**Sarah F. Collins, MA, LP, Inc.**

**Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_**

***Client Information***

**Personal Information**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_M.I.\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age:\_\_\_\_\_

Phone (Home)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Cell)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Please Circle the preferred method for me to contact you.)**

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship Status: Single Married Engaged Partnered Separated Divorced  Widowed

How did you hear about me?\_\_\_\_\_\_\_\_\_:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you on any medications? Yes No If so, please list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Had counseling before? Yes No Would you like me to consult with your past counselor? Yes No

Reason(s) for seeking counseling at this time:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Work Information**

Employment Status:  Full-time Part-time Retired Unemployed Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Method of Payment:**  Self-Pay Insurance (If self pay, do not fill out the following.)

**Primary Insurance Information** (Can be found on your insurance Card)

Name of Insurance Company & Policy:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Information Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Claims Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to the Insured: Self Spouse Family Member

Name of the Primary Insured Person:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_M.I.\_\_\_\_

Primary Insured’s Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insured’s Place of Employment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Authorization**

I hereby certify that the above statements are correct. I authorize the release of any medical information necessary to process this claim. I also authorize benefits under this claim to be paid directly Sarah F. Collins, MA, for the services rendered to me and/or my dependants.

 Client Signature (or parent/guardian):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_

**Payment Responsibility**

I understand that if I am using my insurance, I am responsible for all deductible and co-insurance/co-payment amounts and that these will be paid at the beginning of each appointment unless a prior payment arrangement has been made with my counselor. I also understand that I am financially responsible for full payment of all charges not covered by me insurance company or third-party payer and that my counselor may use an outside agency to receive collection if my account becomes delinquent.

**I agree to be responsible for paying in full all charges for appointments missed or cancelled less than 24 hours in advance** and that my insurance company does not cover these charges.

Client Signature (or parent/guardian):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Client\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FULL NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*After you have read my Informed Consent, please complete this form. Please fill out this form as completely and accurately as possible. If you are uncomfortable with any item or unsure how to answer, leave it blank, and we’ll go over it when it’s appropriate. Your assistance in completing this form prior to your next appointment will help us to be efficient and maximize our time together.*

Please look these items and mark the column that best describes how these symptoms have bothered you ***recently (past couple of weeks).***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Symptoms | Not at all | Mildly (noticeable but relatively easy to manage) | Moderately (more difficult to manage) | Severely (Feeling unmanageable) |
| Depressed, sad, or crying |  |  |  |  |
| Feelings of guilt or shame |  |  |  |  |
| Suicidal thoughts, plan, or attempts.  **Have you ever thought about, planned, or attempted suicide?** **Thought about? y/n** **Planned? y/n** **Attempted? y/n** **If yes to any of these,**  **when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |  |  |  |
| Self-injurous behavior, **please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |  |  |  |
| Changed sleep patterns: **Hypersomnia (sleeping**  **13+ hours at night)? y/n** **Insomnia (difficulty falling**  **or staying asleep)? y/n** **Nightmares? y/n** |  |  |  |  |
| Concerns about eating behavior, attitudes about food, and body image |  |  |  |  |
| Change in weight or eating habits **Increase or decrease?** **How much? \_\_\_\_\_\_\_\_\_\_\_** |  |  |  |  |
| Loss of energy or interest in normally pleasurable activities |  |  |  |  |
| Anxious, nervous, or panicky feelings |  |  |  |  |
| Avoiding places or situations |  |  |  |  |
| Repetitive thoughts |  |  |  |  |
| Repetitive behaviors, **please specify** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |
| Change in time spent at school/work **Increase or decrease?** |  |  |  |  |
| Relationship problems |  |  |  |  |
| Insecurity, inferiority, or low self-esteem |  |  |  |  |
| Physical problems, pains, or illness |  |  |  |  |
| Anger or temper problems |  |  |  |  |
| Change in spending habits |  |  |  |  |
| Headaches |  |  |  |  |
| Memory problems |  |  |  |  |
| Confused or disorganized thoughts |  |  |  |  |
| Hallucinations |  |  |  |  |
| Sexual worries or problems |  |  |  |  |

