

Rock Landing Psychological Group
Adult Client Information

Please Print

Name: _____ Date: _____

Marital Status: Single Married Separated Divorced Widowed

Date of Birth: _____ Female Male Race: _____

Address: _____

City/State/Zip: _____

Home Phone: _____ Cell: _____ Pager: _____

Employer/ School _____ Work Phone: _____

Occupation: _____ SSN: _____

Emergency Contact: _____ Phone: _____

If different than above, Guarantor Information (Responsible Party)

Relationship to Client: Spouse Parent Guardian

Name: _____

Address: _____

Date of Birth: _____ Female Male SSN: _____

Employer: _____ Occupation: _____

Home Phone: _____ Work/Other Phone: _____

Insurance Information

Primary Insurance: _____ Effective Date: _____

Subscriber Name: _____ Subscriber SSN: _____

Policy ID#: _____ Group #: _____

Subscriber's Employer: _____ Work Phone: _____

Secondary Insurance: _____ Effective Date: _____

Subscriber Name: _____ Subscriber SSN: _____

Policy ID#: _____ Group #: _____

Subscriber's Employer: _____ Work Phone: _____

Treatment Contract

Insurance and Financial Policy Statement

Thank you for choosing Rock Landing Psychological Group for counseling. As part of providing high-quality services, we need to clarify our financial policies. Should you have any questions regarding the practice policies, please ask a member of the staff for clarification.

If you are using your health insurance benefits, we will bill your insurance company. To do so, we need you to provide us with accurate and timely information regarding your insurance. **All co-pays, deductibles, and denied payments are your responsibility.** Your health insurance company may require you to make a co-payment and/or satisfy a deductible. The co-payment is determined by your health insurance company and is due at the time of service. If you have a deductible which has not been met, then full fee is due until the deductible has been met.

I authorized a release of information to my health insurance company and I assign all benefits to Rock Landing Psychological Group.

Late Cancellation/No Show Fee

Rock Landing Psychological Group requires 24 hours notice for routine cancellations. Late cancellations and no shows will incur a \$45.00 charge to be paid at your next scheduled session. Please note that your health insurance company will not cover this fee. The practice has a 24 hour answer service to take your cancellations. Please call (757) 873-1736 and the service will take the message and fax to the office. At the time of check-out you are given an encounter form with the date of your next scheduled appointment. Upon request the staff will be glad to give you an appointment card. Our office does not make reminder calls for appointments.

Client Signature: _____ Date: _____

Consent to Treatment

I do hereby seek and consent to take part in the treatment provided by Rock Landing Psychological Group.

I understand that developing a treatment plan with my provider(s) and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures rendered by my provider(s).

I am aware that I may stop treatment with my provider(s) at any time. I will still be responsible for payment of services I have already received.

Signature: _____

Coordination of Treatment

If I am referred to any other clinician or physician at Rock Landing Psychological Group, I give my consent for those clinicians to obtain and release pertinent information to each other for the purpose of coordinating my care.

Signature: _____

Agreement

I hereby attest that all information contained in these pages is current and correct. I understand that I am responsible for informing Rock Landing Psychological Group of any changes. Failure to do so may delay processing of insurance claims, in which case I will incur responsibility for those unpaid claims. Falsification of this information is punishable under Federal Law.

I have received a copy of the Notice of Privacy Information Practices (HIPAA) pertaining to this practice.

Client Signature: _____ Date: _____

Responsible Party Signature: _____ Date: _____

Permission to Call

We will need to reach you to verify or discuss an appointment. Please indicate below how you would prefer us to contact you.

I DO ____ DO NOT ____ Give permission to call my home and/or leave a message there.

I DO ____ DO NOT ____ Give permission to call my place of employment and/or leave message.

I DO ____ DO NOT ____ Give permission for my spouse to coordinate any appointments for me.

I DO ____ DO NOT ____ Give my parents permission to coordinate appointments for me.

I prefer to be contacted at the following number: _____

Referral Information

Who referred you to this practice: _____

May we have permission to thank them for your referral? Yes No

Have you been seen here before? Yes No If “yes” please give approximate date and reason for seeking counseling: _____

Additional Information

Name of Spouse/Partner: _____ Age: _____

Name of Children	Age of Children

Your Education & Training:

- Pre-School to High School Grade ____
- High School Diploma/GED
- Vocational/Technical School
- College
- Graduate/Professional School

Are you currently involved in the legal system? If “yes” please check all which apply:

- Arrest for _____
- Applying for Disability
- Child Custody
- DUI/DWI
- Divorce
- Bankruptcy
- Lawsuit

Brief Health Information

1. List all medications you take:

Medication/Drug	Dose	Taken for

2. List all diseases, illnesses, significant accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, seizures, and any other medical conditions you have or have had.

