Restoring Balance Counseling, LLC

Today's Date_____

Name _____ DOB _____
Address _____ City _____ Zip _____
Main Phone # _____ Second Phone # _____

Emergency Contact _____
Relationship _____ Phone #_____

Check the symptoms which you are currently experiencing or have experienced within at least the last two weeks:

__sad or depressed mood
__mood swings
__decreased pleasure
__excessive crying
__decreased energy
__irritable/anger
__dissociation
__anxiety/panic attacks
__repetitious behaviors
__self -harm
__hyperactivity
__other:_____

__sleep problems
__over/under eating
__weight gain/loss
__headaches
__GI problems
__fatigue
__legal issues
__suicidal
__thoughts
__plan
__attempt

__oppositional
__flashbacks
__guilty
__hallucinations
__delusions
__racing thoughts
__impulsivity
__homicidal
__thoughts
__plan
__attempt

What do you want to change by coming to therapy? _____
_____
_____

Who are your current support systems? Please include family, school, employment, and community organizations, religious or spiritual affiliations. _____
_____

Have you experienced trauma in your past? (circle one) Yes No
If yes, please identify what type (circle all that apply): Physical Sexual Emotional
Other: _____

Current Psychiatrist _____ Last exam _____
City_____ State _____ Phone _____
Meds prescribed: Name Dose Target symptoms
_____ _____ _____
_____ _____ _____
_____ _____ _____

Other current mental health providers: _____
_____

110 W. Linden Dr., Suite B
Jefferson, WI 53549
Ph. 920-674-5050 Fax 920-674-5010
www.restoringbalancecounseling.com

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Previous outpatient mental health treatment: _____

_____

Mental health hospitalizations? (circle one) Yes No

If yes, please identify: Where- _____

When- _____

Reason- _____

What physical illnesses or injuries have you experienced? _____

_____

Primary Physician _____ Last Exam_____

City_____ State _____ Phone _____

Treatment provided:_____

_____

Meds prescribed:	Name	Dose	Target symptoms

Other information that could assist in your treatment: _____

_____

_____

Insurance

☐ Copy of card(s) provided

Primary Insurance _____ Policy #_____

Group# _____

Policyholder_____ Date of Birth_____

I authorize Restoring Balance Counseling, LLC to release the information necessary to my insurer(s) to process payment of claims for mental health treatment. I authorize direct payment of all claims to Restoring Balance Counseling, LLC. I understand that I am responsible for all charges, irrespective of insurance payments.

(X) _____ _____

Responsible Party Signature **Date**

I have received a copy of Restoring Balance Counseling, LLC notice of Privacy Practices (HIPAA).

(X) _____ _____

Signature **Date**

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