Life Guide Counseling Services

New Client Information Date of Office visit__________________

Please fill out the following information as completely and accurately as possible in order to help us better serve your needs. Use the back of the form if you need more space.

Full Name___________________________________ Nickname_________ Birth date: _________Gender: _____

Address: ____City, State, and Zip: _______________________________

Home Phone: ___________________Cell Phone: ____________________Work Phone: ____________________

E-mail: ____ Other: _______________________

Will you permit us to contact you as needed at your: __Work, __Home, __ Cell, __E-mail, __Other

If not permitted to contact you, (please explain) ____

Driver's License #: ______________________________ State: __________ Occupation: __________________

Current Employer ____ Length of employment: _____

Employer's Address: ____

__Part time, __Full time, __Unemployed, __Not working due to ___________________________disability
medical/mental health

Other work: __Home maker, __Self employed-- Type of business owned__________________________

Who do we contact in the event of an emergency or cancellations **if you cannot be reached**?

Name(s): ____ Relationship(s): _____________________

Phone Number(s) Email/Address: ____

____

Referral Source/How did you find this counselor? ______________________________________

May we contact them to thank them for the referral when applicable? __Yes __No

If yes, please provide their contact information: ____

Person/Entity who guarantees the payment for our services: _____________________________________

Guarantor's Information – If different from the above (client)

Guarantor Name: ____ Relationship to Client: ______________

Address: ____ City, State, Zip: __________________________

Phone #(s) ____ Email: __________________________________

Employer: _____________________________________ Employer contact information: ________________

Driver's License #: ______________________________ State: _____ Birthday: ________________ Sex: ____

Insurance Information- Primary (complete only if you plan to use your insurance)

Insurance Co Name: ________________________ Employer of Policy Holder: __________________________

Name of Policy Holder: _____________________ Relationship to Client: _______________________________

Insurance Provider Phone # _________________________ Policy Holder Birth date: __________ Sex: ___

Insurance ID # _____________________________________ Group # ____

Secondary Insurance Co Name: ____ ID #: ____________________

Secondary Insurance Group #: ____________________________________ Phone #: _______________________

ASSIGNMENT OF BENEFITS: I hereby assign all behavioral/mental health benefits to which I am entitled. This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am responsible for all charges financially, whether or not paid by my insurance. I hereby authorize the said assignee to release all information necessary to secure payment. ****PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED, UNLESS PROVIDER HAS AGREED TO ANOTHER ARRANGEMENT****

Client's/Guarantor's Signature: ____ Date: ________________

Client's Other Personal Information

Education: Currently in school ___No ___Yes, If yes, name of the school_________________________________

Part time, ___Full time, **Education Level:** ___High School ___GED ___Some College ___Vocational or Trade school

College Graduate: ____ BA/BS ____MA/MS ____Ph.D./PsyD.

Major/Field of Study ____

Client's Current Status: ___Engaged, ___Married (length of time____________), ___Separated, ___Divorced, ___Widowed, ___Never married ___Unmarried, living in a committed relationship/partnership (length of time____________),

Other (Explain) ____

# of previous marriage(s) ______ List names, number and ages of any children/step children (please indicate which bio/step)______

____

# of people who are currently living in your household including yourself: _____ please list their names, ages and relationship to you: ____

A separate/collateral agreement needs to be completed by any person(s) accompanying the client and attending the session.

General Health Information General Health: ___Excellent ___Good ___Fair ___Poor

Primary Care Physician's Name: ____

Phone Number: _________________________ Date of last complete physical exam ________________

Are you presently seeing a specialist for any other condition? ____ No ____ Yes. If yes, name and phone number of your specialist: ____

Date diagnosed ___________ Diagnosis & Condition for which you are being treated: ______________

____

Do you use alcohol, tobacco, and other drugs? ____ No ____ Yes. If yes, please describe which ones, frequency and quantity: ____

Medication

Please list all current medications including dosage, purpose: ______________________________

____

____

List allergies to any medications, food, environment, etc: ___________________________________

____

Have you ever been, are presently or anticipate in the near future of being involved in any lawsuits or litigation? ____ No ____ Yes. If yes, please describe_____________________________________

____

Mental Health Information

Have you ever been hospitalized for a mental/emotional condition? ____ No ____ Yes. If yes, please state the condition and date(s) you received treatment ____

____

Are you presently receiving counseling or psychological services? ____ No ____ Yes. If yes, please briefly describe the condition and diagnosis if any and the date services began (use the back if necessary): _______

____

Name of therapist/provider and/or agency, ____

Have you received counseling, psychological or psychiatric services in the past? ____ No ____ Yes. If yes, please briefly describe including name of psychiatrist, therapist and/or agency, condition/ issue addressed, diagnosis, dates of service, and reason for ending treatment: _________________________________

____

Reason for this visit:

Briefly describe what brings you to counseling at this time: ______________________________________

____

Briefly describe your past and current ways of coping: ____

____

Please describe what you hope to accomplish in counseling: ______________________________________

____

RELIGION

What is your present religious affiliation, if any? ____

How important is spiritual/religious commitment to you on scale of 0 to 10 (Zero being unimportant to ten being Extremely important) ____. Do you any desire to have your spiritual/religious beliefs and values incorporated into the counseling process? ____ No ____ Not sure ____ Yes. If yes, please explain______________

Please place a check mark next to any of the following, if you have been experiencing them in the last 30 days: ___Aggressive Behavior ___Grief/Loss ___Panic Attacks ___Agitation ___Irritability ____Anger ___Guilt ___Shame ___Anxiety ___Physical Complaints ___Hallucinations (seeing things/people that others do not see) ___Delusions ___Poor Concentration ___Hopelessness ___Sadness, ___Depression ___Dissociative behaviors (such as flashbacks, loss of time, memory lapse) ___Fearfulness ___Drug withdrawal ___Low Self-esteem ___Sleep Disturbance ___Elevated Mood ___Decreased Energy/Low Energy, Appetite (___loss, ___increase) ___Hyperactivity ___Compulsivity ___Impulsiveness ___Excessive Worry ___Feelings of worthlessness ___Thoughts of Harm to Others ___Thoughts of Self-harm Any other not listed: ________________________________

<u>Family Of Origin Information</u>

Mother's age: ____ if deceased, how old were you when she died? ____ Father's age: ____ if deceased, how old were you when he died? ____ If your parents are divorced, how old were you at the time? ____ Number of Siblings/Step siblings and their ages? ____

I was child number ____ in a family of ____ children. Were you adopted or raised with parents other than your biological parents? ____ No ____Yes. If yes, at what age ____

Briefly describe your relationship with your parents/adopted parents/ other individuals who were primarily responsible for raising you: ____

____

Briefly describe your relationship with your siblings, if you have any: ______________________________

____

Is there a family history of mental health conditions, alcohol/substance abuse or sexual, emotional or physical abuse? ____ No, ____ Yes. If yes, please describe: ______________________________

____

Other information you would like to share about your family: ______________________________

____

Client's Signature: ______________________________ **Date:** ______________

If the client is a Minor/disabled adult or elderly, Guardian's Name: ______________________________

Relationship: ______________ Hereby I attest that I am legally responsible for this minor child/disabled adult or elderly, and I authorize treatment of (**name of the client**) ______________________________

by (**name & credential of therapist**)______________________________

Name of Legal Guardian: ______________________________

Signature of Legal Guardian: ______________________________ **Date:** ______________