

Lynn Young, LMHC, NCC
Licensed Mental Health Counselor

1520 Lake Baldwin Lane, Unit B
Orlando, FL 32814
Phone: 407-247-5733
Email: lynn@seekachange.com

ADULT INFORMATION FORM

Name _____ Date of Birth _____ Age _____ M/F

Address _____

Home Phone: (_____) _____ May we leave a message? Yes No

Cell/Other Phone: (_____) _____ May we leave a message? Yes No

E-mail: _____ May we email you? Yes No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Emergency Contact name _____ Relationship _____ Phone _____

Referred by (if any): _____

MEDICAL HISTORY

Name of Primary Care Physician: _____

Physician's Address: _____ Physician's Phone: _____

Many managed care companies require that we have interaction with the client's physician to coordinate care. Do you give us consent to discuss your care with the above named doctor? (Circle One) YES NO

Please sign here for either answer: _____

Date of last medical evaluation: _____ Date of next appointment: _____

Current medications being taken:

- | | | | |
|----------|-------------------|------------------|---------------|
| 1) _____ | Dosage/Freq _____ | Start Date _____ | Purpose _____ |
| 2) _____ | Dosage/Freq _____ | Start Date _____ | Purpose _____ |
| 3) _____ | Dosage/Freq _____ | Start Date _____ | Purpose _____ |
| 4) _____ | Dosage/Freq _____ | Start Date _____ | Purpose _____ |

Prescribed by: _____

Have you ever been hospitalized for medical or psychiatric reasons? (Circle one) YES NO

Hospital	Mo/Yr	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you use recreational drugs? (Circle One) YES NO If no, have you used previously? (Circle One) YES NO

If yes, when did you stop? _____

Type of Drug	How much	How often
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you drink alcohol? (Circle One) YES NO If no, did you drink previously? (Circle one) YES NO

If yes, please list: _____

Type of Alcohol	How much	How often
_____	_____	_____
_____	_____	_____

Do you smoke cigarettes? (Circle One) YES NO

Do you use other forms of tobacco? (Circle One) YES NO If yes, what kind? _____

Describe any important medical history, chronic ailments, or other health problems you experience: _____

Describe any other health problems or important medical history about your immediate family members and close relatives, including chronic ailments: _____

Do you have any close relatives (father, mother, brother, sister, grandparent) who have experienced depression, anxiety, or other emotional difficulties? Please list: _____

School and Family History

Did you experience any developmental, academic or behavior problems as a child or while in school, with peers or teachers? (Circle One) YES NO If yes, please explain: _____

What was the last year of school you completed? _____ If you did not complete high school, please explain: _____

Please list schools (1) currently attending, (2) last attended, (3) graduated:

(1) School(s) _____ Year(s) _____

(2) School(s) _____ Year(s) _____

(3) School(s) _____ Year(s) _____

How would you describe your current support network? (friends, relatives, etc.): _____

Please check all information which applies to your biological parents:

MOTHER	<input type="checkbox"/> living	FATHER	<input type="checkbox"/> living
	<input type="checkbox"/> deceased		<input type="checkbox"/> deceased
	<input type="checkbox"/> married		<input type="checkbox"/> married
	<input type="checkbox"/> divorced		<input type="checkbox"/> divorced
	<input type="checkbox"/> remarried ___# of times		<input type="checkbox"/> remarried ___# of times

Do you consider someone else (step-parent, grandparent, etc.) to be one or both of your "real" parents? If so, whom? _____

Where do your parents live? Mother _____

Father _____

Describe your relationship with your mother while growing up: _____

Currently: _____

Describe your relationship with your father while growing up: _____

Currently: _____

List first names and ages of brothers & sisters, including yourself:

Name	Age	Relationship (natural, step, half, etc.)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Describe any family problems which occurred while growing up relating to:

Alcohol/drug abuse: _____

Sexual/physical/emotional abuse: _____

Any legal problems in the past 5 years: _____

MARITAL HISTORY

Marital status: Single/never married Married Separated Divorced Widowed Living w/someone

If currently married, when were you married? _____ If living w/someone, how long? _____

Spouse/Partner name _____ Date of Birth _____

Please list your children:

Name	Age	Relationship (biological/step)	Lives with
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MENTAL STATUS

Please check any of the following that describe how you have been feeling lately:

sad anxious depressed frightened guilty angry ashamed aggressive resentful
 worthless tearful irritable confused extreme ups/downs jealous hopeless helpless

