CLIENT INFORMATION FORM

Client Name____ New Client? Client Update?
Must be full, legal name of the person being seen for therapy

Address _______________________________ ___________________________ ________ ____________
Street or PO Box City State Zip

Social Security Number_______________________ Date of Birth______________ Gender M F

Home Phone______________________ Y N
May I leave a message?

Work Phone______________________ Y N
May I leave a message?

Other Phone______________________ Y N
Please identify May I leave a message?

Client Marital Status
Single Married Other

Client Employed?
Yes No

Client Student Status
Full Time Part Time

Email:____

How Did You Hear About My Practice? ***Please be as specific as possible***

Former/Current Client Healthcare Professional Yellow Pages Mental Health Provider

Insurance Company Word of Mouth Internet Other Name __________________________

Responsible Party Information ***The responsible party will receive the bill for any services not covered by insurance. Please only complete information that differs from the client.***

Name______________________________________ Home Phone_______________________

Address____________________________________ Work Phone_________________________
Street or PO Box

____ Relationship to Client:________________
City State Zip

Insurance Information ***Information in this section should pertain to the Primary Person listed on the insurance card. Please only complete information that differs from the client.***

Insurance Co_________________________________ Insurance Phone#________________________

Insured's Name____________________________ID#_________________________Group#___________

Patient Relationship to Insured Self Spouse Child Other

Insured's Address ____ Home Phone ____________________
Street or PO Box

Insured SS#___________________

____Insur
City State Zip

Insured's Employer_________________ Insured's DOB______

I hereby authorize the release of all information necessary to secure payment and assign all benefits to which I am entitled.

Signature____ Date_____________________

Office Use Only Therapist:__________________________________Diagnosis Code___________

Billing Notes____

Form v1.0

Client Name:____ Date Completed: _______________

Client Age:_________

Reason for Seeking Treatment: ____

____

____

____

Rate Intensity of Presenting Problem: 1 2 3 4 5 6 7 8 9 10

During the past TWO WEEKS, how much or how often have you been bothered by the following problems?

	None	**Slight** Rare	**Mild** Several Days	**Moderate** More than half the Days	**Severe** Nearly every Day
Little interest or pleasure in doing things?	0	1	2	3	4
Feeling down, depressed, or hopeless?	0	1	2	3	4
Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4
Sleeping less than usual, but still having a lot of energy?	0	1	2	3	4
Starting lots more projects than usual or Doing more risky things than usual?	0	1	2	3	4
Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4
Feeling panic or being frightened?	0	1	2	3	4
Avoiding situations that make you anxious?	0	1	2	3	4
Unexplained aches and pains (e.g., head, back, joints, abdomen, legs?)	0	1	2	3	4
Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4
Thoughts of actually hurting yourself?	0	1	2	3	4
Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4

Client Name: ______________________________

Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4
Problems with sleep that affected your sleep quality overall?	0	1	2	3	4
Problems with memory (e.g., learning new information) or with location (e.g,. finding your way home)?	0	1	2	3	4
Unpleasant thoughts, urges, or images that repeatedly entered your mind?	0	1	2	3	4
Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4
Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4
Not knowing who you really are or what you want out of life?	0	1	2	3	4
Not feeling close to other people or enjoying your relationship with others?	0	1	2	3	4
Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4
Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4

Prior Therapy: ___ ___ With Whom:________________________________
____
Dates:____________________________________
Diagnoses:________________________________

Psychiatric Hospitalization: ___ ___ Where?__________________________________
When?___________________________________
How Long?_______________________________

Current Medications:

Name	Dosage	Date Begun	Prescribed By
____________________	__________	___________	_____________
____________________	__________	___________	_____________
____________________	__________	___________	_____________
____________________	__________	___________	_____________

Medical Conditions:	Yes	No	Explanation:
Hepatitis:	___	___	________________
Thyroid Disease:	___	___	________________
HIV/AIDS:	___	___	________________
Diabetes:	___	___	________________
Heart Disease:	___	___	________________
Gastrointestinal:	___	___	________________
Seizures:	___	___	________________
Migraines:	___	___	________________
Cancer:	___	___	________________
Drug Allergies:	___	___	List:________________
			________________
Other Medical Conditions:	___	___	________________
Hospitalizations:	___	___	Reason:________________
			________________
			When?________________

Family History:

Have members of your family ever had any of the following problems? Include parents, grandparents, uncles, aunts, brothers, sisters, and children.

Depression:	___	___	________________
Anxiety:	___	___	________________
Manic Depression/Bipolar	___	___	________________
Suicide Attempt:	___	___	________________
Completed Suicide:	___	___	________________
Learning Disability:	___	___	________________
Schizophrenia:	___	___	________________
Alcohol Abuse:	___	___	________________
Drug Abuse:	___	___	________________

CONSENT FOR TREATMENT
AND
RECEIPT OF NOTICE OF PRIVACY PRACTICES

This form is an agreement between you, ___________________________, and Joy D. Bennett, LISW. The word "you" also may mean your child or dependent. If you are not the client, write the client's name here: _________________________________.

When I examine, diagnose, treat, or refer you, I will be collecting Protected Health Information about you. I use this information to decide on what treatment is best for you and to provide treatment to you. By signing this form, you are consenting to be treated psychotherapeutically by me.

By signing this form you are agreeing to let me use your information and send it to others who are responsible for your treatment, payment for services, or for administrative functions. The Notice of Privacy Practices explains in more detail your rights and how I can use and share information. Please read this Notice (on my website http://joybennett.org) before you sign this Consent form. Signing this form acknowledges that the Notice of Privacy Practices has been made available to you.

If you do not sign this Consent form agreeing to what is in the Notice of Privacy Practices I cannot treat you.

In the future I may change how I use and share your information and so may change the Notice of Privacy Practices. If I do change it, you can ask me for a copy and I will give one to you.

If you are concerned about some of your information, you have the right to ask me to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell me what you want in writing. Although I will try to respect your wishes, I am not required to agree to these limitations. However, if I do agree, I promise to comply with your wish.

After you have signed this Consent form, you have the right to revoke it by writing a letter telling me you no longer consent. If consent is revoked, treatment will be terminated. I may already have used or shared some of your information, and that cannot be changed.

(Initial below)
_________I understand that if I fail to notify my counselor of a cancellation without 24 hours notice, I will be CHARGED.

_________I understand that communication with my counselor via e-mail or text is not guaranteed to be secure. If accessed by an unauthorized person or through my service carrier, my confidentiality and privacy could be compromised.

(check one)
_________I prefer reminders of appointments by text.
_________I prefer reminders of appointments by phone or voice mail (more secure).

______________________________________ ______________________________
Signature of client or guardian Date

______________________________________ ______________________________
Print name of client or guardian Relationship to the client