Cigarettes and/or Vaping	
Prescription pills (Xanax, Adderall, oxy, etc.)		Other	

Have you ever lost a relationship because of drug or alcohol abuse? Yes No

Have you ever lost a job because of drug or alcohol abuse? Yes No

Have you ever been in legal trouble for drug or alcohol abuse? Yes No

Have you ever been treated for drug or alcohol abuse? Yes No

Facility	Year

Legal History:

Have you ever been in trouble with the law? Yes No

If so, when and what happened?

____

Have you ever been arrested? Yes No

If so, when and what happened?

____

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Have you ever been found guilty of a crime? Yes No

Offense	Date	Length of jail time, probation, or fine

Do you have an active legal case? Yes No
Are you involved in any of the following?

- Lawsuit? Yes No
- Custody Battle? Yes No
- Dependency Court? Yes No
- Personal Injury? Yes No
- Social Security? Yes No
- Workers Compensation? Yes No

Financial History:

Have you ever filed for bankruptcy? Yes No

Describe your current debt:

Do you own your home or pay rent? Own Rent

Are you able to pay your bills on time? Yes No

If No, explain:

Do you have a bank account? Yes No Do you use a bank or credit card? Yes No

Are you able to write a check? Yes No Are you able to balance a checkbook? Yes No

Do you check your bank account balance? Yes No

Do you have any difficulties maintaining your finances? Yes No

If yes, please describe:

Daily Living:

Can you do your own laundry? Yes No
Can you drive a car? Yes No
Do you have a driver's license? Yes No
Do you own/lease your own car? Yes No
Can you calculate change? Yes No

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Can you do your own grocery shopping? Yes No
Can you cook for yourself or your family? Yes No
Can you bathe and dress yourself without help? Yes No

Educational History:

Did you attend Preschool? Yes No If so, where?

Did you graduate high school? Yes No When did you graduate?

If you have not graduated, when do you expect to?

Did you graduate with a standard diploma? Yes No

If you did not graduate high school, did you get a GED? Yes No

Do you intend to go to college? Yes No

Have you attended any college? Yes No Major ______________________

Did you graduate from college? Yes No Degree ______________________

If you attended college but did not finish, please explain.

Please list the schools you have attended.

School	City, State	Ages or Years or Grades Attended

Did you pass state-wide standardized testing (e.g., FSA, FCAT, etc.)? (Circle response below)

Pass Fail Exempt

Were you in special education/Exceptional Student Education (ESE) in school? Yes No

If so, what grade did you begin special education? ______________

Circle any disability that you were placed in ESE/special education for:

Reading learning disability	Math learning disability	Writing learning disability	Speech/Language impaired
Hearing impaired	Visually impaired	Emotional disturbance	Intellectual Impairment

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Autism/Asperger's	Traumatic Brain Injury	Medical impairment	Other Health Impairment
Physical Therapy Impairment	Occupational Therapy Impairment	Developmental Delay	Hospital/Homebound

What types of special classes, accommodations or help with school do/did you receive (mark all that apply)?

Extended time on tests	Tests taken in a quiet space	Tests taken in small group	Additional time to complete assignments
Intensive Reading	Intensive Mathematics	Social-Communication Classroom	Behavior Unit Classroom
Intensive English/Language Arts	Speech or Language Therapy	Occupational Therapy	Physical Therapy
Shortened Assignments	Subjects taught below grade level curriculum	Exempt from state-wide standardized tests	Functioning Living Skills Classroom

What types of grades did you receive? ____

Did you ever have to repeat a grade? Yes No If so, what grade(s)? ____________

Did you ever get in trouble at school? Yes No If so, when did it start? __________

Did you ever get detentions? Yes No Did you ever get suspended? Yes No

What types of behaviors did you get in trouble for at school?

Did you ever get expelled from school? Yes No What grade were you in?

If so, why were you expelled?

Please list any after school activities that you participated in (e.g., clubs, sports)

Currently, what do you like to do for fun?

Job History:

Can you complete a job application without help? Yes No

Circle any of the following that have made it difficult for you to find or keep a job?

Reading	Math	Writing	Medical	Alcohol/Drugs	Mental Health	Legal

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In order, please list your job titles, where you worked, how long and why you left?

Job Title	Business Name	How long?	Why did you leave?

At work, do you have difficulty getting along with supervisors? Yes No
At work, do you have difficulty getting along with co-workers? Yes No
At work, do you have difficulty getting along with customers? Yes No
Have you ever been fired from a job? Yes No

If yes, please explain.____

Have you ever been a victim of harassment or discrimination on the job? Yes No

If yes, please explain.

____

What strengths do you offer a job?

____

What are your weaknesses on the job?

____

What types of jobs would you like to do in the future?

____

What types of jobs would you not like to do in the future?

____

Have you ever done any volunteer work? Yes No

Where?

____

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Are you unemployed? Yes No How long have you been unemployed?

Are you not working because of a disability? Yes No

Are you retired? Yes No