

Client Information

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Ok to leave message? Yes No

Mobile Phone _____ Ok to leave message? Yes No

Work Phone _____ Ok to call at work? Yes No

Email address _____ Ok to send email appt reminder? Yes No

Date of Birth _____ Birth Place _____

Age _____ Male Female Other

Special Instructions / Other phone numbers _____

Years of Education Completed _____ Highest Degree Attained _____ Occupation _____

Employer Name and Address _____

Insurance Company Information exactly as it appears on your card:

Insurance Company _____

Address _____

City _____ State _____ Zip Code _____

Name of Insured _____

Insurance Company Policy # _____ Group # _____

Date of Birth _____ Your relationship to insured _____

Name of the Insured's Employer _____

Is your condition related to Employment? Yes No Auto Accident? Yes No Other Accident? Yes No

Employee Assistance Program

Name of Employee Assistance Program _____

Employee Assistance Program Authorization # _____ # of sessions authorized _____

Referred by

Name _____ May we thank them? Yes No

Have you billed insurance in the past year for counseling sessions as a client with another provider? Yes No

Emergency Contact Information

Name _____ Relationship to you _____

Address _____ City _____ State _____ Zip _____

Phone Home _____ Phone Work _____ Phone Mobile _____

Date of last Physical Exam _____ If you are currently taking any medications, please list: (use back of form if necessary)

Medication _____ Dosage _____ condition prescribed for _____ by _____

Medication _____ Dosage _____ condition prescribed for _____ by _____

Medication _____ Dosage _____ condition prescribed for _____ by _____

Medication _____ Dosage _____ condition prescribed for _____ by _____

Do you have any allergies? Yes No If yes, please list _____

General state of health is: Excellent Good Fair Poor

Please list any significant health problems _____

Spouse or Partner

Current relationship status: single married partner significant other divorced widow/widower

How many committed relationships have you been in? _____ Number of times you have married/partnered _____

First (write first name) _____ Your Age _____ years together _____

Second (write first name) _____ Your Age _____ years together _____

Third (write first name) _____ Your Age _____ years together _____

If currently divorced or single, number of years since break-up or divorce _____

If applicable, reason for break-ups or divorce(s) (include break-up or divorce dates)

Describe quality of relationship with your present spouse/partner:

Current spouse/partner's name _____ Number of years together _____

Children: Name _____ Age _____ Name _____ Age _____

Name _____ Age _____ Name _____ Age _____

Name _____ Age _____ Name _____ Age _____

Name _____ Age _____ Name _____ Age _____

Please describe any custody and visitation arrangements for your minor children if they are not living with you full-time:

Family Of Origin History *List who is in your home and who has been in your home in the past.*

Name Relation to you Current age (or age at death) Describe your relationship when you were a child

Your parent's relationship with each other _____

Any significant events in childhood that impacted you? _____

Please check if you have experienced any of the following stressors in the last six months:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Personal illness | <input type="checkbox"/> Health problem in family | <input type="checkbox"/> Death of a friend | <input type="checkbox"/> Death of a family member |
| <input type="checkbox"/> Lack of employment | <input type="checkbox"/> Job dissatisfaction | <input type="checkbox"/> Job change | <input type="checkbox"/> Retirement |
| <input type="checkbox"/> Financial problems | <input type="checkbox"/> Inadequate housing | <input type="checkbox"/> Homelessness | <input type="checkbox"/> Recent move |
| <input type="checkbox"/> New marriage | <input type="checkbox"/> New relationship | <input type="checkbox"/> Relationship discord | <input type="checkbox"/> Relationship separation |
| <input type="checkbox"/> Divorce | <input type="checkbox"/> New child | <input type="checkbox"/> Discord with family | <input type="checkbox"/> Parenting difficulties |
| <input type="checkbox"/> Physical abuse | <input type="checkbox"/> Sexual abuse | <input type="checkbox"/> Unhappy childhood | <input type="checkbox"/> Victim of crime |
| <input type="checkbox"/> Educational problems | <input type="checkbox"/> Legal problems | <input type="checkbox"/> Inadequate healthcare | <input type="checkbox"/> Discrimination |
| <input type="checkbox"/> Loneliness | <input type="checkbox"/> Brain Injury (concussion/other) | <input type="checkbox"/> Exposure to toxic chemicals | <input type="checkbox"/> Other (please specify) |

What would you like to change in your life and is there anything else you want the counselor to know?

