Acct: _____

Rev: 11/19

New Beginnings
Counseling Center, PLLC

Adult Client Information

Name: _____ Age: _____ Birthdate: _____ SSN: _____

Address: _____

Employer: _____ Occupation/Job Title: _____

Work Address: _____

Home Phone: _____ Cell: _____

Work Phone: _____ Email: _____

Preferred Language (select one):
☐English
☐Spanish
☐Other: _____

Ethnicity (select one):
☐Hispanic or Latino
☐Non-Hispanic or Non-Latino

Race (select one or more):
☐African American
☐Native American
☐Asian
☐Caucasian/White
☐ Other: _____

Person Responsible for Payment (if different): _____

Birthdate: _____ SSN: _____ Phone: ☐Home or ☐Cell _____

Address: _____

Phone for Appointment Reminders: _____ *24-hour notice is required to avoid a possible cancellation fee.*

Emergency Contact: _____ Relationship: _____

Phone: ☐Home or ☐Cell _____ Work Phone: _____

How did you hear about New Beginnings Counseling Center (NBCC)? _____

Consent to Receive Services

Your signature below indicates the following:

- A copy of the **NBCC Provider-Client Service Agreement** and the **NBCC Notice of Privacy Practices** has been made available to you.
- You consent to accept these policies as a condition of receiving mental health services.
- You consent to receive appointment reminders from NBCC.
- You consent to contact of the person you identified in an emergency.
- Any questions you have regarding this information have been addressed.
- You acknowledge your right to ask questions about these policies at any time.
- The confidentiality of the information in your record may be protected by federal and/or state law. If the records are so protected, Federal Regulation (42 CFR Part 2) prohibits disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.

_____ _____

Signature of Patient or Personal Representative Date

_____

Printed Name of Patient or Personal Representative and Description of Personal Representative's Authority (if applicable)

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Personal and Family Information

What brings you to counseling today? _____

_____

What are your goals for counseling? _____

_____

History of Mental Health Services: Have you received mental health services in the past? ☐**Yes** ☐**No** If so, when? _____ ☐Counseling ☐Assessment ☐Psychiatric Care ☐Hospitalization

Briefly describe your experience (including clinician, diagnoses and outcome): _____

_____

Have you previously taken medications for mental health? ☐**Yes** ☐**No** If so, when? _____

If yes, please list medications and treatment outcome: _____

_____

Legal Involvement: Do you have any current or expected legal involvement (including divorce and custody proceedings)? ☐**Yes** ☐**No** If yes, please explain: _____

_____

Are you currently under an order of protection? ☐**Yes** ☐**No** If yes, please explain: _____

_____

Marital Status: ☐Single ☐Married (how long? _____) ☐Cohabitating ☐Separated ☐Divorced (what year? _____) ☐Widowed ☐Other: _____

On a scale of 1-10, how do you rate your overall satisfaction with your marriage? _____ ☐N/A

Are your parents divorced? ☐**Yes** ☐**No** If so, how old were you? _____

Regarding Your Spouse (if applicable): Has your spouse been married previously? ☐**Yes** ☐**No**

Are your spouse's parents divorced? ☐**Yes** ☐**No** If so, how old was your spouse? _____

Spouse's Name: _____ Occupation: _____

Household Information: Please provide the requested info for those currently living in your home:

Name	Age	Relationship to Self

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Psychological Concerns (check all that apply)

Feelings
- ☐ Tension
- ☐ Rage
- ☐ Low self-worth
- ☐ Dread
- ☐ Boredom
- ☐ Loneliness
- ☐ Guilt
- ☐ Anxiety/Panic
- ☐ Hopelessness
- ☐ Helplessness
- ☐ Worthlessness
- ☐ Depression
- ☐ Other: _____

Specific Fears
- ☐ Crowds
- ☐ Small Spaces
- ☐ Death
- ☐ Losing Control/Sanity
- ☐ Being Alone
- ☐ Other: _____

Thoughts
- ☐ Vivid Dreams/Nightmares
- ☐ Persecution
- ☐ Hearing Voices
- ☐ Seeing Visions
- ☐ Being out of Body
- ☐ Thoughts Confused/Controlled
- ☐ Racing Thoughts
- ☐ Obsessive Thoughts
- ☐ Suicidal Thoughts
- ☐ Homicidal Thoughts
- ☐ Other: _____

Trauma History
- ☐ Physical Abuse
- ☐ Sexual Abuse
- ☐ Emotional Abuse
- ☐ Violent Crime
- ☐ Domestic Violence
- ☐ Witness Violent Crime/Death
- ☐ Other: _____

Behaviors
- ☐ Self-Harm
- ☐ Anger Outbursts
- ☐ Eating Issues
- ☐ Spending Issues
- ☐ Stealing
- ☐ Gambling
- ☐ Poor Decision-Making
- ☐ Irresponsibility
- ☐ Obsessive/Compulsive Behaviors
- ☐ Impulsiveness
- ☐ Drug or Alcohol Use
- ☐ Other: _____

Spiritual Concerns
- ☐ Alienated
- ☐ Uninvolved
- ☐ Doubt
- ☐ Other: _____

Social and Occupational Concerns (Check all that apply)

