



CLIENT INFORMATION

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

Partner (or NA): _____
Last First Date of Birth: (MM/DD/YYYY) Age

Names of others within the family (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):

____ Phone: _____ Phone: _____
____ O.K. to leave a message with detailed information _____ O.K. to leave a message with detailed information
____ O.K. to contact or respond via text message _____ O.K. to contact or respond via text message
____ Leave message with call-back number only _____ 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 third party billing is a 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 fee of \$50.00.

Signature of Responsible Party: _____ **Date:** _____

Responsible Party: _____ **Date:** _____

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?

LEGAL 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 addiction including addictions 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 Binging/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 Axis I _____
DIAGNOSIS 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/Ilusions
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? _____



Authorization for Debit/Credit Card Charges

I _____ understand that Arizona Connection Counseling PLLC requires to have my credit card or debit card information on file in order to receive therapy services from any therapist working for Arizona Connection Counseling PLLC. Below is list of services provided by Arizona Connection Counseling PLLC. that may be charged to my card if the services are provided. If a different method of payment is preferred, payment will be taken care of at the time of services. If payment is not made at the time of service, the amount of the service will be charged to the credit or debit card.

1. Individual Therapy (\$100 per hour)
2. Couples Therapy (\$125 per hour)
3. Family Therapy (\$125 per hour)
4. Unscheduled phone session (\$30.00 per 15 minutes)
5. Email correspondence requiring more than 15 minutes (\$30 per 15 min)
6. Staffings/meetings such as IEP's, communication with court personnel, etc. (\$30.00 per 15 minutes)
7. Missed appointments without 24 hour prior notification (\$50.00)
8. Documents written for court or others billed at hourly rate (\$100.00 minimum)
9. Copying a file for an individual or for court (\$15.00 per hour).
10. Attendance at court (\$1200.00 per day)

Name as it appears on the card: _____ Phone #: _____

Email Address: _____

Debit/Credit Card #: _____ Expiration Date: ____/____

CVV (CSC) # _____ (For MasterCard or Visa, it's the last three digits in the signature area on the back of your card. For American Express, it's the four digits on the front of the card.)

Billing Address: _____
Street Address Apt #

City State Zip Code

Signature

Date