CENTRAL FLORIDA PSYCHOLOGICAL CONSULTANTS, INC

WWW.CENTRALFLORIDAPSYCHOLOGY.COM

Central Florida Psychological Consultants
P.O. Box 490134
Leesburg, FL 34749
(352) 365-2243
www.centralfloridapsychology.com

Personal Information & Insurance Form

Name:_____
Last Middle Initial First

Date of Birth: _____/_____/_____

If patient is a minor, parent's (insurance policy holder's) Date of Birth: _____/_____/_____

Sex (circle one): Male / Female

Home #: (_____)_____-_____

Cell #: (_____)_____-_____

Home Address: _____
Street City State Zip

Social Security Number; _____ - _____ - _____

If patient is a minor, parent's (insurance policy holder's) Social Security Number: _____ - _____ - _____

Occupation: _____ Employer: _____

How did you hear about Central Florida Psychological Consultants, Inc.:_____

Reason For Seeking Services: _____

Emergency Contact_____(_____)_____
Full Name Phone Number

Fees and insurance reimbursement:

Assignment of Insurance Benefits and Patient Responsibility

By Signing this form I am voluntarily authorizing the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further agree and acknowledge that my signature on this document authorizes Central Florida Psychological Consultants, Inc.., to submit claims for benefits for services rendered without having to obtain my signature on each and every claim to be submitted for myself and/or my dependents, and that I will be bound by this signature as though I had personally signed each particular claim.

I _____, hereby authorize, _____
(Insured Name) (Name of Insurance Company)

to pay and herby assign directly to Central Florida Psychological Consultants, Inc.., all benefits if any, otherwise payable to me for his/her services as described on this form. **I understand that I am financially responsible for ALL charges incurred, including services not covered by insurance.** I further acknowledge that any insurance benefits, when received by and paid to Central Florida Psychological Consultants, Inc.., will be credited to my account in accordance with the above said statement.

I understand that a NO SHOW or less than 24hr in advance cancellation fee of the full session price will be automatically charged to my credit card and must be paid before my next scheduled appointment. I also acknowledge, that if I am late for an appointment, I will still be charged for the session in full.

_____ Date: _____/_____/_____
Client's Signature

CENTRAL FLORIDA PSYCHOLOGICAL CONSULTANTS, INC
WWW.CENTRALFLORIDAPSYCHOLOGY.COM

Central Florida Psychological Consultants
P.O. Box 490134
Leesburg, FL 34749
(352) 365-2243
www.centralfloridapsychology.com

BILLING PRACTICES

Your insurance company may reimburse you for part of your fee; however it is your responsibility to pay your fee upfront unless other arrangements are made.

Your fee will be collected at the beginning of each session. Our office accepts all major credit cards, checks and cash. If you are using a check please have it ready when you come in to save time. There is a $20.00 fee assessed for bounced checks. Make checks payable to Central Florida Psychological Consultants, Inc. OR CFPC. *Please do not make checks payable directly to the therapist.*

Beginning a course of psychotherapy requires both client and therapist to commit to regular sessions. Your therapist may reserve a weekly, bi-weekly, or monthly time for which you are responsible. If you are unable to keep a given appointment, the policy is to reschedule or cancel no less than 24 hours in advance. If you need to cancel a Monday appointment, then it will need to be canceled by the previous Friday Morning. If you reschedule or cancel with *less* than 24 hours' notice, your credit card on file will be charged the full session fee and is nonrefundable. To avoid a cancellation/no-show fee assessed for missed appointments, cancellations need to be made 24 hours or more in advance. Your therapist will make every effort to work with you to reschedule a missed session. There are therapeutic, as well as business reasons for this policy and your therapist would be happy to discuss any questions or concerns you may have. Missing of scheduled appointments and/or recurrent rescheduling of appointments may result in discontinuation of services. Making scheduled appointments is both a business and a therapeutic necessity.

At times it may be clinically beneficial or necessary for your therapist to provide services in addition to therapy. These services may include but are not limited to phone consultations with adjunct mental health professionals, schools, attorneys, or physicians, as well as to create reports or letter writing, or time spent providing any other service authorized by you including travel time, research and/or any other services involving your care. It is our policy to charge a prorated amount for these services based on your standard session fee, with the exception of legal proceedings detailed below and coping of records. The additional services requested and the fee assessed with be discussed with the client.

