

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 INFORMATION

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 Joseph Self 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 _____

Client History

Please complete the following regarding the individual who will be receiving counseling. Use the back of the form if more space is needed.

Name of **counselee**: _____ Today's date: _____

Medical history (list major illnesses, hospitalizations, surgeries, etc.; include dates)

1. _____
2. _____

List any prenatal and developmental issues : _____

History of counseling or psychiatric care:
 Provider (counselor or facility) Approximate Dates and Nature of problem

1. _____
2. _____

Family history of emotional, behavioral, psychological, or alcohol/drug problems:

Family member (Relationship to person seeking services)	Nature of problem
1. _____	_____
2. _____	_____
3. _____	_____

Employment history (list major jobs beginning with most recent; include approximate dates)

1. _____
2. _____
3. _____

Marital History

1st marriage : Beginning date: _____ Ending date: _____

Spouse: _____

Children and ages: _____

2nd marriage: Beginning date: _____ Ending date: _____

Spouse: _____

Children and ages: _____

Symptom Checklist

Check all that apply regarding the person who will be receiving counseling services. These will be reviewed and discussed with you during the intake interview.

Name of counselee _____ Today's date _____

Emotional symptoms

anger depression anxiety extreme mood shifts irritability worry frustration
 helplessness hopelessness fear apathy lack of emotions guilt feelings of panic
 fear of dying overwhelmed excessive worry Others (specify) _____

Mental symptoms

Problems with concentration inattention memory problems difficulty making decisions
 easily distracted racing thoughts repeated unwanted thoughts suicidal thoughts
 Other (specify) _____

Physical symptoms:

increase or decrease in appetite sleep difficulties muscle tension sweating/chills
 tearfulness/crying spells increased heart rate/pounding heart body pain/numbness
 stomach or intestinal distress frequent or severe headaches body pain/numbness
 Other (specify) _____

Behavioral symptoms:

hyperactivity impulsivity binge eating/overeating suicidal gesture/attempt
 induced vomiting withdrawal arguing increased alcohol use fighting/aggression
 disorganized oppositional/defiant self-injury lying/deceitfulness avoidance of school or job
 other (specify) _____