Client Information Sheet

Name:____

Address:____

____

____

Phone Number to best reach you at:________________________

Insurance Information:

Name of Insurance Company:____________________________

Insurance Phone Number for Providers________________________

ID #:____

Group Number:____________________________________

Date of Birth:____________________________________

Consent to Treatment

I acknowledge that I have received, have read, and understand "Information for Prospective and Ongoing Clients." I have had my questions answered adequately at this time. I understand that I have the right to ask questions throughout the course of my treatment and may request an outside consultation. (I also understand that the therapist may provide me with additional information about specific treatment issues and treatment methods on an as-needed basis during the course of my treatment and that I have the right to consent to or refuse such treatment). The therapist might also seek or suggest outside consultation.

I understand that I will be involved in the development of the initial and ongoing treatment plans and can expect regular review of treatment to determine whether treatment goals are being met. I agree to be actively involved in the treatment and in the review process. No promises have been made as to the results of this treatment or of any procedures utilized within it.

I further understand that I may stop my treatment at any time, but agree to discuss this decision first with the therapist. My only obligation, should I decide to stop treatment, is to pay for the services I have already received.

I have been informed that I must give 24 hours notice to cancel an appointment and that I will be charged if I do not cancel or show up for a scheduled appointment.

I am aware that I must authorize this therapist to release information about my treatment but that confidentiality can be broken under certain circumstances of danger to myself or others. I understand that once information is released to insurance companies or any other third party, that my therapist cannot guarantee that it will remain confidential.

My signature signifies my understanding and agreement with these issues and with the additional information conveyed in "Information for Prospective and Ongoing Clients."

______________________________ ______________________

Client Signature Date

Athena Counseling Services, PLLC
Kimberly Whitney, LCSW

8105 Rasor Blvd, Suite 246
Plano, TX 75024
(214) 732-2067

Acknowledgement of Receipt of
Notice of Privacy Practices

Client Name:______________________ SS#:__________________ DOB______________

By my signature below, I ______________________________ acknowledge that I received a copy of the Notice of Privacy Practices for Athena Counseling Services, PLLC.

____ ________________________
Signature of client (or guardian or personal representative) Date

____
Relationship to the client

FOR OFFICE USE ONLY

I attempted to obtain written acknowledgement of receipt of my Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented me from obtaining the acknowledgement
- Other ____

____________________________________ ________________________
Athena Counseling Services PLLC Kimberly Whitney, LCSW Date

Athena Counseling Services, PLLC
Kimberly Whitney, LCSW

8105 Rasor Blvd., Suite 246
Plano, TX 75024
(214) 732-2067

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. I HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)

I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you that I've created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of this health care. I must provide you with this Notice about my privacy practices, and such Notice must explain how, when, and why I will "use" and "disclose" your PHI. A "use" of PHI occurs when I share, examine, utilize, apply, or analyze such information within my practice; PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use of disclosure is made. And, I am legally required to follow the privacy practices described in the Notice. However, I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI on file with me already. Before I make any important change to my policies, I will promptly change this Notice and post a new copy of it in my office. You can also request a copy of this Notice from me, or you can view a copy of it in my office.

II. HOW I MAY USE AND DISCLOSE YOUR PHI

I may use and disclose your PHI for many different reasons. For some of these uses or disclosure, I will need your prior authorization; for others, however, I do not. Listed below are the different categories of my uses and disclosures along with some examples of each category. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures that are permissible under federal and state law.

A. Permissible Uses and Disclosures Without Your Written Authorization

1. **Treatment.** I may use your PHI in order to provide treatment to you. I may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are involved in your care. For example, if you are being treated by a psychiatrist, I may disclose your PHI to your psychiatrist in order to coordinate your care.

2. **Payment.** I may use or disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I may disclose your PHI to permit your health plan or insurance company to take certain actions before it approves or processing companies and others who may process my health care claims.

3. **Health Care Operations.** I may use and disclose your PHI to operate my practice. For example, I may use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professional who provided such services to you. I may use and disclose your PHI in connection with quality improvement activities, training programs, accreditation, certification, licensing or credentialing activities.

