New Directions Client Information Form

A. Identification

Name: _____ Age: _____ Phone No. _____ Date: _____

Name and ages of family members: _____
_____

B. Chief Concern

Please describe the main difficulty that has brought you to see me: _____
_____
_____
_____
_____
_____
_____
_____

When did your problems begin? _____
_____

Have you ever seriously thought of killing yourself or hurting yourself, or have you ever made such an attempt? _____ Please give details. _____

Have you ever had a strong desire to seriously hurt someone, or have you ever made an attempt to do so? _____
Please give details. _____

C. Previous Treatment

Have you ever taken antidepressant or other medication for mental health issues? □ No □ Yes
Have you ever received psychological or psychiatric or counseling services before? □ No □ Yes

When?	From whom?	For what?	Medications Prescribed?	With what results?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

D. Relationships in your family of origin. Please describe the following:

1. Your parents' relationship with each other: _____

2. Your relationship with each parent and with other adults present: _____

3. Your parents' physical health problems, chemical use, and mental or emotional difficulties: _____
_____

E. Physical Health

1. Date of last physical and name of your doctor: _____

2. Current medical problems or illnesses: _____

3. Allergies: _____

F. Abuse History: □ I was not abused in anyway. □ I was abused.

If you were abused, please indicate the following: For kind of abuse, use these letters

P = Physical, such as beatings
S = Sexual, such as touching/molesting/fondling or intercourse.
N = Neglect, such as failure to feed, shelter or protect you.
E = Emotional, such as humiliation, etc.

Your Age	Kind of abuse	By whom?	Effects on you	Whom did you tell?	Consequences of telling
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

G. Present Relationships (if applicable)

How do you get along with your present spouse or partner? Children? _____
_____
_____

H. Chemical Use

1. Have you ever felt the need to cut down on your drinking? □ No □ Yes

2. Have you ever felt annoyed by criticism of your drinking? □ No □ Yes

3. Have you ever felt guilty about your drinking? □ No □ Yes

4. Have you ever taken a morning "eye opener"? □ No □ Yes

5. How much beer, wine or hard liquor do you consume each week, on the average? _____

6. How much tobacco do you smoke or chew each week? _____

7. Which drugs (not medications prescribed for you) have you used in the last 10 years? _____
_____

8. How many caffeinated beverages do you consume in a day? _____

I. Legal History

Briefly describe any history of arrests and convictions (either felonies or misdemeanors), including any moving violations while in an automobile. _____

J. Religious Background and Beliefs

Please indicate your religious background and current beliefs. _____

New Directions EAP, Inc.

1575 Marion Ave.

Mansfield, OH 44906

Information Form

Please print legibly and return to receptionist

Patient Full Name _____

Preferred Name _____

Birthdate_____ Age_____ Male_____ Female_____

Residence Street Address_____

City, State, Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____

Please Mark * for preferred number

Marital Status_____ Spouse's Name_____

Patient's Social Security Number_____

If a minor, parent of guardian's name(s)_____

Patient's Employer (or Parent's employer, if minor)_____

Are you using EAP Services?_____ If so, what employer?_____

Insurance Company_____

(Please give card to receptionist for copying)

Name of Policy Holder_____ Policy Holder Birthdate_____

Policy Holder's Social Security Number _____

Nearest Relative not residing with you _____

Relationship to you _____ Phone _____

In case of emergency, please contact _____

Relationship to you _____ Phone _____

Date _____

New Directions Counseling Center

CONSENT FOR TREATMENT

I further authorize and request that my therapist carry out psychological examinations, treatments, and/or diagnostic procedures which now or during the course of my care as a patient are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful it may at times be difficult and uncomfortable.

CONFIDENTIALITY

I understand that all information between myself and my therapist is held strictly confidential, and my therapist will not release any information about my therapy unless permitted by law or:

1. I agree in writing to permit such a release.
2. I present a physical danger to myself,
3. I present a danger to others,
4. Child/elder abuse/neglect is suspected.

I understand that in the latter 2 cases, the therapist is required by law to inform potential victims and legal authorities so that protective measure can be taken.

If I participate in group counseling, I agree not to discuss any details of the group outside of the counseling sessions.

FINANCIAL TERMS/CONSENT TO BILL INSURANCE

Upon verification of health plan/insurance coverage and policy limits, my insurance carrier will be billed for me and my Provider will be paid directly by the carrier. I agree to release information to my insurance company for billing as requested. I will be responsible for any applicable deductibles and co-payments. I agree to make these payments at each appointment. I understand that if I am not eligible at the time services are rendered, I am responsible for payment, even if the determination is made after services are rendered. ***Please be advised that failure to give 24 hours notice of cancellation of your scheduled appointment will result in a $35 charge billed directly to you.***

If I am without health plan/insurance coverage, payment arrangements will be made prior to my first visit. Visa and MasterCard accepted.

HIPAA

I have been provided a copy of the Ohio "Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information" notice.

I have reviewed and understand the information.

_____ _____

Print Client Name **Date**

_____

Client Signature (or Parent/Guardian signature if minor)