

LifePractical Counseling

5520 Highway 280 Suite 4, Birmingham AL 35242 205-807-6645 www.lifepactical.org

Client # _____

Client(s) Information Form

(One form per couple or family is all that is necessary)

GENERAL INFORMATION

TODAY'S DATE _____

NAME _____
Last First MidInitial

MAILING ADDRESS _____
Street City State/ZIP

Responsible Party (if different from above)

NAME _____
Last First MidInitial

MAILING ADDRESS _____
Street City State/ZIP

HOME PHONE: _____ Preferred? Leave Message? Y N Email Address: _____

CELL PHONE: _____ Y N Ok to send Text Message? Y N

WORK PHONE: _____ Y N

DOB ____/____/____ AGE _____ MALE FEMALE

EMPLOYER _____ JOB TITLE/POSITION _____

HIGHEST EDUCATION LEVEL ATTAINED, WHERE _____

MARITAL STATUS Single Married Divorced Separated Widowed Committed Relationship

RACIAL IDENTITY American Indian Asian African-American Caucasian Hispanic Middle Eastern

RELIGIOUS/DENOMINATIONAL Preference (if applicable): _____

MEMBER OF A CHURCH? Yes ___ No ___ If Yes, WHAT CHURCH _____

Name of Pastor, Minister, or member of the Clergy _____

EMERGENCY CONTACT _____
Name Contact #

RELATIONSHIP TO YOU _____

SPOUSE/PARTNER # of Years Together: _____

NAME _____ DOB _____ AGE _____
Last First

HOME PHONE _____ CELL _____ WORK _____

EMPLOYER _____ JOB TITLE/POSITION _____

HIGHEST EDUCATION LEVEL ATTAINED _____ EMAIL _____

CHILDREN

Name	Sex	Age	Deceased?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

HOUSEHOLD'S TOTAL INCOME

_____ Less than \$20,000	_____ \$20-39,999	_____ \$40-59,999
_____ \$60-79,999	_____ \$80-99,999	_____ \$100,000 or more

PRESENTING PROBLEM

(please see checklist of concerns)

What brings you to counseling at this time?

Have you (or your family members) ever been involved in counseling? Yes No

If yes, with whom? _____ When? _____

Reason(s): _____

Are you in treatment with another counselor at this time? Yes No If yes, with whom? _____
Reason _____

MEDICAL HISTORY/HEALTH CONDITIONS

Name of Primary Physician _____ Phone _____

Date of Last Physical _____ Date of Last Visit _____

Please indicate if you have now or have had any of the following conditions:

_____ Arthritis	_____ Asthma	_____ Back Problems	_____ Cancer
_____ Chronic Lung Problems	_____ Diabetes	_____ Hearing Problems	_____ Heart Problems
_____ High Blood Pressure	_____ Kidney Problems	_____ Stroke	_____ Thyroid Problems
_____ Vision Problems	_____ Weight loss/gain	_____ Chronic Pain	_____ Headaches
_____ Stomachaches	_____ Ulcer/Gastrointestinal Problems	_____ Sexual Functioning Problems	
_____ Other _____			

Please list all prescribed medications (Medication, Dosage, Frequency, & Name of Prescribing Physician)

Name of Psychiatrist (if applicable) _____ Phone _____

Check which of the following you use, and please note the amount and frequency of each:

Caffeine _____
 Coffee Sodas Other drinks Pills/Supplements

Alcohol/Adult Beverages _____ Tobacco _____

FUTURE APPOINTMENTS

Should we need to contact you regarding your future appointments, please indicate how we may do this if you are not available when we call. Initial all that apply.

- _____ Leave appointment time on answering machine/voicemail
- _____ If no answering machine, leave appointment time with _____
- _____ Leave a message with callback number requesting you contact LifePractical Counseling
- _____ Email or Text appointment information

REFERRAL SOURCE

How did you hear about us? _____

If you were referred to us by a specific person, do we have your permission to thank them? Yes No

Name & Contact Information of Referral source (if applicable)

CLIENT NOTIFICATION OF PRIVACY RIGHTS/ HIPAA

CLIENT NOTIFICATION OF PRIVACY RIGHTS

The Health Insurance Portability and Accountability Act (HIPAA) has created new client protections surrounding the use of protected health information. Commonly referred to as the “medical records privacy law”, HIPAA provides patient protections related to the electronic transmission of data, the keeping and use of patient records, and storage and access to health care records. HIPAA also applies to mental health client care.

