Help Begins Here ...

Central Florida Counseling & Psychological Services, Inc
1514 W. Main St., Leesburg, Fl 34748
(phone)352-365-6506 (fax)352-365-6596

CONFIDENTIAL PATIENT INFORMATION

(Please Print)
Name: _____
First Middle Last
Address: _____
Number Street City State Zip
Mailing Address (If Different):_____
Number Street City State Zip
Please indicate the best number to reach you May we call you: May we leave a message:
Home Phone: ( ) _____ Yes or No Yes or No
Work Phone: ( ) _____ Yes or No Yes or No
Cell Phone: ( ) _____ Yes or No Yes or No
Social Security # _____- _____ -_____ Date of Birth _____/_____/_____ Age ____ o Male o Female
Marital Status: o Single o Married o Divorced o Separated o Partnered o Other
Employer: _____o F/T o P/T Student o F/T o P/T
e-Mail _____ May we contact you through email: o Yes o No
Referred by: Physician/other:_____ **o** Website **o** Yellow Pages **o** Insurance Co.

INSURANCE INFORMATION

Primary Insurance Carrier: _____ Ins. Phone #: _____
Address: _____
Policy Holder Name: _____ Date of Birth:_____
Address:_____ Sex: o Male o Female
Phone: ( ) _____Work Phone: ( ) _____Cell Phone: ( ) _____
Policy/ID Number: _____ Group Number: _____
Social Security # _____-_____-_____ Employer: _____
Relationship of patient to insured: o Self o Spouse o Child o Other _____

Secondary Insurance Carrier: _____ Ins. Phone #: _____
Address _____
Policy Holder Name:_____ Date of Birth_____
Address_____ Sex: o Male o Female
Phone: ( ) _____ Work Phone: ( ) _____Cell Phone: ( )_____
Policy/ID Number: _____ e-Mail:_____
Social Security Number: _____- _____-_____ Employer: _____
Relationship of patient to insured: o Self o Spouse o Child o Other _____

RESPONSIBLE PARTY INFORMATION

Person Responsible for Payment (If other than patient)
Name: _____ Check if: o Custodial Parent o Legal Guardian
Address: _____
Home Phone: ( ) _____ Work Phone: ( ) _____Cell Phone: ( ) _____
Relationship to Patient: _____e-Mail: _____

_____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process all claims. I authorize payment of medical benefits to: CM Reid & Associates, Inc./Central Florida Counseling & Psychological Services, Inc.

SIGNED: _____ **DATE**: _____

FOR OFFICE USE ONLY: Dx: _____
MANAGED CARE: # Sessions Auth'd _____Start _____ End_____ Auth. # _____

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CONSENT FOR SERVICES

This form is to document that I, _____ give my permission and consent
PRINT NAME
to the above, Central Florida Counseling & Psychological Services, Inc., to provide

psychotherapeutic treatment and/or assessments to me and/or _____,
PRINT NAME
who is/are my child/children or for whom I am legal guardian, custodian, or legal Power of

Attorney.

I understand the following:

- Although I expect benefits from this treatment and/or evaluation, such benefits or particular outcomes cannot be guaranteed.
- This therapist is not providing an emergency service. In case of an emergency, please call 911or go to your nearest emergency room.
- Regular attendance will produce maximum benefits, but I am free to discontinue treatment at any time.
- Your therapist may terminate treatment for non-compliance of treatment goals, no shows, last minute cancelations, inappropriate or criminal behavior or non-payment of fees.
- We may utilize a collection service for non-payment of fees.
- Conversations with the therapist are confidential. However, by law, there are certain exceptions to the limits of confidentiality. These limits include actual or suspected child abuse, elder abuse, and threats of harm toward oneself or others. The therapist will make reasonable efforts to discuss these issues before breaking confidentiality, however disclosure may become necessary when ordered by a court of law.

I know of no reasons that I should not undertake this therapy and I agree to participate fully and voluntarily.

