CLIENT INFORMATION FORM

All information is kept confidential

DEMOGRAPHIC INFORMATION

(Complete the following information for yourself, If the patient is your child, enter his/her name in the "Other Family Members" section)

Name (Mr) (Mrs) (Ms) _____ Date_____

Address _____

City, state, and zip code _____

Home phone _____OK to call? ( ) Yes ( ) No Mobile _____OK to call or text? Yes / No

Work Phone _____ OK to call? ( ) Yes ( ) No

Marital Status: Single(Never married) _____; Single (Living Together)_____; Married _____, How long ? _____

Divorced _____; How long? _____ Widowed _____

Your date of birth _____

Spouse name _____ Spouse date of birth _____

Other Family Members *(if the patient is your child, list his/her name here with other family members)*

Name	*Relationship*	*Date of birth*	*Age*
1.			
2.			
3.			
4.			
5.			

Employer _____ Position _____

Employer (of spouse, if applicable) _____ Position _____

Religious preference (optional)_____ Church Membership at _____

Person to contact in case of emergency: Name _____

Address _____ Phone _____

Name of person who will receive counseling or psychological services: _____

Problem category (check as many as apply)

( ) Individual (Adult) ( ) Family ( ) Individual (Child) ( ) Work related

( ) Marital ( ) Alcohol/ drug related

Briefly describe the nature of the problem :

_____

_____

Have you (the person who will receive counseling) ever received mental health treatment?

Yes ( ) No ( )

From whom? _____ When? _____

Medication prescribed (if any) _____

What prescribed medication are you (the person who will receive counseling) now taking?

_____

List any over the counter medications or supplements that you are taking.

_____

FINANCIAL INFROMATION

Standard fee is $ 100 initial evaluation usually 90 minutes then $ 85.00 per 50 minute session. Payment is due at the time of the visit. I do accept some insurance payments and am required by the insurance to collect the co-payment to prevent penalties levied against me from the insurance company.

Sliding Scale is available for those without insurance coverage based on gross family income.

I agree to pay $_____ each one-hour session (50 minute)

I understand that counseling services will be ended if I miss more than 2 scheduled appointments without providing at least 24-hour notice or stop sessions for three months.

What help do you hope to receive from counseling? _____

_____

Parental Consent

I, _____, and _____, the parent/legal Guardian of the minor(s) _____, give my permission for the minor(s) to receive treatment from Rachel McCauley as an individual or part of family therapy. The therapist will inform me of the progress of any individual sessions held with any minor in the family Release of specific information will be discussed and agreed upon prior to individual sessions.

Signed _____ Date _____