4. **Required or Permitted by Law.** I may use or disclose your PHI when I am required or permitted to do so by law. For example, I may disclose PHI to appropriate authorities if I reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. I addition, I may disclose your PHI to the extent necessary to avert a serious threat your health or safety or the health or safety of others. Other disclosure permitted or required by law include the following: disclosure for public health activities, health oversight activities including disclosure to state or federal agencies authorized to access PHPI, disclosure to judicial and law enforcement officials in response to a court order or other lawful process, disclosures for research when approved by an institutional review board, and disclosures to military or national security agencies , coroners, medical examiners, and correctional institutions or otherwise authorized by law. I may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits I offer.

Kimberly Whitney, LCSW
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Dallas, TX 75024
(214) 732-2067

B. Permissible Uses and Disclosures Requiring Your Written Authorization

1. **Psychotherapy Notes.** Notes recorded by me documenting the contents of a counseling session with you will be used only by your clinician and will not otherwise be used without your written authorization.

2. **Marketing Communications.** I will not use your PHI for marketing communications without your written authorization.

3. **Other Uses and Disclosures.** Uses or disclosures other than those described in Section II, A above will only be made with your written authorization. For example, you will need to sign an authorization form before I can send your PHI to your life insurance company, to a school, or to your attorney. You may revoke any such authorization in writing at any time to stop any future uses and disclosures (to the extent that I have not taken any action in reliance on such authorization) of your PHI by me.

III. YOUR INDIVIDUAL RIGHTS CONCERNING YOUR PHI

A. Right to Request Restrictions. You have the right to ask that I limit how I use and disclose your PHI. I will consider your request, but I am not legally required to accept it. If I accept your request, I will put any limits in writing and abide by them except in emergency situations. If I accept your request, you may not limit the uses and disclosures that I am legally required or allowed to make.

B. The Right to Alternative Communications. You have the right to ask that I send information to you at an alternate address (for example, sending information to your work address rather than your home address) or by alternative means (for example, e-mail instead of regular mail). I must agree to your request so long as I can easily provide PHI to you in the format requested.

C. The Rights to See and Get Copies of Your PHI. You may request access to your medical record and billing records maintained by me in order to inspect and request copies of the records. All requests must be made in writing. In certain situations, I may deny your request. I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed. I may charge a fee for the costs of copying and sending you any records requested. (*Note: Sate law may regulate such charges.*) If you are a parent or legal guardian of a minor, please note that certain portions of the minor's medical record will not be accessible to you.

D. The Right to Get a List of the Disclosures I Have Made. You have the right to get a list of instances in which I have disclosed your PHI. The list will not include uses or disclosures that you have already consented to, such as those made for treatment, payment, or health care operations, directly to you, or to your family.

E. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. I will respond within 60 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (i) correct and complete; (ii) not created by me, (iii) not allowed to be disclosed, or (iv) not part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial.

F. The Right to Obtain This Notice. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of it.

IV. QUESTIONS AND COMPLAINTS

If you think that I may have violated your privacy rights you may file a complaint with me at Kimberly Whitney, LCSW, 8105 Rasor Blvd., Suite 246 Plano, TX 75024. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independent Avenue S.W., Washington, DC 20201. I will take no retaliatory action against you if you file a complaint about my privacy practices.

V. EFFECTIVE DATE AND CHANGE TO THIS NOTICE

A. This notice went into effect on January 1, 2006.

B. I may change the terms of this Notice at any time. If I change this Notice I may make the new notice terms effective for all PHI that I maintain, including any information created or received prior to issuing the new notice. If I change this Notice, I will post the revised notice in the office. You may also obtain any revised notice by contacting me at Kimberly Whitney, LCSW, 8105 Rasor Blvd., Suite 246 Plano, TX 75024, (214) 732-2067.