An administration fee (not to exceed $30.00) will be assessed if a records request is initiated by the client, which requires copying of your mental health records. If you are or become involved in legal proceedings that require therapist/providers participation the client is responsible for payment in full prior to the hearing/deposition date. Court fees are set at an hourly rate for preparation, travel, and participation in all forms is $300 per hour with a three-hour minimum to be paid five (5) business days in advance.

All accrued fees are to be paid in full prior to your next scheduled appointment unless prior arrangements have been made with your clinician. In the space below please provide a credit card or debit card number that you would like to keep on file for such fees. You may choose to use the same form of payment for all appointments; however, it is *not* required. For attended sessions, any form of payment is accepted.

CENTRAL FLORIDA PSYCHOLOGICAL CONSULTANTS, INC
WWW.CENTRALFLORIDAPSYCHOLOGY.COM

Central Florida Psychological Consultants
P.O. Box 490134
Leesburg, FL 34749
(352) 365-2243
www.centralfloridapsychology.com

To make therapy as effective as possible it is necessary for patients to attend their scheduled appointments. Central Florida Psychological Consultants, Inc. offers reminder calls for upcoming and missed appointments. These calls are used to provide clients a reminder of upcoming appointments and should not be relied solely on for scheduling purposes. **The client is responsible for all scheduled appointments.**

May we contact you for reminders about upcoming or missed appointments?
Preferred Contact Number:_____
Please circle: CALL / TEXT / BOTH

Central Florida Psychological Consultants, Inc. occasionally sends out newsletters to patients. Typical newsletters are educational and are intended to provide patients with helpful information. They are not intended to take the place of therapy nor or the newsletters patient specific.

Would you like to be added to the Central Florida Psychological Consultants, Inc., newsletter that is send out periodically and includes helpful information on mental health: Please circle either YES or NO.
E mail Address: _____

We require that all therapy clients have a credit/debit care on file. The client is solely responsible to update any changes to the on-file credit/debit card. All copayments and session charges are due in full at the beginning of the session.

Charge this card automatically for appointments? (Please circle one of the following)
YES (Always, for all appointments)
NO (I will be paying with cash or check) – only use this card for missed appointments without 24hr notice)

I authorize Central Florida Psychological Consultants, Inc. to charge the agreed service charge to my credit card provided herein. I understand my card will be charged the full service fee for missed appointments if 24 hours notice is not given. If my appointment is on a Monday at noon, then I must cancel before noon on the Friday before. I understand that Central Florida Psychological Consultants, Inc. may call and offer appointment reminders but that failure to receive a reminder phone call does not relieve me of my responsibility to attend my appointments as scheduled and to cancel my appointments, at least 24 hours in advance. I agree that I will pay for this service in accordance with the issuing bank cardholder agreement.

Card Holder Name as it Appears on Card: _____

Billing Address: _____

Card Type: _____ Expiration Date: _____/_____/_____

Card #: _____ CSC #: _____

_____
Print Name

_____ Date: _____/_____/_____
Client's Signature

_____ Date: _____/_____/_____

Parent/Guardian's Signature

Cardholder – Print Name, Sign and Date Below:

Name: _____

Signed: _____

Dated: _____

CENTRAL FLORIDA PSYCHOLOGICAL CONSULTANTS, INC
WWW.CENTRALFLORIDAPSYCHOLOGY.COM

Central Florida Psychological Consultants
P.O. Box 490134
Leesburg, FL 34749
(352) 365-2243
www.centralfloridapsychology.com

This form is optional and you are free to decline. Central Florida Psychological Consultants, Inc. strives to provide you with the highest standards of psychological care possible. For this reason, we are able (at your request) to send a letter to your primary care physician that states that you are a client at Central Florida Psychological Consultants, Inc., to inform them of your tentative treatment plan and diagnosis, and offer to collaborate in your care. Also, if you would like Central Florida Psychological Consultants, Inc., to communicate with others, such as family members, please list each person's name on this form.

