

Insurance Information

(Please provide id card for photocopy)

Health Status

Please answer the following questions as completely as possible.

Client: _____

Indicate your health status: _____Excellent _____Good _____Poor

When did you have your last physical examination and what were the results?

Have you ever been told by a physician to stop drinking or using drugs? _____yes _____no.

Do you drink alcoholic beverages? _____yes _____no.

If yes, describe your drinking habits.

Have you ever been treated for substance abuse? _____yes _____no.

If yes, where and when _____

Have you ever attended a 12 Step meeting (AA/NA) _____yes _____no.

Have you ever received any other counseling? If yes list where and when. _____yes _____no.

Clinic/Counselor: _____Date: _____

Are you disabled or do you have any physical limitations? If yes, what? _____

Have you had a serious injury or illness in the past? If yes, what? _____

Can you keep your mind on a TV program or on the newspaper? _____yes _____no.

Do you forget things easily? _____yes _____no.

Is exercise a part of your daily or weekly routine? _____yes _____no.

How many times have you been hospitalized for more than 24 hours, including OB/GYN and operations? _____

Name of personal physician or clinic: _____

Does any food or medicine make you sick in any way? If yes, please list: _____

How much coffee, tea or soda-pop do you drink daily? _____

Are you currently taking diet pills? _____yes _____no.

List all prescription medication you are currently taking from any other doctors, including birth control.

Are you taking any over the counter drugs or herbal supplements? If yes what? _____

For Females Only

Is there a chance you may be pregnant now? _____yes _____no.

What was your age at the time of your first pregnancy? _____

How many miscarriages have you had? _____
How many stillbirths have you had? _____
Are your periods regular? _____yes _____no

Consent to Release Information

I, _____ authorize Ellie Fields MS, LMHP, CPC to release information to:

_____ Treatment Provider: _____

_____ Supervisor/HR representative: _____

_____ Third party payer: _____

_____ Other _____

_____ Other _____

The information will consist of:

_____ Attendance Only.

_____ Chemical dependency and Substance Use and Abuse information.

_____ Psychological or Psychiatric Information

_____ Re-release of information (specify) _____

_____ All available information.

_____ Other: Information necessary to obtain authorization and/or release of client benefit information.

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CRF-Part2), and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this consent at any time, in writing, except to the extent that action has been taken in reliance on it. This release will automatically expire on this date _____ or when services are no longer provided by this practitioner.

These records may be released in verbal, photocopied, written or facsimile format(s).

Client signature

Date

Parent/guardian signature

Witness

Date

Emergency Contact:

Name: _____ Relationship: _____

Address: _____

(address, city, state & zip code)

Home#: _____ Work: _____ Cell: _____

Family Physician or Psychiatrist: _____

Address: _____ Phone: () _____

(address, city, state & zip code)

Limits of Confidentiality

Information discussed in the therapy setting is held confidential and will not be shared without written permission except under the following conditions:

1. The client threatens suicide.
2. The client threatens harm to another person(s), including murder, assault or other physical harm.
3. The client is a minor (under 18 years of age) and reports suspected child abuse, including but not limited to neglect, physical beatings and sexual abuse.
4. The client reports abuse of the elderly.
5. The client reports sexual exploitation by a therapist.

State law mandates that mental health professionals may need to report these situations to the appropriate persons and/or agencies. Communications between the clinician and client will otherwise be deemed confidential as stated under the laws of this state.

Having read and understood the above, I agree to these limits of confidentiality.

Signature of client or guardian: _____ Date: _____