New Client Information Sheet

Please complete **ALL** questions

PSY Family Services
301 W. Rosedale, Fort Worth, TX 76104

1. Client Demographics

Patient Name: Last:	First:	Middle:

Sex: ( )M ( )F	DOB:	Age:	School Grade:	Marital Status: ( )Single ( )Separated ( )Married ( )Divorced	Ethnic Origin: ( )Caucasian ( )African-Amer. ( )Amer. Indian ( )Hispanic ( )Asian

Address:	Apt. #:	City:	State/Zip:

Phone Number: ( )-	Social Security #:	Drivers License #:	State of License:

Employer Name:	Occupation:	Length of Employment:	Employer Phone Number: ( )-

Employer Address:	Suite #:	City:	State/Zip:

2. Emergency Contact

Emergency Contact:
Name:

Address:	Apt. #:	City:	State/Zip:

Phone Number: ( )-	Alternate Phone Number: ( )-	Relationship:

3. Referral Source

How were you referred to this office?

( )Insurance ( )Hospital ( )Mental Health Professional ( )Other:_____

4. Previous Counseling

Last 12 months: ( )Yes ( )No	When:	How Long:

Where:	Why:	If ended, why:

5. Health Insurance Information

Insurance Company:	Policy #:	Group Name:	Group #:

Insured's Full Name:	Sex: ( )M ( )F	Relationship:	DOB:

Employer Name:	Employer Phone Number: ( )-

Employer Address:	Suite #:	City:	State/Zip:

PSY Family Services

Assessment and Counseling Services
301 W. Rosedale, Fort Worth, TX 76104
(817) 338-4471

CLIENT INFORMATION AND CONSENT

Client's Name: _____ ***Date of Birth:*** _____

Consent to Treatment
I, voluntarily, agree to receive Mental Health assessment, care, treatment, or services, and authorize the undersigned therapist to provide such care, treatment, or services as are considered necessary and advisable. I understand and agree that I will participate in the planning of my care, treatment, or services, and that I may stop such care, treatment, or services that I receive through the undersigned therapist at any time. I understand that the session may be audio or video taped for educational purposes.

Appointments
Appointments are made by calling (817)338-4471. Please call to cancel or reschedule at least 24 hours in advance, or you may be charged for the missed appointment. Third-party payments will not usually cover or reimburse for missed appointments.

Number of Visits
The number of sessions needed depends on many factors and will be discussed by the therapist.

Length of Visits
Therapy sessions are approximately 45-50 minutes in length. The charge for individual and family sessions is $90.00 per visit, unless there is an agreed-upon rate with your insurance. Different co-payments are required by various group coverage plans.

Assignment of Benefits
We will communicate with and work with your health/medical insurance for you. ***PSY*** will be assigned all medical and psychological benefits from insurance. ***PSY*** will release information necessary for payment to the paying agency. Your insurance carrier(s), including Medicaid, Medicare, private insurance, and any other health/medical plan, will issue payment directly to ***PSY*** for services rendered.

Confidentiality
Discussions between a therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; situations where the therapist has a duty to disclose, or where, in the therapist's judgment, it is necessary to warn or disclose; fee disputes between the therapist and client; a negligence suit brought by the client against the therapist; or the filing of a complaint with the licensing board. If you have any questions regarding confidentiality, you should bring them to the attention of the therapist when you and the therapist discuss this matter further. By signing this information and consent form, you are giving your consent to the undersigned therapist to share confidential information with all persons mandated by law and with the agency that referred you and the managed care company and/or insurance carrier responsible or providing your mental health care services and payment for those services, and you are also releasing and holding harmless the undersigned therapist from any departure from your right of confidentiality that may result.

Duty to Warn

In the event that the undersigned therapist reasonably believes that I am a danger, physically or emotionally, to myself or another person, I specifically consent for the therapist to warn the person in danger and to contact the following persons, in addition to medical and law enforcement personnel.

NAME	**RELATIONSHIP**	**TELEPHONE NUMBER**

Risks of Therapy

Therapy is the Greek word for change. You may learn things about yourself that you don't like. Often, growth cannot occur until you experience and confront issues that induce you to feel sadness, sorrow, anxiety, or pain. The success of our work together depends on the quality of the efforts on both our parts, and the realization that you are responsible for lifestyle choices/changes that may result from therapy.

By signing this Client Information and Consent form, I, the undersigned client, acknowledge that I have read, understood, and agree to all the terms and information contained herein.

