Confidential Client Information-Adult

Brian Sorrells,
LMFT, M.Ed.
Psyche Integration Counseling
3575 Donald Street, Suite 650
Eugene, OR 97405
(541) 556-7652
www.psycheintegration.com

1. IDENTIFYING INFORMATION

Client's Name:_____First Appt. Date:_____

Gender: M___F___ Transgender___ Other___ Age:_____Birth Date:_____

Home Address:_____City/State:_____Zip_____

Home Tele:_____Work Tele:_____

OK to leave message at both?____E-mail:_____

Will anyone else attend counseling with you? If so, who?_____

Others living in the home:

NAME AGE RELATIONSHIP TO YOU

_____

_____

_____

_____

Highest Level of Education: Some High School____GED___High School___ Some College ____

Associates___ Bachelors___ Masters___ Doctorate____ Technical___Other____

Emergency Contact:_____

Name Relationship Telephone

Your Employer:_____Occupation:_____

How long at current job:_____ Military History if any:_____

Relationship Status:_____Spouse/Partner's Name:_____Age:____

Referred By:_____

Do you give me permission to thank the person who referred you? No other information would be disclosed without a specific signed release. Yes____ No____

2. INSURANCE INFORMATION

Primary Insurance Co.: _____Phone:_____

Claims Address:_____City/State/Zip:_____

Name of Insured Member:_____Relationship to Client:_____

Insured Member's SSN:_____DOB:_____Member

ID#:_____Group #:_____

Employer Providing Insurance Benefits:_____

Have you obtained pre-authorization for out-patient mental health services?_____

Co-payment amount required by health plan:_____

Secondary Insurance Co:_____Phone:_____

Claims Address:_____City/State/Zip:_____

Name of Insured Member:_____Relationship to Client:_____

Insured Member's SSN:_____DOB:_____Member

ID#:_____Group #:_____

Employer Providing Insurance Benefits:_____

Payment for *all services expected at each session* unless counselor is under contract with your insurance carrier. Co-payments accepted in cash, or are also *due at each session*.

Please verify *behavioral health benefits and eligibility* and verify that Brian Sorrells, LMFT is a covered provider. directly with your Plan Administrator. Some policies only cover 45 minute sessions, others will allow the more traditional 55-60 minutes.

Brian Sorrells handles all health insurance billing and can be reached at 541-556-7652 or bsorrells@psycheintegration.com. Your signature here indicates that you understand and accept full responsibility for any deductible, claims unpaid, rejected, or uncollectable (longer than 6 months) from your insurance policy. Please speak to Brian to set up payment plans if needed.

Client Signature:_____ Date:_____

3. PRESENTING CONCERNS

Please describe the concern(s) that brought you here and *when* it began to negatively affect you.

_____

_____

_____

_____

_____

How have the concerns you're dealing with affected you in the following areas (please check):

Work/study: ____No impact ____Moderate impact ____Significant impact

Physical Health: ____No impact ____Moderate impact ____Significant impact

Family: ____No impact ____Moderate impact ____Significant impact

Social: ____No impact ____Moderate impact ____Significant impact

What have you tried to resolve these issues?

_____

_____

_____

How will you know if counseling has been successful?

_____

_____

_____

Please list your top goals for counseling:

_____

_____

_____

_____

Current Symptoms

Rate all symptoms that apply from **1 – 5** according to severity **in the last six months**;
1 = low severity 5 = high severity.

Emotional symptoms

__ anger __ depression __ anxiety __ extreme mood shifts
__ irritability __ worry __ frustration __ helplessness
__ hopelessness __ fear __ apathy __ lack of emotions
__ guilt __ others (specifiy) _____

Cognitive symptoms

__ problems with concentration __ inattention __ memory problems
__ difficulty making decisions __ distractibility __ racing thoughts
__ repeated unwanted thoughts __ other (specify) _____

Physical symptoms:

__ increase or decrease in appetite __ sleep difficulties __ muscle tension
__ tearfulness/crying spells __ increased heart rate/pounding heart __ sweating/chills
__ stomach or intestinal distress __ frequent or severe headaches __ body pain/numbness
__ other (specify):_____

Behavioral symptoms:

