CLIENT INFORMATION

When providing therapy to a child or family the file is usually created under the parent's 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?

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 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** **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 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? _____

_____

_____

_____