Informed Consent and Disclosure

Thank you for choosing me as your Mental Health Care Provider. I am committed to giving you excellent mental health care. The following is a statement of informed consent and disclosure and includes my financial policy and other office policies, which I require that you read and sign prior to any treatment. If you have any questions about my financial or office policies or anything else, please do not hesitate to ask me.

The laws of the State of Idaho require that all licensed counselors provide clients at the beginning of treatment with accurate disclosure of information concerning their practice, including the right of clients to refuse treatment, the responsibility of clients for choosing the provider and treatment modality, and the extent of confidentiality (Chapter 34, Title 54-3410B, Idaho Code). Licensure of an individual under this chapter does not imply endorsement by the counselor licensing board nor effectiveness of treatment. The Idaho Counselor Licensing Board, through the Idaho Bureau of Occupational Licenses, Owyhee Plaza, 1109 Main St., Suite 220, Boise, ID 83702, is responsible for licensure of counselors within the state of Idaho. Laura Cromwell is a licensed clinical professional counselor and holds a Master's of Counseling degree from College of Idaho.

Confidentiality

Information disclosed within sessions is confidential and may not be revealed to anyone without your permission. The law provides for certain exceptional situations in which I am required to disclose information including when there is a reasonable suspicion of child abuse, elder or dependent-adult abuse, and when a client threatens violence to an identifiable victim. The law also requires me to break confidentiality when a client presents a danger of harm to others and when a client is likely to harm him/herself unless protective measures are taken. Clear risk of harm to others may include the risk of transmitting a life-threatening illness to an identifiable and uninformed third party. Disclosure may also be required in certain legal proceedings. If you have concerns about the content of our sessions and any legal proceedings in which you are involved or expect to be involved (e.g., child custody cases), please let me know. As part of my professional responsibility, I may also consult with other counseling professionals. Your name is not revealed. This allows you to receive the benefit of other professionals' expertise.

Our Professional Counseling Relationship

A counseling relationship is a professional relationship in which the counselor assists the client in exploring and resolving difficult life issues. Our sessions may be very intimate. However, it is important for you to realize that we have a professional, rather than a personal relationship and our contact will be limited to the paid session you have with me. As a Licensed Clinical Professional Counselor, I will not barter for services or accept gifts or invitations. You will be best served by these professional standards. I am licensed by the State of Idaho to provide counseling services. My ethical code states that sexual intimacy is never appropriate with a client and should be reported to the licensing board. You also have a right to be a participant in treatment decisions, to seek a second opinion, to file a complaint without retaliation, and to refuse treatment. If you have any concerns or questions about my services, I urge you to discuss them with me. You may contact the licensing board at any time by calling (208) 334-3233 or by visiting their website at <https://secure.ibol.idaho.gov/IBOL/BoardPage.aspx?Bureau=COU>. Idaho Bureau of Occupational Licenses is located at 1109 W. State Street, Boise, ID 83702.

Counseling Process

I am dedicated to giving you the best care that I can. It is my conviction that for counseling to be effective, there needs to be a partnership between the counselor and client. As such, you will be expected to be actively involved in choosing the course of your treatment. It is impossible to guarantee any specific results regarding your goals for counseling or length of treatment. However, I assure you that my services will be rendered in a professional manner consistent with accepted ethical standards of practice as adopted by the American Counseling Association and the Idaho Counselor Licensing Board.