RELEASE OF INFORMATION CONSENT

Patient's Name: _____ Date of Birth: _____/_____/_____
Last Middle initial First

I, _____, authorize Central Florida Psychological Consultants, Inc., to
(Patient name)

to send and/or receive information to _____ .
(To whom you want information released to)

Receiving Parties address: _____
Fax #: _____
Phone #: _____

A SEPARATE AUTHORIZATION, AS DEFINED BY HIPAA, IS REQUIRED FOR PSYCHOTHERAPY NOTES.

Please *INITIAL* the following options for what you would like released:

_____ Academic testing results
_____ Behavior programs
_____ Progress reports
_____ Intelligence testing results
_____ Medical reports
_____ Personality profiles
_____ Psychological reports
_____ Psychological testing results
_____ Service Plans
_____ Summary reports
_____ Vocational testing results
_____ Psychotherapy notes
_____ **Entire record**
_____ Other, please specify:
_____

_____ ***INITIAL*** I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

_____ ***INITIAL*** I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after 1 year, this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right

Your relationship to the client: o Self o Legal Representative o Parent/legal guardian
o Other: _____

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Client's Signature: _____ Date: _____ /_____ /_____

Parent/guardians/personal representative (if applicable):

Signature: _____ Date: _____ /_____ /_____

Witness (if client is unable to sign)

Signature: _____ Date: _____ /_____ /_____

CENTRAL FLORIDA PSYCHOLOGICAL CONSULTANTS, INC
WWW.CENTRALFLORIDAPSYCHOLOGY.COM

Central Florida Psychological Consultants
P.O. Box 490134
Leesburg, FL 34749
(352) 365-2243
www.centralfloridapsychology.com

Consent to Treatment and Recipient's Rights

I, _____ the undersigned, hereby attest that I have voluntarily entered into
(your printed name)
treatment, or give my consent for the minor or person under my legal guardianship mentioned above, at Central Florida Psychological Consultants, Inc.., hereby referred to as CFPC. Further, I consent to have treatment provided by a psychologist, social worker, counselor, or intern in collaboration with his/her supervisor. The rights, risks, and benefits associated with the treatment have been explained to me. I understand that the therapy may be discontinued at any time by either party. CFPC encourages that this decision be discussed with the treating psychotherapist. This will help facilitate a more appropriate plan for discharge.

Recipient's Rights: I certify that I have received the Recipient's Rights Information Sheet and certify that I have read and understand its content. I understand that as a recipient of services, I may get more information from my psychotherapist.

Non-voluntarily Discharge from Treatment: A client may be terminated from CFPC if: (A) the client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at CFPC, and/or (B) the client refuses to comply with stipulated program rules, refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner. The client will be notified of the non-voluntary discharge by letter. The client may appeal this decision with their psychotherapist.

Client Notice of Confidentiality: The confidentiality of patient records maintained by CFPC is protected by federal and/or state law and regulations. Generally, CFPC may not say to a person outside CFPC that a patient attends sessions or disclose any information identifying a patient as an alcohol or drug abuser unless: (1) the patient consents in writing, (2) the disclosure is allowed by a court order, or (3) the disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit, or program evaluation. Violation of federal and/or state law and regulations by a treatment facility or provider is a crime. Suspected violations may be reported to appropriate authorities. Federal and/or state law and regulations do not protect any information about a crime committed by a patient either at CFPC, against any person who works for the program, or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child (or vulnerable adult) abuse or neglect, or adult abuse from being reported under federal and/or state law to appropriate state or local authorities. Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful. It is CFPC 's duty to warn any potential victim when a significant threat of harm has been made. In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records. Professional misconduct by a health care professional must be reported by other health care professionals, in which related client records may be released to substantiate disciplinary concerns. Parents or legal guardians of non-emancipated minor clients have the right to access the client's records. When fees are not paid in a timely manner, a collection agency will be given appropriate billing and financial information about the client, not clinical information. My signature below indicates that I have been given a copy of my rights regarding confidentiality. I permit a copy of this authorization to be used in place of the original. Client data of clinical outcomes may be used for program

CONSENT TO TREATMENT

I consent to treatment and agree to abide by the above-stated policies and agreements with Central Florida Psychological Consultants, Inc. Your signature below indicates that you have read the office policies, have been offered a copy of the HIPAA document, understand the Notice of Privacy Practices, and that you are completely responsible for full payment of fees - you are responsible to understand exactly what services your insurance policy covers. Insurance Claims: I authorize the release of any medical or other information necessary to process insurance claims. I also consent to payment of insurance benefits to the provider accepting assignment of said benefits.

