ADULT

Client Information

Date:_____

Name: _____ Social Security # _____

Address: _____ City: _____ St: ___ Zip:_____

Gender: Male/Female/Other_____ Preferred Pronoun: He/Him, She/Her, They/Them

Email address:_____

Home Phone: _____ Okay to call: Yes __ No __

Cell Phone: _____ Okay to call: Yes __ No __

Work Phone: _____ Okay to call: Yes __ No __

Date of Birth: _____ Age: _____ Highest Grade Level: _____

Marital Status: Single __ Married __ (years married ___) Widowed __ Separated __ Cohabitating __ Divorced ___ (number of years divorced ___)

Spouses' Name: _____ DOB: _____ Age: _____

Cell Phone: _____ Okay to call: Yes __ No __

Work Phone: _____ Okay to call: Yes __ No__

Other Household Members	Relationship	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List additional household members on the back of this form.

How did you hear about this counseling service? _____

Emergency Contact: Name _____ Relationship _____

Phone number: Daytime _____ Evening _____

Turning Leaf Counseling & Education Center

Stacy Schmermund-Romo, M.A., LPC, LSOTP

403 E. Hillje St.
El Campo, TX 77437
Phone: (979) 253-3849
office@turningleaftx.net

Statement of Understanding and Consent for Treatment

BENEFITS AND RISKS OF THERAPY:

Research has shown that therapy can help a wide variety of problems for children, adolescents, and adults. However, because therapy is a cooperative effort between client and therapist, participation in therapy does not guarantee problem resolution or that the client necessarily will feel better. As with any treatment, whether psychological or medical, therapy should be entered into with appropriate consideration of the potential benefits and risks. If you have any questions about what to expect from therapy, please ask your therapist.

CONFIDENTIALITY:

Records and information collected about clients will be held and released in accordance with state and federal laws governing confidentiality of client records and information. Disclosure of information regarding services provided to the client is generally released to another party only with the client's written permission. Exceptions to this rule include the following cases: 1) when there is imminent danger to the client or another person, 2) when child abuse or neglect is suspected, 3) when disclosure must be made to medical personal in a medical emergency, and 4) when the therapist is compelled by law to disclose client records or information. There is a $25.00 fee for the first twenty pages of records, and a $.50 cents per page thereafter, plus any shipping costs if required.

CLIENTS WITH DISABILITIES:

It is the policy of **Turning Leaf Counseling & Education Center** to accommodate clients with disabilities, pursuant to federal and state law. Any client with a disability who needs accommodations should inform the therapist prior to receiving services.

NONDISCRIMINATION POLICY:

In accordance with Title VI of the Civil Rights Act of 1964 **Turning Leaf Counseling** does not discriminate against participants or clients on the basis of race, color, or national origin. Services are offered to all eligible persons.

CONSENT FOR TREATMENT/RESPONSIBILITIES OF CLIENTS:

I do hereby authorize and give my consent to **Turning Leaf Counseling & Education Center** to provide treatment in accordance with the customary standards of practice specified by the state and federal laws, regulatory agencies, and professional discipline governing **Turning Leaf Counseling & Education Center**. **Turning Leaf Counseling & Education Center** does not overbook appointments. Each appointment is a reservation of resources specifically for you. **Applicable charges are made for appointments not canceled within 24 hours prior to the appointment.**
Initial Acknowledgement: _____

I have read, understand and agree to the conditions of treatment described in this document.

