

New Client Information Sheet

Please complete ALL questions

PSY Family Services

301 W. Rosedale, Fort Worth, TX 76104

1. Client Demographics

Patient Name: Last:			First:			Middle:		
Sex: ()M ()F	DOB:	Age:	School Grade:	Marital Status: ()Single ()Separated ()Married ()Divorced	Ethnic Origin: ()Caucasian ()African-Amer. ()Amer. Indian ()Hispanic ()Asian			
Address:			Apt. #:	City:		State/Zip:		
Phone Number: ()-		Social Security #:		Drivers License #:		State of License:		
Employer Name:		Occupation:		Length of Employment:		Employer Phone Number: ()-		
Employer Address:		Suite #:		City:		State/Zip:		

2. Emergency Contact

Emergency Contact: Name:				
Address:		Apt. #:	City:	State/Zip:
Phone Number: ()-		Alternate Phone Number: ()-		Relationship:

3. Referral Source

How were you referred to this office?
()Insurance ()Hospital ()Mental Health Professional ()Other:_____

4. Previous Counseling

Last 12 months: ()Yes ()No	When:	How Long:
Where:	Why:	If ended, why:

5. Health Insurance Information

Insurance Company:	Policy #:	Group Name:	Group #:	
Insured's Full Name:		Sex: ()M ()F	Relationship:	DOB:
Employer Name:		Employer Phone Number: ()-		
Employer Address:		Suite #:	City:	State/Zip:

CLIENT INFORMATION AND CONSENT

Client's Name: _____ *Date of Birth:* _____

Consent to Treatment

I, voluntarily, agree to receive Mental Health assessment, care, treatment, or services, and authorize the undersigned therapist to provide such care, treatment, or services as are considered necessary and advisable. I understand and agree that I will participate in the planning of my care, treatment, or services, and that I may stop such care, treatment, or services that I receive through the undersigned therapist at any time. I understand that the session may be audio or video taped for educational purposes.

Appointments

Appointments are made by calling (817)338-4471. Please call to cancel or reschedule at least 24 hours in advance, or you may be charged for the missed appointment. Third-party payments will not usually cover or reimburse for missed appointments.

Number of Visits

The number of sessions needed depends on many factors and will be discussed by the therapist.

Length of Visits

Therapy sessions are approximately 45-50 minutes in length. The charge for individual and family sessions is \$75.00 per visit, unless there is an agreed-upon rate with your insurance. Different co-payments are required by various group coverage plans.

Assignment of Benefits

We will communicate with and work with your health/medical insurance for you. **PSY** will be assigned all medical and psychological benefits from insurance. **PSY** will release information necessary for payment to the paying agency. Your insurance carrier(s), including Medicaid, Medicare, private insurance, and any other health/medical plan, will issue payment directly to **PSY** for services rendered.

Confidentiality

Discussions between a therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; situations where the therapist has a duty to disclose, or where, in the therapist's judgment, it is necessary to warn or disclose; fee disputes between the therapist and client; a negligence suit brought by the client against the therapist; or the filing of a complaint with the licensing board. If you have any questions regarding confidentiality, you should bring them to the attention of the therapist when you and the therapist discuss this matter further. By signing this information and consent form, you are giving your consent to the undersigned therapist to share confidential information with all persons mandated by law and with the agency that referred you and the managed care company and/or insurance carrier responsible or providing your mental health care services and payment for those services, and you are also releasing and holding harmless the undersigned therapist from any departure from your right of confidentiality that may result.

ASSIGNMENT OF BENEFITS AND INSURANCE RELEASE FORM

Client's Name: _____

Date of Birth: _____

Financial Responsibility

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to **PSY** for any charges not covered by my healthcare benefits, as well as any applicable co-payments and deductibles. It is my responsibility to notify **PSY** of any changes in my healthcare coverage. In some cases, exact insurance benefits can not be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by **PSY** and/or my healthcare insurer if the submitted claims or any part of the claims, are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for services rendered.

Assignment of Benefits

I hereby assign all medical, mental health, behavioral health and substance abuse treatment benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including private insurance and any other health/medical plan, to issue payment check(s) directly to **PSY** for substance abuse/behavioral health treatment services rendered to myself and/or my dependent(s). I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize **PSY** to: 1) Release any information necessary to insurance carriers regarding my illness and treatments; 2) To process insurance claims generated in the course of counseling and treatment; and 3) To allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

Copy of Insurance Card/Verification

I understand that it is my responsibility to provide **PSY** with a copy of my current insurance card. It is also my responsibility to notify **PSY** of any changes to my insurance plan or insurance carrier.