_____ _____

Client Date

Any inquiries/complaints about licensees from this office may be addressed by contacting the following:
Complaints Management and Investigative Section, P.O. Box 141369, Austin, Texas 78714-1369

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ASSIGNMENT OF BENEFITS AND INSURANCE RELEASE FORM

Client's Name: _____ ***Date of Birth:*** _____

Financial Responsibility

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to **PSY** for any charges not covered by my healthcare benefits, as well as any applicable co-payments and deductibles. It is my responsibility to notify **PSY** of any changes in my healthcare coverage. In some cases, exact insurance benefits can not be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by **PSY** and/or my healthcare insurer if the submitted claims or any part of the claims, are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for services rendered.

Assignment of Benefits

I hereby assign all medical, mental health, behavioral health and substance abuse treatment benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including private insurance and any other health/medical plan, to issue payment check(s) directly to **PSY** for substance abuse/behavioral health treatment services rendered to myself and/or my dependent(s). I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize **PSY** to: 1) Release any information necessary to insurance carriers regarding my illness and treatments; 2) To process insurance claims generated in the course of counseling and treatment; and 3) To allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

Copy of Insurance Card/Verification

I understand that it is my responsibility to provide **PSY** with a copy of my current insurance card. It is also my responsibility to notify **PSY** of any changes to my insurance plan or insurance carrier.

_____ _____

Patient/Responsible Party Signature Date

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RELEASE OF INFORMATION

CLIENT NAME: _____

DATE OF BIRTH: _____

SOCIAL SECURITY #: _____

By signing below, I hereby authorize ***PSY*** to Release and to obtain information with respect to any physical, psychiatric or drug/alcohol related condition obtained during the course of diagnosis and/or treatment to/from the individual(s) or healthcare providers below. The type of information authorized for disclosures includes, but may not be limited to notification of admission/discharge, Psychiatric Evaluation, reports of Testing, discharge planning and summary, progress and treatment reports, physical exam, assessments, treatment content, treatment progress, payment records, social history, and any statements made by me to ***PSY***. The purpose of this disclosure is to identify persons supporting and using services, to aid in diagnosis, continuing care, and treatment.

Mental Health Professional (name, address, phone)

_____

Primary Care Physician (name, address, phone)

_____

Psychiatrist (name, address, phone)

_____

Family / Parent / Guardian (name, address, phone)

_____

_____

Insurance (name, address, phone)

_____

_____

Other (name, address, phone)

_____

I have been advised that I may revoke this release of information at any time, except to the extent that information has already been released.

_____ _____

Client Signature Date

updated 7-13-2018

Intake Questionnaire For New Patients (Adult)

This questionnaire is for the purpose of getting to know you better in order to provide the best possible mental health services. Please complete this form as honestly and completely as possible. All information that you provide us will be confidential as required by state and federal law.

Date: _____ **Social Security Number**: _____

Name: _____ **Date of Birth**: _____ **Age**: _____

Home Address: _____ **City/State/Zip code**: _____

Home Phone: _____ **Cellular/Alternate Phone**: _____

Marital Status: single married separated divorced
remarried engaged widowed cohabiting

If applicable, please complete the following:
Partner's Name: _____ **Partner's Age**: _____

Partner's Occupation: _____

IF YOU HAVE CHILDREN PLEASE LIST THEIR NAMES AND AGES:

#	Name	Sex	Age	#	Name	Sex	Age
1				4			
2				5			
3				6			

WHO CURRENTLY LIVES IN YOUR RESIDENCE (adults and children):

#	Name	Relation	Sex	Age	#	Name	Relation	Sex	Age
1					4				
2					5				
3					6				

In your own words, describe the current problems as you see them:

_____
_____
_____
_____
_____

How long has this been going on? _____

What made you come in at this time? _____
_____
_____

What do you hope to gain from this evaluation and/or counseling?

_____
_____

If you had difficulties in the past, what have you done to cope? Was it helpful?

