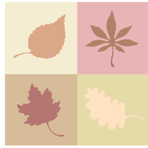

Integrity Counseling & Personal Development

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:______________________________________ Okay to send message? ☐Yes ☐No
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: ____________________Grade/Teacher:____________________
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:______________________)

☐Decreased appetite	☐Decreased sleep	☐Seeing things others do not see
☐Increased appetite	☐Sleeping too much	☐Hearing things other do not hear
☐Low energy/fatigue	☐Waking too early	☐Intrusive or bothersome thoughts
☐High energy	☐Nightmares	☐Repetitive thoughts/actions
☐Withdrawal from others	☐Excessive worrying	☐Inability to hold a job
☐Decreased ability to enjoy things	☐Impulsivity	☐Explosive temper
☐Self-criticism	☐Distractibility/lack of concentration	☐Violence or thoughts of violence
☐Tearfulness/frequent crying	☐Alcohol or drug problems	☐Verbally aggressive (i.e., yelling)
☐Frequent thoughts of death or suicide	☐Sexual problems	☐Legal problems
☐Self-injurious behavior (cutting, etc.)	☐History of abuse, trauma, or accident	☐Generally negative feelings

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

____
____
____
____

Please describe other counseling experiences that you have had, including what was helpful and what was not helpful about those experiences as well as the effectiveness in relieving symptoms:

____
____
____
____
____

Please describe your current pattern of use of the following substances:
Nicotine: ☐ Never ☐ Occasionally ☐ Weekly (packs:____________) ☐ Daily (packs:__________)
Alcohol: ☐ Never ☐ Occasionally ☐ Weekly (drinks:___________) ☐ Daily (drinks:__________)
Illegal Drugs: Type:__________________________________Pattern of use:______________________________________
Past use of any of the above: ☐ No ☐ Yes, explain:____
How much caffeine do you consume in a week? ____

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 (include relationship and known diagnosis):______________________________________

How many close friends would you say that you have? ________

Do you have concerns regarding friendships or other relationships? ☐No ☐Yes, explain: ________________

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

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

What do you hope to resolve by seeking counseling?

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

*Form completed by:*______________________________

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

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

Describe any prenatal complications that this child experienced: _____________________________________
____
____

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

If Using Insurance Benefits:

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
83 Athens 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

CONSENT FORM FOR EXCHANGE/RELEASE OF INFORMATION

CLIENT NAME: ____

DATE OF BIRTH: ______________________________SSN:________________________________

LEGAL GUARDIAN IF PATIENT IS A MINOR: ____

I, ____________________________________, give my permission to Christine Dalton, LCSW, her staff and the person (s) listed below to exchange information and/or records regarding myself or my dependents. I give permission for a faxed or photocopied signature to serve as an original regarding this release. The purpose of this release is to share/release information for the benefit of the patient's diagnosis, treatment planning, continuity of care, family medical leave, disability requests and/or benefit claims for life/health insurance application. The information released pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by the privacy act. This authorization may be subject to revoke by the individual signing this consent by providing a written, signed and dated request to withdrawn the authorization except to the extent that action has already been taken.

1.__Primary Care Physician:____

2.____

3.____

4.____

________________________________ Signature of Client

________________________________ Date signed

________________________________ Signature of parent/ guardian (When applicable)

________________________________ Witness