_____ _____/_____/_____
Signature of Client/Legal Guardian Date

_____ _____/_____/_____
Printed Name (First, Middle Initial, Last) Date

CENTRAL FLORIDA PSYCHOLOGICAL CONSULTANTS, INC
WWW.CENTRALFLORIDAPSYCHOLOGY.COM

Central Florida Psychological Consultants
P.O. Box 490134
Leesburg, FL 34749
(352) 365-2243
www.centralfloridapsychology.com

NOTICE OF PRIVACY PRACTICES

(Health Insurance Portability and Accountability Act provisions)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS DOCUMENT CAREFULLY.

Protecting Your Privacy…

Psychologists have always managed psychological records with great concern for privacy and confidentiality. Although the security of psychological records has continuously been addressed by Psychology Codes of Ethics as well as State and Federal laws, the rules have been strengthened and made more transparent by the provisions of the Health Insurance Portability and Accountability Act (HIPAA) which went into effect on April 14, 2002. The following information provides details about the provisions of HIPAA and your rights concerning privacy and your psychological records.

Who will observe these rules?

The following individuals are required by HIPAA to comply with the privacy rules:

- Your treating psychologist;
- Any secretary or receptionist who may have limited access to your identifying information (e.g., name, address, telephone number);
- Any billing agency or collection agency that handles information about you (e.g., name and address, diagnostic codes, treatment codes, consultation dates, but not actual clinical records).

YOUR RIGHTS REGARDING PSYCHOLOGICAL INFORMATION ABOUT YOU

As a patient or client of CFPC, you have the following rights:

THE RIGHT TO INSPECT AND OBTAIN A COPY OF YOUR PSYCHOLOGICAL RECORD

Professional records constitute an important part of the therapy process and help with the continuity of care over time. According to the rules of HIPAA, your treatment and consultations with CFPC are documented in two ways. The Clinical Record, which is a required record that includes the date of your therapy sessions, your reasons for seeking treatment, your diagnosis, therapeutic goals, treatment plan, progress, medical and social history, treatment history, functional status, as well as any reports to your insurance carrier. Psychotherapy Notes are optional notes that are kept by some providers to document specific content or analyses of therapy conversations, how they impact on the therapy, and notes of your therapist that may assist in treatment. When used, Psychotherapy Notes are kept separately from your Clinical Record in order to maximize privacy and security.

You have the right to inspect and receive a copy of your Clinical Record. Viewing your record is best done during a professional consultation, rather than on your own, in order to clarify any questions that you may have at the time. You may be charged a nominal fee for accessing and photocopying the record. Psychotherapy Notes, however, if they are created, are never disclosed to third parties, HMOs, insurance companies, billing agencies, patients, or anyone else. They are for the use of the treating psychologist in tracking the many details of consultations that are too specific to be included in the Clinical Record. If your case manager or insurance company requests to see the psychotherapy notes, you have a choice about consenting (authorizing release of this information) or denying access to them. If you refuse, it will not affect your coverage or reimbursement in any way, and your insurance provider or HMO is obliged to provide payment as usual.

THE RIGHT TO REQUEST A CORRECTION OR ADD AN ADDENDUM TO YOUR PSYCHOLOGICAL RECORD

- Correction: If you believe that there is an inaccuracy in your clinical record you may request a correction. If the information is accurate, or if it has been provided by a third party (e.g., previous therapist, primary care physician, etc.), it may remain unchanged, and the request may be denied. In this case you will receive an explanation in writing, with a full description of the rationale.
- Addendum: You also have the right to make an addition to your record, if you think it is incomplete.

