



**NEW CLIENT INFORMATION – Adult Assessment**

Date: \_\_\_/\_\_\_/\_\_\_

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

Sex:  Female  Male Marital Status:  Single  Married  Other Employed:  Yes  No

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

May we contact you and leave messages at these phone numbers?  Yes  No

Home Address: \_\_\_\_\_  
(Street) (City) (State) (Zip Code)

May we mail information to this address:  Yes  No

If “no” please give mailing address: \_\_\_\_\_

Email: \_\_\_\_\_ May we email information to you?  Yes  No

Employer: \_\_\_\_\_ Position: \_\_\_\_\_

Previous Employers: \_\_\_\_\_

Level of education completed and name of school: \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_

Primary concern: \_\_\_\_\_

Physician: \_\_\_\_\_ Date of last physical exam: \_\_\_\_\_

Current medications: \_\_\_\_\_

**FINANCIALLY RESPONSIBLE PARTY**

Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

Sex:  Female  Male Marital Status:  Single  Married  Other

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Home Address (if different): \_\_\_\_\_  
(Street) (City) (State) (Zip Code)

Contact Number (if different): \_\_\_\_\_ Social Security #: \_\_\_/\_\_\_/\_\_\_

**ADDITIONAL INFORMATION**

Who currently resides in the household with you? \_\_\_\_\_

\_\_\_\_\_

**Family**

<i>Relationship</i>	<i>Name</i>	<i>Age</i>	<i>Current Occupation/Employer</i>	<i>Highest level of education completed</i>
Mother				
Father				
Spouse/Partner				
Child/Sibling				
Child/Sibling				
Child/Sibling				
Child/Sibling				
Child/Sibling				

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

**Condition**

**Family member**

Alcohol/Substance Abuse	<input type="radio"/> yes	<input type="radio"/> no	_____
Anxiety	<input type="radio"/> yes	<input type="radio"/> no	_____
AD/HD	<input type="radio"/> yes	<input type="radio"/> no	_____
Depression	<input type="radio"/> yes	<input type="radio"/> no	_____
Domestic Violence	<input type="radio"/> yes	<input type="radio"/> no	_____
Eating Disorders	<input type="radio"/> yes	<input type="radio"/> no	_____
Obesity	<input type="radio"/> yes	<input type="radio"/> no	_____
Obsessive Compulsive Disorder	<input type="radio"/> yes	<input type="radio"/> no	_____
Schizophrenia	<input type="radio"/> yes	<input type="radio"/> no	_____
Suicide Attempts	<input type="radio"/> yes	<input type="radio"/> no	_____

**Education**

Please list where you went to school and describe your experiences. Please include specific institution names, locations and dates/ages when known. **BE AS THOROUGH AS POSSIBLE.**

ELEMENTARY SCHOOL: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

JUNIOR HIGH SCHOOL: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

HIGH SCHOOL: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

COLLEGE: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Health**

How would you rate your current physical health? (please select one)

Poor    Unsatisfactory    Satisfactory    Good    Excellent

Please list any specific health problems you are currently experiencing: \_\_\_\_\_  
\_\_\_\_\_

Have you previously received or are you currently receiving any type of mental health services (psychotherapy, psychiatric services, etc.)?    Yes    No      If yes, when? \_\_\_\_\_

If yes, please list name(s) of past/current therapist/practitioner and issues seen for: \_\_\_\_\_  
\_\_\_\_\_

Have you ever been prescribed psychiatric medication?    Yes    No

If yes, please list which medications/ when prescribed: \_\_\_\_\_  
\_\_\_\_\_

Are you currently taking any over-the-counter medication (vitamins, allergy medication, etc.)?    Yes    No

If yes, please list: \_\_\_\_\_  
\_\_\_\_\_

Do you have any past medical problems?    Yes    No

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

Have you had any injuries such as broken bones or head injuries?    Yes    No

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

Do you have any allergies?    Yes    No

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

Do you have any problems with vision or hearing?    Yes    No

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

How many times per week do you generally exercise? \_\_\_\_\_

What types of exercise do you participate in? \_\_\_\_\_  
\_\_\_\_\_

Please list any difficulties you are experiencing with appetite or eating patterns: \_\_\_\_\_

How would you rate your current sleeping habits? (please select one)

Poor  Unsatisfactory  Satisfactory  Good  Excellent

Please list any specific sleep problems you are currently experiencing: \_\_\_\_\_

Usual Bedtime: \_\_\_\_\_ How long to fall asleep? \_\_\_\_\_

Do you sleep through the night?  Yes  No

If you wake, how long does it take to fall back asleep? \_\_\_\_\_

Do you often take naps?  Yes  No

Do you have difficulty getting up in the morning?  Yes  No

Are you currently experiencing overwhelming sadness, grief or depression?  Yes  No

If yes, for approximately how long? \_\_\_\_\_

Are you currently experiencing anxiety, panic attacks or have any phobias?  Yes  No

If yes, when did you begin experiencing this? \_\_\_\_\_

Are you currently experiencing any chronic pain?  Yes  No

If yes, please describe: \_\_\_\_\_

Have you had any previous involvement with the police or the courts?  Yes  No

If yes, please describe: \_\_\_\_\_

What significant life changes or stressful events have you experienced recently? \_\_\_\_\_

What prompted you to initiate AD/HD testing? \_\_\_\_\_

**CONFIDENTIALITY STATEMENT**

All information shared in this treatment is confidential except in circumstances governed by law. If you would like us to confer with another healthcare professional, school, attorney or anyone else pertaining to the client, you will need to sign a "Release of Information" form. Both parties agree to take all reasonable measure to ensure confidentiality with any communication over the telephone and/or Internet.

