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

	Yes	No	Explanation:
Normal Energy Level:	___	___	_____
Sleep Disturbance:	___	___	_____
Appetite Changes:	___	___	_____
Exercise:	___	___	_____
Anger/Hostility:	___	___	_____
Poor Concentration:	___	___	_____
Irritability/Agitation:	___	___	_____
Mood Swings:	___	___	_____
Obsessive Thoughts:	___	___	_____
Compulsions:	___	___	_____
Anxiety/Tension:	___	___	_____
Memory Problems:	___	___	_____
Fearfulness:	___	___	_____
Hallucinations:	___	___	_____
Paranoid Thoughts:	___	___	_____
Depressed Mood:	___	___	_____
Hopelessness:	___	___	_____
Suicidal Thoughts:	___	___	_____
Homicidal Thoughts:	___	___	_____
Family/Friend Support	___	___	_____
Social Isolation:	___	___	_____
Violent Behavior:	___	___	_____
Arrests:	___	___	_____
Legal Issues:	___	___	_____
Prior Therapy:	___	___	With Whom: _____
			_____
			Dates: _____
			Diagnoses: _____
Psychiatric Hospitalization:	___	___	Where? _____
			When? _____
			How Long? _____
Have you ever been on Disability:	___	___	_____

Highest Education You've Attained: _____
Religious/Faith Orientation: _____

Client Name: _____

Caffeine Use	___	___	How Much? _____
Cigarette Smoker	___	___	How Much? _____
Alcohol	___	___	Frequency? _____
			Amount? _____
			Last Used? _____
Drug Use	___	___	Type (s): _____
			Amount? _____
			Last Used? _____

Current Mediations:	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:	___	___	_____

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?

Email:_____

Client Marital Status
Single Married Other

Client Employed?
Yes No

Client Student Status
Full Time Part Time

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's SSN_____
City State Zip

Insured's DOB_____ Gender M F Insured's Employer_____

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

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 what the law calls Protected Health Information about you. I use this information to decide on what treatment is best for you and to provide treatment to you. I may also share this information with others who provide treatment to you or need to arrange payment for your treatment or for other business functions.

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 before you sign this Consent form.

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.

Signing this form also acknowledges that you received a copy of the Notice of Privacy Practices.

If you fail to notify me of a cancellation without 24 hours notice, you will be CHARGED.

_____ _____
Signature of client or guardian Date

_____ _____
Print name of client or guardian Relationship to the client