Intimate Relationships
- ☐ Unfaithful Spouse/Infidelity
- ☐ Pregnancy before Marriage
- ☐ Fertility Issues
- ☐ Work Interference
- ☐ Conflict/Control Issues
- ☐ Sexual Issues
- ☐ Separation/Divorce
- ☐ Post-Divorce Issues
- ☐ Jealousy
- ☐ Other: _____

Sexuality
- ☐ Identity Concerns
- ☐ Changed Desire
- ☐ Misconduct
- ☐ Impotence
- ☐ Fearful/Inhibited
- ☐ Addiction/Excess
- ☐ Other: _____

Family
- ☐ Blended Family
- ☐ Custody Issues
- ☐ Conflict with In-Laws
- ☐ Domestic Violence
- ☐ Death
- ☐ Conflict/Fight
- ☐ Separation
- ☐ Illness
- ☐ Issues with Children
- ☐ Housing Issues
- ☐ Elderly Parents
- ☐ Other: _____

Finances
- ☐ Debt
- ☐ Bankruptcy
- ☐ Bad Checks
- ☐ IRS Problems
- ☐ Other: _____

Education/Occupation
- ☐ Lack of Career Direction
- ☐ Frequent Job Changes
- ☐ Poor Performance
- ☐ Dissatisfaction
- ☐ Harassment/Discrimination
- ☐ Lack of Education/Training
- ☐ Potential Job Loss
- ☐ Other: _____

Leisure
- ☐ No Free Time
- ☐ No Outside Interests
- ☐ Boredom
- ☐ Lack of Enjoyment
- ☐ No Friends
- ☐ No Social Outlets
- ☐ Other: _____

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Physical Health Concerns (Check all that apply)

Changes In:
☐Sleep Habits
☐Appearance/Hygiene
☐Energy Level
☐Weight
☐Other: _____

Cardiac Health
☐Shortness of Breath
☐Heart Racing
☐Rapid Breathing
☐Chest Pain
☐High Blood Pressure
☐Arrhythmia
☐Mitral Valve Prolapse
☐Other: _____

Digestive Health
☐Nausea
☐Vomiting
☐Stomach Pain
☐Diarrhea
☐Ulcers
☐Other: _____

Neurological Health
☐Attention/Focus Issues
☐Memory Problems
☐Headaches/Migraines
☐Vision Problems
☐Seizures
☐Head Injury
☐Confusion
☐History of Concussion
☐Speech Problems
☐Balance/Coordination Issues
☐Numbness/Tingling
☐Paralysis
☐Dizziness
☐Blackouts
☐Tremors
☐Other: _____

Lung Health
☐Asthma
☐Emphysema
☐Chronic Cough
☐Other: _____

Endocrine Health
☐Diabetes
☐Thyroid Issues
☐Hormone-Related Issues
☐Other: _____

Muscle/Bone Health
☐Chronic Pain
☐Back Issues
☐Weakness
☐Other: _____

Gynocological Health
☐Menstrual Difficulties
☐PMS Symptoms
☐Miscarriage
☐Endometriosis
☐Hysterectomy
☐Other: _____

Other
☐Skin Rash/Issues

Additional Health Information (Including treatment dates)

☐Cancer History: _____ ☐Surgeries: _____

☐Allergies: _____ ☐Other: _____

How would you describe your overall health? ☐Excellent ☐Average ☐Poor

Current Prescriptions, Over-the-Counter Medications, Herbs, and Supplements

Name	Dose/Frequency	Condition Treated	Date Prescribed

Alcohol, Tobacco, Marijuana and Other Drugs

Substance	Amount/Frequency	Currently Using (Y/N)	Comments

New Beginnings
Counseling Center, PLLC

Authorization to Release Protected Health Information

Client Name: _____ Birthdate: _____

Address: _____

City: _____ State: _____ Zip: _____

SSN: _____ Phone: _____

I authorize New Beginnings Counseling Center to disclose information from my mental health record to:

Provider's Name: _____

Facility Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Information to be received/released (check all that apply):

☐ Initial notification of services being received at NBCC
☐ Psychological and/or educational evaluation
☐ Diagnosis
☐ Progress notes
☐ Treatment information and updates
☐ Any applicable mental health information
☐ Other (specify): _____

Purpose of disclosure:

☐ Coordinate care with other providers
☐ Participate in counseling sessions as part of my treatment
☐ Referral for additional treatment/services
☐ Other (specify): _____

Your signature below indicates that you understand the following information:

- This authorization shall remain in effect for one year after date of consent unless otherwise specified.
- You may request a copy of this form after you sign it.
- You may revoke this authorization at any time by notifying New Beginnings Counseling Center in writing. It will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.
- Federal law/42 CFR part 2 prohibits unauthorized disclosure of information regarding the treatment of substance use disorders.

_____ _____
Signature of Client (or Parent/Guardian if under 18) Date

_____ _____
Printed Name of Client (or Parent/Guardian if under 18) Relationship to Client (If applicable)

Rhonda Atkins, LCSW
Laura Bhattacharjee, MA
Stacey Breitmann, Neurofeedback
Salida Brooks, LPC/MHSP
Kim Falk, LCSW
E. Grace Ford, LCSW
Donald Hanson, LCSW
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