8105 Rasor Blvd., Suite 246
Plano, TX 75024
(214) 732-2067

Athena Counseling Services, PLLC.
Kimberly Whitney, LCSW

NOTICE OF PRIVACY PRACTICES

The privacy of your health information is important to me. I will maintain the privacy of your health information and I will not disclose your information to others unless you tell me to do so, or unless the law authorizes or requires me to do so.

A new federal law commonly known as HIPAA requires that I take additional steps to keep you informed about how I may use information that is gathered in order to provide health care services to you. As part of this process, I am required to provide you with the attached NOTICE OF PRIVACY PRACTICES and to request that sign the attached written acknowledgement that you received a copy of the NOTICE. This notice describes how I may use and disclose your Protected Health Information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. This Notice also describes your rights regarding health information I maintain about you and a brief description of how you may exercise these rights.

If you have any questions, please contact me, Kimberly Whitney, LCSW, at (214) 732-2067.

Athena Counseling Services, PLLC.
Kimberly Whitney, LCSW
8105 Rasor Blvd., Suite 246
Plano, TX 75024
(214) 732-2067

Information for Prospective and Ongoing Clients

I am pleased you have selected me as your therapist. This document is designed to inform you about my background and to ensure that you understand our professional relationship.

I hold a Master of Science in Social Work from University of Texas Arlington and have been a therapist since 2014. I am licensed by the state of Texas as a Licensed Clinical Social Worker (LCSW). My counseling practice includes work with individuals, couples and groups.

The Nature of Counseling

I define mental health as the ability to be honest with oneself and others, to take responsibility for self and the tasks of life, to have a sense of humor and to engage in meaningful, satisfying relationships, work and social activities. I am willing to explore with you how your thoughts, emotions, behaviors, physiology and or spirit are helping or hindering your full enjoyment of mental health. If there are any areas you do not wish to explore, please tell me and we will not discuss those areas. **You are in charge of your therapy. It is okay to say "no" to any suggestion and to ask me "why" I am doing what I am doing.**

I only accept clients in my practice who I believe have the capacity to resolve their own problems with my assistance. I believe that as people become more accepting of themselves, and more aware of their choices, they are more capable of finding contentment in their lives. Some clients need only a few therapy sessions to achieve their goals, while others may require months or even years of therapy. Please feel free at any time to bring up any changes you would like to see in how your counseling proceeds. Your input is an essential part of your therapy process. If therapy is successful, you will feel that you are able to face life's challenges on your own, with the knowledge that future counseling support will be available if needed.

I believe that a counseling relationship is collaborative. What "collaborative" means to me is that you and I meet as equal human beings with different experiences, knowledge and expertise. You are the expert on our life and have many resources within you that will help you meet your goals in therapy. I bring my own life experiences; my training and information about human psychology and behavior that may assist you to meet your goals in therapy. You and I will decide on mutually acceptable goals for therapy and work together to achieve them. We are both responsible for "the work" of therapy.

I am able to provide outpatient psychotherapy services. In other words, I am able to work with people who can be responsible for their part of the working relationship, take care of themselves between sessions and stay safe from harming themselves or others. I will make recommendations and refer to other professionals who can provide more intense therapy for anyone I perceive cannot take responsibility for her/himself or who cannot remain safe between sessions. I believe

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your part of the working relationship is to set goals, make decisions about how you will live your life and solve your problems and take actions on your new decisions. You are also responsible for telling me what is helpful AND what is not helpful. I am responsible for assessing your needs in therapy, and applying what I have learned to best address these needs, encouraging you to take the power within you to make your life work in for making recommendations of other resources to help you achieve your goals.

I do not believe I can help persons if certain conditions occur on a consistent basis. If these conditions occur, I will be unwilling to continue working with you and will make recommendation for other sources of help. The conditions include the following:

If you are prescribed medication by a physician and are not taking it as prescribed by that doctor, I will terminate professional responsibility for your care and make appropriate referrals.

I am unwilling to continue working with you if you are using drugs, alcohol, or sex/love/relationships in a way that I believe is harmful to you or others or that is impairing your progress in therapy. I am willing to work with you if I perceive you are taking positive steps toward stopping harmful abusive or addictive behaviors.