THE RIGHT TO AN ACCOUNTING OF DISCLOSURES OF YOUR PSYCHOLOGICAL INFORMATION TO THIRD PARTIES

You have the right to know if, when, and to whom your psychological information has been disclosed (exclusive of treatment, payment, and health care operations). However, you likely would already be aware of such disclosures, as you would have signed consent forms allowing for them (such as to other psychotherapists, primary care physicians, etc.). This accounting must extend back for a period of six years.

THE RIGHT TO REQUEST RESTRICTIONS ON HOW YOUR INFORMATION IS USED

You have the right to request restrictions on certain uses or disclosures of your psychological information. These requests must be in writing, and most likely will be honored, although in some cases they may be denied. This office does not use or release your protected health information for any purpose other than treatment, payment, healthcare operations, and other exceptions specified in this notice.

THE RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS

Central Florida Psychological Consultants
P.O. Box 490134
Leesburg, FL 34749
(352) 365-2243
www.centralfloridapsychology.com

You have the right to request that your therapist communicate with you about your treatment in a certain way, or at a certain location. For example, you may prefer to be contacted at work instead of at home, or on a cell phone, in order to schedule or cancel an appointment. Or, you may wish to receive billing statements at a Post Office Box, or at some other address.

THE RIGHT TO A COPY OF THIS NOTICE UPON REQUEST

You have the right to have a copy of this Notice of Privacy Practices.

THE RIGHT TO FILE A COMPLAINT

You have the right to file a complaint if you believe your privacy rights have been violated. You must do so in writing, and may address it directly to CFPC or to the Secretary of the Department of Health and Human Services (address: Office for Civil Rights, 200 Independence Ave., S.W., Washington, D.C. 20201). Filing a complaint will not change the health care provided by this office in any way. If you have questions or concerns about this notice or your health information privacy, please do not hesitate to contact CFPC at (650) 384-6339.

HOW THIS OFFICE MAY USE AND DISCLOSE PSYCHOLOGICAL INFORMATION ABOUT YOU

FOR TREATMENT

CFPC will access your record and use psychological information about you to assist in the continuity of your treatment services. This information will not be shared with other health care professionals; unless you specifically request it or agree to it, and sign a consent form to that effect.

FOR PAYMENT

This office may use and disclose psychological information about you for billing purposes. This generally is restricted to your name and other personal identifiers (address, relevant identifying information, or other needed information), diagnostic and treatment codes, dates of services, and any similar information.

FOR HEALTH CARE OPERATIONS

CFPC may share basic identifying information with an administrative assistant or other office staff to assist in scheduling and treatment procedures. This would not normally include the contents of your psychological record.

AS REQUIRED BY LAW

It is possible (though unlikely) that the Department of Health and Human Services may review how this office complies with the regulations of HIPAA. In such a case, your personal health information could be revealed as part of providing evidence of compliance.

BUSINESS ASSOCIATES

This office may contract with a billing agency or attorneys to attend to business issues on an as-needed basis. In this case, there will be a written contract in place with the agency requiring that it maintain the security of your information in compliance with the rules of HIPAA.

RESEARCH

This office is currently not participating in any research studies.

CHANGES TO THIS NOTICE

Please note that this privacy notice may be revised from time to time. You will be notified of changes in the laws concerning privacy or your rights as we become aware of them. In the meanwhile, please do not hesitate to raise any questions or concerns about confidentiality with Dr. Hargreaves.

Your signature below indicates that you have read and understand the information in this document and agree to abide by its terms.

_____ _____

Printed Name of Client Date

_____

Signature of Client

What to expect:

Central Florida Psychological Consultants
P.O. Box 490134
Leesburg, FL 34749
(352) 365-2243
www.centralfloridapsychology.com

No guarantee is made that the counseling you receive will affect the desired results. Individual success largely depends on the intentional application of the insights, skill and knowledge the client gains through the counseling process and their willingness to be active, open, honest and as consistent as possible with their therapist.

What your therapist expects from you:

Express concerns, ask questions, Complete assignments, Come to counseling free from the influence of any substances, Pay your fees upon arriving to your session (have checks made out in advance), Be on time for your appointments, Cancel 24 hours in advance (by phone or email), (No shows and cancellations made less than 24 hours in advance are billed at full session rate)

What is counseling like?

