PERSONAL INFORMATION FORM – ADULT

NAME:

ADDRESS:

MAILING ADDRESS (if different from above):

Work Phone: Email Address:

Home Phone: Cell Phone:

MARITAL STATUS: Single Married Divorced Widowed

PERSON RESPONSIBLE FOR PAYMENT: DOB:

PERSON WHO REFERRED YOU:

May I send a note of thanks for the referral ( ) Yes ( ) No

SPOUSE’S NAME:

Work Phone: Cell Phone:

Person to contact in case of emergency: NAME PHONE #

 ACKNOWLEDGEMENT AND AGREEMENT:

When scheduling an appointment, I agree that I have contracted for that time. I understand that twenty-four (24) hours’ notice is required in order to cancel my appointment (Monday morning appointments must be canceled no later than the previous Friday morning). For the therapist to maintain consistency from one client to another and to maintain flexibility to be able to meet with clients, I understand that THERE WILL BE NO EXCEPTIONS. If I do not cancel an appointment within this time frame, I will be charged for the session **(payment must be made before further sessions will be scheduled).**

Should I decide to access my “out of network” insurance benefits (if available), I understand I am responsible for filing my insurance claims. I understand that I am ultimately responsible for any and all expenses accrued and that payment is due and will be made when services are received. If additional information is needed, I authorize a Tranquil Hearts Counseling Center therapist to release any medical or necessary data to process my insurance claims, and I accept responsibility for charges for this service.

I signify all information regarding the therapist's policies and procedures such as my rights as a client/responsible party, risks and benefits of services, confidentiality, emergencies, payment, and insurance have been discussed with me to my satisfaction. I attest I have received a copy of the Informed Consent, and that I comprehend all information. My signature below acknowledges acceptance of these policies and procedures, and my agreement to enter therapy (or for my dependent to enter into therapy) with a therapist from Tranquil Hearts Counseling Center.

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Client/Responsible Party Signature Date Therapist Signature Date

**HEALTH:**

General Condition: Excellent ( ) Good ( ) Fair ( ) Poor ( ) Date of last physical

Family Physician: Phone:

Physical Disabilities or Limitations:

Current Medications:

Injury/Illness/Allergies:

Have you ever contemplated or attempted suicide? Yes ( ) No ( )

If yes, when?

Have you ever contemplated or intentionally harmed another person? Yes ( ) No ( )

If yes, when?

Sleep Pattern: Normal ( ) Restless/Broken ( ) Insomnia ( ) Oversleep/Hard to Wake ( ) Nightmares ( )

Substance use? (Alcohol, Tobacco, Illicit Drugs)Yes ( ) No ( )

If yes, what, when, and/or how often?

**PREVIOUS COUNSELING OR PSYCHOTHERAPY?** Yes ( ) No ( ) If yes, when?

Received from: Phone:

**PLEASE RATE THE FOLLOWING 1-5 (1=AWFUL; 5=GREAT):**

Work Family Relationship Peer Relationship\_\_\_\_\_

Marriage/Significant Relationship\_\_\_\_\_ Overall Happiness \_\_\_\_\_

**CHECK ANY YOU HAVE EXPERIENCED IN THE PAST WEEK:**

Anger\_\_\_\_ Fear\_\_\_\_ High Energy\_\_\_\_ Sadness\_\_\_\_ Tension \_\_\_\_ Concerns about body \_\_\_\_ Repetitive Thoughts/Behaviors\_\_\_\_

**PLEASE COMPLETE THE FOLLOWING SENTENCES:**

Some of my strengths are…

Fun for me is …

I came here today…

Six months from now…

I testify that to the best of my knowledge, the information provided above is accurate and complete. I further grant permission for my therapist to consult and share, should she deem it necessary, pertinent information concerning me with other professionals in order to aid my counseling/growth process.

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Client Signature Date