If you arrive for a session under the influence of a non-medically prescribed, mind altering substance, I will not conduct a session with you on that day and will charge you for the session.

If you choose to consistently not follow my recommendations that I deem essential for the maintenance of your mental health, I will notify you of my unwillingness to continue as your therapist and make appropriate referrals.

I will not be able to effectively help you if you consistently engage in self harm or act in violent ways toward persons or property.

I will terminate our relationship if you act in a disruptive, harassing or abusive manner to me, those around me in my place of business or toward any of my family or friends.

If you consistently miss scheduled appointments, we will discuss your continued commitment to therapy and I may recommend termination or referral to other sources of help.

It is important for you to realize that we have a professional relationship and not a personal relationship. Our contact will be limited to the therapy sessions you have with me. You will best be served if our relationship remains strictly professional and if our sessions concentrate exclusively on your concerns.

If you send me an **email**, I will print it out and we will discuss it at your next session.

Cell phone **texting** is for appointment information ONLY.

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(214)732-2067

After you have read this information, please ask me any questions you may have. Keep asking questions until you are satisfied you understand the answers.

Referrals

If, at any time, you should decide that your counseling sessions are not meeting your needs, please let me know so that we can talk about it, and review together the goals that we have set for your therapy. If you continue to feel dissatisfied, I will be happy to provide you with referrals to other therapists.

Fee Policy

My fees are the following:

$130.00.........Per 50 minute session (individual)
$180.00.........Per 50 minute session (couples)
$45.00.........Per 1 ½ hour group therapy
$150.00.........Per hour for consultations on your behalf

The fee for each session will be due and must be paid at the conclusion of each session. Credit cards, cash or personal checks are accepted for payment.

In the event that your check is returned for insufficient funds, you will be expected to pay for the amount of the session plus any fee that my bank charges me for the returned check. *If you have two checks returned for insufficient funds, you will be expected to pay for sessions in cash only.*

Cancellation Policy

In the event that you will not be able to keep an appointment, you must notify me **24 hours** in advance. If I do not receive 24 hours advance notice, you will be responsible for paying a **$65 late cancellation fee** for the session that you missed even if you are using insurance – health insurance does not pay for missed sessions. My voice mail may be reached 24 hours a day, and the date and time of phone calls are recorded. Consistently late cancellations or missed appointments may be cause for termination. Failure to show to scheduled appointment a charge of $130 will be accessed.

Court Testimony

Should I be requested to engage in legal proceedings on a client's behalf, my fee is $200.00 per hour for each hour spent in preparation for testimony, and $200.00 per hour for travel time to and from court. My fee is $200.00 per hour for my time at the courthouse. Should I be called to testify, I require a minimum *prepayment* of four (4) hours of court time, or $400.00. If this prepayment exceeds the final total fee, the excess will be refunded. A retaining fee of $1,500 must be prepaid.

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Request for Records

Should you request a copy of your counseling records, or give permission to another person or organization to request a copy of your counseling records, this office will submit the requested information for a fee of $35.00, *due in advance*. The fee for a written summary of your record is $130.00, *due in advance*. If your insurance company is requesting the information, you may be able to obtain reimbursement from them by submitting a receipt for service from this office.

Records and Confidentiality

All of our communications will become part of the clinical record that is accessible to you on request. I will keep confidential anything you say to me, with the following exceptions:

1. When you authorize release of your records in writing;
2. When the possessory conservator of a child requests access to the child's records, or requests consultation with the therapist;
3. When a court of law subpoenas your record or a therapist's testimony;
4. When there is reasonable concern that harm may come to you or others (i.e., suicide, homicide, child physical/sexual abuse, and neglect);
5. If you have been court-ordered to therapy, information you share may be disclosed to the court or an officer of the court;
6. Certain client information may be given (as required) to any entity responsible for the payment or collection of client fees, and/or
7. Information about your case may be shared within the professional supervision process.