Risks And Benefits

Counseling and psychotherapy are beneficial, but as with any treatment, there are inherent risks. During counseling, you will have discussions about personal issues, which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. The benefits of counseling can far outweigh any discomfort encountered during the process. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem solving. While I cannot guarantee these benefits, I will do everything I can to work with you to attain your personal goals.

Counseling Approaches

I work with adolescents, adults, individuals, couples, and groups. My work with clients is informed by experience and training in anxiety, depression, drug and alcohol misuse/abuse/addiction, compulsive overeating, couples counseling, grief recovery, EMDR and hypnosis. My therapeutic orientation is Adlerian though I integrate techniques from many treatment modalities including but not limited to cognitive-behavioral, existential, solution-oriented, gestalt, rational-emotive, behavioral, insight oriented and family systems.

Client Rights: You have the right to:

1. Request that your records be sent to another professional or agency. Your request will be fulfilled with promptness upon receipt of your written request for transfer of information, provided there is no outstanding balance on your account.
2. Leave the premises at any time. You are not to be detained against your wishes unless you are a danger to yourself or others.
3. Participate in developing an individual plan of treatment.
4. Receive an explanation of services in accordance with the treatment plan.
5. Participate voluntarily in and to consent to treatment.
6. Object to, or terminate or refuse any service you do not want, and to discontinue any services you have already started. However, if you choose to discontinue treatment against professional advice, a notification to that effect could be placed in your records. In the event of court-ordered clients, the terms of the court may supersede this right.
7. Have access to your records.
8. Receive clinically appropriate care and treatment that is suited to your needs and skillfully, safely, and humanely administered with full respect for your dignity and personal integrity.
9. Be treated in a manner which is ethical and free from abuse, discrimination, mistreatment, and/or exploitation.
10. Be free to report grievances regarding services or staff to your counselor or the Idaho Bureau of Occupational Licenses.
11. Be treated by staff that is sensitive to your cultural background and beliefs.
12. Be afforded privacy.
13. Be informed of expected results of all therapies prescribed, including possible adverse effects.
14. Request another therapist
15. Request that another clinician review your records for a second opinion.
16. Know that one parent at least must be involved in the therapy of any minor children.

Professional Fees

\$125 per 60 minute initial intake and new client consultation.

\$125 per 60 minute session for individual, couple, or family counseling.

\$125 per 45 minute session for individual, couple, or family counseling.

\$100 for 30 minute session for individual, couple or family counseling.

\$125 per hour for copying and mailing client records to another professional.

\$125 per hour for written reports, prepared documents, or consultation (over 10 minutes) with another professional at your request, depending on type and purpose.

\$250 - \$450 per hour for preparation and attendance at legal court proceedings, including when called by another party.

\$25 service fee for returned check.

Fee Change

While I rarely raise professional fees during the course of counseling, there may be an occasion where this will be necessary. If this occurs, I will let you know of the fee change and when it will occur as soon as possible. In any event, I will not raise fees more than once per year so you can be assured that if there is an increase, it won't change again for at least one year.

Full payment is due at the time of service by cash or check. Debit or credit cards may be used when service is available. I will bill your insurance company as a courtesy to you, but as your coverage is based on a contract between you and your insurer, you are responsible for any fees or portions of fees not covered by your insurance company. I encourage you to contact your insurance company before the first session and ask them what benefits you may expect. If for any reason your insurance company does not pay for my services as you expect they will, you are responsible for payment in full to me. Insurance companies rarely pay 100% of the fees you incur for my service and you are responsible for paying any co-pays and deductibles at the time of your session. Please confirm with your insurance company their policy related to counseling services provided by a "licensed clinical professional counselor" (LCPC) and your co-pay and deductible amounts for these services. If you are using Employee Assistance Program (EAP) benefits, it your responsibility to provide me with an authorization number and the number of sessions covered prior to your first appointment. Please remember that I may be required by your insurance company to provide confidential information about you and your case if you choose to use your insurance company or Employee Assistance Program for payment for my services.

