



Date: \_\_\_\_\_

**NEW CLIENT DATA AND INFORMED CONSENT AGREEMENT FOR ADULTS**

052006

Your Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birth date: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Gender: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Religion: \_\_\_\_\_ Place of Birth: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Day Phone: \_\_\_\_\_ Cell: \_\_\_\_\_  
Employed by: \_\_\_\_\_ Title: \_\_\_\_\_ How long? \_\_\_\_\_  
Home Phone: \_\_\_\_\_ OK to call/ lv msg. on any phone number? \_\_\_\_\_  
School completed: 9 10 11 12 GED College: 1 2 3 4 Master's: 1 2 3 Doctoral: 1 2 3  
In emergency, contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

**MARITAL STATUS (check all that apply)**

Married (how long? \_\_\_\_\_)  Living together, not married  Single, never married  
 Engaged  Separated (how long? \_\_\_\_\_)  Divorced (how long? \_\_\_\_\_)

• **If married (complete):**

Spouse Name: \_\_\_\_\_ Spouse SS# \_\_\_\_\_ Birth date \_\_\_\_\_  
Spouse's Age: \_\_\_\_\_ Number of prior marriages for you: \_\_\_\_\_, for spouse: \_\_\_\_\_  
Spouse's Education: \_\_\_\_\_ Spouse's religion: \_\_\_\_\_ Are you happy in this marriage? \_\_\_\_\_

**RELATIONSHIP WITH SPOUSE:** Good Strained Conflict not speaking no contact

• **If divorced (complete):**

Dates of prior marriages: from \_\_\_\_\_ to \_\_\_\_\_; from \_\_\_\_\_ to \_\_\_\_\_  
Reason marriage(s) ended: \_\_\_\_\_  
Who has primary custody of children? \_\_\_\_\_

Children:	Age	Sex	Relationship to you	Living at your home?

**COUNSELING HISTORY**

Have you ever been to counseling for any reason? Y N Briefly, what reason? \_\_\_\_\_

\_\_\_\_\_ How long? \_\_\_\_\_ Counselor's Name: \_\_\_\_\_

Are you presently working with any other counselor/psychologist/etc? Y N

Reason: \_\_\_\_\_

Are you involved in any support group(s)? \_\_\_Y\_\_\_N What is the nature of the

group(s) \_\_\_\_\_

Briefly state the nature of the issue that you are currently seeking counseling for: \_\_\_\_\_

What do you want to gain from counseling? \_\_\_\_\_

Who referred you here? \_\_\_\_\_ Limited Release to Referral Source: \_\_\_Y\_\_\_N

How strong is the influence of your religious faith in your life? \_\_\_\_\_

Of you church? \_\_\_\_\_ Of your Pastor? \_\_\_\_\_ Limited Release to Pastor: \_\_\_Y\_\_\_N

**MEDICAL INFORMATION**

Family Physician: \_\_\_\_\_ Limited Release to Physician: \_\_\_Y\_\_\_N

Psychiatrist/Psychologist/Social Worker \_\_\_\_\_ Limited Release: \_\_\_Y\_\_\_N

Are you currently on any medication? \_\_\_\_\_ If yes,

<u>Medication</u>	<u>Purpose</u>	<u>Dosage</u>	<u>How long?</u>	<u>Prescribed by</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Do you drink/smoke? \_\_\_Y\_\_\_N How often/much/when? \_\_\_\_\_

List of medical conditions: \_\_\_\_\_

Date of last physical exam: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

How would you describe your physical health?      Excellent      Good      Poor

## IMPACT OF LIFE CIRCUMSTANCES

**Circle any loses that you have experienced:**

Death of: spouse child father mother sister brother grandparent friend other  
 divorce separation broken engagement miscarriage abortion infertility bankruptcy  
 homelessness natural disaster career or job loss other: \_\_\_\_\_

**Circle any victimization that you have been involved with, directly or otherwise:**

Child abuse: physical emotional sexual incest  
 Spouse abuse: physical emotional sexual  
 Other: rape robbery arrest assault abandonment auto or industrial accident  
 suicide attempt major illness surgery physical disability alienation other: \_\_\_\_\_

**Circle any problems that concern you now:**

*Relationships with:*

spouse children parents in-laws co-workers friends teachers  
 ex-spouse God or church

*Problems with:*

drugs/alcohol binge eating excessive dieting excessive exercise excessive sleeping  
 pornography cult involvement shopping or credit issues work holism procrastination  
 communication intimacy depression boyfriend/girlfriend gender identity sex career  
 loneliness mood swings self-esteem codependency stress fear anxiety nerves  
 shyness anger headaches memory education bowel troubles relaxation health  
 decision-making stomach troubles fatigue ambition inferiority dreams thoughts  
 self control legal matters concentration appetite weight

*Relationship issues:*

communication infidelity time management affection trust sexual performance  
 closeness friendships recreation sexual desire verbal fighting housing finances  
 spouse's cleanliness physical fighting agreeing on chores flirting having fun together  
 showing appreciation conflicting schedules jealousy common interests/goals parenting  
 holding each other down solving problems together

Current situation (check if applicable):	Explanation:
<input type="checkbox"/> Suicidal thoughts, plans, attempts	_____
<input type="checkbox"/> Homicidal thoughts	_____
<input type="checkbox"/> Desire to cause pain to self/others	_____
<input type="checkbox"/> Fear for you life or personal safety	_____
<input type="checkbox"/> Too depressed to care for self/family	_____
<input type="checkbox"/> Often anxious/blue	_____

**PAYMENT INFORMATION**

Treatment Fees will be paid by: \_\_\_\_\_ Phone: \_\_\_\_\_

**Are we filing with your insurance company?** \_\_\_Y\_\_\_ N.

**If yes, you are responsible to know your policy provisions and coverage. Your are also required to obtain all initial authorization. All unpaid fee will be your responsibility.**

Insurance Company; \_\_\_\_\_

**A copy of insurance card and Florida ID is required if we are to file with your insurance carrier**

Insured's Name: \_\_\_\_\_ Insured's Social Security Number: \_\_\_\_\_

Insured's Date of Birth: \_\_\_\_\_ Insured's ID Number: \_\_\_\_\_

Relationship to insured: \_\_\_\_\_ Effective date of policy: \_\_\_\_\_

Insured's Group Number: \_\_\_\_\_ Yearly deductible: \_\_\_\_\_ Met? \_\_\_Y\_\_\_ N

Insured's Employer: \_\_\_\_\_ Limited Release to Insurance Company: \_\_\_Y\_\_\_ N

## CONSENT FOR TREATMENT AND TO PAYMENT PROCEDURE

I consent to psychotherapeutic evaluation and treatment. I have received and read the Client Handbook and understand my rights and responsibilities and those of my counselor in this counseling relationship.

**I understand that fees for services rendered are expected on the day of appointment unless PRIOR arrangements have been made. Appointments cancelled without 24 hours advance notice and any no show will be charged half the standard rate.**

I hereby authorize payment directly to CORE Counseling Service, Inc. of any benefits specified and otherwise payable to me, but not to exceed the charges for services rendered. I authorize the release of information to process these claims.

**The information I have given is true and complete.**

**Before you sign this form, make sure that you've answered all required question**

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name: \_\_\_\_\_

Guardian Signature: \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_