Confidential Client Information — Restored Life Counseling

The following information is **CONFIDENTIAL** and is designed to help me provide the assistance you desire. No individual or institution will be contacted without your prior knowledge and permission.

Name _____ **Date** _____

Address _____**City** _____ **State**_____ **Zip** _____

Phone _____ **Email** _____

Sex: ☐ Male ☐ Female **Age**____ **Birthday** _____ **Relationship** ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Children Names/Ages_____

Referred by _____

IMPORTANT CONTACT INFORMATION!!!
If I need to contact you, can I contact your using the above information? ☐ Yes ☐ No
May our office staff leave a message at the above phone number or email address? ☐ Yes ☐ No

EMERGENCY CONTACT PERSON

_____

Contact Person's name Relationship to client Phone or message #

_____

Responsible Party Name Address

INSURANCE INFORMATION

Primary Insurance Co _____ID #_____

Policy Holder Name _____Relationship to Policy Holder _____

Their Birthday_____ Policy Holders Employer_____

AUTHORIZATION/RELEASE: I authorize payment of insurance benefits directly to the therapist or this office. I authorize the therapist to release all information necessary to communicate with the personal physicians and other health care providers/payers and to secure the payment of benefits. I understand that I am responsible for all costs of therapy and counseling care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my therapist, any fees for professional services will be immediately due and payable**.**

I further understand and agree to allow this healthcare office to use my Patient Heath Information for the purposes of treatment, payment, healthcare operations and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures prior to signing this consent concerning the privacy of your Patient Health Information you may read the HIPAA NOTICE that is available to you at the front desk. If there is anyone you do NOT want to receive your medical records, please inform our office.

Client Signature_____Date _____

Therapist Signature _____Date_____

PRESENTING PROBLEMS/CONCERNS

Describe the issues that brought you here today: _____
_____

_____

What would you like to accomplish through counseling? What are your goals? _____
_____

Have you ever had thoughts/statements/attempts to hurt yourself? ☐ Yes ☐ No Someone Else? ☐ Yes ☐ No

Have you recently been physically hurt, abused or threatened by someone else? ☐ Yes ☐ No

List any major life changes in the last year _____

Are your problems affecting any of the following?

- ☐ Managing everyday tasks
- ☐ Work/school
- ☐ Recreational activities
- ☐ Finances
- ☐ Self esteem
- ☐ Sexual activity
- ☐ Relationships
- ☐ Hygiene
- ☐ Legal matters
- ☐ Arrests
- ☐ Health

Have you experienced any of the following difficulties?

- ☐ Emotional abuse
- ☐ Sexual abuse
- ☐ Physical abuse
- ☐ Parent substance abuse
- ☐ Teen pregnancy
- ☐ Sexual assault/rape
- ☐ Neglect
- ☐ Violence in the home
- ☐ Crime victim
- ☐ Job Loss
- ☐ Placed a child for adoption
- ☐ Miscarriage
- ☐ Lived in a foster home
- ☐ Multiple family moves
- ☐ Homelessness
- ☐ Loss of a loved one
- ☐ Financial problems

Check all the behaviors/symptoms you consider problematic:
Place a letter to the left of the box indicating its frequency: S = Sometimes, O = Often, A = Always

- ☐ Distractibility
- ☐ Hyperactivity
- ☐ Impulsivity
- ☐ Boredom
- ☐ Poor memory/confusion
- ☐ Difficulty concentrating
- ☐ Seasonal mood changes
- ☐ Sadness/depression
- ☐ Loss of pleasure
- ☐ Hopelessness
- ☐ Thoughts of suicide
- ☐ Crying spells
- ☐ Loneliness
- ☐ Low self worth
- ☐ Guilt/shame
- ☐ Fatigue
- ☐ Sleep problems
- ☐ Nightmares
- ☐ Social discomfort
- ☐ Strange thoughts
- ☐ Compulsive behavior
- ☐ Aggression/fights
- ☐ Frequent arguments
- ☐ Irritability/anger
- ☐ Homicidal thoughts
- ☐ Flashbacks
- ☐ Hearing voices
- ☐ Recurring, disturbing memories
- ☐ Visual hallucinations
- ☐ Suspicion/paranoia
- ☐ Changes in appetite
- ☐ Lack of motivation
- ☐ Withdrawing
- ☐ Anxiety/worry/tension
- ☐ Panic attacks
- ☐ Fear away from home
- ☐ Racing thoughts
- ☐ Euphoric, powerful
- ☐ Excessive energy
- ☐ Wide mood swings
- ☐ Risky behaviors
- ☐ Gambling problems
- ☐ Computer addiction
- ☐ Problem w/pornography
- ☐ Lack of appetite
- ☐ Restricting food
- ☐ Binging/purging
- ☐ Parenting problems
- ☐ Sexual problems
- ☐ Relationship problems
- ☐ Work/school problems
- ☐ Alcohol/drug use
- ☐ Other_____
  _____

PREVIOUS MENTAL HEALTH TREATMENT

Treatment	Dates	Provider/Program	Reason for treatment	Successful	
				Yes	No
Outpatient Counseling					
Medication (mental health)					
Psychiatric Hospitalization					
Drug/Alcohol Treatment					
Self-help/ Support Group					

MEDICAL INFORMATION

Date of last physical exam: _____ Primary Care Physician: _____

Medication	Dosage	Date first prescribed	Prescribed by

Over the counter meds (vitamins, herbal remedies, etc.): _____

Please list any CURRENT health concerns: _____

SUBSTANCE USE HISTORY

					Parents/Family Members			
Drug	Y	N	Frequency	Amount	Y	N	Frequency	Amount
Tobacco								
Caffeine								
Alcohol								
Marijuana								
Cocaine/crack								
Ecstasy								
Heroin/Opiates								
Methamphetamines								
Pain killers								
PCP/LSD/Hallucinogens								
Steroids								
Tranquilizers/Sleeping pills								
Appetite suppressants								
Stimulants								

FAMILY HISTORY

Family Mental Health Problems	Who?	Quality of this relationship currently?
Hyperactivity		
Sexually abused		
Depression		
Manic Depression		
Suicide or Suicide attempts		
Anxiety		
Panic Attacks		
Obsessive-Compulsive		
Anger/Abusive		
Schizophrenia		
Eating Disorder		
Alcohol Abuse		
Drug Abuse		
Obesity/Eating Disorder		

INTERPERSONAL/SOCIAL

Please describe your support network (check all that apply):

☐ Family ☐ Neighbors ☐ Friends ☐ Students ☐ Co-workers ☐ Support/Self-Help Group ☐ Community Group

☐ Online Community _____ ☐ Religious/Spiritual Group _____ ☐ Other_____

How important are spiritual matters to you? ☐ Not at all ☐ Somewhat ☐ Very much

☐ Yes ☐ No Would you like spiritual beliefs to be a part of your counseling? _____

CAREER/WORK/LEGAL

Employer: _____ Position: _____

Length of time in this position: _____ Job Duties: _____

Stress level of work: ☐ Low ☐ Medium ☐ High Satisfaction with work: ☐ Low ☐ Medium ☐ High

☐ Yes ☐ No Have you been in the military? Branch: _____ Rank: _____ Combat: ☐ Yes ☐ No

☐ Yes ☐ No Have you ever been convicted of a misdemeanor or felony? _____

☐ Yes ☐ No Are you currently involved in divorce/child custody proceedings? _____

Client Signature_____Date _____

Therapist Signature _____Date_____