Cindi Stoneman, MA, LPC

REGISTRATION INTERVIEW

Professional Counseling Services

CONFIDENTIALITY All information from this form is considered Protected Health Information (PHI) and will be safeguarded in accordance with HIPAA Notice of Privacy Practices

CLIENT INFORMATION

Name:____ Date:____________________
(Last) (First) (Initial)

Address: ____
(Street)

____ ____________________
(City) (State) (Zip Code) (E-mail Address)

Client Birthdate:______________ **Age:**__________ **Social Security No**.:____________________

Marital Status:______________________________ No. of Children:____________________

Name of Spouse:______________________________ Date of Birth-Spouse:____________________

Telephone (Home): (_______)____________________ Cell Phone (_______)____________________

Message Telephone: (_______)____________________ Message Source:____________________

Client Job Title:____

Employer Name:______________________________ Work Phone No.: (_____)____________________

Employer Address:____

Person to Notify in case of emergency: ________________________**Phone**: (_____)________________

GUARANTOR

Who will be responsible for payment for services received? (If other than client)

Name:______________________________________ Social Security No:____________________
(Last) (First) (Initial)

Relationship to Client:__________________________ Birthdate:____________________

Address:____
(Street)

____
(City) (State) (Zip Code)

Telephone: (Home) (______)____________________ (Work) (______)____________________

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REGISTRATION INTERVIEW

INSURANCE INFORMATION

Who Is Your Insurance Provider?

Name of Company:____

Policy No.:__________________________ Group No.:______________________

Phone No.: (______)____

Address:___________________________ City__________State_____ Zip______

REFERRAL INFORMATION

Who sent you to this office? How did you hear about the services?

Name or Place:____

PURPOSE & GOALS

1) What is your reason for coming to counseling?

____

____

____

____

On a scale of 1 – 10 (1 being the **least severe**, 10 being the **most severe**), how severe would you rate the problem for which you are seeking treatment? __________

2) What are your goals for counseling and what do you want to accomplish?

____

____

____

____

On a scale of 1 – 10 (1 being the **least severe**, 10 being the **most severe**), how severe would you like the problem to be at **completion** of treatment? __________

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REGISTRATION INTERVIEW

PERSONAL INFORMATION

Are you : ❑ single ❑ married ❑ divorced ❑ separated

If married, how long?________________________ Do you have children by this marriage? ❑ Yes ❑ No

Child's Name	**(M)**ale or **(F)**emale	Age	Date of Birth

Who do they live with?____

Any previous marriages? ❑ Yes ❑ No How Many? _________________

Do you have children by a previous marriage? ❑ Yes ❑ No

Names & Ages & Birthdates:____

Who do they live with?____

Do you have Brothers? ❑ Yes ❑ No Sisters? ❑ Yes ❑ No

Names & Ages:____

____

What is your educational (school) history?
(Please list name of school, city & state school is located, year you graduated or how long attended)

Grammar School:____

High School:____

College or Technical School:____

What is your work history?

<u>Company</u> <u>City & State of Company</u> <u>Year</u>

____

____

____

____

____

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REGISTRATION INTERVIEW

COMMUNICATION ABILITIES

Do you prefer to communicate in
❑ English? ❑ Spanish? ❑ Sign Language? ❑ Other?____

If you are deaf or have a hearing impairment, what is the degree of your loss?
right ear?__________________ left ear?_________________

When did your hearing loss first occur and how old were you?
____

What was the reason for your hearing loss?
____

MEDICAL INFORMATION

Do you have any medical or physical problems or limitations? (Example: heart, back problems, vision)
____
____

Are you under a doctor's care? ❑ Yes ❑ No
If yes, please explain:____

Who is your doctor? Name:____
Address:____Telephone:________________

Are you taking any prescription medications? ❑ Yes ❑ No

Name of **Prescription** Medication(s)	Dosage	Taken Since

Do you take any ***over-the-counter drugs/medications***? ❑ Yes ❑ No

Name of **Over-The-Counter** Medication(s)	Dosage	Taken Since

ADVERSE CHILDHOOD EXPERIENCES

Please check any of the following boxes if you experienced them in your childhood:

❑ Recurrent and severe physical abuse
❑ Recurrent and severe emotional abuse
❑ Contact sexual abuse
❑ An alcoholic or drug-user in the household
❑ A household member being imprisoned
❑ Your mother being treated violently
❑ Both biological parents ***not*** being present in the household
❑ A mentally ill, chronically depressed, or institutionalized household member

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REGISTRATION INTERVIEW

PRIOR TREATMENT

Have you ever had any psychological counseling? ❑ Yes ❑ No
Name:______________________________ Telephone:____________________

Have you ever had any psychiatric care? ❑ Yes ❑ No
Doctor's Name:______________________________ Telephone:____________________

What were your reasons for treatment or counseling? ______________________________

SUBSTANCE USE INFORMATION:

ALCOHOL

Do you drink for "enjoyment"? ❑ Yes ❑ No

How long since your last drink?____________ How much did you drink at that time?____________

How many days drinking in last 30 days?____________

Have your parents or spouse ever complained about your drinking? ❑ Yes ❑ No
Have you ever missed work or appointments because of your drinking? ❑ Yes ❑ No

If yes, how much did you drink? ______________________________
Why?______________________________

