

REBECCA LOWRY
Licensed Professional Counselor

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CLIENT INFORMATION FORM

NOTE: If the client is under 18 years of age, this form must be completed and signed by a parent or legal guardian.

Client Name (Last, First, Initial) _____ Date of Birth _____

Social Security # _____ (SS# is often required to file insurance) Gender: MALE FEMALE

Address _____ City/State _____ Zip _____

Telephone: Home # _____ Work # _____ Cell # _____

E-Mail: _____ Marital Status: SINGLE MARRIED DIV SEP WIDOW COHABIT ENG

NOTE: In providing cell number(s) you acknowledge that you are aware that a cell phone is not a secure and private line.

In which order should I use these numbers? _____

May I leave a recorded message? _____ May I leave a live message? _____ With whom? _____

Please list individuals I may contact ONLY IN CASE OF AN EMERGENCY:

Name _____ Phone # _____ Relationship _____

Name _____ Phone # _____ Relationship _____

NOTE: It is my policy to mark all correspondence "Confidential."

If you would like billing statements and/or correspondence from my office sent to an address other than your home please clearly print the address: _____

Name of person who referred you: _____

May we thank this person for the referral? YES NO Initial here if "yes" _____ Phone # _____

Address _____

Financial and Insurance Information

Billable Party: _____ Relationship to Client _____

Address _____ Phone # _____

Client's relationship to Primary Insured: SELF SPOUSE CHILD OTHER _____

Primary Insured's Name (if "self" skip the next two lines): _____

Address _____ City/State _____ Zip _____

Birth Date _____ MALE FEMALE Insured's SS# _____

Primary Insured's Employer _____

Primary Insurance _____

Primary ID # _____ Group # _____

Secondary Insurance _____

Secondary ID # _____ Group # _____

PATIENT'S, INSURED'S, OR AUTHORIZED PERSON'S SIGNATURE: I hereby authorize the release of any medical or other information necessary to process all claims for the client described above. I also request and assign payment of insurance, medical, and/or government benefits to Rebecca Lowry, LLC.

Signature _____ Date _____

BRIEFLY STATE NATURE OF CURRENT PROBLEM AND WHY YOU ARE SEEKING HELP NOW:

PREVIOUS INPATIENT AND OUTPATIENT TREATMENT AND/OR COUNSELING:

Where: _____ When: _____ Who: _____

Did it help? _____

Where: _____ When: _____ Who: _____

Did it help? _____

SOCIAL

Please list names and ages of everyone who lives in your home:

EDUCATION

Name of school if currently enrolled _____

Grades Completed (Circle One): 1 2 3 4 5 6 7 8 9 10 11 12

High School Diploma? YES NO GED? YES NO College? 1 2 3 4 Degree(s) _____

Graduate School? YES NO Degree _____ Area of Study _____

Business/Technical School? YES NO Course of Study _____

OCCUPATION

Present Occupation _____

Employer _____ Length of Employment _____

Do you enjoy your work? _____ Any problems? _____

MEDICAL

Primary Care Physician: _____ Phone # _____

Address _____

Date of last visit: _____ Reason: _____

May I notify your physician that I am treating you? YES NO If "yes" initial here _____

▪ List any **medications** or **nutritional supplements** you are taking currently and reason for taking them:

▪ List any serious illness or injuries, especially anything involving the head:

▪ List any surgeries (where you were put to sleep) you have had to date:

▪ List any allergies to foods or drugs:

Do you exercise on a regular basis? YES NO If "yes," what type? _____ Times per week? _____