Telephone Calls and Writing

If you are experiencing a life-threatening emergency, call 911 or have someone take you to the nearest emergency room for help. Phone consultation for check-in calls and reading of writings or messages of 5 minutes or less in duration will not be added to your billing. Consultation calls and reading time longer than 5 minutes will be billed at the normal prorated service rate. If you must get a message to me, the best way is to leave a voice message. I cannot guarantee a quick reply due to the nature of my practice, but will get back to you as soon as I can. You need to be aware that I do not provide any crisis or emergency services.

Special Reports, Services, and Letters

Occasionally it is necessary for me to write special letters or reports or provide other services on a client's behalf. I am glad to comply with such requests. There is a fee charged based upon the type and purpose as well as the length of time required for the service.

Counseling and Technology

Email

Since email is not totally secure and sometimes unreliable, I use email with caution and urge you to do the same. If you choose to use electronic messages, please be brief and don't include anything you wouldn't want others to read just in case there is a security breach. If you imagine the possibility of you (or me) losing our computer or smart phone and someone else reading your message, you will know the reason to be extra cautious when communicating electronically.

Phone

Conversations by cell phone or cordless phones may be picked up by people in the area. The safest phone call is from one old-fashioned corded phone to another. I realize that we rely on mobile and cordless phones so just know that they may not be totally secure. When we have a phone call, be sure that you can't be overheard. **If you need to cancel your appointment within the 24-hour time limit, definitely use the phone so I will get the message right away. Only a phone message will be considered for official notification of cancellation.**

Social Networking and Computer Contact

I usually don't "friend" anyone who is or has been a client of mine to respect your privacy. If you want to show me something on Facebook, on your blog, or any other social media, you can share it with me during our session. I realize some of my clients drive long distances so I will sometimes use the phone or Skype to work with clients but only for very rare and special circumstances on a pre-arranged basis. Again, please know that confidentiality cannot be assured when using this type of technology.

Litigation Limitation

I do not do court work (such as, but not limited to, testifying in divorce and custody disputes, injuries, lawsuits, etc...) If you need these services I will give you referrals to forensic psychologists who specialize in these cases. My desire is to protect your counseling from the intrusiveness of legal proceedings.

1. Confidentiality – Your counselor cannot release any information about you without your written permission (exceptions to this such as child or elder abuse, danger to self or others are explained in above).
2. Confidentiality in Couple's Therapy – Your counselor cannot release records unless both clients give written permission.

To be in counseling with me you must agree that neither you nor your attorney, nor anyone else acting on your behalf, will call on any counselor at this practice to testify in court or at any other proceeding, nor will a disclosure of counseling or treatment records be requested for legal proceedings.

This is in your best interest because:

1. If you place your mental status at issue in litigation initiated by you, the defendant (other side) has the right to obtain your counseling records and/or testimony by your counselor. Your adversary would have the right to know everything you've talked about in counseling.
2. Forensic psychology (custody evaluations, workers comp, lawsuits, etc.) is not an area of expertise for me.
3. If you are involved in legal proceedings, subpoenaing a counselor without forensic expertise to testify could hurt your case more than help. Forensic psychologists do assessments (not counseling or psychotherapy) and are trained as expert witnesses.
4. The goals of legal proceedings (winning a case) are inconsistent with the goals of ongoing counseling (exploring conflicted emotions and behavior in a safe, protected place). Whenever possible, counselors are required to avoid dual roles, which may interfere with the client's counseling.
5. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. These fees are listed above.

I understand and agree to this litigation limitation.

Signature of Client _____

Date _____

Cancellations and Missed Appointments

Please make every effort to keep your scheduled appointment. This practice respects my time and allows me to use that time to see other clients who are in need. **Unless I hear from you by phone at least 24 hours in advance, I will, unfortunately, have to charge you the full fee for a missed or cancelled appointment.** When appropriate, telephone sessions can sometimes be done in place of the scheduled in-person session. **Cancellations need to be made by calling and leaving a message.** (208.376.5683).