_____ _____

Client Signature / Parent or Guardian **Date**

Client Information

Name: _____

PROBLEM INFORMATION:

For whom are you requesting counseling? _____ If other than you what is your relationship to them? _____

Briefly describe the nature of the problem: _____

_____

_____

Have you (or the person who will be receiving counseling) ever received outpatient counseling? Yes __ No __

If yes, from whom? _____ When? _____

Have you (or the person who will be receiving counseling) ever received inpatient treatment? If yes from whom? _____ When? _____

Are you currently being treated by a mental health professional? Yes __ No __ If yes from whom? _____When _____

Medication prescribed for mental health issues:

_____

_____

_____

Medical Information

Name: _____ Date: _____

MEDICAL INFORMATION:
Which of the following illnesses or complaints have you (the client) experienced?
___ Diabetes ___ Head Injury ___ Ulcer ___ Irregular menses

___ High Blood Pressure ___ Thyroid problems ___ Glaucoma ___ Difficulty Sleeping

___ Epilepsy ___ Seizures ___ Dizzy Spells ___ Loss of Appetite

___ Liver problems ___ Hepatitis ___ PMS ___ Herpes

___ Kidney problems ___ Asthma ___ Back Pain ___ Sexually Transmitted Disease(s)

___ Headaches/Migraines ___ Respiratory problems ___ Frequent constipation disease(s)

___ Heart attack ___ Stroke ___ Loss of consciousness ___ Other _____

What prescription medications are you currently taking and why?
Medication Reason for taking it
1. _____ _____

2. _____ _____

3. _____ _____

4. _____ _____

Please identify any allergies that you have:

1. _____ 2. _____ 3. _____

What over the counter medications do you regularly take? _____

_____

Name and Phone number of your **Primary care Physician**: _____

_____

When was the last time you saw your doctor? _____ Why? _____

_____

The last time you had a physical? _____

_____ _____
Signature Date

_____
Completed By – Print Name

Insurance Information:

Insurance Provider:_____

Group/ID Number:_____

Primary Insured (Policy Holder):_____

Primary Insured Date of Birth:_____

Relationship to patient:_____

*Please make sure to have driver's license and insurance card ready!

Prior hospitalizations or inpatient treatment for psychological or CD issues? [ ] No [ ]Yes *If yes, complete the following:*

Age at time	Hospital/Treatment Center	Duration	Circumstances for treatment

PREVIOUS DIAGNOSES

Have you ever been diagnosed with a psychiatric, substance abuse, learning, emotional, or behavioral disorder?

[ ] No [ ] Yes *If yes, complete the following*:

Diagnosis	Age	Diagnosis made by	Agree?

CURRENT SYMPTOM CHECKLIST (*Rate the intensity of the symptoms presents in the last two weeks)*

None = This symptom is not present at this time **Mild** = This symptom is currently impacting my quality of life, but not impairing my day-to-day functioning **Moderate** = This symptom is significantly impacting my quality of life and/or functioning **Severe** = This symptom is profoundly impacting my quality of life and/or day-to-day functioning

Symptom	None	Mild	Moderate	Severe
Depressed mood				
Low energy				
Sleep disturbances				
Dissociation				
Hyperactivity				
Bingeing				
Decreased sex drive				
Unresolved guilt				
Irritability				
Nausea/acid indigestion				
Social anxiety				
Self-mutilation/cutting				
Impulsive actions/speech				
Nightmares				
Elevated mood				
Losing train of thought				
Mood swings				
Disorganized				
Anorexia				
Social isolation				
Grief				
Phobias				
Headaches				
Loneliness				
Problems at Home				

Symptom	None	Mild	Moderate	Severe
Increased or decreased appetite				
Unplanned weight gain				
Unplanned weight loss				
Paranoid thoughts				
Poor concentration/indecisive				
Purging/over-exercising				
Excessive worrying				
Low self-worth				
Anger management problems				
Tension				
Hallucinations				
Racing thoughts				
Restlessness				
Loss of interest in normal activity				
Decreased creativity/productivity				
Unresolved anger				
Easily distracted				
Memories of trauma				
Hopelessness				
Marital problems				
Panic attacks				
Suicidal thoughts				
Feel panicky/anxious				
Work problems				
Has attempted suicide in the past				

