

Cleary Counseling and Consultation, Inc

Jacquyn R. Cleary, MS, LPC, LMFT

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Tulsa, OK 74119

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Date _____

CLIENT INFORMATION

Client Name _____

Address _____

City _____ State _____ Zip Code _____

Primary Contact Ph # _____ Cell Home Work

Secondary Ph # _____ Cell Home Work

Email Address _____ Do you text? Yes No

Birth date _____ Social Security Number _____

Occupation _____ Place of Employment _____

Education (Highest Grade Completed) _____ Marital Status _____

SPOUSE OR PARENT INFORMATION (If applicable)

Name _____

Address _____

City _____ State _____ Zip Code _____

Primary Contact Ph # _____ Cell Home Work

Birth date _____ Social Security Number _____

Occupation _____ Place of Employment _____

Education (Highest Grade Completed) _____ Marital Status _____

CHILDREN/SIBLINGS

<u>Name</u>	<u>Birth date/Ages</u>	<u>Grade in School</u>	<u>Living at Home</u>
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Name of Emergency Contact _____ Relationship _____

Emergency Contact Ph # _____ Cell Home Work

Preferred way of confirming appointments: _____ Home _____ Cell _____ Text _____ E-mail

Whom may we thank for referring you to us? _____

May we send a thank-you to the referral source? Yes _____ No _____

1. Briefly describe the problem for which you are seeking help.

2. How do you think we can best assist you?

3. Who is your personal physician/pediatrician? _____

4. When was your last physical examination? _____

5. Please describe any physical disabilities or health problems.

6. Please list any medications you are now taking:

7. Have you or your child received psychiatric help or psychological counseling before? (Circle) YES NO

If yes, with whom and dates? _____

Please check any of the following symptoms/problems that pertain:

- | | | |
|--|--|--|
| <input type="checkbox"/> Fears or phobias | <input type="checkbox"/> Inferiority Feelings | <input type="checkbox"/> Anger/Temper |
| <input type="checkbox"/> Shyness | <input type="checkbox"/> Suicidal thoughts | <input type="checkbox"/> Frustration |
| <input type="checkbox"/> Having to do things over and over | <input type="checkbox"/> Lack of ambition | <input type="checkbox"/> Self control |
| <input type="checkbox"/> Intrusive thoughts | <input type="checkbox"/> Blocked emotions | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Making decisions | <input type="checkbox"/> Tiredness | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Need to be in control of everything | <input type="checkbox"/> "Up-and-down" feelings | <input type="checkbox"/> Bowel Problems |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Lack of Energy | <input type="checkbox"/> Health Problems |
| <input type="checkbox"/> Relaxation | <input type="checkbox"/> Loss/Increased Appetite | <input type="checkbox"/> Weight |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Sleep problems | <input type="checkbox"/> Sexual Problems |
| <input type="checkbox"/> Coping with a traumatic event | <input type="checkbox"/> Concentration | <input type="checkbox"/> Alcohol or drug use |
| <input type="checkbox"/> Unresolved grief | <input type="checkbox"/> Procrastination | <input type="checkbox"/> Education |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Memory | <input type="checkbox"/> Work |
| <input type="checkbox"/> Unhappiness | <input type="checkbox"/> Relationship problems | <input type="checkbox"/> Career choices |
| | <input type="checkbox"/> Loneliness | <input type="checkbox"/> Parents |
| | | Separation/Divorce |
| | | <input type="checkbox"/> Legal Matters |

Parenting Issues

- | | | |
|-------------------------------------|---|---|
| <input type="checkbox"/> Discipline | <input type="checkbox"/> Divorce Issues | <input type="checkbox"/> Parenting Skills |
|-------------------------------------|---|---|

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CONSENT FOR TREATMENT AND ACCEPTANCE OF FINANCIAL RESPONSIBILITY

I acknowledge that I have received, read, and understand the policies and procedures as described in the Client Information forms and do so indicate by affixing my initials next to each of the following points:

_____ 1) Confidentiality - I am aware that an authorized agent of my insurance carrier or other third party payer may request and be provided with information about the type(s), cost(s), and date(s) of any services or treatments I receive so that payment may be provided to my therapist.

_____ 2) Payment and Billing Policies - I am aware that I am responsible for payment in full for any charges for services provided on my behalf unless they are specific services provided under the benefit plans of my insurance and as designated in any contract between my therapist and my insurance company and its lawful delegates.

_____ 3) Financial Responsibility - I am aware that I may terminate treatment at any time without consequence, but that I will still be responsible for payment of the services I have received. I am aware that if I have not paid for services received, my treatment may be discontinued and my account turned over for collection.

_____ 4) Appointments and Cancellations - I am aware that any cancellations of appointments must be made at least 24 hours in advance of the appointment and if I do not cancel or do not show up I will be charged for that appointment.

_____ 5) Intra-agency Consultation - I am aware that my therapist may consult or share information with other members of the professional staff in the therapeutic office if such consultation can be expected to be helpful in dealing with a problem being discussed in therapy and that those staff may have access to relevant information in my client file. I am also aware that no information about me, or my situation, may be communicated to others outside this therapeutic office without my explicit permission unless such action is required by law.

_____ 6) Risks of Psychotherapy - I am aware that the practice of psychotherapy is not an exact science and that predictions of the effects are not precise or guaranteed. I acknowledge that no guarantees have been made to me regarding the results of treatment or procedures provided by the therapist identified below.

_____ 7) Court Testimony and Custody Evaluations - I am aware that therapists make every effort to maintain client confidentiality and therefore do not testify in court regarding custody, divorce action, or other legal matters. I agree not to contact my therapist personally or via my attorney to testify in court. If my therapist is contacted/subpoenaed on my behalf for testimony, I agree to pay all court costs, legal fees, and hourly rates for my therapist's time.

_____ 8) I do _____ do not _____ have questions about this consent for treatment.

I do hereby seek and consent to participate in evaluation and or treatment with the therapist identified below.

Client Signature

Date

Therapist

Date