New Horizons
COUNSELING CENTER

Client Information

(Please print clearly and complete ALL sections)

Name: _____ Social Security #: _____
First Middle Last

Address: _____

City, State, ZIP _____ Parish _____

Home phone: _____Work phone:_____ Cell phone: _____

Best contact number: ____ Home ____ Work ____ Cell ____ May we leave a message? ____ Y ____ N

Date of Birth: _____ /_____ / _____ Age: _____Gender: ____ M ____ F

Marital Status: _____ Single _____ Married _____ Divorced _____Widowed _____ Other

Email: _____

Emergency phone: _____Emergency Name: _____ 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: _____ How long?: _____

School name (for students): _____Grade: _____

Who referred you? _____

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

Name (First, Middle, Last	Relationship	Age	Birthdate

List immediate family members ***NOT*** in the home.

Name (First, Middle, Last	Relationship	Age	Birthdate

Client Name: _____

Biopsychosocial History

Presenting Problems | Duration (months) | Additional Information:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Symptoms Checklist (Please do NOT leave blank)

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

Prior psychotherapy? ◯ Yes ◯ No If yes, please provide information below.

Provider	Location	When	How Long	Diagnosis

Family History of Psychiatric Issues and/or Treatment

Relationship to client	When was treatment received?	Diagnosis

Client Name: _____

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 read over 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 which may not be listed.

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

Has there been any 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.

_____

_____

_____

_____

_____

_____

_____

_____

Client Name: _____

Would you like information on an Advance Directive for Mental Health Treatment? (please check one)

_____ Yes (If this is checked, we will provide you with a copy.) _____ No (check this if you are refusing information)

Primary Care Physician (PCP):

Name of PCP: _____ Address of PCP: _____

_____

_____

_____ Permission granted to contact PCP (Please initial) _____ Permission denied (Please initial)

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 in order to improve your therapy?

Client Name: _____

Office Billing and Insurance Policy

I authorize:

- use of this form on all of 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 ***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 cancelled 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.

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

The parties agree that this agreement 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.

Signature: _____ Date (mm/dd/yyyy) _____

Counselor: _____ Date (mm/dd/yyyy) _____

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 ***Brenda Roberts, EdD, LPC, LMFT*** with New Horizons Counseling Center, L.L.C. The parties agree that this agreement 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.

Signature: _____ Date (mm/dd/yyyy) _____

Counselor: _____ Date (mm/dd/yyyy) _____

Client Name: _____