CLIENT INFORMATION SHEET

Date: _____ Counselor (circle one): Chris, Jim, Dorothy, Jill, Alicia, or Tonya

Client name: _____ Date of birth: _____
Last First MI

Sex: M F Civil status: M / D / Single / Sep / W SSN: _____

Address: _____
Street/PO Box

_____
City State Zip

Home phone: _____ Work phone: _____ Cell phone: _____
May we call? Y or N Y or N Y or N

Employer: _____ Employer address: _____

Have you received counseling previously? Yes or No Counselor:_____

Family members living in patient's home (full names and ages):

_____

_____

SPOUSE, SIGNIFICANT OTHER, PARENT, OR GUARDIAN (circle one):

Name: _____Date of birth: _____
Last First MI

Address: _____
Street/PO Box City State Zip

Home phone:_____ Work phone _____ Cell phone _____
May we call? Y N Y N Y N

Employer: _____

Responsible party for billing: _____

INSURANCE INFORMATION:

Employee Assistance Program: Yes or No Number of sessions approved: _____

Name of policy holder: _____Date of birth: _____

Employer: _____SSN:_____

Insurance company: _____Policy number:_____

Group number: _____phone number:_____

Mailing address for claims:_____

_____

Print client name _____

1. **I authorize the release of any medical information to an insurance company or any third party payer necessary to process this claim and all future claims.**
2. **I authorize payment of medical benefits to the physician/provider for these services and future claims.**
3. **I will make any disputes of charges at the time of service. All charges will remain as charged on the day of service.**
4. **I understand that I am responsible for understanding my individual insurance coverage.**
5. **I understand that I am ultimately responsible for payment for services that my insurance company does not pay.**
6. **I understand that Anastasi Counseling Services has the right to charge for appointments that are not kept and/or are not cancelled at least 24 hours before scheduled time. These charges will not be billed through any benefit program and I am fully responsible for all charges.**
7. **I understand that if my account balance becomes delinquent, it may be turned over to a collection agency and the collection fees will be added to my balance. I agree to reimburse Anastasi Counseling Services the fees of any collection agency, which may be based on a percentage at a maximum of 32% of the debt, and all costs and expenses, including reasonable attorney's fees which may occur in collection efforts.**
8. **I understand that I am here of my own free will, that there are potential benefits and risks to therapy, and that therapy may not help. I also understand that bringing others into a therapy session may compromise my privacy and I am willing to take that risk.**
9. **I understand that my therapist is a mandatory reporter and will report child abuse, dependent adult abuse, and will take necessary steps in the case of serious threats to self or others.**
10. **I understand that confidential information may be disclosed without written consent if required by laws such as a court order or as self protection in response to a legal suit.**
11. **I understand that confidentiality will be maintained except for the above exceptions and other exceptions you may consent to in writing.**
12. **I understand that under the Health Insurance Portability and Accountability Act (HIPAA) of 1996 the privacy of your health information is protected by law. Anastasi Counseling services maintains a "Notice of Privacy Practices" that describes how your protected health information may be used and disclosed and how you can obtain.**
13. **I understand that I can ask my therapist about clarification of any of these agreements and/or any other concerns regarding therapy.**

Signed:
Client_____ date: _____

Parent/Guardian: _____ date: _____

Spouse/significant other: _____date _____

INITIAL COUNSELING INTAKE

NAME: _____ DATE: _____
AGE: _____ BIRTHDATE: _____

What do you hope for through counseling? _____
_____
_____

What are your symptoms? (Please check all that apply)

___ Addictions (list) _____
___ Aggression/Anger outburst
___ Alcohol/drug abuse
___ Anxiety
___ Appetite changes
___ Avoidance of people
___ Concentration difficulties
___ Depression
___ Distractibility
___ Eating disorder
___ Elevated mood
___ Fatigue
___ Fears (list) _____
___ Grief
___ Hallucinations
___ Helplessness
___ Hopelessness
___ Impulsivity
___ Irritability
___ Loneliness
___ Loss of interest
___ Memory problems
___ Mood swings
___ Panic attacks
___ Physical health issues
___ Sadness
___ Self harm
___ Sexual difficulties
___ Sleep issues
___ Stressed
___ Suicidal thoughts
___ Trembling
___ Weight gain/loss
___ Withdrawal
___ Worrying

Other psychological/emotional problems_____
When did these symptoms first begin? _____
Whom have you seen professionally to help you with these problems?
_____
What are the issues/situations that brought about these symptoms?
_____
_____
_____
Who in your family has experienced similar symptoms?_____
_____
What medical concerns do you have?_____
_____
_____
Who is your medical doctor?_____
What prescribed medications are you currently taking? _____
_____
Are you safe with yourself? (circle) YES NO
Are others safe with you? (circle) YES NO If no, who is at risk? _____
_____
Who referred you to Anastasi Counseling? _____
If there is anything else you think your counselor should know to be most helpful to you, please describe here._____

CLIENT SELF-ASSESSMENT

Name: _____

Please circle how you would describe your current functioning:

	5	4	3	2	1	0
Marriage/relationship	excellent	very good	good	fair	poor	n/a
Parenting	excellent	very good	good	fair	poor	n/a
Step-parenting	excellent	very good	good	fair	poor	n/a
Family of origin	excellent	very good	good	fair	poor	n/a
Friends	excellent	very good	good	fair	poor	n/a
Relationships at work or school	excellent	very good	good	fair	poor	n/a
Balancing work, family and other areas	excellent	very good	good	fair	poor	n/a

Do you drink alcoholic beverages? Yes No
If yes, please answer the following:

Have you ever thought you should cut down on your drinking?	Yes	No
Have you ever felt annoyed by other's criticism of your drinking?	Yes	No
Have you ever felt guilty about your drinking?	Yes	No
Do you have a morning "eye opener"?	Yes	No
Has your drinking caused any problems?	Yes	No

Do you currently use street drugs? Yes No
If yes, what drugs do you use? _____
Quantity/frequency? _____

List any relatives who have had trouble with alcohol or other substance: _____
_____