

**NEW CLIENT INFORMATION/CONSENT FORM**

**Client Name:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_  
(To be completed by the Parent/Guardian if client is younger than 18 years)

**Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Social Security #:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Phone (May we call you at):** Home? \_\_\_\_\_ Work? \_\_\_\_\_ Cell? \_\_\_\_\_

**Relationship Status:** Single \_\_\_ Married: Date \_\_\_\_\_ Separated/Divorced: Date \_\_\_\_\_ Widowed: Date \_\_\_\_\_  
(Check one) Living together – Date \_\_\_\_\_ Partnered – Date \_\_\_\_\_ Other: \_\_\_\_\_

**People living in home: name/age/relationship to you:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Employer/School:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Person to be contacted in case of emergency:**  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

**Presenting Problem (s): Please describe the reasons you are seeking counseling (include date the problem started):**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medical History: Please list any prescription medications you currently use:**

<u>NAME</u>	<u>DOSAGE</u>	<u>FREQUENCY</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Please list any past or present conditions that you are of have been treated for:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**When did you last have a physical examination?** \_\_\_\_\_

**Who did you see?** Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Phone (May we call you at):** Home? \_\_\_\_\_ Work? \_\_\_\_\_ Cell? \_\_\_\_\_

### Psychiatric History:

Have you ever received psychological or psychiatric treatment of any kind before?  Yes  No

If you answered Yes to the above question, please answer the following:

What type of care did you receive?  Inpatient (hospital)  Outpatient  Both

Dates you were in treatment: \_\_\_\_\_

Where? \_\_\_\_\_

How long was your treatment? \_\_\_\_\_

Who was your therapist or doctor? \_\_\_\_\_

Were you prescribed medicine at this time?  Yes  No  Not applicable

If Yes, what was prescribed (include dosages if you know): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Family History:** Please describe any significant emotional, medical, or chemical dependency conditions of your parents and/or other family members: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Substance Use History:** Have you ever used drugs or alcohol?  Yes  No - If Yes, please describe:

<u>Substance</u>	<u>Amount</u>	<u>Frequency</u>	<u>When? (First and Last use)</u>
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever received substance abuse treatment of any kind before?  Yes  No

Do you have a history of blackouts, seizures, or withdrawal symptoms?  Yes  No

**Please describe anything else you'd like your clinician to know:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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<b>Habits:</b>	<b>Amount Currently Using</b>	<b>Most Ever Used</b>
Coffee (cups/day):	_____	_____
Cigarettes:	_____	_____
Alcohol:	_____	_____

**PLEASE INDICATE HOW YOUR PROBLEMS ARE AFFECTING THE FOLLOWING AREAS:**

	No Effect	Little Effect	Some Effect	Much Effect	Significant Effect	Extreme Effect
Marriage/Relationship	1	2	3	4	5	6
Family	1	2	3	4	5	6
Job/School Performance	1	2	3	4	5	6
Friendships	1	2	3	4	5	6
Hobbies	1	2	3	4	5	6
Financial Situation	1	2	3	4	5	6
Physical Health	1	2	3	4	5	6
Anxiety level/nerves	1	2	3	4	5	6
Mood	1	2	3	4	5	6
Eating Habits	1	2	3	4	5	6

If your eating habits are affected, describe how: \_\_\_\_\_

Sleeping Habits	1	2	3	4	5	6
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If your sleeping habits are affected, describe how: \_\_\_\_\_

Sexual Functioning	1	2	3	4	5	6
Ability to concentrate	1	2	3	4	5	6
Ability to control temper	1	2	3	4	5	6
Self-confidence	1	2	3	4	5	6

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**Confidentiality:** All information between counselor and client is held strictly confidential, unless:

1. The client authorizes release of information with his/her signature.
2. The client presents a physical danger to self.
3. The client presents a danger to others.
4. Child/elder abuse/neglect are suspected.

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

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## Financial Terms:

The client is responsible for payment of psychotherapy services. Unless otherwise negotiated with therapist payment of services is due in full at the time of service. Payment arrangements should be made prior to your first visit.

**Fee per visit is \$95 for individuals, \$120 for couples/families.** This fee shall be paid in full at the time of appointment (for Health Insurance, see below\*) *Therapist reserves the right to increase the fee with reasonable notification (at least 30 days).*

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## Canceled/Missed Appointments:

A scheduled appointment means that time is reserved only for you. If an appointment is missed or canceled with less than 24 hours notice, the client will be billed according to the scheduled fee.

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## INSURANCE INFORMATION:

Health Plan/Insurance: \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Employer: \_\_\_\_\_ Ins. Phone: \_\_\_\_\_

(If Applicable) Preauthorization/Referral needed? Yes No Auth Code: \_\_\_\_\_ Physician Name: \_\_\_\_\_

### \*Financial Terms with Health Insurance:

Many clients have insurance coverage for psychotherapy services. As with all health care, the client or designated party is responsible for payment of services. Insurance forms will be prepared on a monthly basis to help collect from insurance carriers when the forms and information required by the insurance company are submitted to this office.

**Aimee Zakrewski of AZ Growth is an Out-of-Network Provider.** *The client shall pay fee in full each session.* Insurance forms will be prepared on a monthly basis. Aimee Zakrewski of AZ GROWTH deems no responsibility for the reimbursement of payment from the client's insurance carrier. **It is the responsibility of the client to send in the forms and receive reimbursement from their insurance carrier**, unless otherwise agreed upon.

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## Consent for Treatment:

I further authorize and request that AZ GROWTH provide psychological treatment and/or diagnostic procedures, which now or during the course of my care as a client are advisable. I understand that the purpose of these procedures will be explained to me upon my request and are subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable.

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**Confirmation of Acceptance to Terms:** I agree to all of the above information.

\_\_\_\_\_  
Client (or Parent/Guardian) Print

\_\_\_\_\_  
Client (or Parent/Guardian) Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client (or Parent/Guardian) Print

\_\_\_\_\_  
Client (or Parent/Guardian) Signature

\_\_\_\_\_  
Date