By law, we are required to secure your signature indicating you understand this Client Notification of Privacy Rights document. If you have any questions about LifePractical Counseling’s Notice of Privacy Rights, please contact the Privacy Officer listed below.

Privacy Officer

Paul Johnson, MEd, LMFT, LPC, NCC
5520 Highway 280, Suite 104-B
Birmingham, Alabama 35242
Telephone No. (205) 807-6645
Email address: lifepacticalcounseling@gmail.com

PLEASE SIGN BELOW TO INDICATE YOU HAVE READ AND UNDERSTAND THE CLIENT INFORMATION AND CONSENT TO TREATMENT FORM, INCLUDING THE CLIENT NOTIFICATION OF PRIVACY RIGHTS SECTION.

Client(s) (and/or Guardian) Signature

Date

<u>For Office use only</u>			
<i>Client’s Consent/Fee Info Signed</i>	__ Y __ N __ N/A	<i>Demographic Form</i>	__ Y __ N __ N/A
<i>Consent for Minors</i>	__ Y __ N __ N/A	<i>CC on File Necessary</i>	__ Y __ N __ N/A
<i>HIPAA Offered/Signed</i>	__ Y __ N __ N/A	<i>Initial Assessment Summary</i>	__ Y __ N __ N/A
<i>Release of Information</i>	__ Y __ N __ N/A	<i>Treatment Plan</i>	__ Y __ N __ N/A
<i>Prayer or Spiritual Issues Discussed</i>	__ Y __ N __ N/A	<i>Client Satisfaction Form</i>	__ Y __ N __ N/A
<i>Suicidality & Homicidality Assessed</i>	__ Y __ N __ N/A	<i>Discharge Summary</i>	__ Y __ N __ N/A
<i>Insurance Information</i>	__ Y __ N __ N/A	<i>Client Record Audit Date(s)</i>	_____

Checklist of Concerns

(please check any relevant concerns; initial if referring to more than one person)

THOUGHTS/FEELINGS/MOOD

- Anger/frustration/hostility
- Anxiety, nervousness
- Attention, concentration, distractibility
- Confusion
- Depression
- Disliking others
- Emptiness
- Euphoria
- Excessive worry
- Failure
- Fatigue
- Fear
- Grieving (death, loss, divorce, etc)
- Guilt
- Hearing things other people don't
- Homicidal thoughts
- Intrusive thoughts
- Judgment problems
- Memory difficulties
- Negative thoughts
- Obsessive thoughts
- Oversensitivity to criticism
- Oversensitivity to rejection
- Panic attacks
- Perfectionism
- Sadness
- Seeing things other people don't
- Self-centeredness
- Self-esteem (low)
- Shyness
- Spiritual, religious, or moral issues
- Stress
- Sudden mood changes
- Suicidal thoughts
- Suspiciousness
- Temper problems
- Thoughts of hurting self or others

BEHAVIOR

- Aggression, violence
- Alcohol use
- Argumentative
- Avoidant
- Compulsive behavior/rituals
- Controlling
- Decreased/lack of sexual interest
- Dependency
- Destruction of property
- Drug use: prescription, over-the-counter, street
- Eating problems
- Financial problems, debt
- Gambling
- Hyperactivity
- Internet problems
- Irresponsibility
- Isolation
- Legal problems
- Letting others take advantage of you
- Lying
- Not able to relax
- Pornography
- Preoccupation with sex
- Procrastination
- Purging
- Self destruction/sabotaging
- Self-neglect
- Sexual dysfunction
- Smoking
- Stealing
- Threats
- Weight, gain/loss
- Withdrawal from others
- Loss of interest in what I used to like
- Sleep difficulty
- Loss of appetite
- Overeating

FAMILY & RELATIONSHIPS

- Affair
- Childhood issues (your childhood)
- Divorce
- Friendships
- Housework/chores
- Interpersonal conflicts
- Parenting
- Problems w/ child(ren)
- Problems w/ parents
- Problems w/ spouse/partner
- Separation

ABUSE

- Abuse of alcohol
- Abuse of drugs
- Emotional abuse by another
- Emotional abuse of another
- Financial abuse
- Neglect
- Physical abuse by another
- Physical abuse of another
- Sexual abuse by another
- Sexual abuse of another
- Verbal abuse

WORK & SCHOOL

- Absenteeism
- Career concerns, goals, choices
- Difficulty with coworkers
- Difficulty with supervisor
- Performance
- Tardiness
- Procrastination
- School problems

OTHER CONCERNS

I have no problems or concerns bringing me here.

(The information requested in this form will be kept confidential)