Grace Counseling

606 S. Tyndall Parkway
Panama City, FL 32404
850.872.1188 | goodnessofgodchurch.com

Client Name:_____

Date of Birth (mm/dd/yyyy):_____ Age_____ Sex_____

I give my permission to contact me at the following mailing address:

Address:_____

City/State:_____ Zip:_____

I give permission to call and leave messages for me at the following phone numbers:

Home:_____ Cell:_____ Work:_____

Employer:_____ Position:_____

SSN: ____-___-_____

Spouse/Guardian Name:_____ Age:_____

Address (if different):_____

Home:_____ Cell:_____ Work:_____

Children	Age	School/Grade	Married	Location
_____	_____	_____	Y/N	_____
_____	_____	_____	Y/N	_____
_____	_____	_____	Y/N	_____
_____	_____	_____	Y/N	_____

Family Physician:_____ Phone:_____

Religious Affiliation:_____

How did you hear about us:_____

Have you sought counseling previously? Y / N If Yes, with whom:_____

When (mm/dd/yyyy – mm/dd/yyyy): _____

Client Signature:_____ Date:_____

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Dear Client:

My intention is to help you find the solution to your problem(s). I operate from a Christian worldview, and I believe that with God's help, my facilitation and your cooperation, we can harness the internal and external resources you have to alleviate the problem(s). How you take care of your body, mind (soul) and spirit are important to me. I will ask questions in these areas and welcome questions. I will listen to your problem(s), look for your strengths and clarify any negative patterns that have persisted in your life. As your therapist, I am available to provide a safe and trusting environment, where you are encouraged to change and grow individually, in relationship to others and to the Trinity. Individual, marital and family therapy is available to you.

Additional policies regarding confidentiality:

- Any reasonable suspicion of child abuse, physical or sexual, is required by the State of Florida to be reported to the Department of Health and Rehabilitative Services.
- If you utilize third-party payment to reimburse yourself, information you have authorized therapist to disclose may be available for retrieval by others.
- If you disclose to your therapist that you intent to harm yourself, confidence with be broken and appropriate persons will be notified for your physical protection.
- IN cases where outside consultation or referral is deemed necessary, you will be asked to sign an Authorization to Disclose Confidential Information form to provide information about your case. No information is released without your written consent.
- Records may be subpoenaed in some court cases.

I, _____ have read the above policies regarding fees and confidentiality and agree to these conditions for services.

Client Signature:_____ Date:_____

Guardian Signature:_____ Date:_____

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Authorization to Use and Disclose Protected Health Information

1. I am completing this form to allow the use and sharing of protected health information about

Printed Name:_____ Date of Birth:_____

2. I authorize this person or organization:_____

_____

3a. To use or disclose the following information:

- Inpatient or outpatient treatment records for physical and/or psychological, psychiatric, or emotional illness or drug and/or alcohol abuse.
- Admission and discharge summaries
- Psychological or psychiatric evaluation(s), reports, assessments, treatment notes, summaries, or other documents with diagnoses, prognoses, recommendations, or testing records, and behavioral observations or checklists completed by any staff member or the patient, or similar documents.
- Treatment, recovery, rehabilitation, aftercare plans and other similar plans.
- Progress, nursing, case or similar notes.
- Evaluations and reports of consultants.
- Information about how the patient's condition(s) affects or has affected his/her ability to work, and to complete tasks or activities of daily living.
- Vocational evaluations and reports.
- Billing records.
- Academic and educational records, including achievement and other tests' results, reports of teachers' observations and all other school or special education documents.
- HIV-related information and drug and alcohol information contained in these records will be released under this authorization unless indicated here: ____Intials: Do Not Release These
- Complete copy of medical record.
- Other:_____

3b. Dates of care included from:_____to_____
AND From:_____ to_____
AND From:_____ to_____

4. To this person or organization:_____
_____

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5. The information will be used/disclosed for the following purposes:_____

_____

_____

6. I understand and agree that this Authorization will be valid and in effect until

_____ (Enter date or event upon which this Authorization expires.) I understand that after that date/event , no more of this information can be used/released to the person or organization unless I sign a new Authorization like this one.

7. I understand that I can revoke or cancel this authorization at any time by sending a letter to the Privacy Office of the organization listed above and which is to supply this information. If I do this, I will prevent any releases after the date it is received by can not change the fact that some information may have been sent to shared before that date.

8. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the professional or facility listed at number 4 above, nor will it affect my eligibility for benefits.

9. I understand that I may inspect and have a copy of the health information described in this authorization.

10. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations.

11 I understand that his professional or facility will received compensation for the use or disclosure of my health information. The arrangement has been explained to me and I understand and accept it. _____ Initials: DOES NOT APPLY

12. I affirm that everything in this form that was not clear to me has been explained, and I believe I now understand all of it:

_____ _____
Signature of client or his/her personal representative Date

_____ _____
Printed name of client or personal representative Relationship to client

_____

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Description of personal representative's authority

14. _____Initials: I acknowledge that I received a copy of this completed form

15. I, a mental health professional, have discussed the issues above with the client and/or his/her personal representative. My observations of his/her behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____
Signature of professional Date

_____
Printed name of professional

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Client Name:_____ Date:_____

Referral Information:
How did you hear about our services? Circle all that apply.

Physician	Counselor	Church Website
Court referral	Employer	Search Engine
Insurance company	Base Referral	
Other: _____		

Name of person who referred you to our center:_____

Presenting Problem(s):

Why are you seeking help at this time? _____

_____

_____

_____

Please check any of the following problems you or your family have experienced which may have contributed to your seeking help. Briefly explain each problem checked below.

