New Life Counseling Center

Client Information							
Name:	Date of Birth:	Age:	Email:				
Address:		City:		State:	Zip:		
Home Phone:	Cell Phone:	Work Phone:					
Which phone would you like us to use? Home Cell Work		Is it ok for us to leave messages at this number? Yes No					
Occupation:	Length of Employment:	Family Income:					
Last year of school completed_____grade or GED College: 1 2 3 4 Degree:							
Person to contact in case of an emergency: (name / phone number / relationship to you)							
Marital Status: Single Married Separated Divorced Cohabitating Widowed							
Total number of marriages for you: For your spouse:							
Spouse's / Significant Other Name:	Age:	Length of Relationship:					
Education:	Occupation:						
Briefly describe your relationship with your spouse / significant other:							
If you have any children (step children), please complete the following information:							
Name:	Age:	Three words that describe this child:	Live in your home?				
Any Miscarriages? Yes No	Any Abortions? Yes No						
Briefly describe the reason you are seeking counseling: What do you hope to accomplish through counseling?							

What characteristics do you think are important in a counselor?

What is your most difficult relationship right now?

What is your most difficult emotion right now?

What do you want to change about yourself?

How do you hope therapy will help you make these changes?

What are the positive factors in your life right now?

What are your major strengths?

Have you ever experienced any of the following:

- ☐ Harsh physical punishment or abuse as a child
- ☐ Sexual advances made toward you as a child
- ☐ Sexual abuse
- ☐ Incest
- ☐ Rape
- ☐ Physical abuse by a spouse or lover
- ☐ Verbal or emotional abuse as a child or an adult (If yes, please explain).

Family of Origin:

Name	Age	Occupation	3 words that describe your relationship with this person
Father:			
Mother:			
Sibling:			
Sibling:			
Stepmom:			
Stepdad:			

Has anyone in your family ever had counseling before? If yes, for what?

Any history of durg / alcohol abuse for self, father, mother, siblings? Yes No
If yes, please describe:

Any history of physical or sexual abuse to you or your brothers / sisters? Yes No
If yes, please explain:

Have you ever felt the need to cut down on your drinking? Yes No

Have you ever felt annoyed by criticism of your drinking? Yes No

Have you ever felt guilty about your drinking? Yes No

Have you ever had a drink first thing in the morning to help you get over a hang-over or get your day started?
Yes No

Have you ever experienced any sexual difficulties? Yes No
If yes, explain:

Have you ever had counseling before? Yes No
If yes, when? With whom? Approximately how many sessions?
Reason:

Was this a positive experience? Yes No If no, why not?

Describe any major changes that have occurred to you or your family in the last few years. (moves, changes in number of family members, marital status, income / employment)

List any major health problems for which you have received treatment in the last 24 months:

Are you taking any prescription drugs at this time? Yes No
If yes, what type, for what purpose, and who prescribed?

Spiritual Life
How important are religious beliefs and practices in your life? Not at All Somewhat Neutral Important Very Important
Are you affiliated with any church or denomination? Yes No If yes, what?
Would you like prayer to be included in your counseling at New Life? Yes No
Do you have any spiritual concerns you would like to discuss in counseling? Yes No If yes, what?
How much of an impact do your religious beliefs or convictions have on your behavior and decision making? None Some A Good Bit Very Much
How important was religion / spirituality in your family growing up? Not at all A little A Good Bit Very Much
Legal History
Is your reason for coming to counseling related to an accident or injury? Yes No
Are you required by a court, the police, or a probation / parole officer to have this appointment? Yes NO If yes, please explain: Name of Probation/ Parole Officer: Phone:
If counseling is mandatory, how will this impact your level of motivation / attitude toward counseling?
Are you currently involved in any legal matters? Yes No If yes, please explain:
Crisis Information:
Do you have any current suicidal thoughts, feelings, or actions? Yes No
Do you have any current homicidal thoughts, feelings, or actions? Yes No
Have you had any previous suicidal or homicidal thoughts feelings, or actions? Yes No
Have you had any past problems, hospitalizations or jailing for suicidal or assaultive behavior? Yes No If yes, please explain:

Common Problems / Symptoms Checklist

Please mark all of the items below that apply, and feel free to add any others at the bottom under "any other concerns or issues." You may also add a note or details in the space next to the concern checked.

