Tracy E. Crain, M.S., LPC-S, LCDC
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Today's date:	PCP:

PATIENT INFORMATION

Patient's last name: First: Middle:	☐ Mr. ☐ Mrs.	☐ Dr. ☐ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	Nickname/Preferred Name:	Birth date: / /	Age:	Sex: ☐ M ☐ F

Street address:	Social Security no.:	Cell phone: ( ) - Home phone ( )

P.O. Box:	City:	State:	Zip Code:

Occupation:	Employer:	Employer phone no.:

Chose clinician because/Referred to clinic by (please check one)	☐ Dr.	☐ Hospital/Treatment facility

☐ Family	☐ Friend	☐ Close to home/work	☐ Internet	☐ Other

Other family members seen here:

IN CASE OF EMERGENCY

Name of contact person:	Relationship to patient:	Cell phone: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance.

Patient/Guardian/Legal Representative signature *Date*

Tracy E. Crain, M.S., LPC-S, LCDC

CLIENT DETAIL

(Please Print)

Name:	Date:
Reason for seeking counseling:	
Names and ages of children, if any:	
Describe any significant problems with any of these children:	
Describe any previous marriages or relationships:	
Any history of current or past abuse:	
Describe relationship with parent(s) and sibling(s):	
Describe any past or present legal issues and status if applicable:	
Indicate both past and present use of alcohol and/or drugs:	
Indicate any financial problems past or present:	
Describe any significant religious/cultural influences:	
List any medical problems that you are currently experiencing:	
List any medications that you are taking:	
Have you ever seen a psychiatrist or counselor before: If yes, when:	
Any inpatient or outpatient psychiatric hospitalizations:	

Check any of the following problems that you experience:

__appetite change
__excessive drinking
__anger management
__drug use
__nervousness
__fatigue
__panic attacks
__anxiety/tension
__loneliness
__nightmares
__headaches
__weight change
__sexual problems
__difficulty relaxing
__stomach problems
__pain
__low self-esteem
__relationship problems
__confusion
__feelings of unreality
__flashbacks
__depression
__job stress
__agitation/irritability
__memory problems
__sleep disturbance
__fears/phobias
__obsessive thoughts
__compulsive behavior
__marital/family trouble
__poor impulse control
__trouble concentrating
__difficulty trusting
__suicidal thoughts
__suicide attempts
__withdrawing/isolating

MENTAL HEALTH DISCLOSURE FORMS

Brief therapy is goal-directed, problem-focused treatment. This means that a treatment goal or several goals are established after a thorough assessment. All treatment is then planned with the goal(s) in mind and progress is made to accomplishment of that goal in a time efficient manner. You will take an active role in setting and achieving your treatment goals. Your commitment to this treatment approach is necessary for you to experience a successful outcome. If you ever have any questions about the nature of the treatment or your care, please do not hesitate to ask. **Initial here: _____**

Limits of Confidentiality Statement

All information between practitioner and patient is held strictly confidential. There are legal exceptions to this:

1) The patient authorizes a release of information with a signature.
2) The patient's mental condition becomes and issue in a lawsuit.
3) The patient presents as a physical danger to self (Johnson v. County of Los Angeles, 1983)
4) The patient presents as a physical danger to others (Tarasoff v. Regents University of California, 1967)
5) Child or Elder abuse and/or neglect is suspected (Welfare & Institution and/or Penal Codes)

In the latter two cases, the practitioner is required by law to inform potential victims and legal authorities so that protective measures can be taken.

All written and spoken material from any and all sessions is confidential unless written permission is given to release all or part of the information to a specified person, persons, or agency. If group therapy is utilized as part of the treatment, details of the group discussion are not to be discussed outside of the counseling sessions. **Initial here: _____**

Release of Information

I authorize release of information to my Primary Care Physician, or other health care providers, institutions, and referral sources for the purpose of diagnosis, treatment, consultation and professional communication. I further authorize the release of information for claims, certification, case management, quality improvement, benefit administration and other purposes related to my health plan. Should there be a specific consent needed, a separate consent form will be signed. **Initial here: ___**

Emergency Access

I am available after hours to handle emergencies. By calling the main office number after office hours, you will be instructed how to contact me. **Initial here: ___**

Cell Phone Contact or Skype Sessions

In the event that you contact me after hours or for a scheduled phone session via my business cell or prefer at any time to participate in a Skype session, please note that I cannot ensure your complete privacy or confidentiality as it pertains to HIPAA regulations. Please be aware that I will ensure your confidentiality as much as possible but due to the internet, satellite, etc. it is very difficult to completely secure. **Initial here: _____**

Financial Terms: Insurance Coverage and Co-payments

I do not accept insurance. If you would like a receipt to file with your insurance company, please let the office staff know and we will provide you with the necessary documentation for submission.

Please note:
Any late cancellation/missed appointment without 24 hours notice will be charged $150.00.
These payments are due and payable at each appointment. If you have a missed appointment charge, we expect that payment prior to your next appointment. **Initial here: _____**