Confidential Client Information

CLIENT INFORMATION

Date: _____ Referred by: _____

Full Name: _____ Sex: □ Male □ Female
Name you prefer: _____ Age:_____ Date of Birth:_____
Employer:_____ Length of Employment:_____
Occupation: _____ Special Training:_____

Highest Level of School Completed: □9 □10 □11 □12 □GED College: □1 □2 □3 □4 □Other: _____

CONTACT INFORMATION

Address: _____ City: _____ State: _____ Zip Code: _____
May we send mail here: □ Yes □ No

Home Phone: (_____) _____-_____ May we leave a message here: □ Yes □ No

Cell Phone: (_____) _____-_____ May we leave a message here: □ Yes □ No

Email Address: _____ May we send a message here: □ Yes □ No

Emergency Contact Authorized: _____ Relationship: _____ Phone: _____

REASONS FOR COUNSELING AND GOALS

What do you hope to gain or change by coming for counseling?

_____
_____
_____
_____

LEVEL OF DISTRESS

Indicate how distressed you are by circling on the scale below (1= Very Little Distress; 10=Extreme Distress):

1 2 3 4 5 6 7 8 9 10

Are you currently experiencing any suicidal thoughts? □ Yes □ No Have you had them in the past? □ Yes □ No

Have you ever attempted suicide? □ Yes □ No. If yes, when & how? _____

_____

Are you taking these medication(s) according to your doctor's recommendations? ☐ Yes ☐ No. If no, briefly explain:

_____

List significant conditions, illnesses, surgeries, hospitalizations, traumas, or treatments you've had.

_____

_____

_____

VOLUNTARY MEDICAL RELEASE OF INFORMATION

If needed, I authorize Sandra Bass to release and or obtain medication records and relevant medical information from _____ (doctor's name and office name) for the purpose of providing continuity of quality mental health services.

I understand that I do not have to sign this authorization and my refusal to sign will not affect my ability to obtain treatment. I understand that I may revoke this authorization at any time by written request to my counselor.

Print Name: _____ Date: _____

Client Signature: _____ Date: _____

SUBSTANCE USE

Do you currently use or have you previously used: (Please Check all that apply)

	Current	Past		Current	Past		Current	Past
Beer			Hallucinogens/Acid/Ecstasy/etc			Amphetamines/Speed/Meth/etc		
Wine			Inhalant/Huffing/Whippets/etc			Cocaine/Crack/etc		
Liquor			Phencyclidine/Mushrooms/etc			Opioids/Heroin/Opium		
Marijuana/Pot/Has/etc			Sedatives/Valium/etc			Over the Counter/Prescriptions		

Are you a recovering alcoholic or drug addict? ☐ Yes ☐ No ☐ Maybe

If yes, please explain: _____

TRAUMA/ABUSE HISTORY

Have you ever experienced a severe trauma? ☐ Yes ☐ No ☐ Maybe. If yes or maybe, please explain: _____

_____

_____

PERSONAL STRENGTHS

Please list three things that you are proud of:

1) _____

2) _____

3) _____

Please list three personal strengths:

1) _____

2) _____

3) _____

RELATIONAL INFORMATION

Current Marital Status: □ Single □ Engaged □ Married □ Separated □ Divorced □ Widowed

On a scale of 1-10, how would you rate your relationship satisfaction? (1 being low and 10 being high)

1 2 3 4 5 6 7 8 9 10

If married, how long? _____ Number of previous marriages for you: _____

If separated or divorced, how long? _____ If widowed, how long? _____

Please list family members and other household members (continue on back if necessary):

Name	In/Out of home	Age	Gender	Relationship

MEDICAL INFORMATION

Primary Physician: _____ City: _____ Zip: _____

Phone number: (_____) _____-_____ Fax number: (_____) _____-_____

Are you currently receiving medical treatment? □ Yes □ No. If yes, please specify: _____

List all current medications you are taking, including those you seldom use or take only as needed.

Medication	Dosage	Purpose for Medication

PREVIOUS COUNSELING

Please list any previous counseling, psychiatric treatment and diagnosis or residential/in-patient care you received:

Location	Therapist	Dates	Reason/Diagnosis

LEGAL HISTORY *Note: Any legal issues must be disclosed to the therapist by the 1st session.