___Family/Marital Conflict
___Work Problems
___Significant Medical Problems
___Legal Problems
___Shoplifting/Stealing
___Lying
___Grief/Loss Issues
___Depression
___Suicidal thoughts/gestures
___Verbal/Emotional Abuse Victim
___Verbal/Emotional Abuse Offender
___Childhood Sexual Abuse
___Alcohol/Substance Abuse
___Physical Abuse Victim
___Physical Abuse Offender
___Sexual Abuse Victim
___Sexual Abuse Offender
___Domestic Violence Victim
___Domestic Violence Offender
___Sexual Orientation Issues
___Abortion Issues
___Eating Disorder Issues
___Adoption Issues
___Anger Control Issues
___Sexual Dysfunction Issues
___Other

_____

_____

_____

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Family History: _____

_____

_____

Child Development History (*Complete ONLY if client is a child.):*

A. *Pregnancy History: Complications or normal pregnancy? Explain.*

_____

_____

_____

B. *Deliver History: Complications with deliver or normal? Explain*

_____

_____

_____

C. *Infancy History:*

_____

_____

_____

D. *Preschool History:*

_____

_____

_____

E. *Educational History:*

_____

_____

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How many children do you have? _____

Name	Age	Gender	Currently Living with you?
_____	_____	M / F	Y / N
_____	_____	M / F	Y / N
_____	_____	M / F	Y / N
_____	_____	M / F	Y / N

Describe any recent changes in your life:_____

_____

Identify any recent or significant death or losses in your family and how you were affected: _____

_____

_____

How are you coping with your current difficulties?_____

_____

_____

Medical History:

Have you or your family members ever had any of the following? Explain all checked answers below.

___Asthma/Bronchitis
___Hyperactivity
___Hypertension
___Tuberculosis
___Liver Problems
___Stomach Problems
___Hospitalizations
___Epilepsy
___Cancer
___Diabetes
___Hepatitis
___HIV
___Heart Conditions
___Accident related injuries
___Other

_____
_____

Are your immunizations up to date? Y/ N If *NO*, what is needed?_____
_____

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Are you currently taking an medications? Y / N If so, please list below:

Name	Why Prescribed?	Strength	Frequency	Last Use
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Psychiatric/Counseling/Treatment History:

Have you ever been treated or evaluated for a psychiatric or addiction issue? Y / N
(If yes, continue to next question.)

1. Facility/Counselor/Physician_____
   When?_____ How long?_____ Reason_____
   _____
2. Facility/Counselor/Physician_____
   When?_____ How long?_____ Reason_____
   _____
3. Facility/Counselor/Physician_____
   When?_____ How long?_____ Reason_____
   _____

Describe your previous experience with counseling and/or treatment. _____

_____

_____

Was it helpful? Y / N

Why or why not? _____

_____

_____

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Education:

Highest level of formal education completed:_____ GED? Y /N

If you completed college or Vocational training, identify any degree, certification, trade, etc._____

Employment History:

Occupation:_____ Employer:_____

How long at job?_____ Satisfaction?_____

If unemployed, why?_____

How long?_____ Last Employer?_____

If unemployed, how do you support yourself financially?_____

How many jobs have you held in the last 5 years? _____

Have you ever been fired/laid off from a job? Y / N If yes, please describe circumstances_____
_____
_____

Military History:

Have you ever served in the military service? Y / N Branch:_____

Honorable Discharge? Y / N Explain:_____

Combat Experience? Y / N Describe:_____

Describe any effect military service has had on your current difficulties:_____

_____

_____

_____

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Have you experienced any of the following depressive symptoms?

Symptoms	Currently	Past History
Feeling down most every day	_____	_____
Loss of pleasure in almost all things	_____	_____
Significant weight loss or gain	_____	_____
Over or under sleeping	_____	_____
Over or under activity	_____	_____
Feelings of worthlessness/hopelessness	_____	_____
Recurrent thoughts of death	_____	_____

Explain:_____

_____

_____

_____

Have you experienced any of the following anxiety symptoms?

Symptoms	Currently	Past History
Restlessness	_____	_____
Easily fatigued	_____	_____
Difficulty concentrating	_____	_____
Mind goes blank	_____	_____
Irritability	_____	_____
Muscle Tension	_____	_____
Disruptive sleep	_____	_____

Explain:_____

_____

_____

_____

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Marital History:_____

_____

_____

_____

_____

_____

_____

Divorce History:_____

_____

_____

_____

_____

_____

_____

Custody Arrangements:_____

_____

_____

_____

_____

_____

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Social and Cultural Influences:

Who or what makes up your support system(s)- i.e. friends, family, church, etc.? _____

_____

_____

Identify any social or cultural influences which may influence your treatment:_____

_____

_____

Describe your relationship with peers:_____

_____

_____

Has your peer group changed in the year? Y / N If *Yes*, explain:_____

_____

_____

Spiritual Orientation:

Religious Affiliation:_____

Describe the impact spirituality has had on you, and whether you see religion as impacting your current difficulties:_____

_____

_____

How would you describe your most important values?_____

_____

_____

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Legal Status:

Have you ever had any legal charges against you? Y / N
If *Yes*, what for?_____

_____

_____

Do you currently have any pending legal charges? Y / N
If *Yes*, what for?_____

_____

_____

Are you currently on probation or parole? Y / N
If *Yes*, what for?_____

_____

_____

Who is your Probation/Parole Officer?_____

Address_____ Phone Number_____

Leisure Activities:

What do you do for fun?_____

_____

_____

_____

How often do you include these activities into your schedule?_____

_____

_____

_____

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Patient/Family's Expectation of the Treatment Program:

What do you want to accomplish during the course of treatment here?_____

_____

_____

_____

_____

_____

_____

_____

Please identify any handicaps you might have which may impact treatment (i.e. deaf, illiterate, etc.)_____

_____

_____

_____

_____

_____