

Grace Counseling

2205 Arcadia Road
Holiday, FL 34690 (Tampa Bay Area)
850.348.0609 | goodnessofgodchurch.com

Client Name: _____

Date of Birth (mm/dd/yyyy): _____ Age _____ Sex _____

I give my permission to contact me at the following mailing address:

Address: _____

City/State: _____ Zip: _____

I give permission to call and leave messages for me at the following phone numbers:

Home: _____ Cell: _____ Work: _____

Employer: _____ Position: _____

SSN: ____ - ____ - _____

Spouse/Guardian Name: _____ Age: _____

Address (if different): _____

Home: _____ Cell: _____ Work: _____

<u>Children</u>	<u>Age</u>	<u>School/Grade</u>	<u>Married</u>	<u>Location</u>
_____	_____	_____	Y/N	_____
_____	_____	_____	Y/N	_____
_____	_____	_____	Y/N	_____
_____	_____	_____	Y/N	_____

Family Physician: _____ Phone: _____

Religious Affiliation: _____

How did you hear about us: _____

Have you sought counseling previously? Y / N If Yes, with whom: _____

When (mm/dd/yyyy – mm/dd/yyyy): _____

Client Signature: _____ Date: _____

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Dear Client:

My intention is to help you find the solution to your problem(s). I operate from a Christian worldview, and I believe that with God's help, my facilitation and your cooperation, we can harness the internal and external resources you have to alleviate the problem(s). How you take care of your body, mind (soul) and spirit are important to me. I will ask questions in these areas and welcome questions. I will listen to your problem(s), look for your strengths and clarify any negative patterns that have persisted in your life. As your therapist, I am available to provide a safe and trusting environment, where you are encouraged to change and grow individually, in relationship to others and to the Trinity. Individual, marital and family therapy is available to you.

Additional policies regarding confidentiality:

- Any reasonable suspicion of child abuse, physical or sexual, is required by the State of Florida to be reported to the Department of Health and Rehabilitative Services.
- If you utilize third-party payment to reimburse yourself, information you have authorized therapist to disclose may be available for retrieval by others.
- If you disclose to your therapist that you intent to harm yourself, confidence with be broken and appropriate persons will be notified for your physical protection.
- IN cases where outside consultation or referral is deemed necessary, you will be asked to sign an Authorization to Disclose Confidential Information form to provide information about your case. No information is released without your written consent.
- Records may be subpoenaed in some court cases.

I, _____ have read the above policies regarding fees and confidentiality and agree to these conditions for services.

Client Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

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Authorization to Use and Disclose Protected Health Information

1. I am completing this form to allow the use and sharing of protected health information about

Printed Name: _____ Date of Birth: _____

2. I authorize this person or organization: _____

3a. To use or disclose the following information:

- Inpatient or outpatient treatment records for physical and/or psychological, psychiatric, or emotional illness or drug and/or alcohol abuse.
- Admission and discharge summaries
- Psychological or psychiatric evaluation(s), reports, assessments, treatment notes, summaries, or other documents with diagnoses, prognoses, recommendations, or testing records, and behavioral observations or checklists completed by any staff member or the patient, or similar documents.
- Treatment, recovery, rehabilitation, aftercare plans and other similar plans.
- Progress, nursing, case or similar notes.
- Evaluations and reports of consultants.
- Information about how the patient's condition(s) affects or has affected his/her ability to work, and to complete tasks or activities of daily living.
- Vocational evaluations and reports.
- Billing records.
- Academic and educational records, including achievement and other tests' results, reports of teachers' observations and all other school or special education documents.
- HIV-related information and drug and alcohol information contained in these records will be released under this authorization unless indicated here: ___Initials: Do Not Release These
- Complete copy of medical record.
- Other: _____

3b. Dates of care included from: _____ to _____

AND From: _____ to _____

AND From: _____ to _____

4. To this person or organization: _____

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5. The information will be used/disclosed for the following purposes: _____

6. I understand and agree that this Authorization will be valid and in effect until

_____ (Enter date or event upon which this Authorization expires.) I understand that after that date/event, no more of this information can be used/released to the person or organization unless I sign a new Authorization like this one.

7. I understand that I can revoke or cancel this authorization at any time by sending a letter to the Privacy Office of the organization listed above and which is to supply this information. If I do this, I will prevent any releases after the date it is received by can not change the fact that some information may have been sent to shared before that date.

8. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the professional or facility listed at number 4 above, nor will it affect my eligibility for benefits.

9. I understand that I may inspect and have a copy of the health information described in this authorization.

10. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations.

11 I understand that his professional or facility will received compensation for the use or disclosure of my health information. The arrangement has been explained to me and I understand and accept it. _____ Initials: DOES NOT APPLY

12. I affirm that everything in this form that was not clear to me has been explained, and I believe I now understand all of it:

Signature of client or his/her personal representative

Date

Printed name of client or personal representative

Relationship to client

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Description of personal representative's authority

14. _____ Initials: I acknowledge that I received a copy of this completed form

15. I, a mental health professional, have discussed the issues above with the client and/or his/her personal representative. My observations of his/her behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Signature of professional

Date

Printed name of professional

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Client Name: _____ Date: _____

Referral Information:

How did you hear about our services? Circle all that apply.

Physician	Counselor	Church Website
Court referral	Employer	Search Engine
Insurance company	Base Referral	
Other: _____		

Name of person who referred you to our center: _____

Presenting Problem(s):

Why are you seeking help at this time? _____

Please check any of the following problems you or your family have experienced which may have contributed to your seeking help. Briefly explain each problem checked below.

