Folsom Counseling Services

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FOLSOM, CA 95630

CLIENT INFORMATION FORM

Full Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Gender: _____

Address: _____
(Street) (City) (State) (Zip code)

Marital Status: _____ Date married (if applicable): _____

Employer: _____ Occupation: _____

Home phone: _____ Work phone: _____

Cell phone: _____

Referred to Practice By: _____

Address: _____ Phone: _____

To (re)schedule appointments, where may I call?

Home: Yes No **Work:** Yes No **Cell:** Yes No

May I leave a message on the answering machine? Yes No

May I leave a message with someone at this number? Yes No

Please list any restrictions: _____

***Whom may I contact in case of an emergency*?**

Name: _____ Relationship: _____

Phone: _____ Alternate phone: _____

Please complete the following:

In the space below, please briefly describe the reason(s) for seeking services:

_____

_____

_____

When did this problem begin?: _____

Have you ever had previous counseling or psychotherapy? Yes No

If "yes," by whom and when? _____

Reason for treatment? _____

Are you currently taking any psychotropic medication (e.g. antidepressants, anti-anxiety, etc.)?

Yes No *If yes, list medication(s) and current dosage(s):* _____

_____

Name of Psychiatrist: _____ Phone: _____

Have you ever been psychiatrically hospitalized? Yes No *If so, when and where?*

_____

Have you ever made a suicide attempt/gesture? Yes No *If so, please explain:*

_____

Please use the scale below to indicate your current level of distress with the following items:

	No Concern	**Some**	**Moderate**	**Urgent**
Feelings over a recent loss/death	0	1	2	3
Relationship with friends /family	0	1	2	3
Relationship with romantic partner	0	1	2	3
Sexual concerns	0	1	2	3
Sexual orientation	0	1	2	3
Survivor of abuse	0	1	2	3
Racial/ethnic issues	0	1	2	3
Low self-esteem	0	1	2	3
Loneliness	0	1	2	3
Depression	0	1	2	3
Anxiety	0	1	2	3
Fears/worries	0	1	2	3
Sleep problems	0	1	2	3
Eating problems	0	1	2	3
Body image concerns	0	1	2	3
Problems with alcohol/drugs	0	1	2	3
Losing contact with reality	0	1	2	3
Suicidal feelings/behaviors	0	1	2	3

Any important family issues you wish to share

_____

_____

_____

Name of person responsible for payment_____

Referred by_____

I agree to pay the agreed upon fee in full at the end of each session.

I understand the standard appointment length is a *50 minute session*. Consultations with physicians, school personnel, etc may be sometimes necessary. Such contacts will be made with your consent first and you will be advised, in advance of any charges.

I agree to a $20.00 handling fee for returned checks.

*******I agree to pay for a missed session when I have not given a minimum 24 hour notice.*** **Other than emergency cases, I am aware I am responsible for payment of the missed session. I have read the above and understand and agree to the policies outlined.**

I agree that if I do not give Kelly Richardson 48 business hours cancellation notice, she will bill my credit card.

Credit Card # _____ exp date _____ cvv # _____

Client's Signature _____ Date _____