

NEW CLIENT BIOGRAPHICAL INFORMATION		Date:
Name:	Date of Birth:	Age:
Address:		City, State, Zip:
Phone: (Home)	(Work)	(Cell)
May we contact you at home? <input type="checkbox"/> Yes <input type="checkbox"/> No    Would you prefer to be contacted at <input type="checkbox"/> home <input type="checkbox"/> work <input type="checkbox"/> cell?		
Email Address:		
May we add you to our email list <input type="checkbox"/> Yes <input type="checkbox"/> No?		
Occupation:		
Occupation:		Education:
Employer:		
Address:		
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Engaged <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Co-Habiting		
Spouse's Name:		Age:
Occupation:		Employer:
Names & Ages of Children:		
Number of Marriages & Length of Each:		
Religious Practice As A Child:		
Religious Practice As A Child:		As An Adult:
Name of Current Place of Worship:		
Address:		
May we contact your place of worship about our services (counseling, groups, seminars, etc.)?		
<input type="checkbox"/> Yes, but don't mention my name <input type="checkbox"/> Yes, and you can mention my name <input type="checkbox"/> No thanks!		
Emergency Contact:		
Phone: (Home)	(Work)	(Cell)
Who referred you, or suggested that you come to seek counseling? Check all that apply.		
<input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Friend <input type="checkbox"/> Employer <input type="checkbox"/> Other		
Please summarize the issues for which you are seeking help. If there is more than one reason, rank them in order.		
1)	2)	
3)	4)	
Circle the number that represents the severity of your concerns.		
Not Severe	1	2
	3	4
	5	Very Severe

Family of Origin (Parents, Siblings):

Name	Age	Relationship

Does anyone in your family suffer from alcoholism, an eating disorder, depression or anything that might be considered a mental health issue? Please explain.


**MEDICAL/EMOTIONAL HISTORY**

Physicians Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of last Physical: \_\_\_\_\_

Please list any medical treatments & operations within the last year:


Please list all current illnesses: (allergies, ulcers, tensions, back problems, skin disorders, etc.)


Please list any prescription medications you have taken within the last six months, circle current medications:


Have you had any prior personal counseling? \_\_\_\_ Yes \_\_\_\_ No (If yes, please list therapists, dates, and addresses)


Have you ever been hospitalized for an emotional disorder, eating disorder or chemical dependency, etc.?

\_\_\_\_ Yes \_\_\_\_ No (If yes, please list hospital, doctor's name and dates with a brief explanation)

Have you ever considered or attempted suicide? Please explain briefly.

Have you ever been sexually, physically, or emotionally abused? If so, by whom and how long ago?

Check any of the following problems that apply to you:

- |                                |                                  |                          |
|--------------------------------|----------------------------------|--------------------------|
| ____ Headaches                 | ____ Dizziness                   | ____ Fainting spells     |
| ____ Heart Palpitations        | ____ Poor appetite               | ____ Bowel disturbances  |
| ____ Fatigue                   | ____ Insomnia                    | ____ Nightmares          |
| ____ Sedative use              | ____ Problem with alcohol        | ____ Tension/anxiety     |
| ____ Panic attacks             | ____ Tremors                     | ____ Depressed           |
| ____ Thoughts of suicide       | ____ Drug use                    | ____ Difficulty relaxing |
| ____ Difficulty making friends | ____ Lack of enjoyment in life   | ____ Sexual problems     |
| ____ Difficulty keeping a job  | ____ Difficulty making decisions | ____ Legal Matters       |
| ____ Inferiority feelings      | ____ Poor home environment       | ____ Financial problems  |
| ____ Educational difficulties  | ____ Feelings of loneliness      | ____ Anger               |
| ____ Problems with children    | ____ Self-control problems       | ____ Memory problems     |
| ____ Career Choices            | ____ Parenting issues            | ____ Distractability     |
| ____ Binge/Vomit/Laxative Use  | ____ Loss of time/blackouts      | ____ Hyperactivity       |
| ____ Difficulty sitting        | ____ Compulsive behavior         | ____ Marital problems    |
| ____ Racing Thoughts           | ____ Divorce                     | ____ Separation          |

Briefly list what you think are your personal strengths and weaknesses. Think in terms of your personality, work habits, intellectual capabilities, and other skills or talents.

Strengths

Weaknesses

**MARKETING INFORMATION**

How did you hear about Living Well Dallas?

What type of seminars interest you?

- |  |   |                                       |                                |
|--|---|---------------------------------------|--------------------------------|
| <input type="checkbox"/> Relationships | <input type="checkbox"/> Depression       | <input type="checkbox"/> Nutrition    | <input type="checkbox"/> Other |
| <input type="checkbox"/> Anger         | <input type="checkbox"/> Sexual Abuse     | <input type="checkbox"/> Exercise     |                                |
| <input type="checkbox"/> Marriage      | <input type="checkbox"/> Spiritual Growth | <input type="checkbox"/> Organization |                                |
| <input type="checkbox"/> Pre-marriage  | <input type="checkbox"/> Parenting        | <input type="checkbox"/> Self-Image   |                                |

Any Additional Comments:

### **CLIENT RIGHTS AND RESPONSIBILITIES:**

I am pleased that you have selected me as your counselor. This document is designed to inform you about my background and qualifications as a therapist to ensure that you understand our professional relationship as well as your rights and responsibilities

### **EDUCATION:**

Masters of Arts in Professional Counseling, specialization in Marriage and Family Therapy, Texas State University

Bachelor of Arts in Psychology, University of Texas at Austin

### **METHOD OF TREATMENT:**

I see therapy as a special and unique relationship between client and therapist. It is important that I meet you, the client, where you are at—meaning, that what works for one client may not work for another. Therefore, therapy will be tailored to meet your individual needs. I also believe that early experiences, in part, help shape the kind of people we are today. This means that as the client, you may spend some time talking about your family of origin and past issues. I am also interested in what you expect from and what you hope to achieve from therapy. I feel that this goal setting is an important part of therapy, as it allows both you and I to see and feel what progress is made during the counseling process.

