Revelation Counseling Center

502-224-4478

PART 1: CLIENT INFORMATION

Name: _______________________________________ Date of Birth: ___/_____/_______ Age: _______

Address: ____ Zip: ______

Primary Phone: _________________________ Home / Cell / Work Ok to Leave a Message? Y / N

Secondary Phone: __________________________ Home / Cell / Work Ok to Leave a Message? Y / N

Email: ____

Emergency Contact: __________________________ Relation: _______________ Phone: _____________

_______ By initialing here, I give my provider permission to contact my emergency contact person if provider's calls are not returned within an adequate timeframe and she believes I am a threat to myself or others.

Education Completed: High School College Degree Graduate Degree Post Graduate

I am working as a: Full/PT Employed Self-Employed Stay-At-Home Parent Student Unemployed Other

Employer: ____

How did you hear about us? Online Search Psychology Word of Mouth Other ____________________

Have you ever been in therapy before? Yes No Was therapy a positive experience? Yes No

If yes, briefly describe the reason and length of treatment:

____

Members of your family unit/ household: (Please list names, ages & relation to you)

____

Faith Tradition or Religious Affiliation you were raised with:

____

Current Faith Tradition or Religious Affiliation:

____

PART 2: RELATIONSHIP STATUS

Please circle the choice(s) that best describe your current relationship:

Single Never Married Divorced It's Complicated

Cohabitating Committed Partner Separated Widowed

How long have you been in your current relationship? ______________________________

Do you ever wish you had not gotten into a relationship with your current mate?

Frequently Occasionally Rarely Never

How often do you confide in your current partner? Almost Never Rarely In most things In everything

Have you and your partner ever separated? Yes No

If yes, indicate circumstances and dates of separation:

____

Have you consulted a lawyer regarding separation or divorce? Yes No If so, when

____

Is there a history of divorce/remarriage/affairs in your family of origin? Yes No

If so, please explain

____

____

PART 3: HEALTH & MENTAL STATUS

Primary Care Physician Contact

Name: ____

Office Address:

____

Office Phone: ____________________________________ Office Fax: _________________________

Date of Last physical: _________________ How often do you see this clinician? __________________

Does this health care provider prescribe medications for any (circle) psychological/pain/sleep/addiction recovery/stress complaints or issues? Yes No

Other Physician, Psychiatrist, ARNP, Physician Assistant or Prescribing Practitioner you see with regularity:

Name of Provider:

____

Practice/Clinic:

____

Office Address:

____

Office Phone: ___________________________________ Office Fax: _________________________

How often do you see this clinician? _________________________

Does this health care provider prescribe medications for any (circle) psychological/pain/sleep/addiction recovery/stress complaints or issues? Yes No

If you have any chronic illness, medical conditions or injuries, please list them:

____

____

Please list all prescription, contraception, herbal supplements and non-prescription medication you are presently taking, with dosage in milligrams:

____

If you have recently stopped or changed medication, please list those, along with dates of change:

____

Is there a history of substance abuse or alcoholism in your family of origin? Yes No

If so, what substance and by whom? Use back of page if needed.

____

____

Circle any of the following substances you use, indicating frequency for each:

Tobacco _____________x day/week Marijuana _____________x day/week

Alcohol _____________x day/week Amphetamines _____________x day/week

Caffeine _____________x day/week Hallucinogens _____________x day/week

Sedatives _____________x day/week Diet or Pain Pills _____________x day/week

Other (list):

____

Have you experienced 10 or more pounds of weight gain or loss in the last 30 days? Yes No

Has your appetite changed? Yes, increased. Yes, decreased. No change

How many hours do you sleep, per night, in general? _________ Is your sleep interrupted? Yes No

If yes, please explain:
____

____

Have you ever attempted suicide? Yes No Have you ever been hospitalized for suicidal thoughts? Yes No

If yes, please describe circumstances and include dates:
____ ________________________________

____

Are you currently having suicidal thoughts? Yes No Do you have access to a gun or deadly weapon? Yes No

Do you currently have a Suicide plan? Yes No Has a member of your family attempted suicide? Yes No

If yes, please explain including who and when:
____
____

List any other significant behavior changes in the last month
____

PART 4: SERVICES

Briefly describe your reason for seeking services at this time: ______________________________

____

Circle any that apply to your reasons for seeking services today:

Major Life Transition Infidelity Physical Abuse Suicidal Issues

Roles & Responsibilities Jealousy Sexual Abuse Temper

Occupational Problems Lack of Sexual Desire Stress Sleep Issues

Loss of Loved One Family-Of-Origin Issues Depression/Sadness Anxiety/Fear

Health problems Mood swings Finances

Life/Job Coaching Loneliness Lack of closeness Arguments

Domineering Partner   Legal Matters   Lack of Social Support   Parenting

Unmet Emotional Needs   Divorce/Separation   Spiritual/Religious Matters

What do you wish to accomplish through our meetings (your goal)? ______________________________

____

____

How will you know this problem has been resolved/when we don't need to meet anymore (what will have changed)? ____

____

PART 5: FEE POLICY

Unless other arrangements are made, payment is expected at the time of service. Cash, Charge, Health Savings Account Card, or Flexible Spending Account Card are acceptable forms of payment.

There is a $20 charge for each fifteen (15) minutes of a telephone consultation lasting longer than 5 minutes. Matters requiring lengthy email responses are billed at the same rate. For issues or questions requiring more than a brief phone conversation or email exchange you are encouraged to schedule an in-office visit to avoid this fee.

A minimum of 24-hour notice is required for rescheduling or canceling an appointment.

A $80 fee will be charged to your credit card for the first session missed or cancelled without 24-hours notice.

You will be charged the full session fee for subsequent appointments rescheduled, cancelled, or missed with less than 24-hours notice.

Repeated cancellations (more than two) without sufficient notice may result in the termination of services. The full fee is always charged for sessions missed completely. Multiple sessions missed result in the termination of services.

Credit Card #: ____________________________ Valid Thru: _____________ CVV/3-Digit Code: ________

Name on card: ____ Billing Zip Code: ________________

By signing below, I attest that I understand and agree to the fee policy. I authorize my provider to charge my credit card for missed appointments; appointments not cancelled or rescheduled 24 hours before scheduled appointment time, missed appointments, co-payments, and any fees uncollected after 30 days.

Signature: ____ Date: _______________________