Age	Illness	Treatment	Treated By	Result

3. Are you now being treated for any medical condition? Yes No

4. When was your last medical exam? _____

5. Your health is: Excellent Good Fair Poor

Brief Health Information (continued)

6. Describe any allergies you have: _____ No Allergies/Adverse Reactions

To What	Reaction You Have	Allergy Medication You Take

7. Have you done any kind of work during which you were exposed to toxic chemicals?

Date	Chemicals	Kind of Work	Effects

8. Health Habits:

Do you smoke cigarettes? No Yes # of packs per day: _____

Use other tobacco products? No Yes Use per day: _____

Do you drink alcohol? No Yes Drinks per: Day ___ Week ___ Month ___
 Drunk per: Day ___ Week ___ Month ___

How many cups of caffeinated beverages do you drink each day (coffee, tea, cola)?
 None # _____

Do you frequently take over-the-counter medications? No Yes
 Aspirin/Tylenol/Ibuprofen Antihistamines Antacids Laxatives

Do you take vitamins/food supplements? No Yes
 What? _____

Do you use street drugs? No Yes Which ones? _____

Do you engage in any of the following? Restrict food intake Binge eating Use Laxatives
 Self-induced vomiting Over-eat

How often do you exercise? Never times a week times a month

9. Mental Health History

Have you ever had a psychiatric hospitalization? No Yes

If the answer is yes: Date(s): _____

Facility: _____

Reason: _____

Was it helpful? Yes No

Have you ever had mental health/family/marriage counseling? No Yes

If the answer is yes: Date(s): _____

Counselor: _____

Was it helpful? Yes No

Have you ever been under the care of a psychiatrist? No Yes

If the answer is yes: Date(s): _____

Provider: _____

Was it helpful? Yes No

Have you ever thought a lot about trying to harm or kill yourself? No Yes

If the answer is yes: When: _____

Where: _____

Have you every tried to harm or kill yourself? No Yes

If the answer is yes: When: _____

Where: _____

Name _____ Date _____

Please mark all of the items below that apply, and add any others at the bottom of the next page under “Additional concerns or issues.”

Mood

- Anger, hostility, arguing, irritability
- Aggression, violence
- Nervousness, panic/anxiety attacks
- Crying spells
- Depression, low mood, sadness
- Emptiness
- Failure
- Fatigue, tiredness, low energy
- Fears, phobias
- Grieving deaths, losses, divorce
- Guilt
- Hopelessness
- Loss of control, outbursts
- Inferiority
- Loneliness
- Low self-esteem
- Mood swings
- Nervousness, tension
- Pessimism
- Shyness
- Stress, tension
- Suspiciousness
- Suicidal thoughts
- Withdrawal, isolating

Relationship Problems

- Children, child management, child care, parenting
- Childhood issues (own childhood)
- Child custody/visitation
- Dependence
- Marital conflict, infidelity/affairs
- Sexual issues, dysfunctions, desire differences, etc.
- Family conflict
- Friendships
- Interpersonal conflicts
- Divorce, separation

Substance Use Problems

- Alcohol abuse/dependency
- Over-the-counter medications
- Prescription medications
- Smoking and tobacco use
- Street drugs

Health Problems & Concerns

- Overeating
- Under-eating/food restriction
- Binging
- Vomiting
- Illness/injury
- Medical concerns
- Physical problems
- Headaches
- Menstrual problems
- PMS
- Menopause
- Self-neglect, poor self-care
- Sleep to much
- Sleep to little
- Insomnia
- Nightmares

Adult Checklist of Concerns (continued)

Problems with thinking

- Attention, concentration, distractibility
- Decision making, indecision, mixed feelings, putting off decisions
- Obsessions, compulsions (thoughts or actions that repeat)
- Delusions (false ideas)
- Memory problems
- Confusion

Abuse

- Physical
- Sexual
- Emotional
- Neglect (of child or elderly)
- Cruelty to animals

Employment/Career Problems

- Career goals
- Career choices
- Over-working
- Problems with co-workers
- Unemployment
- Can't keep a job

Financial/Legal Problems

- Bankruptcy
- Consumer debt
- Impulsive spending
- Low income
- Gambling
- Arrest
- Lawsuit
- DWI/DUI

Other Problems

- Over sensitivity to rejection
- Perfectionism
- Procrastination
- Self-centeredness
- Low motivation, laziness
- Judgment problems, risk taking
- Irresponsibility

Additional concerns or issues: _____

Please look back over the concerns you have checked off and choose the one which you most want help with . It is: _____