NEW BEGINNINGS
PATIENT INFORMATION SHEET

DATE: _____ THERAPIST: _____

PATIENT INFORMATION

NAME_____DATE OF BIRTH_____M_____F_____

HOME ADDRESS_____CITY_____STATE_____ZIP_____

MARTIAL STATUS: SINGLE MARRIED DIVORCED WIDOWED COHABIT OTHER

SOCIAL SECURITY NUMBER_____

HOME #_____ CELL # _____

WORK #_____ EMAIL: _____

CAN WE LEAVE A MESSAGE? ____YES ____NO

WHICH NUMBER DO YOU WANT US TO CALL? _____

IN CASE OF EMERGENCY CALL: _____TELEPHONE NO._____

ADDRESS: _____

INSURANCE INFORMATION

NAME OF INSURED_____DATE OF BIRTH_____M_____F_____

HOME ADDRESS_____CITY_____STATE_____ZIP_____

INSURANCE COMPANY_____ TELEPHONE NO._____

ID #_____ SOCIAL SECURITY NO._____

GROUP NAME OR NUMBER_____ EMPLOYER_____

INSURANCE INFORMATION

NAME OF INSURED_____DATE OF BIRTH_____M_____F_____

HOME ADDRESS_____CITY_____STATE_____ZIP_____

INSURANCE COMPANY_____ TELEPHONE NO._____

ID #_____ SOCIAL SECURITY NO._____

GROUP NAME OR NUMBER_____ EMPLOYER_____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ASSIGN ALL BENEFITS TO THE PROVIDER**. I UNDERSTAND THAT MISSED APPOINTMENTS WILL BE CHARGED UNLESS A 48 HOUR NOTICE IS GIVEN.**
SIGNATURE_____DATE_____

Name_____ **Date of Birth**_____

Briefly describe your reason for seeking counseling at this time:
_____
_____

How long has this problem been a concern to you? _____

When was the problem first noticed?
_____

Check the current stressors that apply to your life:
___Marriage___Work___School___Children___Finances___Parents___Health___Other

Check the items below that describe your current symptoms:

__Appetite Disturbance	**___Difficulty Concentrating**	**___Crying Spells**
__Sleep Problems	**___Anxiety**	**___Isolation**
__Irritability	**___Suicidal Thoughts/Plans**	**___Work/School Absence**
__Moodiness	**___Homicidal Thoughts/Plans**	**___Aggressiveness**
__Memory Impairment	**___Hallucinations**	**___Poor Impulse Control**
__Weight Gain/Loss	**___Cut/Burn on Self**	**___Domestic Violence**
__Feeling of Sadness	**___Suicidal Attempts**	**___Sexual Abuse**
__Self Abuse	**___Sexual Issues**	**___Road Rage**

Have you received prior counseling? Please list with whom_____
Was the counseling helpful? Why or Why Not: _____
Has anyone in your family received counseling or psychiatric services? _____
_____
Notes: (For Clinical Use Only)

Where were you born? _____
Where did you grow up? _____
What are your parents' names and ages?
Mother: _____ **Age:** _____
Father: _____ **Age:** _____

Are your parents:
____Married
____Divorced: When did it occur? _____
____Widowed: When did it occur? _____

Briefly describe who raised you: _____

Name_____ Date of Birth_____

Please list the names of all your siblings:

_____ Age: ___ **_____ Age: _____**
_____ Age: ___ **_____ Age: _____**
_____ Age: ___ **_____ Age: _____**
_____ Age: ___ **_____ Age: _____**

If married/cohabitating, please answer the following:
Name of spouse or partner: _____ Age: _____
How long have you been together_____ married_____

Please list the names and ages of your children:
_____ Age: ___ **_____ Age: ___**
_____ Age: ___ **_____ Age: ___**
_____Age: ___ **_____ Age: ___**
_____Age: ___ **_____ Age: ___**

If you have ever been divorced, please answer the following:
Name of ex-spouse _____ Year divorced occurred _____
Name of ex-spouse _____Year divorced occurred _____
Do you have any stepchildren? _____
_____ Age: _____ **_____ Age: ____**
_____ Age: _____ **_____ Age: ____**
_____ Age: _____ **_____ Age: ____**

If you are widowed, please answer the following:
Name of Spouse: _____ Age at time of death: _____
How long were you married? _____ Date spouse died? _____
Describe cause of death: _____
How did the death affect you? _____

How much education have you completed? _____
What school are you attending? _____
What grade are you in? _____ What is your current grade average? _____
Are you having trouble in school? _____
Are you presently employed? ____Yes ____No
If yes, where are you employed? _____
How long have you worked there? _____
List any prior jobs in the last three years:
_____ **_____**
_____ **_____**
If you are unemployed, what is your primary source of income? _____