Athena Counseling Services, PLLC.

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Everything that is said in therapy is always kept confidential by your therapist. I am committed to keeping what you tell me private and confidential. However, some laws and careful professional practices may require me to tell others what you have said to me. Please carefully read and initial each of the following statements about some of the situations in which I cannot promise to protect your confidentiality. Changes in the laws and other circumstances out of my control may add situations to the list below may affect your privacy. Please ask questions about what you read and only initial or sign when you are satisfied you understand the answers. In addition to initialing here, you will be given a copy of your privacy rights at your first session. Please take this document home and read it carefully and ask me questions about items you do not understand.

________I understand that my therapist is required by law to report suspected or actual incidents of abuse or neglect of children, the elderly or others unable to care for themselves.

________I understand that the law permits my therapist to notify law enforcement officials or medical professionals if she believes I am dangerously close to harming myself or others.

________My initial here gives my therapist permission to notify the following persons in cases of emergency or if she believes I am dangerously close to hurting myself or others. I understand that my therapist may choose to tell the following persons in order to get me the best help possible.

Name	Address	Phone
1.____________________	______________________________	_____________________
2.____________________	______________________________	_____________________

________I understand my therapist is concerned about the life and safety of all persons and that she may choose to notify any person she perceives I am dangerously close to harming (in addition to notifying law enforcement officials) in order to safeguard my safety and the safety of others.

________I understand my therapist may be required to turn over my mental health records to an attorney or a judge if I am involved in a legal case such as child custody, civil litigation or criminal proceedings.

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________I have been informed that upon termination, my therapy records will be kept for ten years then shredded; that a Custodian of Records has been designated to notify me, refer me and terminate my file should Kimberly Whitney, LCSW, die, become incapacitated or otherwise no longer be able to practice.

_____ I understand my therapist may consult with other professionals concerning my case in order to assure high quality service to me. I understand that she will protect my identity and confidentiality (within the limits listed above) when consulting with other professionals on my behalf.

________I understand that email and other forms of electronic communications are not confidential

My signature below means I have read this form, been given opportunity to ask questions an have received answers to my questions that I understand. My signature also means I am making a voluntary, informed choice to enter a counseling/therapy relationship with Kimberly Whitney, LCSW.

Signature______________________ ____________________ Date___________________________

Athena Counseling Services, PLLC.
Kimberly Whitney, LCSW

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Therapist/Client Contract

In return for a fee of _____________ for an initial intake session, and ______________ per session thereafter, I agree to provide counseling services for you. Sessions are 50 minutes long unless otherwise agreed upon.

Your insurance company, ____________________________________, has agreed to cover _______ EAP sessions at no charge to you. Should you decide to continue in therapy beyond the EAP sessions, and elect to use your insurance, sessions will be billed to your insurance company at the rate of ___________ for an initial session, followed by a fee of ___________ per session thereafter. Your deductible is ___________. Your co-pay will be ___________ for the intake session and ___________ thereafter. Other insurance stipulations include ____.

Unless otherwise agreed, sessions are 50 minutes long.

By your signature below, you are indicating that you agree to this fee. ***Please remember that you are ultimately responsible for payment of services if your insurance company does not pay***. In addition, you are indicating that you have read and understood this document and/or that any questions you have had about this statement have been answered to your satisfaction.

_______________________________________ _____________________________

Client Signature (or Parent/Guardian) Date

_______________________________________ _____________________________

Therapist Date

Intake/Psychosocial Information

Today's Date____/____/_____ Client Name______________________________ Birthdate_____/_____/_____

Relationship Status: _____Single _____Married _____Divorced _____Separated _____Widowed

CURRENT PROBLEM (Please briefly describe when the problem started and why you're seeking help now.)