INITIAL HERE _____

My signature below indicates that I understand and agree to these terms and those on the Informed Consent and Disclosure and I am giving my consent for treatment. I understand and agree to comply with these policies and have been given a copy of this policy. I understand that I must call at least 24 hours in advance of my appointment to avoid paying the full fee for a missed or cancelled appointment. I understand I am financially responsible for payment of services rendered to me and will pay for all services rendered and any legal expenses incurred should this account be turned over to another party for collection. I give my consent to share confidential information with all persons mandated by law, the counselor and agency that referred me, the insurance carrier responsible for my mental health care benefits and payment for those services, and financial information forwarded to another party for collection. I am releasing and holding harmless Laura Cromwell, LCPC, LLC from any departure from my right of confidentiality that may result.

Print Client Name _____

Client Signature _____

Date _____

If financially responsible person is different than above, please complete the following:

Print Financially Responsible Party's Name _____

Financially Responsible Party's Signature _____

Date _____

Financially Responsible Party's Address (if different from above) _____

City _____

State _____

Zip _____

2971 E Copper Point Drive, Suite 100, Meridian ID 83713
ph. 208 376-5683 fax 208 376-5683

Summary Notice of HIPAA Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

SUMMARY OF YOUR PRIVACY RIGHTS

We may use your health information to treat you, to get paid, to operate the counseling office, to tell you about other health benefits & services, to tell family and friends about you in an emergency, to avert threats to health and safety reasons, for military purposes, for worker's compensation requests, for lawsuits, for law enforcement requests, for national security reasons, for coroner, medical examiner or funeral director use.

You have the right to review and get a copy of your medical and billing records (but not psychotherapy notes), change your medical record if you think it's wrong, get a list of with whom we share your health information, ask us to limit the information we share, ask for a copy of our privacy notice, complain in writing if you believe your privacy rights have been violated, request alternative forms of communication.

COMPLAINTS - If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services at:

Office for Civil Rights Region 10, U.S. Department of Health and Human Services, 2201 Sixth Avenue - M/S: RX-11 Seattle, WA 98121-1831, Voice Phone (800) 368-1019, FAX (206) 615-2297, TDD (800) 537-7697

To file a complaint with Laura Cromwell, LCPC, LLC contact Laura Cromwell, LCPC. *You will not be penalized for filing a complaint.*

I acknowledge receipt of the Laura Cromwell, LCPC, LLC "Notice of Privacy Practices."

Client Signature: _____ **Date:** _____

Printed Name: _____

Relation : _____ **Printed Name:** _____
(if other than client)

Signature: _____ **Date:** _____

Client declined to sign receipt (staff signature): _____

Client unable to sign (witness signature): _____

Clinical History Form

Briefly describe the reason(s) you are seeking counseling:

About how long have you been concerned about this: 1 month 2-3 months 6 months 1 year Other

SYMPTOMS SCREENER

For the questions below, select one option for each question that best represents your answer.

OVER THE PAST TWO WEEKS, HAVE YOU:	Not at all	1-2 days	3-5 days	Daily
Experienced sadness, weepiness, or crying spells?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Felt hopeless, pessimistic or discouraged about the future?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not been able to enjoy things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Felt tired, slowed down or had no energy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lacked motivation or interest in doing things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had difficulty falling asleep or frequent waking/sleeping too much?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had difficulty making decisions or concentrating?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Experienced decreased/decreased appetite?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Felt guilty or worthless?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Felt like you wanted to die, or wished you were dead?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seriously considered or planned to end your own life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Felt restless, worried, or nervous?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had headaches, stomachaches or pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much distress would you say these symptoms caused you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HISTORY OF RECREATIONAL DRUG USE

