Jennifer Harned Adams, PhD
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Health & Wellness Services
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Client Information Form

Today's date: _____

Your name: _____ Date of birth: _____ Age: _____
Preferred Name: _____
Home street address: _____ Apt.: _____
City: _____ State: _____ Zip: _____
Preferred phone: _____ e-mail: _____
Calls or e-mail will be discreet, but please indicate any restrictions: _____

Referral Information: Who gave you my name to call?
Colorado Reproductive Endocrinology: ___ Dr. Woodford ___Dr. Trout

Other provider: _____

Internet Search: ___ Google ___ Psychology Today ___Good Therapy
_____ RESOLVE ___ ASRM ___I don't know ___ Other: _____

Emergency information
If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?
Name: _____ Phone: _____ Relationship: _____

Your medical care: From whom or where do you get your PRIMARY medical care?
Clinic/doctor's name: _____ Phone: _____
Date of last physical/medical exam: _____

Your current employer
Employer: _____ Occupation: _____

Religious and racial/ethnic identification
Current religious affiliation ❑ Protestant ❑ Catholic ❑ Jewish ❑ Islamic ❑ Buddhist ❑ Hindu

Other (specify): _____

Involvement: ❑ None ❑ Some/irregular ❑ Active

How important are spiritual concerns in your life? _____

Ethnicity/national origin/ Race/ or other similar way you identify yourself and consider important:_____

Education and Employment History

High School (Name and City): _____ Graduate? ❑ No ❑ Yes _____ (year)
Vocational Training (if applicable): _____ Graduate? ❑ No ❑ Yes _____ (year)
College (if applicable): _____Graduate? ❑ No ❑ Yes _____ (year)
Graduate Studies (if applicable): _____ Graduate? ❑ No ❑ Yes _____ (year)

Did you ever have any significant educational concerns or support, such reading support, speech theapy, repeat or skip a grade, or receive gifted services? If so, please describe: _____

_____

Please list the three most recent and/or personally important occupational or volunteer positions you have held:

Dates	**Position (indicate PT/FT)**	**Organization**	**Reason for leaving**
1.			
2.			
3			

Family-of-origin history

Relative	**Name**	**Current age** *or age at death & year*	**Health Concerns** *or cause of death*	**Relationship Status**
Mother				❑ Satisfactory ❑ A source of mild stress ❑ A source of major stress/not speaking ❑ NA
Father				❑ Satisfactory ❑ A source of mild stress ❑ A source of major stress/not speaking ❑ NA
Sibling				❑ Satisfactory ❑ A source of mild stress ❑ A source of major stress/not speaking ❑ NA
Sibling				❑ Satisfactory ❑ A source of mild stress ❑ A source of major stress/not speaking ❑ NA
Sibling				❑ Satisfactory ❑ A source of mild stress ❑ A source of major stress/not speaking ❑ NA
Other important relative				❑ Satisfactory ❑ A source of mild stress ❑ A source of major stress/not speaking ❑ NA
Other important relative				❑ Satisfactory ❑ A source of mild stress ❑ A source of major stress/not speaking ❑ NA

Significant Adult Relationship History

Relationship	Partner's First Name	Relationship status	Reason for break-up
Current or Most recent		❑ Satisfactory ❑ A source of mild stress ❑ A source of major stress ❑ NA/ ended	❑ NA - current

Children

Name	DOB/Current Age	Relationship Status
		❑ Satisfactory ❑ A source of mild stress ❑ A source of major stress ❑ estranged
		❑ Satisfactory ❑ A source of mild stress ❑ A source of major stress ❑ estranged
		❑ Satisfactory ❑ A source of mild stress ❑ A source of major stress ❑ estranged
		❑ Satisfactory ❑ A source of mild stress ❑ A source of major stress ❑ estranged

HEALTH HISTORY

Please list any major illness, important diagnoses (ie, autoimmune diseases), injuries and surgeries below. Continue on the back of this sheet if you need more space.

Health Concern	Date/Age	Still an active problem?	Impact on life today
		❑ yes ❑ no	❑ no impact ❑ mild impact ❑ moderate impact ❑ major impact DESCRIBE: _____
		❑ yes ❑ no	❑ no impact ❑ mild impact ❑ moderate impact ❑ major impact DESCRIBE: _____
		❑ yes ❑ no	❑ no impact ❑ mild impact ❑ moderate impact ❑ major impact DESCRIBE: _____
		❑ yes ❑ no	❑ no impact ❑ mild impact ❑ moderate impact ❑ major impact DESCRIBE: _____

Health habits
What kinds of physical exercise do you get? _____
_____

Have you ever tried to restrict your eating in any way?
When? _____

How? _____

Why? _____

4. Do you have any problems getting enough sleep? ❑ No ❑ Yes. If yes, what problems? _____
_____

For women (not required for partners of GC candidates)
At what age did you start to menstruate (get your period): _____

Menstrual period experiences:

a. How regular are they? _____

b. How long do they last? _____

c. How much pain do you have? _____

d. How heavy are your periods? _____

e. Other experiences during periods? _____

Please describe any pregnancies:

