CLIENT INFORMATION FORM

PLEASE FILL OUT THIS FORM COMPLETELY

CLIENT NAME:____
(FIRST) (MIDDLE) (LAST)

STREET ADDRESS:____

CITY: ____________________ STATE: ______________ ZIP: ______________

HOME PHONE: ____________________ WORK / OTHER PHONE: ____________________

CLIENT SOCIAL SECURITY NUMBER: ____________________ DATE OF BIRTH: ____________________

SEX: MALE / FEMALE MARITAL STATUS:______________ RACE / ETHNICITY(OPTIONAL)______________

EMPLOYER/SCHOOL:____
(NAME)

____
(ADDRESS)

PRIMARY CARE PHYSICIAN NAME: ____

PRIMARY CARE PHYSICIAN ADDRESS: ____

____

PRIMARY CARE PHYSICIAN PHONE: ______________________________

PRIMARY CARE PHYSICIAN FAX: ______________________________

REFERRED BY: INSURANCE CO / EAP; PHONE BOOK; INTERNET; PCP OR OTHER PHYSICIAN; FAMILY / FRIEND; OTHER

IF YOU WERE REFERRED BY YOUR EAP PLEASE PROVIDE EAP PHONE:______________ # OF SESSIONS APPROVED:________

INSURANCE INFORMATION

INSURANCE COMPANY (NAME AND ADDRESS: ____

____

POLICYHOLDER'S NAME:______________________________ DATE OF BIRTH:______________________
MONTH/DAY/YEAR

POLICYHOLDER'S ADDRESS:____

CITY:______________ STATE:__________ ZIP:______________ SEX: MALE / FEMALE

WORK PHONE: ______________________________ HOME: ______________________________

POLICYHOLDER'S SOCIAL SECURITY #:______________ RELATIONSHIP STATUS: ______________________

MEMBER ID NUMBER #:______________________________ GROUP/PLAN/POLICY#: ______________________

PHONE # FOR MENTAL HEALTH BENEFITS/SERVICES: ____

DID YOU OBTAIN AUTHORIZATION FOR SERVICES FROM YOUR INSURANCE COMPANY? YES / NO / NOT REQUIRED

AUTHORIZATION NUMBER: ____

POLICYHOLDER'S EMPLOYER NAME AND ADDRESS: ____

____

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT:_______________________________________ RELATIONSHIP:________________________________

STREET ADDRESS:____

CITY:____________________ STATE:__________ ZIP:_____________ SEX: MALE / FEMALE

HOME PHONE: ____________________________________ WORK PHONE: ____

PAGER: ____ CELL PHONE: ____

SPOUSE/PARTNER (IF NOT EMERGENCY CONTACT): ____

HOME PHONE: ____________________________________ WORK PHONE: ____

PAGER: ____ CELL PHONE: ____

CONTACT INFORMATION

MAY I CONTACT OR LEAVE MESSAGES FOR THE CLIENT OR PARENT/LEGAL GUARDIAN AT HOME NUMBER LISTED? YES / NO

NOTICE TO CLIENTS

I CANNOT RELEASE INFORMATION OF ANY KIND, INCLUDING INFORMATION ABOUT APPOINTMENTS OR BILLING TO ANYONE OTHER THAN THE CLIENT OR PARENT / LEGAL GUARDIAN OF THE CLIENT.

____ ___________________________

SIGNATURE OF CLIENT OR LEGAL GUARDIAN **DATE**

Authorizations and Consents

Client Name:____

1. Authorization for Release of Information for Insurance Submission and Payment

If you wish to have my office file your insurance, please present your insurance card. Some companies pay fixed allowances for treatment and others pay a percentage of the charge. It is your responsibility to pay for any deductible amount, co-pay, any non-covered service, or service in which you are ineligible. Authorization of service and payment by the insurance company is contingent on eligibility (at time of service) and benefits available. It is your responsibility to pay co-pay's at each visit. I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits directly to the therapist indicated on the claim. I hereby authorize release of information (including diagnosis) necessary for treatment and processing of claims for insurance reimbursement. I understand I am financially responsible for any balance not covered by my insurance.

____ ____________________

Signature of Consumer/Legal Guardian/Legal Representative **Date**

2. Authorization to Release Information to PCP

Communication between behavioral health providers and your primary care physician is important to ensure that you receive comprehensive and quality health care. I hereby authorize release of my protected health information related to my evaluation and treatment to my primary care physician (PCP). I understand this information may include diagnosis, treatment plan, progress and medication information if necessary. I understand that I may revoke this consent in writing at any time except to the extent that it has been relied upon.

____ ____________________

Signature of Consumer/Legal Guardian/Legal Representative **Date**

3. *Failed Appointments*

I agree to notify Joe Miller at least twenty-four (24) hours prior to the beginning of my scheduled appointment if I decide to cancel/change. I understand I will be charged a $50.00 fee (not the copay amount) for an appointment not kept or canceled at least 24 hours prior to the beginning of my scheduled appointment. I also understand that this charge is not reimbursable by my insurance.