A safe place where you will be accepted no matter what your struggle or difficulty An opportunity to grow personally and spiritually, Personally challenging Teaches responsibility for the things you have control over, Most sessions are approximately 1 hour in length

What to expect from your therapist:

Return your calls within 24 hours in most cases, Continue to update their skills and obtain ongoing training, Treat you with kindness and respect, Develop a plan with you to help you achieve your goals and objectives, Discuss discharge planning with you as soon as clinically appropriate, Seek confidential consultation with other professionals when appropriate, Help you to find an appropriate referral if necessary, Counseling may be terminated for consistent failure to complete assignments, failure to pay fees, and failure to consistently show for scheduled appointments.

Couples Therapy

Successful marriages are based on trust. Therefore openness and honesty is the best policy. For successful therapy there can be no secrets within couples counseling. However, sometimes there are issues that are disclosed during individual sessions that may be difficult for one spouse to disclose to the other. When that is the situation, you and your counselor will work together on the best way to share that information with your spouse.

Records and Confidentiality

The code of ethics for counselors and the state laws regulating most kinds of counseling consider personal information you discuss to be confidential. Except in a small number of situations, the helping professional may not reveal any information about you to another person without your explicit permission. Records of your treatment will be kept for seven years after your final session. One exceptions to this rule includes if your fees are paid by a third party such as an insurance company, certain details of your treatment (e.g. dates of treatment, diagnosis, symptoms, progress) may be required to be revealed in order to obtain reimbursement. Most insurance companies allow you to file claims directly with them so that your employer will not see the information. In cases where a court order has been issued and records have been subpoenaed the counselor has a legal responsibility to comply.

Suicidality and Abuse

Another exception where counselors are legally required to disregard confidentiality involves situations where there is a potential for suicide or homicide. For example, if you reveal information that indicates a clear danger of injury to yourself or others the counselor will need to contact the appropriate authorities or family members. Another exception to confidentiality is that all helping professionals are required by law to report any knowledge of abuse or neglect of a child or incompetent person or disabled person including suspected abuse.

If you are able and time permitting, please begin to fill out the following background information. Your therapist will review the following information with you during your initial session.

Mental Health History: (Past outpatient services and hospitalizations, include dates)

Central Florida Psychological Consultants
P.O. Box 490134
Leesburg, FL 34749
(352) 365-2243
www.centralfloridapsychology.com

_____
_____
Was it effective/how so? _____
What was your diagnosis (es)? _____
Have you ever experienced suicidal/homicidal ideations? (circle one) Yes/No
Intentions? (circle one) Yes/No
If yes, please explain: _____
_____

Legal Issues: (List any past and/or present legal issues: i.e., arrests, convictions, bankruptcy, divorce etc. include dates) _____
_____
_____

Abuse History (has client been victim of any type of abuse?)**: (Please circle Yes or No)**
Physical abuse: Yes No **Emotional Abuse:** Yes No
Sexual Abuse: Yes No **Domestic Violence:** Yes No
Abandonment: Yes No **Neglect:** Yes No
Age(s) at time of abuse: _____ Treatment received: _____
Who was perpetrator? _____
Reported to Authorities? _____ Finding/disposition: _____

Did client witness any types of abuse listed above: Yes No
If yes, which type of abuse? _____
Who was the victim? _____ Who was the perpetrator? _____
Has client been the perpetrator of any abuse? Yes No Who was the victim? _____
If yes, which type of abuse? _____

Addiction/Substance Use History (If you need more space for explanation, please use back of this page)**:**
Please circle Yes or No

Alcohol Yes / No	Pain Pills Yes / No	Marijuana Yes / No
Tranquilizers Yes / No	Stimulants Inhalants Yes / No	Pornography Yes / No
Sleeping Pills Yes / No	Narcotics Yes / No	Other:
Hallucinogens Yes / No	Heroin/Meth Yes / No	
Sex Yes / No	Gambling Yes / No	

_____
Drug of preference: _____ How long used? _____ Last used? _____
Treatment program: _____ When? _____ How long? _____ How long clean/sober? _____

Medical History (If you need more space use back of page)**:**
List any major accidents, illnesses, operations with date of occurrence: _____
_____
_____
List date and type of any head injuries or seizures: _____
_____
List current medications and reason prescribed: _____
_____
List any allergies to medications: _____