Average number of hours of sleep per night _____ Problems? _____

Indicate if you are currently experiencing any of the following symptoms:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Family Problems | <input type="checkbox"/> Changes in Menstrual Pattern | <input type="checkbox"/> Inability to Make Decisions | <input type="checkbox"/> Inability to Relax |
| <input type="checkbox"/> Death of a Loved One | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Eating Problems |
| <input type="checkbox"/> Illness of a Loved One | <input type="checkbox"/> Allergy | <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Poor Body Image |
| <input type="checkbox"/> Relationship Problems | <input type="checkbox"/> Headache | <input type="checkbox"/> Unexplained Mood Changes | <input type="checkbox"/> Sexual Problems |
| <input type="checkbox"/> Parenting Difficulties | <input type="checkbox"/> Tingling or Numbness | <input type="checkbox"/> Poor Concentration | <input type="checkbox"/> Hearing Voices |
| <input type="checkbox"/> Financial Stress | <input type="checkbox"/> Changes in Bowel Habits | <input type="checkbox"/> Learning Problems | <input type="checkbox"/> Seeing Things Others Don't |
| <input type="checkbox"/> Problems at Work | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Irritability | <input type="checkbox"/> Racing Thoughts |
| <input type="checkbox"/> Legal Problems | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Loneliness | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Difficulty with Daily Routine | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Unexplained Anger | <input type="checkbox"/> Addiction |
| <input type="checkbox"/> Abuse | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Feelings of Sadness | <input type="checkbox"/> Pornography |
| <input type="checkbox"/> Spiritual Issues | <input type="checkbox"/> Muscle Tension | <input type="checkbox"/> Excessive Guilt | <input type="checkbox"/> History of Physical Abuse |
| <input type="checkbox"/> Health Problems | <input type="checkbox"/> Appetite Changes | <input type="checkbox"/> Social Withdrawal | <input type="checkbox"/> History of Sexual Abuse |
| <input type="checkbox"/> Muscle/Joint/Bone Problems | <input type="checkbox"/> Weight Gain or Loss | <input type="checkbox"/> Anxious or Nervous | <input type="checkbox"/> Thoughts of Harming Others |
| <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Loss of Sexual Interest | <input type="checkbox"/> Phobias | <input type="checkbox"/> Thoughts of Harming Self |
| <input type="checkbox"/> Recent Surgery | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Past Suicide Attempts |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Feelings of Worthlessness | <input type="checkbox"/> Compulsive Behaviors | <input type="checkbox"/> Other _____ |
| | <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Stress | <input type="checkbox"/> Other _____ |

Indicate if any of your blood relatives have had the following:

- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cardiac Problems | <input type="checkbox"/> Drug Dependency | |
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Mental/Emotional Problems | |

Check substances you use in any amount at all:

	Age First Used	How much do you use per...			Last Used
		Weekday	Weekend	Month	
<input type="checkbox"/> Beer	_____	_____	_____	_____	_____
<input type="checkbox"/> Liquor	_____	_____	_____	_____	_____
<input type="checkbox"/> Wine	_____	_____	_____	_____	_____
<input type="checkbox"/> Marijuana	_____	_____	_____	_____	_____
<input type="checkbox"/> Cocaine/Crack	_____	_____	_____	_____	_____
<input type="checkbox"/> Methamphetamine/Crystal	_____	_____	_____	_____	_____
<input type="checkbox"/> Heroin	_____	_____	_____	_____	_____
<input type="checkbox"/> Barbiturates (downers)	_____	_____	_____	_____	_____
<input type="checkbox"/> PCP, LSD (Hallucinogens)	_____	_____	_____	_____	_____
<input type="checkbox"/> Tobacco (in any form)	_____	_____	_____	_____	_____
<input type="checkbox"/> Other _____	_____	_____	_____	_____	_____

IS FAITH OR SPIRITUALITY AN IMPORTANT PART OF YOUR LIFE? PLEASE EXPLAIN:

WHAT ARE YOUR GOALS FOR COUNSELING?

CONSENT FOR TREATMENT

I hereby give my consent to my clinician, Rebecca K. Lowry, MA, LPC (N.C. license #4137) to provide evaluation, treatment and/or other services that we may mutually determine to be appropriate. I understand that services will be rendered in a professional manner, consistent with accepted ethical standards.

I understand that I will likely gain the most benefit from counseling if I am committed to the process and attend regularly. I also understand that it is not uncommon, over the course of therapy, to temporarily experience increased distress. This is an indicator that important work is underway and significant changes are beginning. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I acknowledge that I have received, have read the professional disclosure sheet and the HIPAA information sheet. I understand that I may ask questions at any time about any of the information given to me, and about treatment options.

I understand that the fee for the initial assessment is \$115, and fee for subsequent 50-minute session is \$100.00. Several insurance providers and other referral sources with funding are accepted for payment. I have read the fee schedule and understand that I must cancel an appointment at least 24 hours before the scheduled time. Otherwise I will be financially responsible for the full fee for the session. Payment will be due and payable to the therapist at the beginning of each session unless other arrangements have been negotiated. Please come prepared to pay by cash, check or credit/debit card.

I understand that if payment for services I receive here is not made, therapist may stop my treatment.

I understand that I may discontinue my involvement in therapy at any time. If I choose to do so, I will inform my counselor of my decision.

Due to the typical work schedules of counselors, I understand that it may take my counselor up to 24 hours to return a phone call. If at anytime during treatment I cannot wait for a return call from my counselor, I agree to contact my psychiatrist, family physician or go to the nearest emergency room.

Signature of Responsible Party

Date

CONSENT FOR TREATMENT OF CHILDREN AND ADOLESCENTS:

I/We consent that _____ may be treated as a client or clients by **Rebecca Lowry, MA, LPC**.

Signature of Parent or Guardian

Date

Signature of Parent or Guardian

Date