Symptoms

Please **check** any symptoms or experiences that you have had **in the last month**

- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Difficulty getting out of bed
- ☐ Not feeling rested in the morning

Average hours of sleep per night: _____

- ☐ Persistent loss of interest in previously enjoyed activities
- ☐ Withdrawing from other people
- ☐ Spending increased time alone
- ☐ Depressed Mood
- ☐ Feeling Numb
- ☐ Rapid mood changes
- ☐ Irritability
- ☐ Anxiety
- ☐ Panic attacks
- ☐ Frequent feelings of guilt
- ☐ Avoiding people, places, activities or specific things
- ☐ Difficulty leaving your home
- ☐ Fear of certain objects or situations (i.e., flying, heights, bugs) Describe: _____
- ☐ Repetitive behaviors or mental acts (i.e., counting, checking doors, washing hands)
- ☐ Outbursts of anger

- ☐ Worthlessness
- ☐ Hopelessness
- ☐ Sadness
- ☐ Helplessness
- ☐ Fear
- ☐ Feeling or acting like a different person

- ☐ Changes in eating/appetite
- ☐ Eating more
- ☐ Eating less
- ☐ Voluntary vomiting
- ☐ Use of laxatives
- ☐ Excessive exercise to avoid weight gain
- ☐ Binge eating
- ☐ Are you trying to lose weight? _____
- ☐ Weight gain: _____ lbs
- ☐ Weight loss: _____ lbs.

- ☐ Difficulty catching your breath
- ☐ Increase muscle tension
- ☐ Unusual sweating
- ☐ Easily started, feeling "jumpy"
- ☐ Increased energy
- ☐ Decreased energy
- ☐ Tremor
- ☐ Dizziness
- ☐ Frequent worry
- ☐ Physical sensations others don't have
- ☐ Racing thoughts
- ☐ Intrusive memories

- ☐ Difficulty concentrating or thinking
- ☐ Large gaps in memory
- ☐ Flashbacks
- ☐ Nightmares
- ☐ Thoughts about harming or killing yourself
- ☐ Thoughts about harming or killing someone else

- ☐ Feeling as if you were outside yourself, detached, observing what you are doing
- ☐ Feeling puzzled as to what is real and unreal
- ☐ Persistent, repetitive, intrusive thoughts, impulses, or images
- ☐ Unusual visual experiences such as flashes of light, shadows

☐ Hear voices when no one else is present
☐ Feeling that your thoughts are controlled or placed in your mind
☐ Feeling that the television or the radio is communicating with you

☐ Difficulty problem solving
☐ Dependency on others
☐ Inappropriate expression of anger
☐ Difficulty or inability to say "no" to others
☐ Sense of lack of control
☐ Abusive relationship
☐ Concerns about your sexuality
☐ Difficulty meeting role expectations
☐ Manipulation of others to fulfill your own desires
☐ Self-mutilation/cutting
☐ Ineffective communication
☐ Decreased ability to handle stress
☐ Difficulty expression emotions

Sexual Orientation: ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ I choose not to answer

Please describe any other symptoms or experiences you have had problems with:

_____
_____
_____
_____

Have you seen a counselor, psychologist, psychiatrist or other mental health professional before?
☐ No ☐ Yes If so:

Name of therapist: _____ Dates of Treatment
Reason for seeking help: _____ _____

Name of therapist: _____ Dates of Treatment
Reason for seeking help: _____ _____

Are you **CURRENTLY** taking **PSYCHIATRIC** medication? ☐ No ☐ Yes If YES, please list:

Medication	**Dosage**	**How long have you been taking it?**	**Has it been helpful?**

Are you **CURRENTLY** taking **NON-PSYCHIATRIC** medication? ☐ No ☐ Yes If YES, please list:

Medication	**Dosage**	**How long have you been taking it?**

Have you been on **PSYCHIATRIC** medication in the past? ☐ No ☐ Yes If YES, please list:

Medication	**Dosage**	**First/Last time you took it**	**Effect of Medication**

Have you been hospitalized for psychiatric reasons? ☐ No ☐ Yes If YES, describe:

Hospital	Dates	Reason

Have you ever attempted suicide? ☐ No ☐ Yes If YES, describe:

_____

_____

_____

_____

MEDICAL HISTORY

Are you **CURRENTLY** under treatment for any medical condition? ☐ No ☐ Yes If YES, describe:

_____

_____

_____

_____

List any PRIOR illnesses, operations and accidents

_____

_____

_____

FAMILY HISTORY

Father: Age: ☐ Living ☐ Deceased Cause of death:
If deceased, HIS age at time of his death____ YOUR age at time of his death_____
Occupation: _____ Health: _____
Frequency of contact with him: _____ Are you/Have you been close to him? _____

Mother: Age: ☐ Living ☐ Deceased Cause of death:
If deceased, HER age at time of his death___ YOUR age at time of his death_____
Occupation: _____ Health: _____
Frequency of contact with her: _____ Are you/Have you been close to her? _____

