New Horizons Counseling Center

Client Information

(Please print clearly and complete **ALL** sections)

Name: _____ Social Security #: _____
First Middle Last

Address: _____ Home phone: _____

City, State, Zip: _____ Work phone: _____

Parish: _____ Cell phone: _____

Best contact number: Home ____ Work____ Cell ____ May we leave a message? Y_____ N_____

Date of Birth: _____/_____/_____ Age: _____ Gender: M _____ F _____

Marital Status: _____ Single _____ Married _____ Divorced _____ Widowed _____Other

Email: _____ Emergency phone: _____

Emergency Name: _____ Relationship to client: _____

Insurance Carrier:_____ Policy # _____ Policy Holder:_____

Relationship:_____ Date of Birth:_____ Social Security #:_____

Employment Status: ___Employed ___Unemployed ___Child/Student ___Disabled ___Retired

Employer (for children, list parent's employer) _____

Position _____ How long? _____

School name (for students)_____ Grade: _____

Who referred you?: _____

Please list family members in the household and their relationship to you.

Name (First – Middle – Last)	Relationship	Age	Birthdate

List immediate family members **NOT** in the home.

Name (First – Middle – Last)	Relationship	Age	Birthdate

Client Name: _____

Biopsychosocial History

Presenting Problems Duration (months) Additional Information:

_____

_____

_____

_____

Symptoms Checklist (Please do NOT leave blank)

___ Depressed Mood
___ Appetite Disturbance
___ Sleep Disturbance
___ Fatigue / Low Energy
___ Poor Concentration
___ Poor Grooming
___ Mood Swings
___ Agitation
___ Overly Emotional
___ Irritability
___ Anxiety
___ Panic Attacks
___ Phobias
___ Obsessions / Compulsions
___ Thoughts of Harming Others

___ Bingeing/Purging
___ Anorexia
___ Paranoid Ideas
___ Excessively negative
___ Delusions
___ Hallucinations
___ Aggressive behaviors
___ Conduct Problems
___ Legal Problems
___ Oppositional Behavior
___ Sexual Dysfunction
___ Grief
___ Hopelessness
___ Suicidal Thoughts
___ Suicide Attempts

___ Worthlessness
___ Guilt
___ Elevated Mood
___ Hyperactivity
___ Self-mutilation
___ Health problems (list on next page)
___ Significant Weight Change
___ Emotional Trauma Victim
___ Physical Trauma Victim
___ Sexual Trauma Victim
___ Substance Dependence
___ Social Isolation
___ Other (specify)
_____
_____

Prior psychotherapy? ____ yes ____ no If yes, please provide information below.

Provider	***Location***	***When***	***How Long***	***Diagnosis***

Client Name: _____

Family History of Psychiatric Issues and/or Treatment

Relationship to client	***When was treatment received***	***Diagnosis***

Medical Information

Please provide the following information in regards to the client. If a child is the client, please complete the form for your child.

Medical Checklist

Please read over the following list and **check any that apply – *now or in the past***. Please use the blank space to list any medical problems or conditions which may not be listed.

___ Alcohol Abuse
___ Alcoholism
___ Fibromyalgia
___ Allergies
___ Asthma
___ Autism
___ Back Problems
___ Birth Defects
___ Blindness
___ Cancer
___ Cardiovascular Problems
___ Cerebral Palsy
___ Deafness
___ Developmental Disability
___ Diabetes
___ Drug Abuse
___ Autoimmune Disorder
___ Epilepsy
___ Headaches
___ Hearing Impairment
___ Heart Disease
___ Kidney Disease
___ Mental Illness
___ Mental Retardation
___ Multiple Sclerosis
___ Muscular Dystrophy
___ Respiratory Illness
___ Speech Problems
___ Sleeping Disorder
___ Stomach Problems
___ Tuberculosis
___ Venereal Disease
___ Weight Problem
___ Cystic Fibrosis
___ Other (specify)
_____

Has there been any substance abuse past or present? Yes _____ No _____

If Yes, please specify _____

Have there been any suicidal tendencies or attempts? Yes _____ No _____

If you have documented allergies above, have there ever been any adverse reactions to medications/treatments? Yes _____ No _____

Client Name: _____

Medications

Please list all medications and the dosages you are currently taking.

_____

_____

_____

_____

_____

Would you like information on an Advance Directive for Mental Health Treatment? **(please check one)**

Yes _____(if this is checked, we will provide you with a copy.

No _____(check this if you are refusing information)

Primary Care Physician (PCP):

Name of PCP: _____

Address of PCP: _____

_____

_____ *Permission granted to contact PCP* (Please initial) _____ *Permission denied* (Please initial)

Please list below your goals, strengths, motivation, etc. Also, do you have family support and is your spouse (if applicable) willing to meet with the counselor in order to improve your therapy?

_____

_____

_____

_____

_____

Client Name: _____

Office Billing and Insurance Policy

I authorize:

- use of this form on all of my insurance or other payor submissions.
- the release of information to my insurance company or other payor.
- direct payment from my insurance company or payor to ***Amanda Creel, PhD, LPC, LMFT*** and/or ***New Horizons Counseling Center, L.L.C.***

I understand:

- It is my responsibility to pay any deductible amount, co-payment, or co-insurance amount on the day and time services are provided.
- Reminder calls are **not** guaranteed and are provided as a courtesy. Clients are responsible for keeping track of their appointment dates and times.
- Appointments are expected to be cancelled at least **24** hours prior to the appointment time. If necessary, I may leave a message on the office voicemail of New Horizons Counseling Center.
- **Failure to provide appropriate notice of cancellation will result in a *$60.00* failed appointment fee.**
- Delinquent accounts will be turned over for collection after 90 days unless prior payment arrangements have been made.
- Fees for court appearances or reports written for legal purposes will not be charged to insurance companies and are my responsibility. *These fees must be paid prior to the court appearance and/or the reports being released*. It is my responsibility to request a copy of court related fees.

In signing this, I consent to counseling services for myself and/or dependant and agree to the above billing policy. I also acknowledge that I have been given a copy of Amanda Creel's "Declaration of Practices and Procedures" which includes information regarding the counseling relationship, billing, emergency information, and limitations to confidentiality.

Signature _____ ***Date*** _____

Counselor _____ ***Date*** _____

Client Name: _____

CONSENT FOR TREATMENT OF CHILDREN AND ADOLESCENTS

I/We, being the parent(s) or legal guardian(s) for _____, a minor child, consent for counseling services to be provided by ***Amanda Creel, PhD, LPC, LMFT*** with ***New Horizons Counseling Center, L.L.C.***

Signature _____ ***Date*** _____

Signature _____ ***Date*** _____

Client Name: _____