Have you ever had a "blackout" because of drinking too much? ❑ Yes ❑ No

Have you ever been arrested for a D.U.I.? ❑ Yes ❑ No

Age first used alcohol? __________

Have you ever been involved in a 12-step/AA program? ❑ Yes, currently ❑ Yes, but not currently ❑ No

DRUGS

Do you use drugs for "enjoyment"? ❑ Yes ❑ No

What kind of drugs do you use?______________________________

How long since you last used drugs?____________ How much drugs did you take at that time?____________

How many days using drugs in last 30 days?____________

Have your parents or spouse ever complained about your using drugs? ❑ Yes ❑ No
Have you ever missed work or appointments because of using drugs? ❑ Yes ❑ No

How much did you use?______________________________
Why?______________________________

Have you ever been arrested for possession? ❑ Yes ❑ No

Have you ever been arrested for D.U.I.? ❑ Yes ❑ No

Age first used drugs? __________

Have you ever been involved in a 12-step program? ❑ Yes, currently ❑ Yes, but not currently ❑ No

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SUBSTANCE USE INFORMATION, continued:

CIGARETTES

Do you ***currently*** smoke cigarettes? ❑ Yes ❑ No

If yes, how many cigarettes do you smoke a day? ____________________

Have you smoked cigarettes in the past? ❑ Yes ❑ No

If yes, how many cigarettes ***did*** you smoke a day and when did you quit? ____________________

CAFFEINE

How much caffeine do you consume each day?

# of ounces: ____________Types: ____________________

HOBBIES/ENJOYABLE ACTIVITIES/STRENGTHS

What do you do for enjoyment or as hobbies? ____________________

____

What are your strengths? ____________________

____

SYMPTOMS (check all that apply)

- ❑ Anxiety or nervousness
- ❑ Depressed, sad, empty mood or pessimism
- ❑ Irritability
- ❑ Loss of pleasure, including sex
- ❑ Weight gain or loss
- ❑ Change in appetite, eating more or less than usual
- ❑ Change in sleeping pattern, more or less than usual
- ❑ Decreased energy or fatigue
- ❑ Feeling worthlessness or guilt
- ❑ Concentration problems
- ❑ Difficulty making decisions
- ❑ Thoughts of death or suicide
- ❑ Grief
- ❑ Panic or anxiety attacks
- ❑ Mood swings
- ❑ Decreased need for sleep
- ❑ More talkative than usual
- ❑ Easily distracted
- ❑ Obsessions/compulsions
- ❑ Hyperactivity
- ❑ Spending more money than usual
- ❑ Fear of something specific, i.e. heights, crowds, etc.
- ❑ Nightmares
- ❑ Stress
- ❑ Memory problems
- ❑ Paranoia
- ❑ Tearfulness or crying
- ❑ Inappropriate anger
- ❑ Other, please describe

____

____

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REGISTRATION INTERVIEW

SIGNATURE PAGE

_______ Initial

CANCELLATION: Since scheduling of an appointment involves the reservation of time specifically for you, a **minimum of 24 hours notice is required for re-scheduling or canceling an appointment.** Unless we reach a different agreement, a fee will be charged for sessions missed without such notification. Most insurance companies do not reimburse for missed sessions, therefore payment of this fee is the responsibility of the client.

I/we have read the document entitled Agreement/Informed Consent for Psychotherapy Services and Office Policies and General Information carefully; have had the opportunity to ask questions; understand the agreement, policies, and information; agree to comply with them; and agree to begin treatment:

X

Client/parent/guardian (print) Date Signature

Client/parent/guardian (print) Date Signature

For office use only - Verification that client/parent/guardian has read the document entitled Agreement/Informed Consent for Psychotherapy Services and Office Policies and General Information, had the opportunity to ask questions, understands the agreement, policies, and information, agrees to comply with them, and agrees to begin treatment.

Cindi Stoneman, MA, LPC, NCC: ______________________________ Date: ____________________

I/we acknowledge receipt of the HIPAA Notice of Privacy Practices and have read and understand my rights:

X

Client/parent/guardian (print) Date Signature

Client/parent/guardian (print) Date Signature

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS (TPO)

Federal regulations (HIPAA) allow me to use or disclose Protected Health Information (PHI) from your record in order to provide treatment to you, to obtain payment for the services we provide, and for other professional activities (known as "health care operations."). Nevertheless, I ask your consent in order to make this permission explicit. The Notice of Privacy Practices describes these disclosures in more detail. You have the right to review the Notice of Privacy Practices before signing this consent. I reserve the right to revise the Notice of Privacy Practices at any time. If I do so, the revised Notice will be posted in the office. You may ask for a printed copy of the Notice at any time.

You may ask me to restrict the use and disclosure of certain information in your record that otherwise would be disclosed for treatment, payment, or health care operations; however, I do not have to agree to these restrictions. If I do agree to a restriction, that agreement is binding.

You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the consent prior to the revocation.

This consent is voluntary; you may refuse to sign it. However, I am permitted to refuse to provide health care services if this consent is not granted, or if the consent is later revoked.

I hereby consent to the use or disclosure of my Protected Health Information as specified above.

X

Client/parent/guardian (print) Date Signature

Client/parent/guardian (print) Date Signature