Yadullah and Randall Counseling Services

Holistic Wellness

505 Old York Road Suite 100 Jenkintown PA 19046 267.420.0704

New Patient information

Patient's Full name:_____ D.O.B/Age_____

Highest level of edcuation:_____

Sibling(s):_____ Parents' names:_____

Address:_____ City_____ State_____

Parents' phone number_____ Parents' work phone number_____

Parents' email address:_____

Secondary Email address_____

Emergency Contact's Name and Number: _____ _____

Referral Source:_____

Primary Care Physician_____ Office Number:_____

Previous Mental Health Provider:_____

Inpatient treatment:_____

Previous/Current Diagnosis:_____

Previous Medications:_____

Current Medications:_____

Reason for services:_____

_____

_____

How long have you been experiencing issues/conflict/problems?

_____

_____

_____

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Informed Consent and Client Responsibilities

Please sign on the large lines and initial on the small lines below if you agree

I_____, do herby consent to mental health treatment at 505 Old York Rd Suite 100 19046, with Practitioner(s) Khalilah Yadullah and or Rasheda Randall.

Communication between a client and therapist is privileged and protected by law. No content from our session will be discussed with anyone without your consent. There are exceptions when, by law I am required to break confidentiality. *_____

Payments are made at the end of each session or prior to the session. * _____

Payment plans are available and will be made on a case by case basis. *_____

A 24-hour notice is required to cancel an appointment and not be charged. If a 24 hour notice is not given you will be charged for the full session. *_____

Please print and sign on the lines below

Client's name: _____

Parent/Guardian or Person responsible for payment:_____

Date_____

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Teletherapy Informed Consent

Please initial and sign if you agree, understand and would to like to have Teletherapy sessions.

Teletherapy sessions are now available. Teletherapy sessions allow clients opportunities to participate in sessions while in the comfort of their own home. These sessions are conducted from the privacy of the therapist's office and can be a convenient way for you to attend your sessions. Sessions are secure and HIPPA compliant on the therapist's end. Please make sure you are in a secure setting and using a secure device before starting your session. *_____

Please refrain from being in bed during the session. Please refrain from playing music and having flashing light on during the session. Please refrain from playing with the screen settings during the session when not related to connection issues (ex: changing the background, etc.) Sessions will stop immediately if client is driving, walking, around others/others in the camera view or if the background noise disrupts the session. **Full payment is still expected** *_____

Please start your session on time. If issues arise please contact your therapist directly. Without contacting the therapist and 15 minutes after the start time of your session will result in a **no-call-no-show with requirements of full payment.** *_____

Client's name: _____

Parent/Guardian or Person responsible for payment:_____

Date_____

Abuse History

Physical: Yes/No At what age_____ Reported to Police? Yes/No Details:_____

Sexual: Yes/No At what age_____ Reported to Police? Yes/No Details:_____

Emotional: Yes/No At what age_____ Reported? Yes/No Details:_____

Psychological: Yes/No At what age_____ Reported? Yes/No Details:_____

Culture and Ethnicity

_____

Developmental and Medical Health History

_____

_____

Educational History

_____

_____

Family and Relationships

_____

_____

Gender/Sexuality _____

Legal issues/ substance issues: _____

Spirituality and Religion

_____

Support System _____

_____

Other

_____

_____