Are you facing any current or future civil or criminal legal issues? ☐ Yes ☐ No

Have you been subject to a restraining order in the last 10 years? ☐ Yes ☐ No

Have you filed for a restraining order in the last 10 years? ☐ Yes ☐ No

Have you experienced any legal issues relating to divorce or child custody in the last 10 years? ☐ Yes ☐ No

Do you expect the possibility of legal issues relating to divorce or child custody in the next 5 years? ☐ Yes ☐ No

CURRENT STATUS

Please check any of the following physiological symptoms that apply to you presently or in the recent past:

Headaches	☐ Past ☐ Present	Visual Trouble	☐ Past ☐ Present	Weakness	☐ Past ☐ Present
Insomnia	☐ Past ☐ Present	Change in Appetite	☐ Past ☐ Present	Hearing Voices	☐ Past ☐ Present
Dizziness	☐ Past ☐ Present	Sleep Trouble	☐ Past ☐ Present	Tension	☐ Past ☐ Present
Intestinal Trouble	☐ Past ☐ Present	Tiredness	☐ Past ☐ Present	Seeing Things	☐ Past ☐ Present
Stomach Trouble	☐ Past ☐ Present	Trouble Relaxing	☐ Past ☐ Present	Rapid Heart Rate	☐ Past ☐ Present
Hearing Noises	☐ Past ☐ Present	Pain	☐ Past ☐ Present	Other	☐ Past ☐ Present

Has your weight changed in the last 2-3 months? (If so, how?) _____

Please check any of the following problems that apply to you and/or your family.

Abortion	☐ You ☐ Family	Eating Problems	☐ You ☐ Family	Trouble with Job	☐ You ☐ Family
Ambition	☐ You ☐ Family	Being a Parent	☐ You ☐ Family	Disaster	☐ You ☐ Family
Anxiety	☐ You ☐ Family	Depression	☐ You ☐ Family	Terminal Illness	☐ You ☐ Family
Bad Dreams	☐ You ☐ Family	Unwanted Thoughts	☐ You ☐ Family	Impulsive Behavior	☐ You ☐ Family
Career Choices	☐ You ☐ Family	Children	☐ You ☐ Family	Recent Loss	☐ You ☐ Family
Communication	☐ You ☐ Family	Verbal Abuse	☐ You ☐ Family	Anger	☐ You ☐ Family
Concentration	☐ You ☐ Family	Memory	☐ You ☐ Family	Self-Control	☐ You ☐ Family
Grief	☐ You ☐ Family	Alcoholism	☐ You ☐ Family	Fears	☐ You ☐ Family
Hopelessness	☐ You ☐ Family	Loneliness	☐ You ☐ Family	Friends	☐ You ☐ Family
Making Decisions	☐ You ☐ Family	Finances	☐ You ☐ Family	Guilt	☐ You ☐ Family
Marriage	☐ You ☐ Family	Emotional Abuse	☐ You ☐ Family	Temper	☐ You ☐ Family
Nervousness	☐ You ☐ Family	Unhappiness	☐ You ☐ Family	Apathy	☐ You ☐ Family
Physical Abuse	☐ You ☐ Family	Sexual Abuse	☐ You ☐ Family	Aggressiveness	☐ You ☐ Family

Have you ever been physically or sexually abused? □ Yes □ No □ Maybe. If yes or maybe, please explain:_____

_____

_____

Have you ever been emotionally or mentally abused? □ Yes □ No □ Maybe. If yes or maybe, please explain:_____

_____

_____

RELIGIOUS/SPIRITUAL INFORMATION

Is Faith, Religion or Spirituality important to you? □ Yes □ No □ Maybe. If yes or maybe, please explain:_____

_____

_____

COUNSELING FEES

Fees are paid at the time of service. If you fail to show for a scheduled appointment or do not call to cancel 24 hours before a scheduled appointment (386-547-2876), I ask that you pay the full amount of the agreed upon fee ($50).

Initial: _____

LEGAL FEES

**The standard fixed rate for an assessment, letter, or other work for any third party (Court System, Lawyer, Investigator, Employer, School, etc.) is $150 per hour.

Sign:_____ Date:_____

**If your counselor receives a subpoena to appear in court, the fee is $150 per hour for communication with your attorney and court preparation, with a minimum of 8 hours for each day subpoenaed to court, plus travel time to and from court. PAYMENT MUST BE PAID IN ADVANCE. (It is our policy to resist all subpoenas.)

Sign:_____ Date:_____

TERMS OF SERVICE

I understand that it is customary to pay for professional services when rendered. I accept full responsibility for payment of any balance incurred for services. I further understand that without 24-hour notice of cancellation, I will be charged $50

CLIENT RIGHTS AND RESPONSIBILITIES

Sandra Bass is committed to providing service to you, the client, without regard to race, sex, color, religion, handicapping condition, national origin, or ability to pay in a manner appropriate to your need.

AS A CLIENT YOU HAVE THE RIGHT TO:

INDIVIDUAL DIGNITY, to be treated in a respectful and confidential manner.