__ hyperactivity __ impulsivity __ binge eating/overeating
__ suicidal gesture/attempt __ induced vomiting __ withdrawal/isolating
__ arguing __ fighting/aggression __ disorganized
__ oppositional/defiant __ self-injury __ lying/deceitfulness
__ avoidance of school or job __ other (specifiy)_____

Relationships

__friends __romantic relationship __separation/divorce
__shyness __loneliness __fear of being alone
__distancing others __sexual problems __other (specify)_____

Self-Care

__work __career choices __education
__legal matter __finances __stress
__incest __other (please specify)_____

5. COUNSELING HISTORY

Have you ever been in counseling before? Yes___ No___

If yes, how many times:_____

Have you ever bee hospitalized for psychological or emotional problems Yes____ No___

If yes, how many times_____

If yes to either questions above, please describe your experience(s) below beginning with the most recent previous episode of treatment.

Treatment Episode

When did you see the counselor (your age or dates):_____

Who did you see:_____

Did you go alone or with others?_____

What problems were addressed? _____

_____

What did you like or gain from that experience?_____

_____

What did you not like?_____

Treatment Episode

When did you see the counselor (your age or dates):_____

Who did you see:_____

Did you go alone or with others?_____

What problems were addressed? _____

_____

What did you like or gain from that experience?_____

_____

What did you not like?_____

(Please use additional page if you have other past counseling experiences to report.)

6. FAMILY BACKGROUND

Where did you grow up and who did you live with?

How would you describe your childhood?

What problems did your family have? Strengths?

Please give 3 adjectives to describe your primary caregivers (all parents and other active caregivers)

Who are you closest to today?

Please describe any family history (past/present) of psychological or emotional problems.

Other important family information (moves, economic concerns, illnesses, cultural/ethnic influences)

7. MEDICAL INFORMATION

Have you seen a doctor in the last year? Yes___ No___

If yes, for what problems?_____

_____

Who is your Primary Doctor?_____ Doctor's phone:_____

Please list any medications you are taking now including dosage and frequency:

_____

_____

Do you have any allergies? Yes____ No____

Have you ever been treated in a hospital? Yes___ No___

If yes, for what?

_____

_____

Have you ever been in an accident or suffered any kind of physical/emotional/sexual trauma?

Yes___ No___

Please give brief description of what kind of trauma and when it happened: _____

_____

What kind of treatment did you receive, if any?_____

Have you ever had a head injury? Yes___ No___

Other serious medical conditions past or present: _____

1. SUBSTANCE USE HISTORY

Do you use/have you used alcohol? ___current ___past ___no

Alcohol Frequency

__never ___less than 1x/month ___1-4x/month ___daily

Usual Alcohol Consumption

__none ___1-2 drinks/sitting ___3-4 drinks/sitting ___5 or more drinks

Intoxication Frequency

__never ___less than 1x/month ___1-4x/month __2-3x/week __daily

Other Substance Use: (Check all used in the past 6 months)

___None ___Marijuana ___Sedatives ___Stimulants (speed, crank)

___Cocaine ___Inhalants ___Opiates ___Hallucinogens

___Prescription Drugs ___Caffeine (# of cups/day)_____

___Tobacco (# of cigarettes/day)_____

Alcohol or Other Drug Related Problems:

___Binges ___Job problems ___Sleep disturbances ___Hangover

___Physical withdrawal ___Legal problems ___Medical concerns

___Blackouts/memory loss ___Problems with friends/family ___Seizures

___Assaults ___Passing out ___Changes in tolerance ___Concern over use

___Inability to stop after first drink/use

History of Substance Abuse Treatment

___None ___Stopped on own ___Attended AA/other 12-step program

___ In-patient ___ Out-patient __Attended community based program

Please describe substance abuse treatment received and outcome:

_____

_____

Please describe any family substance abuse history:

_____

_____

Other Impulsive/Addictive Concerns:

____Gambling ____Impulsive spending/shopping ___Pornography

____Internet surfing ____Excessive Television watching ___Impulsive eating

9. COORDINATION WITH OTHER SERVICES

Please indicate if there are other agencies/service providers you are currently working with:

Other Mental Health Provider_____ Attorney:_____

Physician_____ Juvenile Dept:_____

Corrections:_____ Child Protective Services:_____

Career Counselor:_____ Employee Assistance Program:_____