**CONSENT TO AUDIO/VIDEO RECORDING**

The undersigned understands that sessions for assessments and evaluations may be audio recorded or videotaped for note-taking purposes only. The audio/video will be stored in a locked cabinet and is subject to the same degree of confidentiality and security as medical records. If you do not agree to taping and/or recording of any sessions with the clinician, you will need to advise the clinician before the session begins. If you consent to audio/video recording, please initial to the right. **INITIAL \_\_\_\_\_**

**FINANCIAL AGREEMENT**

The fee for the assessment is \$\_\_\_\_\_, your initial payment is \$\_\_\_\_\_ and the final payment is \$\_\_\_\_\_. Additional professional services rendered at your request, such as phone contact over 5 minutes, consults with other professionals, preparation of special forms, reports, letters, etc. will be billed at the rate of \$140.00 per hour with a \$100 minimum. If additional copies of the report are requested by the client, or on behalf of the client, there will be a fee of \$25 per report. If we are involved in any legal endeavors on your behalf and/or are subpoenaed, there will be an upfront payment of \$200 per hour. **INITIAL \_\_\_\_\_**

**NO-SHOW/LATE CANCELLATION POLICY**

Your visit has been reserved for you. 48 business hours' notice is required to give us ample time to fill your appointment. If you do not cancel prior to 48 business hours there will be a no show/late cancel fee of \$130.00 per hour. Please note that reminders are sent by our administrative staff to assist you in remembering your appointment but are done as a courtesy and should not be relied upon. Absence of a reminder from our office does not relieve you of your responsibility to adhere to the cancellation policy. **INITIAL \_\_\_\_\_**

**PAST DUE BALANCE**

The undersigned understands and agrees to accept full financial responsibility for all charges. The clinician reserves the right to collect payment from the client and/or client's guarantor. Should the account be referred to an attorney or collection agency, the undersigned will be responsible for actual attorney fees and/or collection expenses.

**CREDIT CARD INFORMATION:** Credit Card  Visa  MasterCard

I authorize **Stone Creek Psychotherapy** to keep my signature on file and to charge my account for recurring charges, on-going treatment and account balances. I understand that this form is valid for 4 years unless I cancel through written notice to the health care provider.

Client's Name: \_\_\_\_\_ Card Holder's Name: \_\_\_\_\_

Credit Card #: \_\_\_\_\_ Exp. Date: \_\_\_\_/\_\_\_\_ 3-digit CVD code: \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Payment is due before each session. Fees are subject to change**

**NOTICE OF PRIVACY PRACTICE**

The notice in our waiting area describes how psychological and health information about you may be used and disclosed and how you can get access to this information.

I have read and received (if requested) and understand the privacy practices information. I understand that my signature on this form acknowledges receipt of these documents and acceptance of the conditions of the privacy policies of Stone Creek Psychotherapy and Wellness Center.

**STATEMENT OF UNDERSTANDING:**

I have read and understand this information sheet and informed consent.

\_\_\_\_\_  
Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

**Regarding release of mental health medical records for adults and minors:**

Texas Health and Safety Code, Chapter 611, Mental Health records, specifically Sections:

611.0045 (c) If the professional denies access to any portion of a record, the professional shall give the patient a signed and dated written statement that having access to the records **would be harmful to the patient's physical, mental, or emotional health** and shall include a copy of the written statement in the patient's records.

**INITIALS** \_\_\_\_\_

**CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION**

I, \_\_\_\_\_ authorize \_\_\_\_\_,  
Client Therapist's Name

**Mark the one(s) that apply to you:**

To disclose and discuss financial and scheduling information to anyone who is or may be responsible for payment of all or a portion of the charge. **INITIAL** \_\_\_\_\_

To disclose and discuss clinical and treatment information with \_\_\_\_\_  
Other Mental Health Provider's Name OR Attorney/Law Firm

To exchange clinical information, such as diagnosis, treatment goals, and medication issues with my physician, \_\_\_\_\_, for the purpose of treatment planning and coordination.  
Physician's Name

Contact phone number and address: \_\_\_\_\_

To disclose and discuss clinical and treatment information with, \_\_\_\_\_ and/or \_\_\_\_\_  
School Name Counselor(s) /Teacher(s)

To disclose and discuss clinical and treatment information with, \_\_\_\_\_  
Spouse/Other  
please explain: \_\_\_\_\_

I prefer that no clinical and/or medical information be released at this time.

I, the undersigned, understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that in any event this consent shall remain in effect unless revoked or replaced. Specification of the date, event or condition upon which consent expires: \_\_\_\_\_

\_\_\_\_\_  
**Client Name (Please print)**

\_\_\_\_\_  
Witness

\_\_\_\_\_  
**Client Signature**

\_\_\_\_\_  
Date

To the party receiving this information: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

## **Appointment Reminders and Online Appointment Scheduling**

You can receive an appointment reminder to your email address, your cell phone (via a text message), or your home phone (via a voice message) 48 hours before your scheduled appointments.

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Client name: \_\_\_\_\_

Your name: \_\_\_\_\_

Your email address: \_\_\_\_\_

Your home phone number: \_\_\_\_\_

Your cell phone number: \_\_\_\_\_

Where would you like to receive appointment reminders? (check one)

Via a text message on my cell phone (normal text message rates will apply)

Via an email message to the address listed above

Via an automated telephone message to my home phone

None of the above. I'll remember my appointments on my own.  
(Missed appointment fees will still apply)

Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private and requesting that it be handled as I have noted above.

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Signature

-----  
Date