- | | |
|--|---|
| <input type="checkbox"/> Family/Marital Conflict | <input type="checkbox"/> Physical Abuse Offender |
| <input type="checkbox"/> Work Problems | <input type="checkbox"/> Sexual Abuse Victim |
| <input type="checkbox"/> Significant Medical Problems | <input type="checkbox"/> Sexual Abuse Offender |
| <input type="checkbox"/> Legal Problems | <input type="checkbox"/> Domestic Violence Victim |
| <input type="checkbox"/> Shoplifting/Stealing | <input type="checkbox"/> Domestic Violence Offender |
| <input type="checkbox"/> Lying | <input type="checkbox"/> Sexual Orientation Issues |
| <input type="checkbox"/> Grief/Loss Issues | <input type="checkbox"/> Abortion Issues |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Eating Disorder Issues |
| <input type="checkbox"/> Suicidal thoughts/gestures | <input type="checkbox"/> Adoption Issues |
| <input type="checkbox"/> Verbal/Emotional Abuse Victim | <input type="checkbox"/> Anger Control Issues |
| <input type="checkbox"/> Verbal/Emotional Abuse Offender | <input type="checkbox"/> Sexual Dysfunction Issues |
| <input type="checkbox"/> Childhood Sexual Abuse | <input type="checkbox"/> Other |
| <input type="checkbox"/> Alcohol/Substance Abuse | |
| <input type="checkbox"/> Physical Abuse Victim | |

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Family History: _____

Child Development History (Complete ONLY if client is a child.):

A. Pregnancy History: Complications or normal pregnancy? Explain.

B. Deliver History: Complications with deliver or normal? Explain

C. Infancy History:

D. Preschool History:

E. Educational History:

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How many children do you have? _____

<u>Name</u>	<u>Age</u>	<u>Gender</u>	<u>Currently Living with you?</u>
_____	_____	M / F	Y / N
_____	_____	M / F	Y / N
_____	_____	M / F	Y / N
_____	_____	M / F	Y / N

Describe any recent changes in your life: _____

Identify any recent or significant death or losses in your family and how you were affected: _____

How are you coping with your current difficulties? _____

Medical History:

Have you or your family members ever had any of the following? Explain all checked answers below.

Asthma/Bronchitis

Cancer

Hyperactivity

Diabetes

Hypertension

Hepatitis

Tuberculosis

HIV

Liver Problems

Heart Conditions

Stomach Problems

Accident related injuries

Hospitalizations

Other

Epilepsy

Are your immunizations up to date? Y/ N If *NO*, what is needed? _____

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Are you currently taking an medications? Y / N If so, please list below:

Name	Why Prescribed?	Strength	Frequency	Last Use
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Psychiatric/Counseling/Treatment History:

Have you ever been treated or evaluated for a psychiatric or addiction issue? Y / N
(If yes, continue to next question.)

1. Facility/Counselor/Physician _____
When? _____ How long? _____ Reason _____

2. Facility/Counselor/Physician _____
When? _____ How long? _____ Reason _____

3. Facility/Counselor/Physician _____
When? _____ How long? _____ Reason _____

Describe your previous experience with counseling and/or treatment. _____

Was it helpful? Y / N

Why or why not? _____

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Education:

Highest level of formal education completed: _____ GED? Y / N

If you completed college or Vocational training, identify any degree, certification, trade, etc. _____

Employment History:

Occupation: _____ Employer: _____

How long at job? _____ Satisfaction? _____

If unemployed, why? _____

How long? _____ Last Employer? _____

If unemployed, how do you support yourself financially? _____

How many jobs have you held in the last 5 years? _____

Have you ever been fired/laid off from a job? Y / N If yes, please describe circumstances _____

Military History:

Have you ever served in the military service? Y / N Branch: _____

Honorable Discharge? Y / N Explain: _____

Combat Experience? Y / N Describe: _____

Describe any effect military service has had on your current difficulties: _____

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Have you experienced any of the following depressive symptoms?

Symptoms	Currently	Past History
Feeling down most every day	_____	_____
Loss of pleasure in almost all things	_____	_____
Significant weight loss or gain	_____	_____
Over or under sleeping	_____	_____
Over or under activity	_____	_____
Feelings of worthlessness/hopelessness	_____	_____
Recurrent thoughts of death	_____	_____

Explain: _____

Have you experienced any of the following anxiety symptoms?

Symptoms	Currently	Past History
Restlessness	_____	_____
Easily fatigued	_____	_____
Difficulty concentrating	_____	_____
Mind goes blank	_____	_____
Irritability	_____	_____
Muscle Tension	_____	_____
Disruptive sleep	_____	_____

Explain: _____

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Marital History:

Divorce History:

Custody Arrangements:

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Social and Cultural Influences:

Who or what makes up your support system(s)- i.e. friends, family, church, etc.? _____

Identify any social or cultural influences which may influence your treatment:_____

Describe your relationship with peers:_____

Has your peer group changed in the year? Y / N If Yes, explain:_____

Spiritual Orientation:

Religious Affiliation:_____

Describe the impact spirituality has had on you, and whether you see religion as impacting your current difficulties:_____

How would you describe your most important values?_____

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Legal Status:

Have you ever had any legal charges against you? Y / N

If Yes, what for? _____

Do you currently have any pending legal charges? Y / N

If Yes, what for? _____

Are you currently on probation or parole? Y / N

If Yes, what for? _____

Who is your Probation/Parole Officer? _____

Address _____ Phone Number _____

Leisure Activities:

What do you do for fun? _____

How often do you include these activities into your schedule? _____

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Patient/Family's Expectation of the Treatment Program:

What do you want to accomplish during the course of treatment here? _____

Please identify any handicaps you might have which may impact treatment (i.e. deaf, illiterate, etc.) _____
