Jenna Duffy, MSW, LCSW

129 Park Street, NE, Suite 12B - Vienna, Virginia 22180
(P) 703-282-8428 (F) 571-732-4824

CLIENT INFORMATION FORM

Today's Date _____ ☐ New Client ☐ Updated information

CLIENT INFORMATION	
Full Name: Preferred name (if different): Social Security Number:	Birthdate: Preferred phone number: Other phone number (if applicable): E-Mail Address:
Street Address:	Parent's/Guardian's name if client is under 18 years of age:
City, State, Zip	Marital status (single, married, divorced, other):
School and Current level in school: Major(if appliciable):	Activities in School

PERSON RESPONSIBLE FOR PAYMENT *(if different than client)*	
Name *(If client, write "self" & proceed to next section. Otherwise, give name and complete rest of section)*:	Relationship to client:
Address: City, State, Zip:	Phone number (if it is okay for provider to call this person): *If NOT okay to call and insurance does not pay, client will be held responsible for entire balance due.*

NAMES OF TREATING PHYSICIANS *(Unless the client completes a separate Consent Form, this provider will NOT contact these providers except in the case of emergency or danger to client or others.)*	
Primary Care Physician's Name and Phone Number:	Psychiatrist's Name and Phone Number:

ELECTION WHETHER TO USE INSURANCE BENEFITS TO PAY FOR SERVICES		
Subscriber Name (if different than client):	Subscriber's Birthdate:	Relationship to client:
Primary Insurance Company's Name:	Secondary Insurance Company's Name (if applicable):	

_____I agree that I have no insurance other than the insurances listed, and I have provided all insurance policy information to this provider.

_____I **WISH t**o use my insurance benefits to pay the services rendered by Jenna L Duffy, MSW, LCSW.

OR _____ I do **NOT** wish to use my insurance benefits to pay for the services rendered by Jenna L Duffy, MSW, LCSW.

EMERGENCY CONTACT (All clients MUST enter someone's name for this provider to contact if she fears you are a danger to yourself or to someone else). In such cases, this provider may also be mandated to contact local police or emergency personnel.)	
Name:	Relationship to client:
Phone number:	Other instructions (if applicable):

CONSENT TO TREAT, RELEASE MEDICAL INFORMATION, AND ASSIGNMENT OF INSURANCE BENEFITS

I acknowledge seeking medical care and consent to treatment with Jenna L. Dufy, MSW, LCSW (provider). I request payment of insurance benefits (including Medicare benefits) be made directly to this provider for services she provides to me. I consent to her using or disclosing my personal health information to my insurance company (including the Center of Medicare and Medicaid Services as applicable) to file insurance claims and facilitate emergency treatment. This disclosure of information applies also to insurance reviews (as applicable). I permit a copy of this entire page to be sent/provided to insurance companies and/or emergency personnel as necessary. I realize that each claim to insurance companies includes the date of service and codes related to the visit (the CPT code for type of services rendered and duration of appointment, and an ICD-10 code diagnosis). I know that I may ask this provider to discuss my diagnosis and CPT code at any time. I may revoke this consent at any time in writing. I accept responsibility for paying copays/coinsurance and any balance due for services rendered.

_____ _____

Signature of Client (or Parent/Guardian if client is under 18 years of age) *Date*

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BRIEF EXPLANATION FOR WHY YOU ARE SEEKING THERAPY RIGHT NOW
(Please include referral source and any recent suicide ideation/plan/attempts as well as hospitalizations, etc.)

HAVE YOU EVER BEEN IN THERAPY? *(Please explain when, why, and why it was or was not helpful.)*

LIVING SITUATION: *Please list whom you currently live with (names, ages, and relationship)*

MENTAL HEALTH HISTORY

Current mental health diagnoses (if known) and when diagnosed:

Current medications for mental health & prescribing physician's name (*include dosage and how long you have been taking it*):

Past therapy, hospitalization(s), other treatments *(type, age at time, reason, helpfulness)* as well as any other mental health history that would be helpful for the provider to know: (*If more space is needed, please attach)*

OTHER MEDICAL HISTORY

Current medical conditions:

Current medications & prescribing physician's name:

Past medical/surgical history that would be helpful for provider to know:

TRAUMA/LOSS HISTORY *(Please note any past sexual, physical, or emotional abuse, significant loss or traumatic experiences)*

SAFETY TO SELF AND OTHERS

Have you felt like harming yourself or anyone else in the past 72 hours? *(If Yes, please explain.)* ___ Yes ___No ___ Maybe

Have you felt like harming yourself or anyone else Prior to 72 hours? *(If yes, please explain.)* ___ Yes

Have you ever tried to kill yourself? *(If Yes, please explain.)* ___ Yes ___No ___ Maybe

Have you engaged in any self-harm in the past 72 hours (cutting, burning, etc.)? *(If Yes, please explain.* ___ Yes ___No ___ Maybe

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ADDICTIONS *(Please explain any "Yes" answers.)*			
Have you – or someone else – ever been concerned that you drink too much?	___ Yes	___No	___ Maybe
Have you ever had an eating disorder (or someone expressed concerned that you may have one)?	___ Yes	___No	___Maybe
Have you ever been troubled with a sexual, gambling, or other addiction?	___ Yes	___No	___Maybe

OTHER TROUBLESOME SYMPTOMS IN PAST 72 HOURS (*Please rate 0 to 5, with **0** being "not at all" and **5** being "severe".)*												
Depression	0	1	2	3	4	5	Loss of interest in things I usually enjoy	0	1	2	3	4	5
Anxiety	0	1	2	3	4	5	Thoughts of hurting myself or someone else	0	1	2	3	4	5
Feel helpless/hopeless	0	1	2	3	4	5	Tearfulness	0	1	2	3	4	5
Weight loss or gain	0	1	2	3	4	5	Isolation from friends, family, or usual activities	0	1	2	3	4	5
Trouble sleeping	0	1	2	3	4	5	Lack of motivation	0	1	2	3	4	5
Nightmares	0	1	2	3	4	5	Absent from work a lot	0	1	2	3	4	5
Hypervigilant/easily startled	0	1	2	3	4	5	Can't stop thinking about whatever is on my mind	0	1	2	3	4	5
Hair-pulling/skin-picking	0	1	2	3	4	5	Compulsive eating	0	1	2	3	4	5
Anger	0	1	2	3	4	5	Bizarre thoughts/feeling others are watching me	0	1	2	3	4	5
Irritability	0	1	2	3	4	5	Hearing/seeing things others can't hear/see	0	1	2	3	4	5
Confusion	0	1	2	3	4	5	Relationship difficulties/divorce/separation	0	1	2	3	4	5
Difficulty concentrating/easily distracted	0	1	2	3	4	5	Difficulty at work/unemployment	0	1	2	3	4	5
Daily Living Skills	0	1	2	3	4	5							

PLEASE USE THIS SPACE TO ADD ANYTHING ELSE PROVIDER SHOULD KNOW.