Laura Lewis LMFT
Individual & Family Counseling

CLIENT INFORMATION

Date: ____/____/______

Client's Name: ___________________________ Date of Birth: ____________________ Age: ________________

Gender: ◻ Male. ◻ Female

Address: ________________________________ City: __________________ State: ________ Zip _________

Contact Phone Number: ___________________________ Email: ____

Employer: ____ Occupation: ______________________________

Marital Status:
◻ Single ◻ Married ◻ Separated ◻ Divorced ◻ In a relationship ◻ Engaged ◻ Widowed

Name of Spouse/Partner: ____

Contact Phone Number: ___________________________ Email: ____

Emergency Contact: ________________________________ Relationship to You: _________________________

Contact Phone Number: ______________________________ Email: _______________________________________

FINANCIAL RESPONSIBILITY:

Please indicate who will be responsible for payment:

◻ Self ◻ Spouse ◻ Parent ◻ Other __________________________________

Name of responsible party: ____

Address of responsible party: ____

Contact Phone Number: ________________________________ Email: __________________________________

You have the right to file all counseling services with your insurance company. Reimbursement for services is never guaranteed and payment for counseling services is expected at the time of service. If you would like a Superbill for your insurance company, please check this box ◻

**Superbills are mailed/emailed once per month.*

FAMILY DYNAMICS

Relationship	Name	Age	Living (check if YES)	Living with You (check if YES)
Mother				
Father				
Spouse/ Partner				
Child				
Child				
Child				
Child				

Significant Others (e.g. siblings, grandparents, step-relatives, half-relatives. Please specify relationship.)

Relationship	Name	Age	Living (check if YES)	Living with You (check if YES)

Please acknowledge any significant family events (e.g. death, divorce, illness, affair, physical/emotional/sexual abuse):

____

____

Briefly describe your past and current relationship with your:

Mother:	Father:
Step Mother:	Step Father:
Other Parental Figure:	Other Parental Figure:

Parental Information

- ☐ Parents legally married for _____ years
- ☐ Parents have ever been separated
- ☐ Parents ever divorced
- ☐ Mother remarried: Number of times __________
- ☐ Father remarried: Number of times __________

How would you describe your parents relationship with each other?

____

COUNSELING HISTORY

Have you been previously involved in individual counseling? ☐ Yes ☐ No

If YES, whom have you seen?

Name: ______________________________ When: ____________________

Name: ______________________________ When: ____________________

Name: ______________________________ When: ____________________

Have you ever been hospitalized for mental health reasons?

☐ Yes ☐ No

If YES, please explain:

____

____

____

Have you ever participated in Residential Treatment and/or Partial Hospitalization for any mental health issue?

☐ Yes ☐ No

If YES, please explain:

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____

Is there a history of mental illness in your family? ☐ Yes ☐ No

If YES, please explain:

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Have you ever attempted suicide? ☐ Yes ☐ No

If YES, please explain:

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Have you ever engaged in self-harm behaviors (e.g. cutting, scratching, hair pulling, burning)? ☐ Yes ☐ No

If YES, please explain:

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CURRENT SYMPTOMS CHECKLIST

Please rate the intensity of symptoms **currently** present.

None= This symptom not present at this time
Mild= Impacts quality of life, but no significant impairment of day-to-day functioning
Moderate= Significant impact on quality of life and/or day-to-day functioning
Severe= Profound impact on quality of life and/or day-to-day functioning

Symptom	None	Mild	Moderate	Severe
Agitation				
Anger				
Anorexia				
Anxiety/Worry				
Binge Drinking				
Bingeing/Purging				
Body Image				
Bulimia				
Conflict with Child				
Conflict with Parent				
Crying				
Depression				
Fear				
Grief/Loss				
Guilt				
Hyperactivity				
Impulsivity				
Inability to Focus				
Irritability				
Laxative/Diuretic Use				
Mood Swings				
Nightmares				
Panic Attacks				
Passivity				
Procrastinating				
Relationship Issues				

Self- Injury				
Sexual Functioning Problems				
Sexual Identity Issues				
Social Isolation				
Spiritual Issues				
Substance Use/Abuse				
Suicidal Ideation				
Weight Gain				
Weight Loss				
Other:				

SUBSTANCE USE HISTORY

Substance	Frequency	First Use (Age)	Last Use (Age)	Used in Last 48 Hours (check if YES)	Used in Last 30 Days (check if YES)
Alcohol					
Barbiturates					
Valium					
Cocaine/Crack					
Heroin/Opiates					
Marijuana					
PCP/LSD					
Methamphetamine					
Inhalants					
Nicotine					
Caffeine					
Prescription Drugs					
Other					