- ☐ I have no problem or concern bringing me here
- ☐ Abuse – victim of physical, sexual, and/or emotional abuse or neglect
- ☐ Aggression, violence
- ☐ Alcohol use
- ☐ Anger, hostility, arguing, irritability
- ☐ Anxiety, nervousness
- ☐ Attention, concentration, distractibility
- ☐ Career concerns, goals, and choices
- ☐ Childhood issues (your own childhood)
- ☐ Children, child management, child care, parenting
- ☐ Codependency
- ☐ Communication
- ☐ Confusion
- ☐ Compulsions
- ☐ Custody of children
- ☐ Decision making, indecision, mixed feelings, putting off decisions
- ☐ Delusions (false ideas)
- ☐ Dependence
- ☐ Depression, low mood, sadness, crying
- ☐ Divorce, separation
- ☐ Drug use – prescription medications, over-the-counter medications, street drugs
- ☐ Eating problems – overeating, under-eating, appetite, vomiting
- ☐ Emptiness
- ☐ Failure
- ☐ Faith, religion, spiritual issues
- ☐ Fatigue, tiredness, low energy
- ☐ Fears, phobias
- ☐ Financial or money troubles, debt, impulsive spending, low income
- ☐ Friendships
- ☐ Gambling
- ☐ Grieving, mourning, death, losses, divorce
- ☐ Guilt
- ☐ Headaches, other kinds of pain
- ☐ Health, illness, medical concerns, physical problems
- ☐ Inferiority feelings
- ☐ Interpersonal conflicts
- ☐ Impulsiveness, loss of control, outbursts
- ☐ Irresponsibility
- ☐ Judgment problems, risk taking
- ☐ Legal matters, charges, suits
- ☐ Loneliness
- ☐ Marital conflict, distance/coldness, infidelity / affairs, remarriage
- ☐ Memory problems
- ☐ Menstrual problems, PMS, menopause
- ☐ Mood swings
- ☐ Motivation, laziness
- ☐ Nervousness, tension
- ☐ Obsessions, compulsions (thoughts or actions that repeat themselves)

- ☐ Oversensitivity to rejection
- ☐ Panic or anxiety attacks
- ☐ Perfectionism
- ☐ Procrastination, work inhibitions, laziness
- ☐ Relationship problems
- ☐ School problems
- ☐ Self-centeredness
- ☐ Self-esteem / self-worth
- ☐ Self-neglect, poor self-care
- ☐ Sexual issues, dysfunctions, conflicts, desire differences
- ☐ Shyness, oversensitivity to criticism
- ☐ Sleep problems – too much, too little, nightmares
- ☐ Smoking and tobacco use
- ☐ Stress, relaxation, stress management, tension
- ☐ Suspiciousness
- ☐ Suicidal thoughts
- ☐ Temper problem, self-control, low frustration tolerance
- ☐ Thought disorganization and confusion
- ☐ Threats, violence
- ☐ Weight and diet issues
- ☐ Withdrawal, isolating
- ☐ Work problems, employment, over working, can't keep a job

Any other issues or concerns:

_____

_____

Look back over the concerns you have checked off and choose the top three you would like to address first.

1)_____ 2)_____ 3)_____

If there any information that was not covered on this form that you believe is relevant or important, or that you think I should know about, please explain here:_____

THANK YOU…

for taking the time to complete this extended information form. We will review it in upcoming sessions and use it to identify problem areas and discover / create solutions. New Life Counseling Center maintains strict confidentiality regarding the personal details of your case, subject to the exceptions noted in the contract section of the Disclosure Statement.

New Life Counseling Center, Inc.
14758 West Main Street
Cut Off, LA 70345
(985) 632.3077

Consent to use and disclose your health information

This form is an agreement between you, _____ and me/us _____. When we use the word "you" below, it can mean you, your child, a relative, or other person if you have written his or her name here _____.

When we examine, test, diagnose, treat, or refer you we will be collecting what the law calls Protected Healthcare Information (PHI) about you. We need to use this information here to decide on what treatment is best for you and to provide any treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing to let us use your information here and send it to others. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read this before you sing this Consent form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices we cannot treat you.

In the future we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it, you can get a copy by calling us at 985-632-7797, or from our privacy officer.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to do as you asked.

After you have signed this consent, you have the right *to* revoke it (by writing a letter *to* our Privacy Officer telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on but we may already have used or shared some of your information and cannot change that.

_____ _____
Signature of client or his or her personal representative Date

_____ _____
Printed name of client or personal representative Relationship to the client

_____
Description of personal representative's authority

_____
Signature of authorized representative of this office or practice

☐ Copy given to the client/parent/personal representative.

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We make every effort to make the counseling fees reasonable and affordable. Our fees are due when services are rendered and are as stated in the chart below:

Sliding Fee Scale

Household Income	Fee for Counseling
$25,000 & Below	$45
$26,000 — $30,000	$55
$31,000 — $40,000	$65
$41,000 — $50,000	$75
$51,000 & Above	$85

The sliding fee scale is based on the client's household annual income. Clients may be required to provide proof of income. Any request for a reduction in fees is handled by the New Life Board. Requests must be submitted in writing with a brief explanation of the need for reduction in fees.

Clients who fail to show up for scheduled appointments or do not give at least 24 hours notice of cancellation are required to pay their established fee for the missed appointment. Clients who cancel appointments at least 24 hours in advance are not charged for the session.

I have read, understand, and agree to the fee policies of New Life Counseling Center.

Client Signature:_____Date: _____

Counselor Signature:_____Date: _____