____ ____________________

Signature of Consumer/Legal Guardian/Legal Representative **Date**

4. Client Rights and Responsibilities

A Person Receiving Services is Entitled to:

1. Mental Health/Chemical Dependency services in accordance with standards of professional practice, appropriate to his/her needs and designed to give hirn/her a reasonable opportunity to improve his/her condition.
2. Humane care, protection from harm, and to be treated with dignity and respect.
3. The right to participate in the development and review of his/her treatment plan, including the known effects of receiving and not receiving such treatment, or alternative treatment, if any.
4. The right to receive treatment in the least restrictive settings
5. The right to review his/her own record in the presence of the therapist, unless the therapist's professional judgment deems this to be potentially detrimental to the person.
6. The right to confidential maintenance of all his/her identifying treatment information; no disclosure of such information without his/her written authorization, except in cases of medical emergency, by court order, or when otherwise dictated by law.
7. The right to register complaints and to have his/her complaints heard and action taken, if required, promptly
8. The right to waive any of his/her rights, if the waiver is given voluntarily, knowingly, and in a competent state of mind. The waiver may be withdrawn at any time.

____ ____________________

Signature of Consumer/Legal Guardian/Legal Representative **Date**

5. *Consumer Consent for Use/Disclosure of Health Care Information*

I understand that the consumer's health information is private and confidential. I understand that Joe Miller works very hard to protect the consumer's privacy and preserve the confidentiality of the consumer's personal health information.

I understand that Joe Miller may use and disclose the consumer's personal health information to help provide health care to the consumer, to handle billing and payment, and to take care of other health care operations. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. Examples would be if a consumer threatened to hurt someone or if child abuse is reported.

Joe Miller has a detailed document called the "Notice of Privacy Practices", given to me in my orientation handbook. It contains more information about the policies and practices protecting the consumer's privacy. I understand that I have the right to read the "Notice" before signing this agreement.

Joe Miller may update this "Notice of Privacy Practices". If I ask, Joe Miller will provide me with the most current "Notice of Privacy Practices".

Under the terms of this consent, I can ask Joe Miller to limit how the consumer's personal health information is used or disclosed to carry out treatment, payment or health care operations. I understand that Joe Miller does not have to agree to my request. If Joe Miller does agree to my request, I understand that Joe Miller would follow the agreed limits. Requests must be made in writing and Joe Miller will provide a form for this purpose by request at the office.

I may cancel this consent in writing at any time by doing one of the following:

- Signing and dating a form that Joe Miller can give me called "Revocation of Consent for Use and Disclosure of Health Care Information"; or
- Writing, signing, and dating a letter to Joe Miller. If I write a letter, it must say that I want to revoke my consent to authorize the use and disclosure of the consumer's personal health information for treatment, payment, and health care operations.

If I revoke this consent, Joe Miller does not have to provide any further health care services to the consumer or may require that the consumer pay directly for any service rendered.

My signature below indicates that I have been given the chance to review a current copy of Joe Miller's “Notice of Privacy Practices”. My signatures means that I agree to allow Joe Miller to use and disclose the consumer's personal health information to carry out treatment, payment, and health care operations.

6. I have read the preceding information and have been given the brochure detailing policies and procedures of Joe Miller’s programs. I have been given the opportunity to ask questions and agree to abide by these policies.

I authorize and request my behavioral healthcare professional to carry out psychological evaluations, psychiatric evaluations, treatment and/or diagnostic procedures that now, or during the course of my treatment become, advisable. I understand the purpose of these procedures will be explained to me upon my request and that they are subject to my agreement. I also understand that while the course of my treatment is designed to be helpful, my behavioral healthcare professional can make no guarantees about the outcome of my treatment. Further, the psychotherapeutic process can bring up uncomfortable feelings and reactions such as anxiety, sadness, and anger. I understand that reactions will be worked on between my behavioral healthcare professional and me. With these understandings, I hereby authorize treatment for myself. I give permission for Joe Miller to develop a treatment plan and provide treatment.

