

New Horizons Counseling Center

Client Information

(Please print clearly and complete **ALL** sections)

Name: _____ Social Security #: _____
First Middle Last

Address: _____ Home phone: _____

City, State, Zip: _____ Work phone: _____

Parish: _____ 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)

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

Prior psychotherapy? yes no If yes, please provide information below.

<i>Provider</i>	<i>Location</i>	<i>When</i>	<i>How Long</i>	<i>Diagnosis</i>

Client Name: _____

Family History of Psychiatric Issues and/or Treatment

<i>Relationship to client</i>	<i>When was treatment received?</i>	<i>Diagnosis</i>

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.

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

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 _____

Client Name: _____

Medications

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

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.

In signing this, 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 Brenda Roberts' "Declaration of Practices and Procedures" which includes information regarding the counseling relationship, billing, emergency information, and limitations to confidentiality.

Signature _____

Date _____

Counselor: _____

Date _____

Client Name: _____

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.**

Signature _____

Date _____

Signature _____

Date _____

Client Name: _____