DAMORE THERAPY
555 W Granada Blvd., G-10
Ormond Beach, FL, 32174
Phone: 386.246.7934

CONFIDENTIAL CLIENT INFORMATION FORM

CHILD'S / TEENAGER'S INFORMATION

Date:_____ Referred by:□Internet □Friend □Radio □Magazine/Newspaper Ad□ Other:

Full Name:_____ Sex: □ Male □ Female

Name you prefer:_____ Age:_____ Date of Birth:

Employer:_____ Length of Employment:

Occupation:_____ Special Training:

Highest Level of School Completed: □9 □10 □11 □12 □GED College: □1 □2 □3 □4 □Other:_

CONTACT INFORMATION

Address:_____

City:_____ State:_____ Zip Code:_____ May we send mail here: □ Yes □ No

Home Phone: (_____)_____-_____ May we leave a message here: □ Yes □ No

Cell Phone: (_____)_____-_____ May we leave a message here: □ Yes □ No

Email Address:_____ May we send a message here: □ Yes □ No

REASONS FOR COUNSELING AND GOALS

What do you hope to gain or change by coming for counseling? _____

_____

LEVEL OF DISTRESS

Indicate how distressed you are by circling on the scale below *(1= Very Little Distress; 10=Extreme Distress)*:

1 2 3 4 5 6 7 8 9 10

Are you currently experiencing any suicidal thoughts? □ Yes □ No. Have you had them in the past? □ Yes □ No Have you ever attempted suicide? □ Yes □ No. If yes, when & how? _____

Do you have any current thoughts of suicide? □ Yes □ No If yes, please explain:

_____

PREVIOUS COUNSELING

Please list any previous counseling, psychiatric treatment, or residential/in-patient care you have received:

Location	Therapist	Dates	Reason

CURRENT STATUS

Please check any of the following physiological symptoms that apply to you presently or in the recent past.

How has your weight changed in the last 2-3 months? (If so, how?)

Please check any of the following problems that apply to you and/or your family.

Abortion	You □ Family	Eating Problems	You □ Family	Trouble with Job	You □ Family
Ambition	You □ Family	Being a Parent	You □ Family	Disaster	You □ Family
Anxiety	You □ Family	Depression	You □ Family	Terminal Illness	You □ Family
Bad Dreams	You □ Family	Unwanted Thoughts	You □ Family	Impulsive Behavior	You □ Family
Career Choices	You □ Family	Children	You □ Family	Recent Loss	You □ Family
Communication	You □ Family	Verbal Abuse	You □ Family	Anger	You □ Family
Concentration	You □ Family	Memory	You □ Family	Self-Control	You □ Family
Grief	You □ Family	Alcoholism	You □ Family	Fears	You □ Family
Hopelessness	You □ Family	Loneliness	You □ Family	Friends	You □ Family
Making Decisions	You □ Family	Finances	You □ Family	Other	You □ Family
Marriage	You □ Family	Emotional Abuse	You □ Family	Temper	You □ Family
Nervousness	You □ Family	Unhappiness	You □ Family	Apathy	You □ Family
Physical Abuse	You □ Family	Sexual Abuse	You □ Family	Aggressiveness	You □ Family
Pregnancy	You □ Family	Trauma	You □ Family	Alcohol Use	You □ Family
Racing Thoughts	You □ Family	Loss of Control	You □ Family	Compulsivity	You □ Family
Recent Death	You □ Family	Inferiority Feelings	You □ Family	Shyness	You □ Family
Sexual Problems	You □ Family	Legal Matters	You □ Family	Drug Use	You □ Family
Stress	You □ Family	Panic	You □ Family	Guilt	You □ Family

PERSONAL STRENGTHS

Please list three things that you are proud of:

1. _____
2. _____
3. _____

Please list three personal strengths:

1. _____
2. _____
3. _____

RELATIONAL INFORMATION

Current Marital Status: □ Single □ Engaged □ Married □ Separated □ Divorced □ Widowed

Are you content with your current status? □ Yes □ No. If no, briefly explain:_____

If married, how long?_____ Number of previous marriages for you:_____ For spouse:_____

If separated or divorced, how long?_____ If widowed, how long?_____

Do you have a personal support system? □ Yes □ No. If yes, who? _____

Please list family members and other household members (continue on back if necessary):

Name:	In home or Out of home?	Age:	Gender:	Relationship:

MEDICAL INFORMATION

Primary Physician: _____ City:_____ Zip:_____

Phone number: _____ Fax number: _____

Are you currently receiving medical treatment? □ Yes □ No. If yes, please specify:

List all current medications you are taking, including those you seldom use or take only as needed.

