Mont Belvieu Counseling
Leah E. Neese, M.A., LPC
P.O. Box 297
Mont Belvieu, TX 77580
(713) 825-0086
www.montbelvieucounseling.com

Patient/Client Name: _____

Date of Birth: _____ Gender: _____ Marital Status _____

Social Security Number: _____

Address:
_____

Home Phone Number: _____
Work Phone Number: _____
Cell Number: _____

Email:_____

Emergency Contact Name: _____ Relationship: _____
Phone Number:
_____

Who referred you to Ms. Neese _____

Do you have a primary care physician and/or psychiatrist? Y or N
If so, may I contact them if needed? Y or N

If you grant me permission to contact your PCP or psychiatrist, please provide their name & telephone number:
_____
_____

Please list any medication(s) you are presently taking (prescription & over the counter):
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Billing Information

Responsible Party:
_____

Address:
_____

Phone Number: Home _____ Work _____ Cell _____

SSN: _____ Date of Birth: _____ Relationship to Client _____

In the event that there is a missed appointment, no-show, or cancellation without twenty- four hours notice, I authorize Leah E. Neese, M.A., LPC to use the following credit card information for payment. (REQUIRED INFORMATION**)**

Discover Visa MasterCard American Express (Circle one)

Name as it Appears on Card:
_____

Card Number: _____ Expiration Date: _____

Three-digit number printed on the back of your card (AMEX has a 4-digit number printed on the front of the card):
_____

Email: _____ Phone Number linked to this Card: _____

Client also authorizes Mont Belvieu Counseling to charge the credit card listed above for session fees. Y or N Initials _____

Signature: _____ Date: _____

Insurance Information - Primary Carrier Only
Insurance Company:
_____

Policy ID: _____ Group Number: _____

Name of Insured: _____ Insured's Date of Birth: _____

Insured's Employer: _____ Insured's Phone Number: _____

Insurance Company's Phone Number (back of card): _____

Referral Situation

What recent events or emotional/behavioral problems have led to your seeking assistance?

_____
_____
_____
_____
_____

Please state in your own words the nature of your present problems/symptoms.

_____
_____
_____
_____
_____

Were your problems/symptoms first noted by someone else? If so, by whom?

_____
_____
_____
_____
_____

Please describe briefly your goals and expectations for yourself and what you hope may be accomplished by this evaluation or through counseling.

_____
_____
_____
_____
_____

Current Stress

The following section is designed to help you describe your current stress in greater detail and to identify problems which might otherwise go unnoticed. This will enable me to design a comprehensive treatment program and tailor it to your specific needs.

Circle any of the following behaviors that apply to you:

Overeat Insomnia Odd behavior Eating problems. Procrastination Phobic avoidance
Suicidal attempts Vomiting Withdrawal Work too hard Sleep disturbance
Outbursts of temper Loss of control

Feelings: Circle any of the following feelings that often apply to you:

Angry Relaxed Lonely. Panicky Guilty Sad Anxious. Helpless Unhappy Conflicted
Hopeless Optimistic Energetic Restless Contented Annoyed Tense Fearful
Happy Depressed Hopeful Bored Regretful Excited Take drugs Take too many risks
Drink too much Nervous tics Can't keep a job Smoke Lazy Aggressive behavior Crying

Physical Sensations: Circle any of the following that often apply to you:

Headaches Stomach trouble Skin problems Dizziness Tics Dry mouth Fatigue
Hearing problems Palpitations Twitches Muscle spasms Flushes Chest pains Tension
Numbness Rapid heart beat Watery eyes Tremors Don't like being touched Tingling
Excessive sweating Unable to relax Fainting spells Bowel disturbances Hear things

Images: Circle any of the following that apply to you:

Visual disturbances Burning or itchy skin Back pain Sexual disturbances Blackouts
Pleasant sexual images Unpleasant sexual images Aggressive images Unpleasant
childhood images Lonely images Images of being loved Helpless Seduction

I Picture Myself: Circle any of the following that apply to you:

being hurt hurting others being followed not coping being laughed at succeeding failing
being trapped

Thoughts: Circle each of the following thoughts that apply to you:

I am worthless, a nobody, useless and/or unlovable.
I am unattractive, incompetent, stupid and/or undesirable.
I am evil, crazy, degenerate and/or deviant.
Life is empty, wasted; there is nothing to look forward to.
I make too many mistakes, I can't do anything right.
being in charge losing control

Circle each of the following words that you might use to describe yourself:

Intelligent confident trustworthy loyal worthwhile unattractive confused ambitious
considerate worthless useless memory problems full of regrets a nobody sensitive
attractive morally degenerate a deviant crazy unlovable honest inadequate stupid
conflicted ugly naive good sense of humor incompetent horrible thoughts
can't make decisions concentration difficulties suicidal ideas persevering hard-working

Do you currently use any of the following?
Marijuana Tranquilizers Sedatives Aspirin Cocaine Painkillers. Alcohol Coffee
Cigarettes Narcotics Stimulants. Hallucinogens (LSD, etc)

If so, how often?

_____
_____
_____
_____
_____

Is there any other information that you think would be helpful for your therapist to know?

_____
_____
_____
_____