|  |
| --- |
| ***Presenting Concern*** |

1. Please describe what you hope to accomplish in this therapy or what you hope will be different in your life as a result of attending counseling:
2. How much does this problem affect your life? (please mark the column that best applies)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Not at all | A little | A lot | All the time |
| Personally |  |  |  |  |
| Family Life |  |  |  |  |
| Marriage |  |  |  |  |
| Socially |  |  |  |  |
| School/Work |  |  |  |  |

|  |
| --- |
| ***Contributing Factors*** |

1. Which of the following do you think contribute to your problem(s) or concern(s)? Check all that apply

\_\_Move to new home \_\_Death of a loved one \_\_Disability

\_\_Starting a new job/venture \_\_Birth of a child \_\_Victim of a crime

\_\_Quarreling/Arguing \_\_Fertility issues \_\_Law violations

\_\_Post-divorce adjustment \_\_Spiritual problems ­­\_\_Work problems

\_\_Financial stress \_\_Negative peer influence \_\_Medical problems

\_\_Marital unfaithfulness \_\_Ending of a significant relationship \_\_Violence

\_\_Marital Separation \_\_Drug or Alcohol use \_\_Addictive behavior

\_\_Previous therapy \_\_Relationship concern \_\_Adjustment to new life stage

\_\_Parenting difficulty \_\_Suspected/Known physical/sexual/verbal abuse

\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| ***Mental Health/Medical History***  |

1. List any significant health problems, past or present (include surgeries and significant illnesses). Please note any head injury/trauma or concussions. Also please indicate the approximate date.
2. Are you currently taking any medications? y/n If yes, please list

|  |  |  |  |
| --- | --- | --- | --- |
| Medication | Dose and times per day | For what condition? | Prescribing doctor |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

1. Have you ever taken any medication for depression, anxiety, or other mental health issues? y/n If yes, please list

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Medication | For what condition? | When (approx) | How long were you on the medication? | What were the results? |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

1. Do you take your medications as prescribed? y/n
2. Do you experience any notable side affects to any of your medications? y/n
3. List other therapy or counseling you have received in the past or are receiving now:

|  |  |  |  |
| --- | --- | --- | --- |
| When | From whom? | For What? | With what results? |
|  |  |  |  |

1. Have you ever been hospitalized for psychological, emotional, or nervous problems? y/n If yes, when, where, and what was the main issue?
2. Please describe your use of the following substances:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Daily | Weekly | Occasionally | In the past, but not now | Not at all |
| Caffeine |  |  |  |  |  |
| Tobacco |  |  |  |  |  |
| Alcohol |  |  |  |  |  |
| Prescription Drugs |  |  |  |  |  |
| Inhalants |  |  |  |  |  |
| Street drugs |  |  |  |  |  |
| Over-the-counter meds |  |  |  |  |  |
| Other\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |  |

1. Have you ever experience any of the following as a result of substance use?

Blackouts: y/n Bad reactions: y/n Withdrawl symptoms: y/n Overdose: y/n DUI: y/n Other:\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you ever felt you should cut down on your drinking or drug use? y/n
2. Have people annoyed you by criticizing your drinking or drug use? y/n
3. Have you ever felt bad or guilty about your use? y/n
4. Have you ever had to drink or use drugs as an eye-opener first thing in the morning to steady your nerves, get rid of a hangover, or to get the day started? y/n
5. Have you ever been in treatment or taken part in a recovery program for any type of alcohol or substance use? y/n

When & where?

1. Have you ever made a suicide attempt in your past? y/n When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| ***Other*** |

1. Is there anything else that you would like me to know from the beginning about you that you have not indicated on this form?

I acknowledge that the information on this form is accurate to the best of my knowledge, and that I will inform Sarah F. Collins, MA, LP of any changes in my personal circumstances, including address, symptoms experienced, suicidal thoughts, and substance use.

Client Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_