QUALITY SERVICES, suited to your needs, administered skillfully, safely, humanely, with full respect for your dignity and personal integrity, and in accordance with all statutory and regulatory requirements.

WITHDRAW YOUR CONSENT for any specific activity.

CONFIDENTIALITY OF CLIENT RECORDS, your counselor has the obligation to obtain your written consent prior to any exchange of confidential information. There are a few exceptions to confidentiality listed below: If you present a danger to yourself or others, we are legally, ethically and morally required to protect the safety of threatened persons. If abuse or neglect of a child, elder or disabled person is known or suspected, we are required by law to report it to the Florida Abuse Hotline. If your counselor receives a court order for client records, deposition or court testimony, and we are required by law to comply, we will. In the event that group, or family services are provided, it is acknowledged that Sandra Bass cannot be held responsible for a breach of confidentiality on the part of a family member.

AS A CLIENT YOUR RESPONSIBILITIES INCLUDE:

APPOINTMENTS: Regular attendance is very important to ensure progress with the concerns and issues that have been presented. If there is an emergency and you need to cancel or reschedule an appointment, please call as soon as you know.

PARTICIPATION: Your honest and accurate reporting of dilemmas and concerns is vital to your progress. To the best of your ability you must be open and honest in your sessions.

SAFETY: It is important that you and your children exercise appropriate caution, control and safe behavior on the premises.

WEAPONS: No handguns or weapons of any kind are allowed on property.

TERMINATION: Services may be discontinued for repeatedly missed appointments, if you come to appointments intoxicated and/or under the influence of substances, or if you show evidence of inappropriate behavior.

TRANSFER PLAN: Files/Records are the responsibility of your therapist. If the therapist feels you would be best served by another mental health provider, she will recommend other services.

THERAPY INFORMED CONSENT

SERVICES: We provide many different types of therapy and counseling. Counseling services can vary in length depending on the collaborative effort between therapist and client. The goals for counseling are developed with the therapist and are based on the client's needs and concerns and are reviewed on a regular basis to monitor progress. Our counseling services are voluntary. If the client has court documentation for counseling a copy of this documentation must be provided by the next counseling session. When bringing children for counseling services, the adult providing transportation is required to stay on the premises during the session.

FEES: Counseling session fees are based on the client's agreed upon rate, set at the first counseling session. All fees are due at the beginning of each session.

AUDIO/VIDEO TAPES: Videotapes are sometimes used to assist with supervision, consultation, safety and training of counselors working with their clients. These tapes are not considered part of client files and will be used only to assist the progress of the client's case. The tapes are then destroyed on a regular basis. Sessions will not be audio recorded without prior written consent.

TERMINATION: The client is expected to inform the therapist if the client plans to discontinue counseling for any reason. If a client fails to show up or cancel two appointments, their file will be closed. Counselors may have to discontinue therapy if the client is currently involved in domestic violence, substance abuse, or has shown violent or threatening behavior. The client may be given a referral to other more appropriate services for issues of substance abuse, violence, or severe mental health issues.

BENEFITS/RISKS: The majority of individuals and families that obtain counseling, benefit from the process. Self-exploration, gaining insight, exploring options for dealing with problem behavior, learning new skills, or venting difficult feelings and experiences are generally quite useful. But, some risks do exist. As counseling is begun some individuals experience unwanted feelings. Examining your life can produce unhappiness, anger, guilt or frustration. These unwanted feelings are a natural part of the psychotherapeutic process and often provide the basis for change. Also, sometimes a decision that is positive for one family member will be viewed quite negatively by another.

QUESTIONS: Do not hesitate to discuss counseling goals, procedures, concerns, or your impression of services provided. If there is something you do not understand, please ask for a clarification.

I have read and understand the nature and limits of therapeutic services provided by Sandra Bass.

Client:_____ Date:_____

Therapist: _____ Date: _____

Sandra Bass M.S.,L.M.F.T.
302 Dunlawton Ave
Port Orange Fl 32127

Client Agreement:

My sessions are 50 minutes long(that includes payment and rescheduling time).

I understand that Sandra Bass does not assist in any legal cases (disability, workmen's comp, divorce or child custody or any kind of legal suits).

I have up to 24 hours before my assigned appointment time to cancel or I will be charged a cancelation fee of $50 for the first missed session after that the full $150.00 will charged.

All credit cards will be saved to a Square App to reserve appointments.

I can pay for sessions by credit card , cash, or check.

If using insurance I understand that a clinical diagnosis must be given for the insurance company to reimburse. Also I am responsible for all copays and unpaid reimbursements.

I agree to all the above statements:

Signed_____Date:_____