Signature: _____ **Date**: _____

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FINANCIAL AGREEMENT

As a courtesy, this office will file claims with the insurance company for you. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor/therapist. I understand that it is my responsibility to pay any deductibles, co-insurance or any other balance not paid by my insurance or third party payer within a reasonable period of time, not to exceed 60 days. Unless this office has a direct contract with your insurer, we ask that you pay for each session in advance. We are contracted with Medicare and most other major carriers. However, it is the patient's responsibility to confirm coverage with your insurer and to determine if preauthorization is required.

Treatment Summary Requests, Professional Letters, E-mails or Phone/Conference calls may be billed, if requested, in 15 minute increments at the individual therapeutic rate.

If you need to cancel or reschedule an appointment, please give us 24 business hours advance notice; otherwise, you will be billed at the hourly rate.

If I am asked to participate in any legal proceedings on your behalf, my rates are $240 per hour with a 3 hour minimum and includes preparation, travel and testimony.

Signature(s): _____ **Date**: _____

COORDINATION OF TREATMENT

It is important that all healthcare providers work together. As such, I would like your permission to communicate with your Primary Care Physician and/or Psychiatrist. Your consent is valid for one year. If you prefer to decline consent no information will be shared.

_____ You may inform my Physician(s). _____You may NOT inform my Physician.

Physician/Psychiatrist Name: _____

Address: _____Phone: _____

Physician/Other Name: _____

Address: _____Phone:_____

Signature(s): _____**Date:** _____

NOTICE OF PRIVACY PRACTICES

I have read a copy of HIPPA posted in the office. (A copy is available upon request) I may discuss any concerns about these policies with the therapist.

Signature(s): _____**Date**:_____

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Name: _____ Date: _____ Age: _____

What would you like to see accomplished in therapy? _____

_____

CHIEF COMPLAINT (CHECK ALL THAT APPLY TO YOU):

___ Depression
___ Low energy
___ Low self-esteem
___ Poor concentration
___ Hopelessness
___ Worthlessness
___ Guilt
___ Sleep disturbance (more/less)
___ Appetite/weight change (more/less)
___ Thoughts of hurting yourself
___ Thoughts of hurting someone
___ Isolation/social withdrawal
___ Sadness/loss
___ Stress
___ Anxiety/Panic
___ Heart pounding/racing
___ Chest pain
___ Trembling/shaking
___ Sweating
___ Chills/hot flashes
___ Tingling/numbness
___ Fear of dying
___ Fear of going crazy
___ Nausea
___ Phobias
___ Obsessions/compulsive behaviors
___ Thoughts racing
___ Can't hold onto an idea
___ Easily agitated
___ Excessive behaviors (spending, gambling)
___ Delusions/hallucinations

___ Not thinking clearly/confusion
___ Feeling that you are not real
___ Feeling that things around you are not real
___ Lose track of time
___ Unpleasant thoughts won't go away
___ Anger/frustration
___ Defies rules
___ Blames others
___ Argues
___ Excessive use of drugs and/or alcohol
___ Excessive use of prescriptions Medications
___ Blackouts
___ Physical abuse issues
___ Sexual abuse issues
___ Spousal abuse issues
___ Other problems/symptoms:

_____

_____

_____

The degree to which these symptoms cause distress with day to day functioning:

At Work:
O Minimal **O** Moderate **O** Severe

At Home:
O Minimal **O** Moderate **O** Severe

Socially:
O Minimal **O** Moderate **O** Severe

Previous outpatient therapy? ____ No ____ Yes, with _____
What was accomplished? _____
Previous hospitalization? ____ Yes ____ No Number of hospitalizations _____
ECT? _____ If yes, when_____

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History Form- Adult

Name_____ Date _____ Age _____

What has led you to seek counseling at this time? _____

_____

_____

What is your relationship status?

O Single **O** Engaged **O** Married **O** Partnered **O** Divorced **O** Widowed

O Separated **O** Cohabitating and unmarried Spouse/Partner's Name: _____

How would you describe your current relationship? **O** Excellent **O** Good **O** Fair **O** Poor

How many times have you been married? **O** None **O** Once **O** Twice **O** Three or more

How would you describe your past relationship(s)? **O** Excellent **O** Good **O** Fair **O** Poor

Please describe your current living situation: _____

_____

_____

What is the primary cultural background with which you most closely identify?