Your age	Pregnancy Loss (pls indicate gestational age at time of loss)	Termination	Live birth	Important information

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Mental Health Counseling or Treatment

Have you ever received psychological, psychiatric, drug or alcohol treatment, or relationship counseling services before?
❑ No ❑ Yes If yes, please describe below. Please include reason and age at time of services (inpatient and/or outpatient)

Have you ever taken medications for psychiatric or emotional problems?
❑ No ❑ Yes If yes, please describe. Please indicate name of medication, dosage and age when taking (*to the best of your memory)*

Trauma/ Loss/ Abuse history:
Please briefly describe and provide approximate dates/ages related to any personal history of trauma, abuse, or significant loss you have experienced:

Chemical/substance use
1. How many cups of regular coffee do you drink each day? _____ How many cups of tea? ____.

How many sodas/pop with caffeine (Coke, Pepsi, Mountain Dew, Dr. Pepper, Orange Crush, etc.)? ____

How many "energy drinks"? ____ How often do you use No Doz or similar caffeine pills? _____ .

2. How much tobacco do you smoke or chew each week? _____

3. Have you ever felt the need to cut down on your drinking? ❑ No ❑ Yes

4. Have you ever felt annoyed by criticism of your drinking? ❑ No ❑ Yes

5. Have you ever felt guilty about your drinking? ❑ No ❑ Yes

6. Have you ever taken a morning "eye-opener"? ❑ No ❑ Yes

7. How much beer,wine,or hard liquor do you consume each week,on the average? _____

8. Are there times when you drink to unconsciousness, or run out of money as a result of drinking? ❑ No ❑ Yes

9. Have you ever used inhalants ("huffing"), such as glue, gasoline, or paint thinner? ❑ No ❑ Yes

If yes, which and when? _____

Which drugs (not medications prescribed for you) have you used in the last 10 years? _____

_____

Legal history

Do you have any significant CURRENT legal concerns? ❑ No ❑ Yes Describe:_____

Do you have any significant PAST legal concerns? ❑ No ❑ Yes Describe:_____

Personality and Stress Management Style (not required for partners of GC candidates)

What are your greatest strengths?

What are your areas of greatest challenge? Are there things that any members of your support team (friends and family, health care providers, intended parents) can do to help you with these as you go through the GC process?

How do you handle conflict?

Describe a situation that reflects your reliability and conscientiousness.

Describe the biggest challenge you have faced and how you overcame it.

Describe your biggest current source(s) of stress. What are your go-to strategies for managing stress? What are the cues that help you realize you are feeling stressed out?

About pregnancy and serving as a gestational carrier:
(partners of GC candidates, please note any concerns here as applicable)

What have been the most challenging aspects of pregnancy for you in the past? How did you cope with those?

What do you anticipate your biggest challenges will be or what have your biggest hesitations been (could be physical, emotional, and/or practical) with regard to serving as a gestational carrier?

In general, what supports would be most helpful for you as you go through the GC process?

Please indicate any additional concerns you may have regarding serving as a gestational carrier. If your concern is not included here, please feel free to write it in below. Thank you!

- ❑ Disclosing conception to my child(ren)
- ❑ Concerns related to religious beliefs
- ❑ Managing relationships with the intended parents
- ❑ Mental health concerns during pregnancy
- ❑ Mental health concerns postpartum
- ❑ Managing relationships with the clinic/providers
- ❑ Answering questions from family/friends/acquaintances
- ❑ Concerns related to the impact this will have on my partner
- ❑ Concerns related to the impact this will have on me
- ❑ Health concerns about the pregnancy
- ❑ Other: _____

If you have other questions related to any aspect of this process, or related to any mental health or counseling issues, please indicate those here.

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Disclosure Statement

Degrees, Licenses & Experience:

B.A.	Franklin and Marshall College, Psychology
M.A.	University of Houston, Psychology
Ph.D.	University of Houston, Clinical Psychology

Clinical Psychology Internship:
University of Texas Houston Health Sciences Center
Department of Psychiatry and Behavioral Sciences

Postdoctoral Training:
Postdoctoral Fellowship in Cancer Prevention
University of Texas M.D. Anderson Cancer Center

License: Colorado, Psychologist, #3123

I maintain a practice that includes treatment of adults seen as individuals, couples and in groups. My scope of practice encompasses a wide variety of difficulties and disorders including relationships, phase-of-life concerns, mood disorders, loss, trauma, and parenting and women's health issues. I will provide you with additional information about my past experience and areas of practice upon request.

I am a licensed psychologist in the State of Colorado, and the practice of both licensed and unlicensed persons in the field of psychotherapy is regulated by the Colorado Department of Regulatory Agencies. The Psychologist Examiners Board is located at 1560 Broadway #1550, Denver, CO 80202, and may be reached by telephone at 303-894-7800. In a professional relationship, sexual intimacy between a therapist and client is never appropriate and its occurrence should be reported to the Board of Psychologist Examiners.

