CONFIDENTIAL
CLIENT INFORMATION

Patient Information

Last Name, First Name:_____ MI:___
Address:_____
City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____
Cell Phone:_____ E-Mail:_____
May we communicate via text messaging? _____

Patient's SSN:_____ Date of Birth:_____

Occupation:_____ Employer:_____

Spouse/Partner:_____ Work Phone:_____

In case of emergency, notify:_____ Relationship:_____
Home Phone:_____ Work or Cell Phone:_____

Today's Date:_____ Referred By:_____

Are you involved in litigation at this time? If yes, please explain:_____
_____

Insurance Information

Subscriber's Name:_____ Relationship:_____
Insurance Address:_____
_____
Insurance Phone Number:_____ Subscriber DOB:_____

Patient ID#:_____ Group Number:_____

Subscriber's Employer:_____ Subscriber Occupation:_____

MEDICAL HISTORY

CLIENT NAME:_____ **DATE OF BIRTH:**_____ **AGE:**_____

A. Circle the adjective that describes your present state of health:

Excellent Good Fair Poor

B. Describe any medical problems, conditions or diseases for which you are now being treated: _____

C. List any prescribed medicines you are now taking, including dosages if known: _____

D. List any history of serious illness in your family: _____

E. List any family member who has a mental illness or substance abuse problem and describe their condition: _____

F. Have you now or have you ever had any of the following conditions or symptoms?

	YES	NO		YES	NO
1. Venereal Disease			15. Heart Trouble		
2. Epilepsy or Convulsions			16. Stomach Trouble		
3. Diabetes/Hypoglycemia			17. Bowel Trouble		
4. Anemia			18. Kidney/Liver Problems		
5. Thyroid Problem			19. Bone or Joint Problems		
6. Eye Problem			20. Anxiety		
7. Hearing Problem			21. Depression		
8. Trouble Sleeping			22. Paralysis		
9. Fainting			23. Numbness or Tingling		
10. Headaches			24. Problems with Anger		
11. Memory Problems			25. Emotional/Physical/Sexual Abuse		
12. Hayfever or Asthma			26. Weight Loss/Gain		
13. Sinus Trouble			27. Sexual Difficulties		
14. Breathing/Lung Trouble					

G. For each of the above checked "YES," please explain (diagnosis and treatment): _____

H. List and describe any previous hospitalizations for any reason (including psychiatric): _____

I. Do you smoke? _____ If "YES," how much? _____
Do you drink alcohol? _____ If "YES," how much? _____

J. Are you allergic to any medications? _____ If "YES," which ones? _____

K. Give dates and describe any history of counseling including supervisory referrals: _____

EXAMPLE
HOW MUCH WERE YOU DISTRESSED BY

BODY ACHES..... [2]

0 = NOT AT ALL
1 = A LITTLE BIT
2 = MODERATELY
3 = QUITE A BIT
4 = EXTREMELY

HOW MUCH WERE YOU DISTRESSED BY:

Nervousness or shakiness inside [ ]
Faintness or dizziness [ ]
The idea that someone else can control your mind [ ]
Feeling others are to blame for most of your problems [ ]
Trouble remembering things [ ]
Feeling easily irritated or annoyed [ ]
Pains in your heart or chest [ ]
Feeling afraid in open spaces [ ]
Thoughts of ending your life [ ]
Feeling most people cannot be trusted [ ]
Poor appetite [ ]
Suddenly scared for no reason [ ]
Temper outbursts you could not control [ ]
Feeling lonely even when you are with people [ ]
Feeling blocked in getting things done [ ]
Feeling lonely [ ]
Feeling blue [ ]
Feeling no interest in things [ ]
Feeling fearful [ ]
Your feelings being easily hurt [ ]
Feeling that people are unfriendly or dislike you [ ]
Feeling inferior to others [ ]
Nausea or upset stomach [ ]
Feelings you are being watched or talked about by others [ ]
Trouble falling asleep [ ]
Having to check and double check what you do [ ]
Difficulty making decisions [ ]