Patient/Responsible Party Signature

Date

RELEASE OF INFORMATION

CLIENT NAME: _____

DATE OF BIRTH: _____

SOCIAL SECURITY #: _____

By signing below, I hereby authorize **PSY** to Release and to obtain information with respect to any physical, psychiatric or drug/alcohol related condition obtained during the course of diagnosis and/or treatment to/from the individual(s) or healthcare providers below. The type of information authorized for disclosures includes, but may not be limited to notification of admission/discharge, Psychiatric Evaluation, reports of Testing, discharge planning and summary, progress and treatment reports, physical exam, assessments, treatment content, treatment progress, payment records, social history, and any statements made by me to **PSY**. The purpose of this disclosure is to identify persons supporting and using services, to aid in diagnosis, continuing care, and treatment.

Mental Health Professional (name, address, phone)

Primary Care Physician (name, address, phone)

Psychiatrist (name, address, phone)

Family / Parent / Guardian (name, address, phone)

Insurance (name, address, phone)

Other (name, address, phone)

I have been advised that I may revoke this release of information at any time, except to the extent that information has already been released.

Client Signature

Date

Parent/Guardian (if client is a minor under 18 years of age)

Date

PSY Family Services

Assessment and Counseling Services
301 W. Rosedale, Fort Worth, TX 76104
(817) 338-4471

PARENT AUTHORIZATION, AGREEMENT, AND CONSENT FOR TREATMENT OF CHILD/MINOR

Client's Name: _____

Date of Birth: _____

When a child/minor is the primary client at our counseling office, it is essential that parents and/or legal guardians are in an agreement as to the decision to treatment, the treatment goals, appointment times, and the need to maintain client confidentiality. I understand that my child is the client, not the parent/guardian. This is true no matter who pay for the treatment of the child.

1. Are biological parents ___Married ___Separated ___Divorced ___Never Together
2. Who does the child live with the majority of the time? ___Mom ___Dad ___Other
3. Are there regular visits with the non-custodial parent? ___Yes ___No
4. Are biological parents both actively involved in Minor's life? ___Yes ___No
5. Are biological parents both in support of Minor receiving mental health treatment? ___Yes ___No

As a result, it is the policy of *PSY* that all minors presented for treatment have the following authorization and consent on file.

Please check the most appropriate box:

- Both Legal Parents/Guardians Consent to Treatment (complete page 2)**
- Both legal parents/guardians agree to the treatment and providing of mental health services for their child and will indicate their consent below.
 - If the biological or legally adopted parents are currently separated or going through the divorce process, both parents are still required to sign the **Client Information and Consent Form** before the child can be treated.
- Divorce, Custody or Legal Issues (complete page 3a)**
- Who is the Managing Conservator? ___Mother ___Father ___Joint ___Other
 - Are there any step-parents who have been given authority by the court to consent for treatment of the minor? ___Yes ___No
 - If there is an official certified divorce decree or a legal custody order that indicates that only one parent is legally permitted to determine and decide on the mental health treatment of the minor without the consent of the other parent, please provide our office with a **copy of the Court Order/Divorce Decree in its entirety**.
- Missing or Deceased Parent (complete page 3b)**
- The parent presenting the child for treatment has no access to the other parent due to the following reasons (death, in prison, missing, has left and made no contact, etc.) and therefore will acknowledge that they are the sole primary caretaker of the child for mental health treatment and will bare all responsibility for such consent.

Parent/Guardian Signature

Date

Parent/Guardian Signature

Date

Any inquiries/complaints about licensees from this office may be addressed by contacting the following:
Complaints Management and Investigative Section, P.O. Box 141369, Austin, Texas 78714-1369

Both Legal Parents/Guardians Consent to Treatment

Legal Parent #1 Name: _____

Relationship to Child/Minor: _____

I affirm that I have the authority to make healthcare decisions for _____.
(name of child/minor)

I am aware that all custodial parents and legal guardians must give consent before treatment begins. I understand and agree that any breach of these agreements may result in the termination of treatment services with **PSY**. I am voluntarily signing this agreement.

_____ I agree that I am the Legal Guardian or Managing Conservator of the above-named client and have provided all available information regarding custody agreements applying to the above-named client.

_____ I give consent to **PSY** to provide counseling to the above-named client.

Signature: _____ Date: _____

Legal Parent #2 Name: _____

Relationship to Child/Minor: _____

I affirm that I have the authority to make healthcare decisions for _____.
(name of child/minor)

I am aware that all custodial parents and legal guardians must give consent before treatment begins. I understand and agree that any breach of these agreements may result in the termination of treatment services with **PSY**. I am voluntarily signing this agreement.

