Client Information

Brenda Roberts, EdD, LPC, LMFT
New Horizons Counseling Center, L.L.C.
614 Esplanade Street • Lake Charles, LA 70607
O (337) 478-1411
F (337) 562-1489
broberts614@bellsouth.net

*(Please complete **ALL** sections)*

Name:
First Name Middle Name Last Name Social Security Number

Address: Home Phone:

City, State, ZIP: Mobile Phone:

Parish: Work Phone:

Best Contact Number: Home Mobile Work May we leave a message? Yes No

Email:

Date of Birth: Age: Gender: Female Male

Marital Status: Single Married Divorced Widowed Other

Emergency Name: Emergency Phone:

Relationship to Client:

Insurance Carrier: Policy #: Policy Holder:

Relationship: Date of Birth: Social Security #:

Employment Status: Employed Unemployed Child/Student Disabled Retired

Employer (For children, list parent's employer.):

Position: For how long?

School Name: Grade:

Who referred you?

Please list family members in the household and their relationship to you.

First Name	Middle Name	Last Name	Relationship	Age	Birthdate

Please list family members **NOT** in the household and their relationship to you.

First Name	Middle Name	Last Name	Relationship	Age	Birthdate

Biopsychosocial History

Presenting Problems	Duration (in months)	Additional Information

Symptoms Checklist

Please do NOT leave blank.

- Depressed Mood
- Appetite Disturbance
- Sleep Disturbance
- Fatigue / Low Energy
- Poor Concentration
- Poor Grooming
- Mood Swings
- Agitation
- Overly Emotional
- Irritability
- Anxiety
- Panic Attacks
- Phobias
- Obsessions / Compulsions
- Thoughts of Harming Others
- Bingeing/Purging
- Anorexia
- Paranoid Ideas
- Excessively Negative
- Delusions
- Hallucinations
- Aggressive Behaviors
- Conduct Problems
- Legal Problems
- Oppositional Behavior
- Sexual Dysfunction
- Grief
- Hopelessness
- Suicidal Thoughts
- Suicide Attempts
- Worthlessness
- Guilt
- Elevated Mood
- Hyperactivity
- Self-Mutilation
- Health Problems (List on next page)
- Significant Weight Change
- Emotional Trauma Victim
- Physical Trauma Victim
- Sexual Trauma Victim
- Substance Dependence
- Social Isolation
- Other (Specify)

Prior Psychotherapy? Yes No If yes, please provide the information below.

Provider	Location	When	How Long?	Diagnosis

Family History of Psychiatric Issues and/or Treatment

Relationship to Client	When was treatment received?	Diagnosis

Medical Information

Please provide the following information regarding the client. If a child is the client, please complete the form for your child.

Medical Checklist

Please review the following list and check any that apply – now or in the past. Please use the blank space to list any medical problems or conditions that may not be listed.

- Alcohol Abuse
- Alcoholism
- Fibromyalgia
- Allergies
- Asthma
- Autism
- Back Problems
- Birth Defects
- Blindness
- Cancer
- Cardiovascular Problems
- Cerebral Palsy
- Deafness
- Developmental Disability
- Diabetes
- Drug Abuse
- Autoimmune Disorder
- Epilepsy
- Headaches
- Hearing Impairment
- Heart Disease
- Kidney Disease
- Mental Illness
- Mental Retardation
- Multiple Sclerosis
- Muscular Dystrophy
- Respiratory Illness
- Speech Problems
- Sleeping Disorder
- Stomach Problems
- Tuberculosis
- Venereal Disease
- Weight Problem
- Cystic Fibrosis
- Other (specify)

Has there been substance abuse, past or present? Yes No

If yes, please specify:

Have there been any suicidal tendencies or attempts? Yes No

If you have documented allergies above, have there ever been any adverse reactions to medications/treatments? Yes No

Medications

Please list all medications and the dosages you are currently taking.

Would you like information on an Advance Directive for Mental Health Treatment?

Yes. If you check "yes," we will provide you with a copy.

No. Check "no" if you are refusing information.

Primary Care Provider (PCP)

Name of PCP:

Address:

Permission **granted** to contact PCP.

Permission **denied** to contact PCP.

Goals, Strengths, Motivations

Please list below your goals, strengths, motivation, etc. Also, do you have family support and is your spouse (if applicable) willing to meet with the counselor to improve your therapy?

Office Billing and Insurance Policies

I authorize the following:

- The use of this form on all my insurance or other payor submissions.
- The release of information to my insurance company or other payor.
- Direct payment from my insurance company or payor to **Dr. Brenda Roberts, EdD, LPC, LMFT** and/or **New Horizons Counseling Center, L.L.C.**

I understand:

- It is my responsibility to pay any deductible amount, co-payment, or co-insurance amount on the day and time services are provided.
- Reminder calls are **not** guaranteed and are provided as a courtesy. Clients are responsible for keeping track of their appointment dates and times.
- Appointments are expected to be canceled at least 24 hours prior to the appointment time. If necessary, I may leave a message on the office voicemail of New Horizons Counseling Center.
- **Failure to provide appropriate notice of cancellation will result in a *$60.00* failed appointment fee.**
- Delinquent accounts will be turned over for collection after 90 days unless prior payment arrangements have been made.
- Fees for court appearances or reports written for legal purposes will not be charged to insurance companies and are my responsibility. **These fees must be paid prior to the court appearance and/or reports being released.** It is my responsibility to request a copy of court-related fees.

In signing this document, I consent to counseling services for myself and/or my dependent and agree to the above billing policy. I also acknowledge that I have been given a copy of **Dr. Brenda Roberts, EdD, LPC, LMFT's** "Declaration of Practices and Procedures," which includes information regarding the counseling relationship, billing, emergency information, and limitations to confidentiality.

The parties agree that this document may be electronically signed. The parties agree that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

Client	Client Signature	Date
Counselor	Counselor Signature	Date

Consent for Treatment of Children and Adolescents

I/We, being the parent(s) or legal guardian(s) for , a minor child, consent for counseling services to be provided by **Dr. Brenda Roberts, EdD, LPC, LMFT** with **New Horizons Counseling Center, L.L.C**. The parties agree that this document may be electronically signed. The parties agree that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

Client	Client Signature	Date
Counselor	Counselor Signature	Date