HOW MUCH WERE YOU DISTRESSED BY:

Feeling afraid to travel on buses or trains [ ]
Trouble getting your breath [ ]
Hot or cold spells [ ]
Having to avoid certain things, places and activities because they frighten you [ ]
Your mind going blank [ ]
Numbness or tingling in parts of your body [ ]
The idea you should be punished for your sins [ ]
Feeling hopeless about the future [ ]
Trouble concentrating [ ]
Feeling weak in parts of your body [ ]
Feeling tense or keyed up [ ]
Thoughts of death or dying [ ]
Having urges to beat, injure or harm someone [ ]
Having urges to break or smash things [ ]
Feeling very self-conscious with others [ ]
Feeling uneasy in crowds [ ]
Never feeling close to another person [ ]
Spells of terror or panic [ ]
Getting into frequent arguments [ ]
Feeling nervous when left alone [ ]
Others not giving you proper credit for your achievements [ ]
Feeling so restless you couldn't sit still [ ]
Feelings of worthlessness [ ]
Feeling that people will take advantage of you if you let them [ ]
The idea that someting is wrong with your mind [ ]
Feelings of guilt [ ]

Date

Name

Office Policies

Nancy J. Simons, Ph.D.

As a psychologist, my primary concern is providing services which will hopefully improve your quality of life. It is my sincere hope that our relationship grows into a supportive and beneficial one. It is best that we keep financial matters to a minimum, but as with any business, I must maintain this office and support related costs. Thus, I would like to clearly outline office policies to minimize confusion and maximize the benefits of our therapeutic relationship.

1. Counseling Services are to be paid for at the time they are rendered.
2. Please understand your appointment time is reserved just for you. If you must cancel or reschedule your appointment, please be kind enough to inform me at least 24 hours in advance so I have a chance to offer this time to another client. If this does not occur, the full fee will be charged. Reminder texts are a courtesy and should not be depended upon to remind you of your appointment.
3. Counseling appointments are usually fifty minutes in length. This allows me a few minutes before your session to prepare, then a few minutes after your session to make notes on your behalf.
4. Insurance may be accepted as partial payment for services rendered. You are responsible for your bill, regardless of whether or not your insurance company pays. Should the insurance company not pay, or pay the incorrect amount, you are responsible for calling the insurance company to remedy any billing problems. Should your insurance company not pay your bill in full within a 60-day period after services have been rendered, you will be responsible for the full amount.
5. You will not be charged for short telephone consultations. Phone consults over 10 minutes with the client, or on behalf of the client will be billed at standard rates.
6. You will be charged the standard fee for letters or reports, and completion of forms written on your behalf.
7. Please understand that although I will try my best to be available to you, I cannot guarantee 24-hour accessibility in the event of a mental health emergency. Should you have suicidal ideations, thoughts of hurting someone else, or thoughts of committing dangerous acts, please call 911 or go to the nearest ER for immediate crisis intervention care. If it is not an emergency, and you need to talk with me, please call or txt me on my cell phone (727-656-6457). If I am not available please leave a message and I will get back with you as soon as possible. In certain instances, another therapist may be on call for me and I will leave a message to that effect.
8. Confidentiality- I am bound by law to safeguard the privacy of my clients. Client information cannot be disclosed without a client's expressed permission, except in certain circumstances. These circumstances include: a court order, or if you are in danger of hurting yourself or someone else, or in order to protect a child, elder or dependent adult from abuse.
9. Confidentiality of E-mail, cell phone and fax communication: It is very important to be aware that e-mail and cell phone communication can be accessed by unauthorized people; hence, the privacy and confidentiality of such communication can be compromised. E-mails, in particular, are vulnerable to unauthorized access. Faxes can easily be sent erroneously to the wrong phone number. If you communicate with me using one of these means, you should be aware of this.

By signing below, I_____, am indicating I both understand and agree to all of the above office policies.

Signature_____ Date_____