Describe any other feelings you have had: _____

What activities or hobbies do you participate in? _____

Do you participate in regular exercise? (Circle One) YES NO Describe: _____

Describe your current working environment: _____

Have you had any change in sleeping habits? (Circle One) YES NO Describe: _____

Have you had any change in eating habits? (Circle One) YES NO Describe: _____

Have you ever considered suicide in connection to your current problem? (Circle One) YES NO

If so, please give a brief description with dates: _____

Have you ever considered suicide in the past? (Circle One) YES NO

If so, please give a brief description with dates: _____

Have you attempted suicide recently or in the past? (Circle One) YES NO

If so, please give a brief description with dates: _____

Have you had any homicidal thoughts recently or in regard to your current problem? (Circle One) YES NO

If yes, please explain: _____

Have you ever considered homicide in the past? (Circle One) YES NO

If yes, please explain: _____

LEVEL OF FUNCTIONING

List or describe any current impediments or problems in daily psychological, social or occupational functioning (i.e. isolation from friends/family, significant difficulty getting to work or completing daily tasks, severe financial strain, recent divorce, and problems with supervisor, etc.): _____

THOUGHTS: Please check any of the following that apply to you:

- I sometimes hear voices even though no one nearby is talking to me.
- I sometimes feel that forces outside of me control me.
- I sometimes feel that other people control my thoughts.
- I sometimes have the same thought over and over and cannot control it.
- I sometimes feel that someone is out to hurt me or do something against me.
- I am sometimes unable to control my behavior. Please explain: _____

Is there any other information regarding you or your family that you would like to share with your Therapist that is not covered on this form? You may also use this space to complete earlier responses.

Please list your therapy goals:

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Fee Agreement

I understand that the fee for counseling is \$100.00 per 50-minute session. Payment of fees is expected at the time of each appointment. Payments are accepted by cash, check, or credit card. Credit card payments must be made online and prior to your scheduled appointment at www.seekachange.com. I will be notified by email when you make a payment.

The charge for an insufficient check is \$25.00.

Missed Appointment Policy

Your appointment is reserved especially for you. If you are unable to keep an appointment, please call 407-247-5733 to cancel or reschedule 24 hours prior to the appointment time. IF you do not give 24-hour notification, and you do not keep your scheduled appointment, you will be charged the full fee for the appointment time. With my signature, I accept responsibility for payment of the counseling fee and payment for all missed appointments that have not been advised 24 hours before the appointment time.

Signature of Client/Representative

Date

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Informed Written Consent for Treatment

Therapy is a voluntary relationship between people that works because of clearly defined rights and responsibilities held by each person. The client may withdraw from treatment at any time without penalty and the therapist reserves the right to terminate treatment if deemed ethically or clinically necessary.

I agree to have the necessary information released in order for my therapist to provide treatment, obtain payment or assist me in obtaining reimbursement from my insurance company and to carry out health care operations.

Under the HHealth Insurance Portability and Accountability Act of 1996 (HIPAA), each therapist is considered a provider or "covered entity." By signing this informed written consent for treatment form, I am providing my consent for this therapist to use my protected health information for the purposes of treatment, payment and healthcare operations.

Without my signature on this consent form, my therapist cannot treat me.

Confidentiality

The therapist is committed to maintaining strict confidentiality of the therapy. No information can or will be told to anyone without prior written permission (Release of Information Form).

If the client is a minor, both parents (regardless of marital status or custody arrangement) have the right to be informed about their child's treatment. However, confidences shared in individual sessions by a child or adolescent will be respected so that an effective relationship can be established and maintained.

With regard to couples, family or group therapy, each of the clients must waive confidentiality, in writing, before any records or information can be released. My therapist cannot take responsibility for the actions of others.

There are exceptions to confidentiality, mandated/implicit by Florida law:

Where there is cause to suspect a child, adolescent or elder has been or may be abused.

Where there is reasonable cause to believe that you pose risk of imminent harm to yourself or to others

When there is a valid court order compelling records or witness testimony.

All client records are property of the therapist, and will be maintained in a locked, secure location for a minimum of seven (7) years, according to Florida's 491 Board of Clinical Social Work, Marriage and Family Therapy and Mental Health Counseling.

I consent to participate in Mental Health Treatment with my therapist, and agree to abide by the policies and procedures outlined in this document.

Client Signature/Date

Parents' Signature/Date (For Minor)