Name_____ **Date of Birth**_____

Is there a history of alcoholism/drug abuse in your family? ____Yes ____No
If yes, briefly explain:
_____
_____
Do you drink alcohol? _____
Do you use illegal drugs? _____
Do you misuse prescribed medication? _____
Has any form of substance abuse ever caused problems in your life?
_____
_____

How would you describe your current state of health? _____
Do you have any chronic medical problems? _____
Who is your primary physician? _____
Who is your psychiatrist? _____

List any medications you are currently taking:
_____ **Dosage :** _____
_____ **Dosage :** _____
_____ **Dosage :** _____
_____ **Dosage :** _____
_____ **Dosage :** _____
_____ **Dosage :**_____
_____ **Dosage :**_____

Do you have any current legal involvement (Probation, Parole, CPS)? Please explain:_____
_____
Have you ever been physically or sexually abused? _____
Have you or a member of your family ever been in the military? _____
Are you involved in any religious activities? _____
Describe briefly whom you turn to for support. _____
What do you hope to gain by attending counseling?
_____
_____

Treatment Goals:
1.

2.

3.

NEW BEGINNINGS

Individual, Marital, Group & Family Therapy
PH (361)570-8900 FAX (361)570-8903
1501 E Mockingbird Suite 262
Victoria, Texas 77904

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ATTENTION: All Clients, Prospective Clients

DATE: April 15, 2024

REASON: Office policies on:
Confidentiality, Duty to Warn, Dual Relationships,
Informed Consent Regarding Fees and Professional
Consultation, Client Rights

Dear Client(s) or Prospective Clients of New Beginnings:

Our clinic would like to Thank You for choosing to use the services of New Beginnings. The clinicians at New Beginnings would like to inform you of various office policies, which we believe to be of paramount importance to the welfare of both clients and clinicians alike. These policies are outlined as follows:

CONFIDENTALITY: Communications between a clinician and client and the client's records are considered confidential. No clinician at New Beginnings will be allowed to disclose any communication or records of a client except as provided in Texas Civil Statutes Article 5561h.4. For records to be released by the clinic, a release form must be signed by the client or client's legal guardian if a minor. Records can also be released under court order.

DUTY TO WARN: A clinician shall take reasonable personal action to inform the responsible authorities and appropriate individuals in cases where a client's condition indicates a clear and imminent danger to the client or others.

DUAL RELATIONSHIPS: A clinician shall not under normal circumstances be involved in the counseling of the clinician's family members, intimate friends, close associates, or others whose welfare might be jeopardized by such dual relationship. To preserve clear boundaries between clinician and client, no clinician at New Beginnings shall engage in what may be perceived as social fraternization with their clients, or receive, send or exchange gifts with clients.

INFORMED CONSENT REGARDING FEES: New Beginnings will inform prospective clients regarding fee arrangements for payments which might affect the client's decision to enter the treatment relationship. The policy of New Beginnings is to collect payment for services rendered the day the service is provided unless other arrangements are made. All accounts must remain with balances that are current. Accounts that are not current may incur service interruption until the account balance is cleared (noncurrent accounts are usually those with unpaid balances of $100.00 or more on the patient accounting records). All patient payments must be made at the time-of-service delivery. **There will be a charge of $125.00 for appointments not cancelled 48 hours in advance.**

CHILDREN IN WAITING AREAS: Due to serious safety concerns and the unavailability of our office staff to adequately supervise children in the waiting areas, **children under the age of 12 cannot be allowed to remain unattended in any of the New Beginnings waiting areas and will not be allowed to wander the halls**. Please make appropriate childcare arrangements prior to your scheduled appointments. Your cooperation in this matter is greatly appreciated.

CLIENT RIGHTS: You have the right to professional, ethical treatment regardless of sex, race, color, religion, national origin, disability, sexual orientation, or political affiliation. You have the right to a clear description of services, fees, and billing. You have the right to choose a clinician you believe can help you and to be referred for other assistance if your clinician is unable to help you. Any communication during counseling is confidential unless otherwise provided by law.

I have read and understood the policies and was afforded the opportunity to discuss them with a representative of New Beginnings.

RECEIPT OF NEW BEGINNINGS OFFICE POLICY/NOTICE OF PRIVACY PRACTICES

I, _____ have read and understood the New Beginnings Office Policy Form, and New Beginnings Clinic notice of privacy practices.

Signature of Client: _____Date: _____

_____ Patient has refused to sign New Beginnings Office Policy and New Beginnings Clinic notice of privacy practices.

_____ Patient has received copy of the New Beginnings Office Policy and New Beginnings Clinic notice of privacy practices.

Signature of Witness: _____Date: _____