Amphetamines/Speed	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Age of First Use:	Age of last use:	Method:
Barbiturates	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Age of First Use:	Age of last use:	Method:
Heroin	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Age of First Use:	Age of last use:	Method:
Narcotics (Vicodin, Oxy)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Age of First Use:	Age of last use:	Method:
Cocaine	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Age of First Use:	Age of last use:	Method:
LSD, Ecstasy, Bath Salts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Age of First Use:	Age of last use:	Method:
Cannabis/Marijuana	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Age of First Use:	Age of last use:	Method:
Benzodiazepines	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Age of First Use:	Age of last use:	Method:
PCP	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Age of First Use:	Age of last use:	Method:
Adderall (non-prescribed)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Age of First Use:	Age of last use:	Method:

In the past twelve months have you used drugs for anything other than medical reasons?
 Have you ever experienced withdrawal symptoms when you stopped taking drugs?

Yes No
Yes No

HISTORY OF RECREATIONAL DRUG USE

Do you regularly drink alcohol (including beer or wine?) Yes No

How often do you typically drink?
2x per month or less Weekly Daily

How often do you typically drink?
2x per month or less Weekly Daily

Has your drinking ever caused problems between you and family members or close relationships? Yes No

Have you tried to cut back or stop drinking but not been successful? Yes No

Have you drank alcohol and been hung over while working, going to school or taking care of your children? Yes No

Have you missed or been late for work, school or other activities because you were drunk or hung over? Yes No

Have you ever been in trouble with the law because of drinking? Yes No

Have you ever experienced withdrawal symptoms when you stopped drinking? Yes No

SELF-HARM

Have ever cut yourself or hurt yourself Intentionally? Yes No If yes describe:

PSYCHIATRIC HISTORY

HAVE YOU USED COUNSELING SERVICES IN THE PAST Yes No

Name of Counselor	Primary Reason	Location	Outcome/Was it helpful?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

HAVE YOU HAD A PREVIOUS DIAGNOSIS OF:

Anxiety Depression Panic ADHD OCD Bipolar Anorexia Bulimia PTSD Alcoholism

HAVE YOU EVER BEEN HOSPITALIZED FOR PSYCHIATRIC REASONS Yes No

When/Dates	Location	Purpose	Length of Stay

MEDICAL HISTORY

PRIMARY CARE

Primary Care Physician:

Office Address:

Phone Number:

MEDICAL HISTORY

Current/Past Medical Conditions:

- | | | | | | |
|---|---|--|--|---------------------------------------|--|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Anemia | <input type="checkbox"/> Headaches/
Migraines | <input type="checkbox"/> Stroke | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Shortness of
Breath | <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Cancer | <input type="checkbox"/> Menstrual
Problems |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Hormone
Imbalance | <input type="checkbox"/> Dementia | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> High Blood
Pressure | <input type="checkbox"/> Seizure/Epilepsy | <input type="checkbox"/> Head Trauma | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Smoke |

Other:

Do you have allergies: YES NO List:

Are you currently taking medication: YES NO

Name of Medication

Dosage

Frequency

Purpose

FAMILY HISTORY OF ILLNESS/DISEASE

- | | | | |
|---|--|------------------------------------|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Cancer | <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Dementia/Alzheimer's | <input type="checkbox"/> Hormone Imbalance | <input type="checkbox"/> Migraines | <input type="checkbox"/> Other |

CURRENT PSYCHIATRIC CARE

Psychiatrist Developmental Therapy Case Management Service Coordination CBRS Other:

Name of provider/s

Location

Phone

PERSONAL RESOURCES

DESCRIBE YOUR PERSONAL STRENGTHS

WHAT WOULD YOU LIKE TO SEE IMPROVE AS A RESULT OF COUNSELING (GENERAL GOALS)?

WOULD INCLUDING SPIRITUALITY IN YOUR COUNSELING BE BENEFICIAL? Yes No Not sure

Describe religious background and/or preference?