Briefly describe how the above symptoms impair your ability to function: _____

ENVIRONMENTAL STRESSORS *(check all that apply and are current or recent)*

[ ] Death of a family member
[ ] Health problems in family
[ ] Disruption of family by separation
[ ] Disruption of family by divorce
[ ] Disruption of family by estrangement
[ ] Marriage stress
[ ] Removal from the home
[ ] Remarriage of parent
[ ] Sexual abuse
[ ] Physical abuse
[ ] Parental overprotection
[ ] Inadequate

[ ] Neglect of a child
[ ] Birth of a sibling
[ ] Birth of a child

[ ] Death or loss of a friend
[ ] Inadequate social support
[ ] Living alone
[ ] Difficulty with acculturation
[ ] Discrimination
[ ] Adjustment to life cycle transition
[ ] Illiteracy
[ ] Academic problems
[ ] Discord with teachers or classmates
[ ] Unemployment
[ ] Threat of job loss
[ ] Job

[ ] Stressful work schedule
[ ] Job change
[ ] Discord with boss or coworker

[ ] Inadequate housing
[ ] Unsafe neighborhood
[ ] Discord with neighbors or landlord
[ ] Extreme poverty
[ ] Inadequate finances
[ ] Insufficient welfare support
[ ] Inadequate healthcare
[ ] Inadequate health insurance
[ ] Recent arrest or incarceration
[ ] Involved in litigation
[ ] Victim of a recent crime
[ ] Discord with counselor, social worker, physician, or other caregiver
[ ] Exposure to war, disasters
[ ] Homelessness
[ ] Other_____

PRESENTING PROBLEMS

Please state your reasons for seeking therapy. For each problem please include any additional relevant information including the length of time this has been a problem.

1.

2.

3.

Therapist use only

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Patient Consent for Use and Disclosure of Protected Health Information (HIPPA Acknowledgement)

I hereby give my consent for Turning Leaf Counseling and Education Center to use and disclose **protected health information (PHI)** about me to carry out **treatment, payment and health care operations (TPO)**. (The Notice of Privacy Practices provided by Turning Leaf Counseling and Education Center describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent.
Turning Leaf Counseling and Education Center reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Turning Leaf Counseling and Education Center.

With this consent, Turning Leaf Counseling and Education Center may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including test results, among others.

With this consent, Turning Leaf Counseling and Education Center may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, Turning Leaf Counseling and Education Center may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Turning Leaf Counseling and Education Center restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Turning Leaf Counseling and Education Center to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Turning Leaf Counseling and Education Center may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient's Name Date

_____
Print Name of Patient or Legal Guardian, if applicable

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Electronic Communication

Patient Communication Policy

It is important to note that standard email and text communication is not always secure. Email and text messages can be intercepted and for this reason, our practice does not communicate personal health information through this method. Our Practice will never ask for account information, credit card numbers, or personal information via email or text message. If you think you may have received a suspicious email or text from our practice, please contact our office immediately.

Email and Text Appointment Confirmations

By enrolling in email and text appointment confirmations, you are authorizing our office to send email and text message appointment reminders to you on your provided email address and/or cell phone number. You understand that you may reply with various commands to receive account information such as balances, future appointments, office location and other alerts. You also agree that all individuals associated with your account may receive alerts referencing the account guarantor and/or dependents. Text message charges from your cell phone provider may apply. Your enrollment indicates that you represent and warrant that you are the person legally responsible for all use of the accounts, are at least 18 years of age, and agree to all terms and conditions of use for the text messaging services. Please select either email or phone confirmation, or decline.

- ☐ I consent and accept the risk in receiving appointment confirmations via email. I understand I can withdraw my consent at any time. My email address is: _____
- ☐ I consent and accept the risk in receiving appointment confirmations via text to a mobile number. I understand I can withdraw my consent at any time. My mobile number is: _____
- ☐ I do not consent to receiving any information via email or text. I understand that I can change my mind and provide consent later.

Client Name (Printed) Date

Parent/Guardian Name (if client is under 18 years of age)

Signature (Parent/Guardian if client is under 18 years of age)