CLIENT INFORMATION

When providing therapy to a child or family the file is usually created under the parents name so the client's name is usually the name of one of the parents.

Client Name: ____ ________________________________
Last First Date of Birth: (MM/DD/YYYY) Age

Names of others within the family that may also participate in family therapy (I confirm that I am the legal guardian of anyone under the age of 18 who will participate in therapy services, or I have and can provide proof of consent of the legal guardian):

_________________________ _________________________ _________________________

_________________________ _________________________ _________________________

Address: ____
City State Zip

I wish to be contacted in the following manner (initial all that may apply):

______ Home Telephone: ______________________________
______ O.K. to leave a message with detailed information
______ O.K. to contact or respond via text message
______ Leave message with call-back number only

______ Cell Telephone: ___________________________
______ O.K. to leave a message with detailed information
______ O.K. to contact or respond via text message
______ Leave message with call-back number only

______ **OK to be contacted through email. If so, please provide your email address:** ______________________________

***Release of Information**: I give legal permission to contact the following individuals at the following phone number(s) to discuss my treatment as it relates to the following (initial all that may apply):* ____ All aspects of treatment, ____ Engagement in treatment, _____ Financial information only, _____ Attendance only. _____ Attendance and financial only

Name of person to contact: _______________ Relationship: _______________ Phone # ____________________

***Signature** of Responsible Party*: _________________________ Date: ___________ Expiration Date: __________
This release of information is good for up to one year and can be revoked at any time by signing. I no longer consent to release information to the individuals above (sign) ___________________ Date: __________

IN CASE OF EMERGENCY

Nearest Relative

Name: ____
Name Relationship Home Number Cell Number

FINANCIAL RESPONSIBILITY (please fill out if other than primary client)

Name: ____
Name Relationship Home Number Cell Number

I accept full responsibility for all fees due to professional services. I realize that any third party billing is out of courtesy to me and does not transfer any financial responsibilities for unpaid services. I understand that 24 hours notice is required to cancel or change an appointment, and that if 24 hours notice is not given, I am responsible to pay a cancellation charge of $50.00.

Signature of
Responsible Party: ____ Date: _______________________

ASSESSMENT

WHAT OCCURRED THAT MADE YOU WANT COUNSELING NOW?

WHAT ARE YOUR TOP 3 CONCERNS? (PRESENTING PROBLEMS)

1.

2.

3.

Any other concerns?

PREVIOUS COUNSELING?

Have you, or anyone in your family, ever received psychiatric or psychological help or counseling or any kind? If so, please explain.

MEDICAL PROBLEMS?

MEDICATIONS TAKEN BY CLIENT OR FAMILY MEMBERS?

LEAGAL PROBLEMS?

DRUG USE OR ALCOHOL CONSUMPTION PAST OR PRESENT?

Does anyone in the family consume alcohol or any drugs? If so, what and how often? (This information is confidential).

FAMILY HISTORY OF ADDICTION?

Have you or anyone in your family ever had an addition including additions to alcohol, drugs, gambling, sex, pornography, video gaming, or struggled with an eating disorder? If yes, please explain.

HISTORY OF ABUSE?

Have you or a family member ever experienced physical or sexual abuse or witnessed violence? Please explain if you feel comfortable or you can leave it blank if you're not comfortable explaining. ______

______

______

SUICIDAL/ASSAULTIVE IDEAS OR HISTORY?

Have you or a family member ever tried to commit suicide or been involved in physical violence? ______

______

______

RELIGIOUS OR SPIRITUAL AFFILIATION?

Does your family practice a formal religion or find strength from spiritual beliefs? If yes, please explain.

______

______

CLIENT/FAMILY STRENGTHS?

Please list strengths that you and your family have. ______

______

DAILY PATTERNS (CIRCLE ALL THAT APPLY)

Poor sleep   Social Withdrawal   Anxiety   Nightmares   Anger   Fatigue   Bingeing/Purging
Decreased sexual interest   Decreased job performance   Decrease School Performance
Increase/Decrease apatite   No impairments

TO BE FILLED OUT BY THE THERAPIST

Name: ______ DOB: ______ Intake date: ______ Todays Date: ______

DSM IV DIAGNOSIS

Axis I ______
Axis II ______
Axis III Deferred to PCP
Axis IV ______

Mental Status

Well Groomed
Poor Hygiene
Psychomotor Retardation
Suspicious
Agitated
Clothing Disheveled
Pressured Speech
Cooperative
Uncooperative
Other: ______

General Intellectual Functioning

Able to Abstract
Alert
Memory Impairment
Tangential
Decreased Attention Span
Subnormal Intelligence
Fully Oriented
Logical/Goal Directed
Preoccupied with Detail
Disoriented/Confused
Other: ______

Mood/Affect

Anxious
Angry/Hostile
Depressed/Sad
Anhedonia
Euphoria/Elated
Blunted
Appropriate to Content
Inappropriate to Content
Euthymic
Irritable
Other: ______

Thought/Perceptual Content

Obsessions
Delusions
Compulsions
Ideas of Reference
Hallucination/Illusions
Normal
Other: ______

How did you hear about us? ____

If on line what website or search words did you use? ____

Were you referred? Circle YES or NO If so, who referred you? ________________________________

____

____

____