Have you ever sought help for substance abuse? □ YES □ NO

If YES, please explain:

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MEDICAL HISTORY

Who is your primary care provider? ______________________________ Phone Number:______________

List all prescribed medications:

Medication	Dosage	Prescribed by

Indicate whether you have or have had any of the following:

Allergies
Abortion
Asthma
Arthritis
Cancer
Chest Pain
Chronic Pain
Dental Problems
Diabetes
Dizziness
Epilepsy
Ear Infections

Eating Disorder
Fainting
Fatigue
Headaches
High Blood Pressure
Kidney Problems
Miscarriage(s)
Neurological Disorders
Nausea
Sexually Transmitted Disease
Sleep Disturbance
Sinus Problems

Stroke
Sexual Problems
Thyroid Problems
Vision Problems
Vomiting
Other: _______________
Other: _______________
Other: _______________

List any current health concerns: ____

List any recent health or physical changes: ____

List any past surgeries:

____

List any past hospitalizations (for non mental health issues):

____

Have you ever been diagnosed with an eating disorder:____

TREATMENT GOALS

Please identify areas you would like to work on in counseling:

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CLIENT NOTIFICATION OF PRIVACY RIGHTS

The Health Insurance Portability and Accountability Act (HIPAA) has created new client protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law", HIPAA provides patient protections related to the electronic transmission of data, the keeping and use of patient records, and storage and access to health care records. HIPAA also applies to mental health client care.

By law, I am required to secure your signature indicating you understand this Client Notification of Privacy Rights document. If you have any questions, please let me know.

PLEASE SIGN BELOW TO INDICATE YOU HAVE READ AND UNDERSTAND THE CLIENT INFORMATION AND CONSENT TO TREATMENT FORM, INCLUDING THE CLIENT NOTIFICATION OF PRIVACY RIGHTS SECTION.

____________________________________ ____________________

Client/Guardian Signature Date

CLIENT INFORMATION AND CONSENT TO TREATMENT

APPOINTMENTS: Your scheduled office appointment is a time specifically set aside for you. If you are unable to keep an appointment, ***a minimum of 24 hours notice is required; otherwise you are subject to the full charge for the appointment.***

INSURANCE:
I am not able to bill insurance. However, you may bill your insurance directly. I am happy to provide the necessary paperwork.

COUNSELING METHODS: Counseling methods will vary, depending on your individual needs. Individual, couple or family sessions may be scheduled. Any questions you have about the procedure or process are always legitimate. You always have the right to decline participation in or the use of certain therapeutic techniques. We do not treat minors without parental consent.

EMERGENCY SERVICES: In the event of an emergency, call or go to the nearest emergency room or contact the Crisis Center at 615-244-7444

CONFIDENTIALITY: I strive to maintain privacy and uphold the ethics of confidentiality. This includes all verbal, written and recorded data concerning your treatment, which may not be released without your written consent. Limitations to these rights are: **1) I have a legal duty to warn and protect persons threatening harm to self or others, 2) I have a legal duty to report to proper authorities any knowledge of abuse to children and vulnerable adults, 3) I have to comply with Tennessee State Laws in regard to court ordered subpoenas/court testimony, 4) If you request reimbursement from your insurance company, they may request reports from your me in order to authorize reimbursement.** If you choose to keep a third party informed of your progress in counseling, it will be necessary to complete an “Authorization to Release Information” form that will be kept on file.

Please sign below to indicate that you have read and understand the above notifications and that you are consenting to receive counseling services by Laura Lewis LMFT.

____
Client/Guardian Signature

____
Date

FEE AGREEMENT

The standard fee for therapy is $ 130. for a 60-minute session or consult. You are fully responsible for all services rendered.
Full payment is expected at the time of service, unless other contractual arrangements apply.

Please review the stated policies and initial each indicating that you understand and agree to the policy.

_________ All counseling sessions require a minimum of 24 hours notice for cancellation. If an appointment is missed or cancelled less
than 24 hours prior to the session, the client may be charged the full rate.

_________ Payment is expected at the beginning of each session. You may pay by check or cash. Please make all checks payable to
Laura Lewis LMFT . There will be a $40.00 fee for payments returned as non-sufficient or non-payable.

________ **The fee is $150 for a 55 minutes clinical session.**

I have reviewed and agree to abide by the financial policy outlined above.

____
Client Signature

____
Date