Debbie Smith, M.A., LPC

CLIENT INFORMATION FORM

DATE: _____ REFERRED BY: _____

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE: HOME: _____ WORK:_____ CELL: _____

EMAIL ADDRESS: _____

PREFERRED METHOD OF CONTACT: _____

AGE: _____ DATE OF BIRTH: _____

MARITAL STATUS: Single Married (# years____) Divorced (how long?____)
Widowed (how long?____) Separated(how long?____)

LIST SIBLINGS, STARTING WITH THE OLDEST, AND INCLUDING YOURSELF:

1._____ 4._____

2._____ 5._____

3._____ 6._____

LIST CHILDREN AND AGES, STARTING WITH THE OLDEST:

1._____ 4._____

2._____ 5._____

3._____ 6._____

EMPLOYER/SCHOOL: _____

HIGHEST LEVEL OF EDUCATION:_____

PRESENT CHURCH AFFILIATION:_____

HOW IS YOUR HEALTH?_____ DATE OF LAST MEDICAL EXAM:_____

PRESENTLY TAKING ANY MEDICATION?_____

Deborah L. Smith, M.A., LPC *415 Darby Road, Milton, GA 30004* 678/468-5418

HAVE YOUR SLEEP OR EATING PATTERNS RECENTLY CHANGED? _____

DO YOU DRINK ALCOHOL? _____ HOW MUCH?_____

DO YOU USE OTHER SUBSTANCES?_____ WHICH, AND HOW MUCH?_____

DO YOU SEE YOUR CURRENT USAGE AS A PROBLEM?_____

HAVE YOU EXPERIENCED A RECENT INCREASE IN USE OF ALCOHOL OR OTHER SUBSTANCES? _____

WHO DO YOU CURRENTLY LIVE WITH?_____

WHO CAN YOU COUNT ON FOR SUPPORT?_____

HAVE YOU HAD COUNSELING BEFORE? Y/N

IF YES, PLEASE LIST NAMES, AND DATES SEEN: _____

_____

_____

WHY ARE YOU SEEKING COUNSELING AT THIS TIME?:_____

_____

_____

WHAT DO YOU HOPE TO ACCOMPLISH THROUGH THIS PROCESS?:_____

_____

_____

IS THERE ANYTHING ELSE YOU FEEL WE SHOULD KNOW ABOUT YOU?_____

_____

_____

INFORMED CONSENT

WHAT TO EXPECT: Counseling is a cooperative venture with responsibility resting on both the counselor and the client. In order for us to work most effectively together, please read the information contained in this form, and discuss any questions or concerns with me.

I, Debbie Smith, am a Licensed Professional Counselor in the State of Georgia. In our work together, my approach will reflect my view that we need to take care of our whole selves – our physical, psychological, relational and spiritual health – in order to be whole and mature.

Change on a deep level is difficult and uncomfortable at times. It is not unusual that the counseling process can entail periods where you feel worse rather than better, especially at the beginning of the process, as you move toward lasting change and true freedom. This is to be expected, and can often be a sign that good work toward change is being done.

CONFIDENTIALITY: You have a right to expect confidentiality during the entire counseling process. No information about you will be released to anyone without your written consent, except under the following conditions:

- If a client appears to be an imminent danger to self or others,
- If a client reveals abuse of a child by self or others, or
- If a client reveals abuse of an elderly or incompetent person by self or others.

CANCELLATION POLICY: If you find that you cannot keep a scheduled appointment, please cancel at least 24 hours in advance. Appointments cancelled within 24 hours will incur a fee of half the rate scheduled. No shows will incur a fee of the entire rate scheduled. Exceptions will be made for illness or other unavoidable emergencies.

FINANCIAL POLICY: Full payment is due at the time of service, unless other arrangements have been made. At this time I do not file insurance claims, but am happy to provide you with a receipt to submit to your insurance company for reimbursement. Fee is $125 per 1 hour session. Fees for phone consultation or reports can be discussed with your counselor.

EMERGENCIES: If you experience an emergency in between sessions (something that cannot wait until your next appointment), please leave a message at 678/468-5418 and mark it 'urgent'. If you do not receive an immediate return call and feel you cannot wait, please call 911 or go to the nearest hospital emergency room for help.

_____ _____

Signature Date