



# Integrity Counseling & Personal Development

## CLIENT HISTORY & DEMOGRAPHIC SHEET

Please take some time to fill out as much of this as you are able. If there are things you are unsure of or uncomfortable marking, we can discuss them during your first appointment.

Client's Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender:  Female  Male Social Security #: \_\_\_\_\_

Parent/Legal Guardian (s) (if applicable): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Okay to leave a message?  Yes  No

Cell Phone#: \_\_\_\_\_ Okay to leave a message?  Yes  No

Work Phone#: \_\_\_\_\_ Okay to leave a message?  Yes  No

Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Previous marriages? \_\_\_\_\_

Student: Full time:  Part time:  School: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Who referred you? \_\_\_\_\_ May we send an acknowledgement for the referral?  Yes  No

Who should be contacted in the event of an emergency?

Name: \_\_\_\_\_ Phone #'s: \_\_\_\_\_

Address: \_\_\_\_\_

Person Responsible for Bill: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Primary Insurance Company (if filing insurance): \_\_\_\_\_

Company Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Under whose name is the policy? \_\_\_\_\_

Insured SS#: \_\_\_\_\_ Insured Date of Birth: \_\_\_\_\_

Insured's Address \_\_\_\_\_

Insured's Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Policy/Group #: \_\_\_\_\_ Member #: \_\_\_\_\_

Insured's Co-payment %/amount: \_\_\_\_\_ Has deductible been met for this client?  Yes  No

Limits for this type of benefit: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_

Company Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Under whose name is the policy? \_\_\_\_\_

Insured SS#: \_\_\_\_\_ Insured Date of Birth: \_\_\_\_\_

Insured's Address \_\_\_\_\_

Insured's Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Policy/Group #: \_\_\_\_\_ Member #: \_\_\_\_\_ Group?  Yes  No

Please mark areas of distress that you have experienced:

(If information provided by someone other than the client, provide name/relationship: \_\_\_\_\_)

- |  |  |
|--|--|
| <input type="checkbox"/> Decreased appetite                | <input type="checkbox"/> Seeing things others do not see               |
| <input type="checkbox"/> Increased appetite                | <input type="checkbox"/> Hearing things other do not hear              |
| <input type="checkbox"/> Low energy                        | <input type="checkbox"/> Intrusive or bothersome thoughts              |
| <input type="checkbox"/> High energy                       | <input type="checkbox"/> Repetitive thoughts/actions                   |
| <input type="checkbox"/> Withdrawal from others            | <input type="checkbox"/> Inability to hold a job                       |
| <input type="checkbox"/> Decreased ability to enjoy things | <input type="checkbox"/> Relationship problems                         |
| <input type="checkbox"/> Excessive worrying                | <input type="checkbox"/> Sexual problems                               |
| <input type="checkbox"/> Explosive temper                  | <input type="checkbox"/> Alcohol or drug problems                      |
| <input type="checkbox"/> Self-criticism                    | <input type="checkbox"/> Legal problems                                |
| <input type="checkbox"/> Tearfulness                       | <input type="checkbox"/> Verbally aggressive (i.e., yelling)           |
| <input type="checkbox"/> Frequent crying                   | <input type="checkbox"/> Violence                                      |
| <input type="checkbox"/> Nightmares                        | <input type="checkbox"/> Thoughts to harm others                       |
| <input type="checkbox"/> Sleeping too much                 | <input type="checkbox"/> Self-injurious behavior (cutting, etc.)       |
| <input type="checkbox"/> Decreased sleep                   | <input type="checkbox"/> Thoughts to harm self or suicidal thoughts    |
| <input type="checkbox"/> Waking too early                  | <input type="checkbox"/> Frequent thought of death                     |
| <input type="checkbox"/> Impulsivity                       | <input type="checkbox"/> History of abuse, trauma, or serious accident |
| <input type="checkbox"/> Distractibility                   | <input type="checkbox"/> Decreased concentration                       |

List significant stressors, changes, traumas that you feel have lead to you seeking counseling at this point in your life:

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Please describe other counseling experiences that you have had, including what was helpful and what was not helpful about those experiences.