Medication	Dosage	Purpose for Medication

Are you taking these medication(s) according to your doctor's recommendations. □ Yes □ No. If no, briefly explain: List significant conditions, illnesses, surgeries, hospitalizations, traumas, or treatments you've had. _____

_____

_____

VOLUNTARY MEDICAL RELEASE OF INFORMATION

I authorize Nona Damore, LLC to release and or obtain medication records and relevant medical information from (*Doctor's name and Office name*) _____

for the purpose of providing continuity of quality mental health services.

I understand that I do not have to sign this authorization and my refusal to sign will not affect my ability to obtain treatment.

I understand that I may revoke this authorization at any time by written request to Nona Damore, LLC / Damore Therapy.

Print Name: _____ Date: _____

Client Signature: _____ Date:_____

TRAUMA/ABUSE HISTORY

Have you ever experienced a severe trauma? □ Yes □ No □ Maybe. If yes or maybe, please explain:

Have you ever been physically or sexually abused? □ Yes □ No □ Maybe. If yes or maybe, please explain:

Have you ever been emotionally or mentally abused? □ Yes □ No □ Maybe. If yes or maybe, please explain:

SUBSTANCE USE

Do you currently use or have you previously used: *(Please Check all that apply)*

	Current	Past		Current	Past		Current	Past
Beer			Hallucinogens/Acid/ Ecstasy/etc			Amphetamines/ Speed/Meth/etc		
Wine			Inhalant/Huffing/ Whippets/etc			Cocaine/ Crack/etc		
Liquor			Phencyclidine/ Mushrooms/etc			Opioids/ Heroin/Opium		
Marijuana/Pot/ Has/etc			Sedatives/ Valium/etc			Over the Counter/ Prescriptions		

Are you a recovering alcoholic or recovering drug addict? □ Yes □ No. If yes, please specify:

RELIGIOUS/SPIRITUAL INFORMATION

Is Faith, Religion or Spirituality important to you? □ Yes □ No □ Maybe. If yes or maybe, please explain:_____

_____

Would you like to include prayer as part of your counseling experience? □ Yes □ No

The fee is paid at the time of service. If you fail to show for a scheduled appointment or do not call to cancel 24 hours before a scheduled appointment (386-246-7934), we ask that you pay the full amount of the agreed upon fee.

The standard fixed rate for assessments for any third party (Court System, Lawyers, etc.) will be $80 per hour.

TERMS OF SERVICE

I understand that it is customary to pay for professional services when rendered. I accept full responsibility for payment of any balance incurred for services. I further understand that without 24-hour notice of cancellation, I will be charged the full fee for professional service.

PAYMENT

All accounts are requested to have a credit card on file to reserve appointments. This information will be kept confidential and will only be used to process payments at your request or to bill for late cancellations and missed appointments.

Credit Card Number: _____ Exp. Date:_____

Type of Card: □ AMEX □ VISA □ MC Code on the back of card: _____

Name on card: _____ Billing Zip Code: _____

Billing Address: (Same as above □ Yes)_____

Client Signature: _____ Date:_____

Therapist Signature: _____ Date:_____

CLIENT RIGHTS AND RESPONSIBILITIES

Nona Damore, LLC is committed to providing service to you, the client, without regard to race, sex, color, religion, handicapping condition, national origin, or ability to pay in a manner appropriate to your need.

AS A CLIENT YOU HAVE THE RIGHT TO:

INDIVIDUAL DIGNITY, to be treated in a respectful and confidential manner.