_____ I agree that I am the Legal Guardian or Managing Conservator of the above-named client and have provided all available information regarding custody agreements applying to the above-named client.

_____ I give consent to **PSY** to provide counseling to the above-named client.

Signature: _____ Date: _____

Divorce, Custody or Legal Issues (a)

Legal Parent Name: _____

Relationship to Child/Minor: _____

I affirm that I have the authority to make healthcare decisions for _____.
(name of child/minor)

I am aware that all custodial parents and legal guardians must give consent before treatment begins. I understand and agree that any breach of these agreements may result in the termination of treatment services with **PSY**. I am voluntarily signing this agreement.

I understand that it is ultimately my responsibility to make sure that I am following all legal conditions set forth by my divorce decree, separation agreement, etc.

_____ I agree that I am the Legal Guardian or Managing Conservator of the above-named client and have provided all available information regarding custody agreements applying to the above-named client.

_____ I give consent to **PSY** to provide counseling to the above-named client.

Signature: _____

Date: _____

Missing or Deceased Parent (b)

Legal Parent Name: _____

Relationship to Child/Minor: _____

I affirm that I have the authority to make healthcare decisions for _____.
(name of child/minor)

I hereby swear and affirm under any applicable perjury laws that there I no legal divorce decree, custody order, or separation agreement that restricts or limits me from making any or all decision in regard to my child's mental health treatment. I further acknowledge that **PSY** has asked and attempted to collect any and all such documents from me.

I understand that it is ultimately my responsibility to make sure that I am following all legal conditions set forth by my divorce decree, separation agreement, etc. I understand and agree that any breach of these agreements may result in the termination of treatment services with **PSY**. I am voluntarily signing this agreement.

Signature: _____

Date: _____

Intake Questionnaire For New Patients (Children & Adolescents)

This questionnaire is for the purpose of getting to know you better in order to provide the best possible mental health services. Please complete this form as honestly and completely as possible. All information that you provide us will be confidential as required by state and federal law.

Date: _____

Social Security Number: _____

Name: _____

Date of Birth: _____

Age: _____

Home Address: _____

City/State/Zip code: _____

Home Phone: _____

Cellular/Alternate Phone: _____

WHO CURRENTLY LIVES IN YOUR RESIDENCE (adults and children):

#	Name	Relation	Sex	Age	#	Name	Relation	Sex	Age
1					4				
2					5				
3					6				

In your own words, describe the current problems as you see them:

How long has this been going on? _____

What made you come in at this time? _____

What do you hope to gain from this evaluation and/or counseling?

If you had difficulties in the past, what have you done to cope? Was it helpful?

Symptoms

Please **check** any symptoms or experiences that you have had **in the last month**

<input type="checkbox"/> Difficulty falling asleep	<input type="checkbox"/> Difficulty staying asleep
<input type="checkbox"/> Difficulty getting out of bed	<input type="checkbox"/> Not feeling rested in the morning
Average hours of sleep per night: _____	
<input type="checkbox"/> Persistent loss of interest in previously enjoyed activities	
<input type="checkbox"/> Withdrawing from other people	<input type="checkbox"/> Spending increased time alone

Depressed Mood		Feeling Numb
Rapid mood changes		Irritability
Anxiety		Panic attacks
Frequent feelings of guilt		Avoiding people, places, activities or specific things
Difficulty leaving your home		
Fear of certain objects or situations (i.e., flying, heights, bugs) Describe: _____		
Repetitive behaviors or mental acts (i.e., counting, checking doors, washing hands)		
Outbursts of anger		
Worthlessness		Hopelessness
Sadness		Helplessness
Fear		Feeling or acting like a different person
Changes in eating/appetite		
Eating more		Eating less
Voluntary vomiting		Use of laxatives
Excessive exercise to avoid weight gain		Binge eating
Are you trying to lose weight? _____		
Weight gain: _____ lbs		Weight loss: _____ lbs.
Difficulty catching your breath		
Unusual sweating		Easily started, feeling “jumpy”
Increased energy		Decreased energy
Tremor		Dizziness
Frequent worry		Physical sensations others don’t have
Racing thoughts		Intrusive memories
Difficulty concentrating or thinking		
Flashbacks		Nightmares
Thoughts about harming or killing yourself		Thoughts about harming or killing someone else
Feeling as if you were outside yourself, detached, observing what you are doing		
Feeling puzzled as to what is real and unreal		
Persistent, repetitive, intrusive thoughts, impulses, or images		
Unusual visual experiences such as flashes of light, shadows		
Hear voices when no one else is present		
Feeling that your thoughts are controlled or placed in your mind		
Feeling that the television or the radio is communicating with you		
Difficulty problem solving		Difficulty meeting role expectations
Dependency on others		Manipulation of others to fulfill your own desires
Inappropriate expression of anger		Self-mutilation/cutting
Difficulty or inability to say “no” to others		Ineffective communication
Sense of lack of control		Decreased ability to handle stress
Abusive relationship		Difficulty expression emotions
Concerns about your sexuality		