O Caucasian O Black/ African American O Hispanic/ Latino O Asian O Biracial

O Other: _____

Please list your strengths: _____

_____

_____

Please tell us about your children: **O** I do not have children

Age of First Pregnancy _____ **or** Age of First Fatherhood _____

1. Name _____ Age _____ Sex _____

O Biological **O** Adopted **O** Step **O** Foster **O** Relative **O** Other _____

Does this child live with you? **O** Yes **O** No

Does this child have a physical disability? **O** Yes **O** No

Does this child have an emotional or psychological disability? **O** Yes **O** No

Does this child have a learning disability? **O** Yes **O** No

How you describe your relationship with this child? **O** Excellent **O** Good **O** Fair **O** Poor

2. Name _____ Age _____ Sex _____

O Biological **O** Adopted **O** Step **O** Foster **O** Relative **O** Other _____

Does this child live with you? **O** Yes **O** No

Does this child have a physical disability? **O** Yes **O** No

Does this child have an emotional or psychological disability? **O** Yes **O** No

Does this child have a learning disability? **O** Yes **O** No

How you describe your relationship with this child? **O** Excellent **O** Good **O** Fair **O** Poor

3. Name _____ Age _____ Sex _____

O Biological **O** Adopted **O** Step **O** Foster **O** Relative **O** Other _____

Does this child live with you? **O** Yes **O** No

Does this child have a physical disability? **O** Yes **O** No

Does this child have an emotional or psychological disability? **O** Yes **O** No

Does this child have a learning disability? **O** Yes **O** No

How you describe your relationship with this child? **O** Excellent **O** Good **O** Fair **O** Poor

* Please include additional children on the back of this form

Family History:

Parents

Parents Marital Status: **O** Single **O** Married **O** Divorced **O** Widowed **O** Separated

O Cohabitating (Living together) **O** Other _____

Length of their relationship: _____years (s) _____months (s)

How would you describe their relationship? **O** Excellent **O** Good **O** Fair **O** Poor

Mother _____ Age _____ Father _____ Age _____

Deceased? **O** Yes **O** No Deceased? **O** Yes **O** No

If yes, cause _____ If yes, cause _____

Your age at their death_____ Your age at their death _____

Her occupation_____ His occupation_____

Her health _____ His health _____

How would you describe your relationship with your mother: **O** Excellent **O** Good **O** Fair **O** Poor

How would you describe your relationship with your father: **O** Excellent **O** Good **O** Fair **O** Poor

Do you have step-parents? **O** Yes **O** No

If yes, list names and ages:

Name _____ Age _____

Name _____ Age _____

Describe your relationship with your step-parents? **O** Excellent **O** Good **O** Fair **O** Poor

- Please include additional step-parents to the back of this form

Siblings

Brothers:

1. Name _____ Age _____ **O** Living **O** Deceased

If living, how would you describe your relationship? **O** Excellent **O** Good **O** Fair **O** Poor

2. Name _____ Age _____ **O** Living **O** Deceased

If living, how would you describe your relationship? **O** Excellent **O** Good **O** Fair **O** Poor

3. Name _____ Age _____ **O** Living **O** Deceased

If living, how would you describe your relationship? **O** Excellent **O** Good **O** Fair **O** Poor

Sisters:

1. Name _____ Age _____ **O** Living **O** Deceased

If living, how would you describe your relationship? **O** Excellent **O** Good **O** Fair **O** Poor

2. Name _____ Age _____ **O** Living **O** Deceased

If living, how would you describe your relationship? **O** Excellent **O** Good **O** Fair **O** Poor

3. Name _____ Age _____ **O** Living **O** Deceased

If living, how would you describe your relationship? **O** Excellent **O** Good **O** Fair **O** Poor

- Please include additional siblings on the back of the form

Education

What is the highest grade you have completed?