____

____

____

____

____

Education: _____Grade School _____High School Graduate _____GED _____College Graduate
_____Graduate Degree _____Other

Educational or career goals:____

Jobs held in last five years, including homemaker:_______________________________

____

____

Describe any significant family of origin information that may have impacted your view of the world (such as relationships, family values, moving, divorce, deaths, illnesses, friendships, etc.):

____

____

____

____

Intake/Psychosocial Information

Prior to your 18th birthday:

Did a parent or other adult in the household often or very often, swear at you, insult you, put you down, or humiliate you? Or, act in a way that made you afraid you might be physically hurt?

Did a parent or other adult in the household often or very often push, grab, slap or throw something at you? Or, ever hit you so hard that you had marks or were injured?

Did an adult person at least 5 years older than you ever touch or fondle you, or have you touch their body in a sexual way? Or, attempt or actually have oral, anal or vaginal intercourse with you?

Did you often or very often feel that no one in your family loved you or thought you were important or special? Or, your family didn't look out for each other, feel close to each other, or support each other?

Did you often or very often feel that you didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? Or, your parents were too drunk or high to take care of you or take you to the doctor if needed?

Were you parents ever separated or divorced?

Was your mother or stepmother often or very often pushed, grabbed, slapped or had something thrown at her? Or, very often kicked, bitten, hit with a fist, or hit with something hard? Or, ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs or suffered with another addiction such as sex/porn or gambling?

Did you have a household member who suffered from depression, or was mentally ill, or attempted or completed suicide?

Did you have a household member who went to jail/prison or was deported?

Prior to Your 18th Birthday (continued)

Did you ever experience homelessness or been in foster care?

Did you have to move or change schools a number of times?

Did you ever experience a major illness or injury of a family member, or have you ever been extremely ill or injured?

Did you ever experience the death of a very close friend or family member?

Have you ever been pregnant or gotten someone pregnant?

Intake/Psychosocial Information

DRUGS/ALCOHOL

_____self
_____family

ADDITIONAL INFORMATION

_____yes	_____no	Do you feel you are a normal drinker?
_____yes	_____no	Do friends or relatives think you are a normal drinker?
_____yes	_____no	Have you ever attended a meeting of Alcoholics Anonymous (AA)?
_____yes	_____no	Have you ever lost friends/relationships because of drinking?
_____yes	_____no	Have you ever gotten into trouble at work because of drinking?
_____yes	_____no	Have you ever neglected your obligations, your family or your work for two or more days in a row because of drinking?
_____yes	_____no	Have you ever had delirium tremors (DTs), severe shaking, heard voices or seen things that weren't there after heavy drinking?
_____yes	_____no	Have you ever gone to anyone for help about your drinking?
_____yes	_____no	Have you ever been in a hospital because of drinking?
_____yes	_____no	Have you ever been arrested for drunk driving or driving after drinking?

WHICH OF THE FOLLOWING (IF ANY) HAVE YOU USED?

	Within 1 year	Past	Never	Additional Information
Marijuana	_____	_____	_____	
Cocaine	_____	_____	_____	
Tranquilizers	_____	_____	_____	
Sleeping Pills	_____	_____	_____	
Pain Medication	_____	_____	_____	
Others	_____	_____	_____	

_____yes	_____no	Have family or friends ever expressed concern over your use of drugs?
_____yes	_____no	Have you ever been arrested for any offense involving drugs?
_____yes	_____no	Have you ever been treated for chemical dependency?
_____yes	_____no	Have you ever overdosed on drugs (*accidental or purposefully*)?

Intake/Psychosocial Information

Family History	Name	Age	Emotional Problem (describe)	Drug/Alcohol Problems (describe)
Yourself				
Mother				
Step-mother				
Father				
Step-father				
Brothers				
Sisters				
Spouse				
Children				

Describe any developmental difficulties you might have had:

How would you describe your mother?

How would you describe your father?

Your counseling or psychiatric history (past issues dealt with in therapy, past psychiatric hospitalizations, etc.)

Current Medications:

Past psychotropic medications (such as for anxiety, panic, depression, mood imbalances, ADHD, etc.)

What are some of your best strengths?

If things were as you wished, what would be different in your life right now?

Thank you for completing the intake information.