Brothers and Sisters

Name	Sex	Age	Whereabouts	Are you close to him/her?			
					No		**Yes**
					No		**Yes**
					No		**Yes**
					No		**Yes**

During your childhood, did you live any significant period of time with anyone other than your natural parents?
☐ No ☐ Yes If so, please give the persona's name and relationship to you

Name: _____ Relationship to you:_____

Please place a check mark in the appropriate box if these are or have been present in your relatives

	Children	Brothers	Sisters	Father	Mother	Uncle/Aunt	Grandparents
Nervous Problems							
Depression							
Hyperactivity							
Counseling							
Psychiatric Medication							
Psychiatric Hospitalization							
Suicide Attempt							
Death by Suicide							
Drinking Problem							

SOCIAL HISTORY

Past Marital History

Have you been married previously?_____ If Yes, please describe:
When?_____ How long? _____
When?_____ How long? _____

Education

Highest grade level completed: _____
Degree obtained, if applicable: _____
Did you have any disciplinary problems in school? _____
If yes, please explain: _____
Were you considered hyperactive/ADHD in school? _____
If yes, were/are you on any medication? _____
If yes, were/are you on any medication? _____
If so, which medication? _____
What kinds of grades did you get in school? _____

Have you served in the military? _____
If yes, please describe briefly: _____
_____

What type of discharge (separation) did you get? _____

Employment

Are you currently employed? _____
If yes, employer's name: _____
What type of work do you do? _____

Employment History (most recent first)

Type of Job	Dates	Reason for Leaving

Have you been arrested? _____
If yes, please describe: _____

Do you have a religious affiliation? _____
If yes, what is it? _____

What kind of social activities do you participate in? _____

Who do you turn to for help with your problems? _____

Have you ever been abused?
☐ Verbally ☐ Emotionally ☐ Physically ☐ Sexually ☐ Neglected

Please describe: _____
_____

SUBSTANCE ABUSE

Alcohol
Do you drink alcohol? _____ If yes, age of first use _____
How much do you drink? _____
How often do you drink? _____
Have you ever passed out from drinking? _____ How often? _____
Have you ever blacked out from drinking? _____ How often? _____
Have you ever had the "shakes"? _____ How often? _____
Have you ever felt you should cut down on your drinking/drug use? _____
Have people annoyed you by criticizing your drinking/drug use? _____
Have you ever felt bad or guilty about your drinking/drug use? _____
Have you ever drank/used drugs in the morning to steady your nerves or relieve a hangover? _____
Do you use tobacco? _____
If yes, how often? _____

Other Drugs:
Please indicate for each drug listed below

Drug	Ever Used?	Age at 1st use	Time Since Last Use	Approx use in last 30 days
Marijuana				
Cocaine				
Crack				
Heroin				
Methamphetamine				
Ecstasy				

Is there anything else you would like us to know about you?

The Holmes-Rahe Scale

Read each of the events listed below, and **check the box** next to any even which has occurred in your life **in the last two (2) years.** There are no right or wrong answers. The aim is to identify which of these events you have experienced lately.

Life Events	Life Crisis Units	
Death of Spouse	100	
Divorce	73	
Marital Separation	65	
Gone to jail	63	
Death of close family member	63	
Personal injury or illness	53	
Marriage	50	
Fired at work	47	
Marital reconciliation	45	
Retirement	45	
Change in health of family member	44	
Pregnancy	40	
Sexual Difficulties	39	
Gain of new family member	39	
Business readjustment	39	
Change in financial state	38	
Death of a close friend	37	
Change to different line of work	36	
Increase in arguments with spouse	35	
Mortgage over $100,000	31	
Foreclosure of mortgage or loan	30	
Change in responsibilities at work	29	

Life Events	Life Crisis Units	
Son or daughter leaving home	29	
Trouble with in-laws	29	
Outstanding personal achievement	28	
Spouse begins or stops work	26	
Begin or end school	26	
Change in living conditions	25	
Revision in personal habits	24	
Trouble with boss	23	
Change in work hours or conditions	20	
Change in residence	20	
Change in schools	20	
Change in recreation	19	
Change in church activities	19	
Change in social activities	18	
Mortgage or loan less than $30,000	17	
Change in sleeping habits	16	
Change in number of family get-togethers	15	
Change in eating habits	15	
Vacation	13	
Christmas alone	12	
Minor violations of the law	11	

Your Total Score: _____

updated 7-13-2018