Patient Name:_____ Date:_____

PEACE OF MIND COUNSELING

3311 Old Forest Rd Suite 101, Lynchburg, VA 24501 434-363-4815

Client Information

Date:_____ Patient #_____ Therapist:_____

Name:_____ Social Security #_____Home Phone: _____

Address:_____City:_____ State:_____ Zip:_____

E-mail address:_____ Cell Phone:_____

Age:_____ Birth Date:_____ Race:_____ Marital: M S W D

Occupation:_____ Employer:_____

Employer's Address:_____ Office Phone:_____

Spouse:_____ Occupation:_____ Employer:_____

How many children?_____Names and Ages of Children:_____

_____

Name of Nearest Relative:_____ Phone:_____

How were you referred to our office?_____

Family Medical Doctor (first and last name): _____

When healthcare professionals work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? _____

HISTORY OF PRESENT PROBLEM:

Purpose of this appointment:_____

_____

Have you ever had the same or a similar condition? ____ Yes ____ No If yes, when and describe:

_____

_____

PAST HISTORY

Do you ever have: (Place a check mark by conditions that apply to you)

__ Anxiety
__ Depression
__ Anger
__ Abandonment
__ Alcoholism
__ Drug Addiction
__Eating Disorder
__ Post Traumatic Stress Disorder
__ Adoption Issues
__ Other. List: _____
__ Other. List: _____
__ HIV Positive

Have you had any major illness, hospitalizations or surgeries? Women, please include information about childbirth (include dates): _____

_____

Patient Name:_____ Date:_____

Have you been treated for any health condition by a physician in the last year? ____ Yes ____ No

If yes, describe: _____

What medications or drugs are you taking? (List name and dosage)

_____

_____

Please list any other health problems you have, no matter how insignificant they may be: _____

_____

_____

SOCIAL HISTORY:

Do you drink alcoholic beverages?_____ If so, how much per week?_____
Do you use any tobacco products?_____Do you smoke?____ If so, packs per day: _____
Do you take vitamin supplements?_____ If so, please list:_____
Do you consume caffeine?_____ If so, how much per day:_____
Do you exercise?_____ If yes, what is the frequency and type of exercise?_____
Do you sleep well at night? _____ If no, why not? _____
What are your hobbies?_____
What percentage of time during the day (at home or at your job away from home) do you spend:
Under normal stress load: _____% Under considerable stress: _____% Resting or relaxed: ____%

FAMILY HISTORY:

Parents:
Father: living ___ deceased ____ (check one) Current age if still living:_____ Cause of death and age at death if deceased:_____

Mother: living ___ deceased ____ (check one) Current age if still living:_____ Cause of death and age at death if deceased:_____

Check if applicable to you: ___ I am adopted ___ As an adopted child, little is known of my birth parents or family.

Do you have any family members who suffer from the same condition you do? _____ If so, please list: _____

_____

FAMILY DISEASES (if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):

__ Anxiety
__ Depression
__ Anger
__ Abandonment
__ Alcoholism
__ Drug Addiction
__Eating Disorder
__ Post Traumatic Stress Disorder
__ Adoption Issues
__ Other. List: _____
__ Other. List: _____
__ HIV Positive

AUTHORIZATION AND RELEASE: I authorize payment for counseling services directly to the therapist or therapist's office. I authorize the therapist to release all information necessary to communicate with personal physicians and other healthcare providers and payors to secure payment. I understand that I am responsible for all costs of therapy and counseling care. I also understand that if I suspend or terminate my schedule of care as determined by my treating therapist, any fees for professional services will be immediately due and payable.

Patient Name:_____ Date:_____

The client understands and agrees to allow this healthcare office to use his/her Client Health Information for the purposes of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Client Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Client Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Client's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____