QUALITY SERVICES, suited to your needs, administered skillfully, safely, humanely, with full respect for your dignity and personal integrity, and in accordance with all statutory and regulatory requirements.

WITHDRAW YOUR CONSENT for any specific activity.

CONFIDENTIALITY OF CLIENT RECORDS, Nona Damore, LLC / Damore Therapy has the obligation to obtain your written consent prior to any exchange of confidential information. There are a few exceptions to confidentiality listed below: If you present a danger to yourself or others, we are legally, ethically and morally required to protect the safety of threatened persons. If abuse or neglect of a child, elder or disabled person is known or suspected, we are required by law to report it to the Florida Abuse Hotline. If Nona Damore, LLC / Damore Therapy receives a court order for client records, deposition or court testimony, we are required to comply. We are also required to report attendance compliance by court ordered clients. In the event that group or family services are provided, it is acknowledged that Nona Damore, LLC / Damore Therapy cannot be held responsible for a breach of confidentiality on the part of a family member.

AS A CLIENT YOUR RESPONSIBILITIES INCLUDE:

Appointments: Regular attendance is very important to ensure progress with the concerns and issues that have been presented. If there is an emergency and you need to cancel or reschedule an appointment, please call as soon as you know.

Participation: Your honest and accurate reporting of dilemmas and concerns is vital to your progress. To the best of your ability you must be open and honest in your sessions. *Safety:* It is important that you and your children exercise appropriate caution, control and safe behavior on the premises. *Termination*: Services may be discontinued for repeatedly missed appointments, if you come to appointments intoxicated and/or under the influence of substances, or if you show evidence of inappropriate behavior. *Transfer Plan:* Files/Records are the responsibility of your therapist and Nona Damore, LLC / Damore Therapy. If your therapist leaves Nona Damore, LLC / Damore Therapy, your files will stay with Nona Damore, LLC / Damore Threapy.

THERAPY INFORMED CONSENT

SERVICES: We provide many different types of therapy and counseling. Counseling services can vary in length depending on the collaborative effort between therapist and client. The goals for counseling are developed with the therapist and are based on the client's needs and concerns, and are reviewed on a regular basis to monitor progress. Our counseling services are voluntary. If the client has court documentation for counseling a copy of this documentation must be provided by the next counseling session. *When bringing children for counseling services, the adult providing transportation is required to stay on the premises during the session.*

STAFF: Nona Damore is a Licensed Mental Health Counselor #12185.

FEES: Counseling session fees are based on the client's agreed upon rate, set at the first counseling session. All fees are due at the beginning of each session.

TERMINATION: The client is expected to inform the therapist if the client plans to discontinue counseling for any reason. If a client fails to show up or cancels three consecutive appointments, their file will be closed. Counselors may have to discontinue therapy if the client is currently involved in domestic violence, substance abuse, or has shown violent or threatening behavior. The client may be given a referral to other more appropriate services for issues of substance abuse, violence, or severe mental health issues.

BENEFITS/RISKS: The majority of individuals and families that obtain counseling, benefit from the process. Self- exploration, gaining insight, exploring options, for dealing with problem behavior, learning new skills, or venting difficult feelings and experiences are generally quite useful. But, some risks do exist. As counseling is begun some individuals experience unwanted feelings. Examining ones life can produce unhappiness, anger, guilt or frustration. These unwanted feelings are a natural part of the psychotherapeutic process and often provide the basis for change. Also, sometimes a decision that is positive for one family member will be viewed quite negatively by another.

QUESTIONS: Do not hesitate to discuss counseling goals, procedures, concerns, or your impression of services provided. If there is something you do not understand, please ask for a clarification.

I have read and understand the nature and limits of therapeutic services provided by Nona Damore, LLC.

Client:_____ Date:_____

Parent/Guardian:_____ Date:_____

Counselor/Therapist:_____ Date:_____

IF PARENTS ARE SEPARATED OR DIVORCED, THE PARENT INITIATING TREATMENT IS RESPONSIBLE FOR CONTACTING THE NON-INITIATING PARENT WITH FULL CONTACT INFORMATION OF THE COUNSELOR

Signature _____ Date _____