O Some high school **O** GED **O** Special High School Diploma

O High School Diploma **O** Some College **O** AA/ AS Community College

O Bachelor's degree **O** Master's degree **O** Specialist's Degree

O Doctorate Degree **O** Other _____

Occupation:

Are you currently employed? **O** Yes, full-time **O** Yes, part- time **O** No

If yes, how long have you been employed? _____

Employer: _____

Job Title/ Occupation: _____

(If retired, previous occupation)

Are you currently receiving disability? **O** Yes **O** No

Legal History/ Social Agency Involvement:

Have you ever been charged with a crime, other than a minor traffic offense? **O** Yes **O** No

If yes, please describe_____

_____

Medical History:

Have you ever had the following (if yes, please describe):

O Major Illness_____ Date: _____

O Serious Physical Injury _____ Date: _____

O Accident _____ Date: _____

How would you describe your current health? **O** Excellent **O** Good **O** Fair **O** Poor

Please describe any current medical problems: _____

_____

Medications: Include prescription and non-prescription drugs and/or supplements.
(If you need to add more - please put on the back of this sheet or attach a list)

Drug	Dose Frequency	Reason given	Prescribing Doctor	Date started	Comments

Have you received any outpatient psychiatric/ psychological/ counseling in the past? **O** Yes **O** No

If yes, please describe: _____

Has a physician ever recommended any anti-anxiety, anti-depressant, ADHD, or anti-psychotic medication for you? **O** Yes **O** No

If yes, please describe: _____

_____

Substance usage:

Do you use drugs? **O** Yes **O** No

If you use drugs, what kind do you use? Select all that apply

O Amphetamines/ Speed/ Meth/ etc.
O Marijuana/ Pot/ Hash/ etc.
O Hallucinogens/ Acid/ Ecstasy/ etc.
O Opioids/ Heroin/ Opium/ etc.
O Inhalant/ Huffing/ Whippets/ etc.
O Cocaine/ Crack/ etc.
O Phencyclidine/ Mushrooms/ etc.
O Other_____

Do you consume alcohol? **O** Yes **O** No

If you consume alcohol, how much do you consume?

Beers: ____ per week/ ____ per occasion
Mixed/straight drinks: ___ per week/ ___per occasion
Wine: ____ per week/ ____ per occasion
Malt Liquor: ___ per week/ per occasion

Have you ever felt like you should cut down on your alcohol or other drugs use (including prescription drugs)? **O** Yes **O** No

Has a friend or relative discussed concerns about your drug use? **O** Yes **O** No

Have you ever felt guilty about your drinking or drug use? **O** Yes **O** No

Have you ever had to take a drink or use a drug the next day to steady your nerves? **O** Yes **O** No

Are you a recovering alcoholic or recovering drug addict? **O** Yes **O** No

Is there a history of problems with alcohol or drug use in your family? **O** Yes **O** No

Tobacco Use:

Do you use tobacco of any form? **O** Yes **O** No

Religious/ Spiritual Issues:

Are religious or spiritual issues important to you? **O** Yes **O** No

Do you wish to discuss them in counseling, when relevant? **O** Yes **O** No

Socialization Skills

List clubs and organizations you belong to: _____

_____

What do you do for pleasure and relaxation? _____

_____

Suicide Assessment:

Have you attempted suicide? **O** Yes **O** No

If yes, how long ago was the last attempt? _____ Year(s) _____ Month(s)

How many times have you attempted suicide? **O** 1 **O** 2 **O** 3 **O**4 **O** 5 or more

Do you have current thoughts of harming yourself? **O** Yes **O** No

If yes, do you have a plan? **O** Yes **O** No

If yes, please describe your plan: _____

_____

Do you have the means to carry out this plan? **O** Yes **O** No

Your intention on initiating the plan: **O** None **O** Minimal **O** Moderate **O** Severe

Elder Maltreatment: (If you are 65 years old or older please complete)

One in nine seniors reported being abused, neglected or exploited in the past 12 months. Please indicate any concerns that you may have or would like to discuss regarding actual or possible:

O Physical Abuse **O** Emotional/Psychological Abuse **O** Abandonment

O Sexual Abuse **O** Neglect **O** Self Neglect **O** Financial or Material Exploitation

O I have no concerns **O** I do not wish to answer **O** Not applicable

Do you feel you have a support system? **O** Yes **O** No

If yes, who are they? _____

_____

_____

_____

(Family, Friend, Agencies, Church)

Additional comments: _____

_____

_____

_____