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Please list all medications that you are currently taking, including any for mental health reasons:

| Medication/Dose | Who prescribes | Purpose | Helpful? |
|-----------------|----------------|---------|----------|
|                 |                |         |          |
|                 |                |         |          |
|                 |                |         |          |
|                 |                |         |          |

Describe the people that you currently live with:

| Name | Age | Your relationship to that person |
|------|-----|----------------------------------|
|      |     |                                  |
|      |     |                                  |
|      |     |                                  |
|      |     |                                  |
|      |     |                                  |

Is there anyone in your immediate or extended family with a history of mental illness or substance abuse

No  Yes, Explain: \_\_\_\_\_

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How many close friends would you say that you have? \_\_\_\_\_

Do you have concerns regarding friendships or other relationships?  No  Yes, explain: \_\_\_\_\_

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What are your spiritual and religious beliefs and how do they impact you daily?

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Any cultural considerations that would be important to consider during the counseling process:

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What do you hope to resolve by seeking counseling?

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Anything else you would like for the therapist to know prior to the first session:

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Form completed by: \_\_\_\_\_

If client is a child, please mark these areas as well:

- |   |   |
|---|---|
| <input type="checkbox"/> Decline in grades  | <input type="checkbox"/> Tantrums                                 |
| <input type="checkbox"/> Isolates self from peers                                       | <input type="checkbox"/> Stealing                                 |
| <input type="checkbox"/> Bedwetting   | <input type="checkbox"/> Change in sleep patterns                 |
| <input type="checkbox"/> Bathroom issues  | <input type="checkbox"/> Sibling conflict                         |
| <input type="checkbox"/> Drug/alcohol use   | <input type="checkbox"/> Change in grades                         |
| <input type="checkbox"/> Lack of respect for authorities                                | <input type="checkbox"/> Run away from home, whereabouts known    |
| <input type="checkbox"/> Suspension from school/bus                                     | <input type="checkbox"/> Run away from home, overnight or unknown |
| <input type="checkbox"/> Skipping School  | <input type="checkbox"/> Fire setting or play with fire           |
| <input type="checkbox"/> Unusual fears  | <input type="checkbox"/> Cruel to animals                         |
| <input type="checkbox"/> Involvement with Juvenile Probation (Probation Officer: _____) |   |
| <input type="checkbox"/> Involvement with DFCS (Caseworker: _____)                      |   |

School/Day Care: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

Is SST in place?  Yes  No Does the child have an IEP?  Yes  No

Do you have school concerns for the child/adolescent?  No  Yes, explain: \_\_\_\_\_

Child lives with: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Child's parents are  Married  Separated  Divorced  Never Married  Deceased

If child is not living with both parents, explain the reasons and how often does he/she see the other parent?

What is the child's relationship like with parents/caregivers? \_\_\_\_\_

What is the child's relationship like with siblings? \_\_\_\_\_

What is the child's relationship like with friends? \_\_\_\_\_

Are all immunizations up to date?  Yes  No

Did child reach all developmental tasks on schedule?  Yes  No-Explain: \_\_\_\_\_

Please have responsible party read and sign below:

**Statement of Responsibility**

I have read the PSYCHOTHERAPIST-CLIENT SERVICES AGREEMENT and agree to its terms and I also acknowledge that I received the GEORGIA NOTICE FORM described in the agreement. I understand that I am financially responsible for all charges made to me by my therapist even through I have insurance that may pay part of or all of my incurred charges. **I understand that I will be billed for any appointments not canceled with 24 hours notice.**

\_\_\_\_\_  
Signature: Client or parent/guardian

\_\_\_\_\_  
Date

**Assignment of Benefits**

I hereby assign any and all rights or payments which may be due or payable to me under policy number \_\_\_\_\_ with \_\_\_\_\_ insurance company. This assignment is made in behalf and directly to Christine Dalton, Integrity Counseling & Personal Development, I authorize the release of any psychotherapeutic information necessary to process my claims. If any current policy prohibits direct payment to the named company, I hereby instruct my insurance company to make out the check to me and mail it as follows:

Integrity Counseling & Personal Development  
Christine Dalton, LCSW  
138 Washington Street  
Jefferson, GA 30549

**Insurance Verification Waiver**

I authorize Christine Dalton, LCSW, and her staff to communicate with my employer's insurance representative, my insurance company, or their designated verification individual for the purpose of verifying coverage of my insurance policy. I authorize Christine Dalton, LCSW, to file complaints to the insurance commissioner on my behalf.

\_\_\_\_\_  
Signature: Client or parent/guardian

\_\_\_\_\_  
Date