NEW CLIENT INFORMATION

Client Name:_____ Today's Date:_____
Social Security #:_____ Age:_____ Date of Birth:_____
Home Address:_____
City:_____ State:_____ Zip:_____
Employer:_____ Work Location:_____
Home #_____ Work #_____ Cell/Pager #_____
Person Responsible for Payment:_____
Referred by:_____

HOUSEHOLD MEMBERS

Name	Birth Date	Relationship	Are you legal guardian?
_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No

PERSONAL HISTORY

Highest level of Education:_____ School attended:_____
Leisure Activities/Hobbies:_____
_____

Alcohol Use: ☐ Never ☐ Occasional ☐ Weekly # of drinks/week:_____
Cigarette Use: ☐ No ☐ Yes # of packs/day_____

What concern(s) brought you to counseling?_____
_____
_____
_____

What changes do you want to see as a result of counseling?_____
_____
_____

MEDICAL HISTORY

Doctors involved in your health care	Specialty	Frequency Seen

Current Health Problems: _____

MEDICATIONS ☐ NONE

Prescription Medication	Dosage	Dr who prescribed	Reason for taking

Non-prescription Medication	Dosage	How Often	Reason for taking

Past Hospitalizations (medical, psychiatric care, chemical dependency) ☐ NONE

Dates	Reason	Hospital/Facility

PREVIOUS COUNSELING, EAP, or CHEMICAL DEPENDENCY SERVICES ☐ NONE

Therapist/Facility Name	Dates Seen	Reason	Helpful?
			☐ Yes ☐ No
			☐ Yes ☐ No

HOW MAY WE CONTACT YOU? (please check all that are okay)

By mail: ☐ at home ☐ at work
By phone: ☐ at home ☐ at work ☐ on cell/pager

CONSENT FOR TREATMENT

I, the undersigned, hereby voluntarily request to receive clinical services from Vidisha A. Patel, Ed.D. I understand that these services may include individual, group, family and/or marital therapy. I acknowledge that no guarantees have been made to me as to the effect of therapeutic assessments, therapy, treatment or care of my condition. I further understand that before beginning any treatment procedure I will be given an explanation of the nature and purpose of such treatment and any probable risks involved. I may refuse any and all treatment at any time.

I understand that the information I share with the therapist will be held in the strictest confidence with the exception of the following reasons as outlined by Florida Statutes:

(1) you consent in writing
(2) someone's life or safety is seriously threatened
(3) disclosure is required by law
(4) you file a benefit claim and the claims payor requires information

I understand that I am responsible for the payment of all services and I agree to provide payment should my insurance carrier fail to do so.

Signature_____ Date_____