____ ____________________

Signature of Consumer/Legal Guardian/Legal Representative **Date**

Client Self Report

Client Name: ____ Age: ________ Date:______________________

Name of person competing this form (if not the client): ______________________________________

1. Briefly describe the problem which brought you here today: ______________________________
____
____

2. What do you want to see changed?:____

3. Check any issues with which you are having difficulty.

ADHD	DEPRESSION	ANXIETY	RELATIONSHIP
___hyperactive	___sad	___excessive worry	___marital/significant other
___implusive	___sleep problems	___panic attacks	___parenting
___under achievement	___neg. thinking	___irrational fear	___difficulty with friends
___non-compliant	___poor concentration	___obsessions	___work/school problems
___inattentive	___hopeless/worthless	___social isolation	___personal growth
___poor concentration	___mood swings	___phobias	___grief/loss
___disorganized	___guilt	___compulsive	___bullying/teasing

ANGER	ADDICTIONS	ABUSE	OTHER
___short-fused	___alcohol	___physical	___agitated
___temp. tantrums	___drugs	___emotional	___mania
___impulse control	___gambling	___domestic violence	___paranoia
___violent/assaultive	___relationships/sex	___rape	___delusions
___runaway risk	___eating disorders	___sexual	___tics/tourettes
___fighting	___cyber/internet	___dissociative	___cutting behavior
___irritable	___spending		___appetite changes
___oppositional			___nightmares/flashbacks
			___eating disorders

4. Are you having thoughts of hurting yourself or someone else? ___now ___past ___never
Comments: ____

Past Treatment | **Therapist Comments**

5. Have you ever been treated for psychiatric, substance abuse, emotional, or behavioral problems in the past? ___Yes ___No

6. If yes, when, where, and with whom? ______________________________
Inpatient ______________________________________
Outpatient _____________________________________
___counselor ___psychologist ___psychiatrist ___substance abuse counselor

7. Did you find past treatment helpful? ___yes ___no
If yes, how? ____________________________________
If no, why not?__________________________________

8. Please list any medications given: __________________________
____

9. Are you currently under the care of a psychiatrist or therapist for your current problem?
___yes ___no

10. Are you currently taking any medications for psychiatric problems? ___yes ___no
If yes, please list ________________________________
____

Medical Problems

11. Do you have any current medical problems? ___yes ___no
If yes, please list:_________________________________

12. When was the last time you were seen by a medical doctor? ______________

Therapist Comments

13. Are you currently taking medication for medical problems? ___yes ___no
    If yes, please list medication dosage, and purpose:____________________
    ____

14. Do you have any allergies to medication? ___yes ___no
    If yes, please list: ____

15. Do you have a history of (check all applicable)
    ___head injury ___seizures ___loss of consciousness

16. (Women only) Are you pregnant? ___yes ___no

17. Do you have pain management issues? ___yes ___no

Substance Abuse

18. Have you been treated for drug, alcohol abuse, or other addictions (food, gambling, sex)? ___yes ___no

19. Do you currently attend support groups? ___yes ___no

20. Circle the following you have used in the past 30 days: tobacco, alcohol, marijuana, tranquilizers, sleeping pills, pain killers, heroin, cocaine/crack, amphetamines/speed/crystal meth, methadone, LSD, PCP, ecstasy, inhalants.

21. Have you experienced withdrawal symptoms? ___yes ___no

22. Have you had a DUI? ___yes ___no

23. Do you have current legal problems? ___yes ___no

24. Are you currently on probation/parole? ___yes ___no

25. Do you have a DFACS worker? ___yes ___no

26. Circle current employment status: full time, part time, unemployed, homemaker, student, disabled, retired.

27. Are you currently on leave from work or seeking medical leave disability?
    ___yes ___no
    If yes, do you have paperwork that needs to be completed? ___yes ___no
    If yes, please give paperwork to the clinician at beginning of session.

28. Circle educational background: current student, did not complete high school, graduated high school, GED, some college, graduated college, advanced degree.

Family Relationships

29. List anyone who lives in your home, his/her age, and relationship: ________
    ____
    ____

30. Does anyone in your immediate family have psychiatric, emotional, substance abuse, or behavioral problems. ___yes ___no
    If yes, describe: ____

Therapist Comments

31. Is your immediate family supportive of you seeking treatment? ___yes ___no

32. Does anyone in your extended family have psychiatric, emotional, substance abuse, or behavioral problems? ___yes ___no

33. Are there domestic violence issues? ___yes ___no

34. Is your support network (family, neighbors, religious organizations, etc) ___good ___fair ___poor?

35. What are your hobbies/interests? ____________________________________
____

36. Do you have difficulties or concerns about how you get along with other people? ___yes ___no

37. Are you having difficulties with spiritual or religious matters? ___yes ___no

38. Do you have any sexual orientation/gender issues or concerns? ___yes ___no

Childhood and Adolescent Issues

39. Were there problems with the your mother's pregnancy or your delivery? ___yes ___no

40. Is there a history of you having developmental problems? ___yes ___no

41. Is there a history of sexual/physical/emotional abuse? ___yes ___no

42. Is there a history of learning disabilities? ___yes ___no

43. Have you ever been screened for Attention Deficit/Hyperactivity Disorder? ___yes ___no

44. Have you ever been suspended or expelled from school? ___yes ___no

45. Circle all which apply: Attended Home School, Special Education or Alternative School.

46. Please list any other concerns: ____
____
____

____ ____

Client (or person completing this form) signature **Date**

I have reviewed and discussed this information with the client.

____ ____

Therapist signature Date