Sexual Orientation:	Heterosexual	Homosexual	Bisexual	I choose not to answer
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Please describe any other symptoms or experiences you have had problems with:

Have you seen a counselor, psychologist, psychiatrist or other mental health professional before?

<input type="checkbox"/> No	<input type="checkbox"/> Yes	If so:
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Name of therapist: _____
Reason for seeking help: _____

Dates of Treatment _____

Name of therapist: _____
Reason for seeking help: _____

Dates of Treatment _____

Are you **CURRENTLY** taking **PSYCHIATRIC** medication? No Yes If YES, please list:

Medication	Dosage	How long have you been taking it?	Has it been helpful?

Are you **CURRENTLY** taking **NON-PSYCHIATRIC** medication? No Yes If YES, please list:

Medication	Dosage	How long have you been taking it?

Have you been on **PSYCHIATRIC** medication in the past? No Yes If YES, please list:

Medication	Dosage	First/Last time you took it	Effect of Medication

Have you been hospitalized for psychiatric reasons? No Yes If YES, describe:

Hospital	Dates	Reason

Have you ever attempted suicide? No Yes If YES, describe:

MEDICAL HISTORY

Are you CURRENTLY under treatment for any medical condition?	No	Yes	If YES, describe:
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List any **PRIOR** illnesses, operations and accidents

FAMILY HISTORY

Father: Age: Living Deceased Cause of death:
 If deceased, HIS age at time of his death ____ YOUR age at time of his death ____
 Occupation: _____ Health: _____
 Frequency of contact with him: _____ Are you/Have you been close to him? _____

Mother: Age: Living Deceased Cause of death:
 If deceased, HER age at time of his death ____ YOUR age at time of his death ____
 Occupation: _____ Health: _____
 Frequency of contact with her: _____ Are you/Have you been close to her? _____

Brothers and Sisters

Name	Sex	Age	Whereabouts	Are you close to him/her?	
				No	Yes
				No	Yes
				No	Yes
				No	Yes
				No	Yes

During your childhood, have you lived any significant period of time with anyone other than your natural parents?

No	Yes	If so, please give the persona's name and relationship to you
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Name: _____ Relationship to you: _____

Please place a check mark in the appropriate box if these are or have been present in your relatives

	Brothers	Sisters	Father	Mother	Uncle/Aunt	Grandparents
Nervous Problems						
Depression						
Hyperactivity						
Counseling						
Psychiatric Medication						
Psychiatric Hospitalization						
Suicide Attempt						
Death by Suicide						
Drinking Problem						

SOCIAL HISTORY

Education

Highest grade level completed so far: _____

Have you had any disciplinary problems in school? _____

If yes, please explain: _____

Were you considered hyperactive/ADHD in school? _____

If yes, were/are you on any medication? _____

If yes, were/are you on any medication? _____

If so, which medication? _____

What kinds of grades do you get in school? _____

Have you been arrested or had any contact with the police? _____

If yes, please describe: _____

Do you have a religious affiliation? _____

If yes, what is it? _____

What kind of social activities do you participate in? _____

Who do you turn to for help with your problems? _____

Have you ever been abused?

<input type="checkbox"/>	Verbally	<input type="checkbox"/>	Emotionally	<input type="checkbox"/>	Physically	<input type="checkbox"/>	Sexually	<input type="checkbox"/>	Neglected
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Please describe: _____

SUBSTANCE ABUSE

Alcohol

Do you drink alcohol? _____ If yes, age of first use _____

How much do you drink? _____

How often do you drink? _____

Do you use tobacco (cigarettes, dip)? _____

If yes, how often? _____

Other Drugs:

Please indicate for each drug listed below

Drug	Ever Used?	Age at 1 st use	Time Since Last Use	Approx use in last 30 days
Marijuana				
Cocaine				
Crack				
Heroin				
Methamphetamine				
Ecstasy				

Is there anything else you would like us to know about you?