### **EFFECTS OF COUNSELING:**

There is always a risk of psychological side effects from psychotherapy. Sometimes symptoms worsen before they get better. Often therapy brings up painful emotions. Counseling is a personal exploration and may lead to major changes in your life perspectives and decisions. These changes may affect significant relationships, your job, and/or your understanding of yourself. Some of these life changes could be temporarily distressing. The exact nature of these changes cannot be predicted. Together we will work to achieve the best possible results for you.

### **LENGTH OF TREATMENT:**

Length of treatment is very difficult to predict. Some clients achieve their goals in only a few counseling sessions; others may require months or even years of counseling. As a client, you are in complete control and may end our counseling relationship at any time. You also have the right to refuse or discuss modification of any of our counseling techniques or suggestions that you believe might be harmful.

### **OUR RELATIONSHIP:**

Although you will be sharing personal things during the course of therapy, the tie between us is professional rather than personal. It is important to keep this relationship clear, so spending time with you socially or accepting phone calls from you at my home is inappropriate. Sexual intimacy between a therapist and a client is always inappropriate and illegal. If this has happened to you in the past, you should file a complaint with the appropriate licensing agency.

### **YOUR RIGHT TO PRIVACY:**

I will not share the things you tell me without your written permission and I will respect your privacy within the parameters. However, I may be forced to reveal our communications if:

- I suspect child or elder abuse.
- I feel that there is a threat that you will harm yourself or others.
- You become unable to take care of yourself and additional help is needed.

- There is a licensure board inquiry
- Legal matters are involved.

It is important in the field of psychotherapy to consult with other professionals about difficult cases. Therefore, it is possible that I will discuss your case with other therapists for the purpose of gaining information or insight about your situation. If this occurs, your name will not be revealed during these discussions.

**FEES:**

The cost for each session is **\$110 a 50 minute session**. Payment is expected in full at each session. You will be billed for missed sessions unless you call 24 hours in advance to cancel the appointment. By signing this agreement you authorize me to bill the following credit card for outstanding balances after 60 days of non-payment.

Credit Card # \_\_\_\_\_ Security Code \_\_\_\_\_ Exp. Date \_\_\_\_\_

Signature \_\_\_\_\_

**EMERGENCIES:**

In the event of an emergency, contact your physician, your local emergency room or the local police department when necessary and appropriate. It is your responsibility to seek the appropriate resources in emergency situations.

**\*\*\*I have read the preceding information and understand my rights and responsibilities as a client\*\*\***

\_\_\_\_\_  
Client signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Therapist signature

\_\_\_\_\_  
Date

Complaints may be directed to:  
**TEXAS STATE BOARD OF EXAMINERS OF PROFESSIONAL COUNSELORS**  
**1100 West 49<sup>th</sup> Street**  
**Austin, Texas 78756-3183**  
**(512) 834-6658**

## CANCELLATION AND GUARANTEE OF PAYMENT

I, \_\_\_\_\_, hereby authorize

Erica Gould, LPC of **LIVING WELL DALLAS** to charge the credit card listed below

for any balance I accrue that is outstanding after 60 days of non-payment on past due accounts. I

also authorize Living Well Dallas to charge my credit card if I miss a scheduled session or cancel within less than 24 hours.

\_\_\_\_\_  
*Credit Card Number*

\_\_\_\_\_  
*Security Code*

\_\_\_\_\_  
*Ex. Date*

\_\_\_\_\_  
*Name as it appears on card*

\_\_\_\_\_  
*Billing Address (please include zip code)*

\_\_\_\_\_  
*Phone number & email address*

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Witness*

\_\_\_\_\_  
*Date*

# LIVING WELL

: health & wellness center :

## Parental or Legal Guardian Consent for Treatment

By signing this statement, you agree to allow Erica Gould, LPC, to evaluate and counsel your child in group and/or individual sessions. Erica Gould, LPC agrees to keep the information you provide in accordance with Federal and State Confidentiality guidelines. Issues involving harm to self and others including child abuse are not confidential.

I hereby give consent to Erica Gould, LPC to conduct an assessment and interview on my my son/daughter \_\_\_\_\_

I understand that the questions asked may be of personal nature involving such things as chemical use, family history, etc. I understand that the information, which is given during the assessment, will be used to help determine the needs of my child and family. I acknowledge that I have read the Parental Consent statement.

\_\_\_\_\_  
Printed Name (Parent/Guardian)

\_\_\_\_\_  
Signed Name

\_\_\_\_\_  
Today's Date

**LIVING WELL DALLAS**  
**PH# 972-930-0260 FAX 972-559-3648**

**Patient Consent and Acknowledgement of Receipt of Privacy Notice**  
**- In accordance with federal *Health Insurance Portability and Accountability Act (HIPPA)***

I understand that as part of the provision of healthcare services, Living Well Dallas creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I have been provided with a *Notice of Privacy Practices* that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and Practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc . ) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment, or health care operations be restricted. I also understand that the Practice and I must a) agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information and b) agree to terminate any restrictions in writing on the use and disclosure of my protected health information which have been previously agreed upon.
4. My medical and care records may be disclosed to other Living Well Health & Wellness Center providers in order to manage my care including sharing diagnosis, testing results and patient care notes.

I hereby authorize Living Well Dallas and their representatives to be able to discuss my medical status and test results with the following individuals:

\_\_\_\_\_

\_\_\_\_\_  
Patient's Name (Printed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Signature (Or Guardian, if a Minor)