Physician:
Are you currently under a physician's care? _____
Names of Physicians/Specialists who are treating you: _____
_____

Education:
Highest grade completed: _____ Degree Obtained: _____
Any difficulty learning to Read: _____ Write: _____ Math: _____
Did you ever repeat a grade? Yes/No For what reason: _____

Central Florida Psychological Consultants
P.O. Box 490134
Leesburg, FL 34749
(352) 365-2243
www.centralfloridapsychology.com

Favorite subject: _____ Most accomplished subject: _____
Circle One:
I learn best by (circle response): seeing it done / reading about it / hearing about it

Occupation:
Current occupation/vocation: _____ How long: _____
On a scale of 1-10, 10 being very satisfied how satisfied are you with your current occupation? _____
Please describe any difficulties you are having concerning your occupation: _____
_____

Social Relationships:
How frequently do you socialize with friends? _____
How frequently do you socialize with extended family? _____
What kinds of activities do you do when you get together? _____
On a scale of 1-10, 10 being very satisfied:
Rate your satisfaction with peer relationships: _____
Rate your satisfaction with extended family relationships: _____
Who do you feel is "on your side" in life? _____
Are there any people in your life you can talk to about your problems? _____
Please describe any difficulties you are having socially: _____
_____

Family History (Please list those family members with a history of mental illness, learning disabilities, mental retardation or addictions) (If you need more space use back of page)
Children: _____
Parents: _____
Siblings: _____
Maternal Grandparents: _____
Paternal Grandparents: _____
Maternal Aunts and Uncles: _____
Paternal Aunts and Uncles: _____

Developmental History:
Prenatal health issues: _____
_____
Birth Trauma (C-section, birth injuries, complications): _____
_____
Developmental Milestones: Describe any problems with the following:
Attachment/bonding: _____
Motor skills: _____
Toileting: _____
Speech/language: _____
Social Skills: _____
Temperament: _____

Sexual History:
Age at first sexual experience? _____
On a scale of 1-10, 10 being very satisfied, how would you rate your sexual experiences: _____
On a scale of 1-10, 10 being very satisfied, how satisfied are you with your sexual self-image: _____
On a scale of 1-10, 10 being very satisfied, how satisfied are you with the frequency of sex: _____
Please describe any sexual difficulties you are having: _____
_____

Nutrition:
Do you eat a balanced diet by the food pyramid standard? _____
How much caffeine do you consume daily (8 oz. cups of coffee/tea, 12 oz. sodas etc.)_____
How much tobacco do you smoke/chew daily? _____

Central Florida Psychological Consultants
P.O. Box 490134
Leesburg, FL 34749
(352) 365-2243
www.centralfloridapsychology.com

How many Alcoholic drinks do you consume: 1-3 Daily 1-3 Weekly 1-3 Monthly None
How much fast food do you eat: 1-3 Daily 1-3 Weekly 1-3 Monthly None
Energy level: lethargic low average high hyperactive
How would you rate your current health: poor fair good excellent
List any food allergies you have: _____
How would you rate your weight/height/body fat ratio: poor fair good excellent
On a scale of 1-10, 10 being very satisfied, how satisfied are you with your body image
Please describe any difficulties you are having with health, nutrition, body image: _____
_____
_____

Spiritual History:

Do you have a religious affiliation with which you are active? Yes No
How does your faith help you to cope with life's problems? _____
_____
What spiritual disciplines do you practice and how much time do you spend (i.e. prayer, reading, study, worship etc.)?_____
Please describe any difficulties you are having concerning your faith _____

Goals for Counseling:

What three things would you like to change by participating in counseling?
1. _____
2. _____
3. _____
How long do you think it will take to make these changes? _____
_____
_____
What do you think it will require on your part to make these changes? _____
_____
_____

_____
How will you know when you have accomplished your goals for counseling? _____
_____
_____

_____
What else do you think is important for your counselor to know about you? _____
_____
_____
_____
_____
_____

Emergency Contact:

Who do you want contacted in case of an emergency? (Include name, phone number and relationship.)
_____
_____