Confidentiality
Information provided by you to a psychologist in the course of an evaluation or treatment is privileged communication, which means it is legally confidential. In most cases information can be released to another individual only by written permission from you, as is the case with gestational carrier evaluations/consultations. **However, there are certain exceptions to the confidentiality law** (CRS 12-43-218). For example, if you become suicidal, or unable to care for yourself, I am legally required to ensure that you are safe and receive the care that you need. If I believe that you seriously intend to harm someone else, I am required to warn that person, and the appropriate authorities, to ensure that individual's safety (CRS 21-10-101 & 13-21-117). If a child or elderly person is suspected of being abused, I am required to report the abuse to the Department of Social Services (CRS 19-3-301).

Consent to evaluation for Gestational Carrier Candidates
The psychological evaluation/consultation conducted by Dr. Adams will be used to assess all gestational carrier candidates. This process will involve a clinical interview and psychological testing with the MMPI-2, a well-validated self-report psychological inventory that is commonly used in evaluations for health-related procedures. This process is not meant to be comprehensive, but rather, will be specific to serving as a gestational carrier.

We will discuss many aspects related to your candidacy as a gestational carrier, including such topics as your ability to manage the stress of treatment and pregnancy, including any complications that may arise; potential negative emotional reactions you may experience during the process; ability to understand the complex nature of the psychological aspects of this process; and how this experience may affect you, and your family, in the present and in the future.

We will also discuss your personal and family mental health history, as well as any personal experiences of trauma, abuse, or loss. We will discuss hypothetical situations that may arise during the process and in the future, such as the need to consider selective reduction and how you will manage issues related to disclosure (to the intended child as well as your own family/friends) and any future relationships with the intended family. These discussions are critical to insure a good match between the gestational carrier and the intended parents. Another goal of this evaluation is to help you understand and examine your decision to become a carrier, as well as any concerns you may have about the process.

This evaluation process will yield a detailed report that will summarize our interview as well as the test results, clinical impressions, and recommendations. This report will be released to the referring agency, the medical clinic coordinating treatment, and potentially to the attorney handling the legal contract. Information obtained in the interview or through testing deemed relevant may also be shared with the intended parents.

My rights
I understand that any time, I may question and/or refuse therapeutic or diagnostic procedures or methods or request additional information regarding procedures. I understand that I should not hesitate to discuss any concerns and/or complaints with Dr Adams so that we can work toward a resolution. Concerns can also be brought to the attention of the Colorado Department of Regulatory Agencies.

I understand that although Dr. Adams may evaluate me to be a psychologically appropriate candidate, I must weigh the potential risks/benefits and decide for myself whether serving as a gestational carrier is the right decision for me. I agree that I will not hold Dr. Adams legally responsible for decisions resulting from this evaluation or the records created by it. I also understand and agree that no doctor- patient relationship exists between Dr. Adams and myself.

My signature below indicates that I understand and agree to a psychological evaluation by Dr. Adams based on the policies outlined above.

Printed name of person to be evaluated

_____

Signature of person to be evaluated

_____

Date: _____

Name, Address, Phone/Fax Number of Referring Agency

_____
_____
_____
_____

Medical Clinic Coordinating Treatment

_____
_____
_____
_____

Name, Address, and Phone Number of Financially Responsible Party:

_____
_____
_____
_____

I have reviewed the above policies and informed consent with the patient and there is no misunderstanding or disagreement.

_____

Jennifer Harned Adams, Ph.D.

_____

Date

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AUTHORIZATION TO DISCLOSE INFORMATION

Name of person to be evaluated: _____

Records requested from:
Jennifer Harned Adams, PhD
222 Milwaukee Street, #211
Denver, CO 80206

To be disclosed and shared with:

Referring Agency
_____
_____
_____
_____

Medical Clinic Coordinating Treatment
_____
_____
_____
_____

Attorney
_____
_____
_____
_____

Type and Amount of Information to be disclosed:
Report related to evaluation/consultation for candidacy for gestational carrier

I understand that the information released by this authorization will include information discussed during our consultation appointment. I understand that this authorization will expire, without my express revocation from one year from the date of signing. I understand that this authorization of this information is voluntary and I can refuse to sign this authorization.

_____ _____
Signature of person to be evaluated Date

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ACCOUNT/BILLING/PAYMENT INFORMATION

Candidate Information:
Name: _____
Address:_____
Phone: _____

Financially Responsible Party:
Name: _____
Address:_____
Phone: _____
Relationship to Client:_____

Credit Card Information:
If you wish to pay by credit card (VISA, MC), please fill out the following:
Type of Card:_____ Card #:_____
Expiration Date:_____ 3 Digit Security Code:_____
Name On Card:_____ Billing Zip Code: _____
Signature:_____

Referring Agency/Agencies (If applicable):
Agency Name:_____
Contact Person:_____
Address:_____City, State: Zip:_____
Phone #:_____ Fax #: _____

I authorize release of any medical information needed to process claims. I understand that if I am the financially responsible party identified above, I am responsible for any charges not covered by insurance and for cancellation with less than 48 hours notice.

_____ _____
Client/Responsible Party Signature Date

Charges will appear on the card statement as jenniferharnedadams@me.com and then Propay.com