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Individual Form

Date: _____

Name: _____

Address: _____

City: _____ Zip: _____

Note: HIPPA requirements state that Lee must obtain your written permission to contact you via mail, email, or phone, etc.

May Lee send mail to your listed address above? (ex: newsletter or business mail) to the above address? Y N

Phone Numbers: H: W: C:

May we text you? Y N

If we call, on which numbers may we leave a message? (Circle) H W C None
May we text on your cell phone regarding appointments? Y N

E-mail address: _____ May we e-mail you? Y N

Birth date: _____ Age: _____

Where did you grow up? _____

Education: (last level completed) _____

Occupation:

How did you hear about us? (Circle)

Google/Internet search

(If Google search, do you remember your search terms? _____

Medical professional – if so, who? _____

Friend or family member? If so, who? _____

Family Background

Family: Spouse or partner? Y N N/A Name: _____

Years together/married? _____

If married, is this your first marriage? Y N

List marriage(s) prior to this one:

Are your parents living?	Father	Y	N	Year deceased?
	Mother	Y	N	Year deceased?

Did your parents divorce? Y N

If your parents divorced, at what age were you? _____

Do you have stepparents?

Stepmother _____ Stepfather _____

Do you have children? Y N

In space below list names and ages of children. (Designate which are your children, and which are stepchildren):

List siblings, including you, from oldest to youngest, with current age:

Names/Age: 1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

Any family history of alcohol, drug, or physical abuse in your biological family? Y N

What type of abuse?

Add anything else you'd like me to know about your family.

Basic Health and Counseling History

How do you rate your overall health?

Good Fair Poor Date of last physical? _____

Are you taking any prescription medications, vitamins, herbal remedies? If so, please list what they are, and what they're for, i.e. Prozac = depression:

_____

Have you been hospitalized in the last 3 years? Y N
If so, for what?

Do you drink alcohol? Y N If yes, how much? _____

Would you say that your alcohol use is an issue in your life? Y N

Do you use illegal drugs? Y N If yes, what, and how much? _____

Would you say that your drug use is an issue in your life? Y N

Do you have any physical, emotional, or mental condition now or in the past that we need to be aware of? Y N If yes, please list:

Have you had counseling in the past? Y N If so, was it a positive experience? Y N

Do you have, or have you had, any of the following:

Body aches and pains? Y N If so, what? _____

_____

(For each issue circled "yes" below, give details on frequency and severity to the right.)

Details, frequency, severity

Chronic pain Y N

Migraines/headaches	Y	N
Stomach problems	Y	N
Thyroid issues	Y	N
Cancer	Y	N
Heart Disease	Y	N
Diabetes	Y	N
Carpel tunnel	Y	N
Numbness, tingling	Y	N
Panic or anxiety attacks	Y	N
Depression	Y	N
Feeling spacey or "out of body"	Y	N
Phobias/fears	Y	N
Extreme fatigue	Y	N
Little energy	Y	N
General anxiety	Y	N
Sleep issues	Y	N

If yes, circle any that apply:

Difficulty falling asleep

Difficulty staying asleep

Sleeping, waking, and unable to fall back to sleep.

Sleeping too much

How many hours a night do you sleep? _____

Is that amount of sleep usual for you? Y N

Please rate your overall energy level by filling in the blank for the following sentence… (circle the one that most applies to you)

"I am exhausted/tired and have little energy …"

always most of the time half of the time sometimes rarely I have plenty of energy

Answer the following TRUE or FALSE statements:

"I have lost interest in many things I once enjoyed doing." T F Unsure

"I have racing thoughts and find it difficult to concentrate." T F Unsure

"I feel afraid much of the time." T F Unsure

If you checked true to any of the above statements, are these symptoms recent or been going on for a long time?

Any thoughts of suicide? Y N

Any syndrome, disease, condition, or illness we need to be aware of? Y N

If yes, what?

Current reasons for seeking counseling

Why did you make the effort to call a professional counselor?

What would you like to see happen as a result of counseling?

The thing that concerns me the most now is?

Is there anything else you think it important for the counselor to know right now?

What do you want most to talk about in today's session?

Please list any major changes or stressors in your life in the last 12 months: (ex: separation, divorce, death of a family member, loss of a job, major illness, moving, etc.)

POLICY

A counseling session is normally 60 minutes long. Payment is expected at the beginning of each session. If you cannot make it to an appointment, 24-hours notice is required. If appointments are made, and 24-hour notice is not given, the usual fee will apply even for clients with Blue Cross Blue Shield.

The therapist requires that credit card information be kept on file in case a no-show charge is applied. Refusal may result in cancellation of appointment by the therapist. **THE CREDIT CARD INFORMATION GOES ON THE INFORMED CONSENT FORM. Please be sure read and sign the Informed Consent form, which states that you understand and agree to the policies of this therapist.**

The therapist will maintain strict confidentiality. However, I understand that suicidal threats, homicidal threats, or child abuse will be reported.

I understand and give permission to my therapist to seek clinical supervision or consultation about my situation when necessary.

I understand that I have the right to refuse treatment at any time.

Counselor Signature: _____ Date: _____

Client Signature: _____ Date _____