bewelltherapy, PLLC

PROFESSIONAL OUTPATIENT THERAPY, DWI AND SUBSTANCE ABUSE SUPPORT CENTER

Welcome to our counseling center! We look forward to providing you with excellent and efficient counseling services. Please take a few minutes to fill out this form. The information will help us better understand your situation as well as how best to help you create and maintain solutions for your current situation. Please note: the information is confidential and will not be released to anyone without your written permission.

Today's Date: _____

Services Requested (Check all that apply):

___Individual adult ____Individual child ___Family ___Marital/Couple ____Group/Workshop

Client Name: _____

First Middle Last

Address: _____

City_____ State _____ Zip Code_____

Home Phone ( ) _____ Cell Phone ( ) _____

Email _____DOB: _____ Age _____

SSN: ____-____-____ **Insurance and Policy Number:** _____

Race: ___African-American ___Asian ___Caucasian ___Hispanic ___Indian ___Other

Marital Status: ___Married ____ Single ____Widowed ____Divorced _____Separated

 # Of Children_____ **Total # in household**_____

Highest Level of Education: _____ **Military Status:** ____ Yes ____ No

Employment Status: __Unemployed __ Employed __ Student __Retired __Homemaker

Primary Care Physician and Telephone Number: _____

Emergency Contact Person: _____**Relationship:** _____

Phone Number of Emergency Contact:_____

Legal Responsible Person (if client is a child):_____

Home Phone: _____ **Cell Phone:** _____ **Work:** _____

Revised 7/2015

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Source of Stress: What are the primary concerns that bring you here?

_____

_____

_____

_____

What is the most important thing you think your therapist should know about these concerns?

_____

_____

_____

Struggles: Is anyone in the family struggling with the following? **Check all that apply**

___Parent/Child conflict	___Partner violence/abuse	___School failure
___Couple concerns	___Sexual abuse/rape	___Truancy runaway
___Anger issues	___Alcohol/drug concerns	___Fighting w/ peers
___Depression/hopelessness	___Loss/grief	___Hyperactivity
___Anxiety/worry	___Legal issues	___Bed Wetting
___Communication problems	___Eating Problems	___Isolate/withdraw
___Divorce adjustment	___Sexuality/intimacy	___Child abuse
___Remarriage adjustment	___Suicide thoughts/attempts	___Eating Concerns
___Job problems/unemployed	___Major life changes	___Other

How much are the issues checked above disrupting your life?

____ A minor disruption ____ Somewhat of a disruption ____ Overwhelming disruption

Have you ever participated in counseling of any type?

____Yes _____No

Have you ever been hospitalized for a psychiatric problem?

Revised 7/2015

____Yes _____No

Have you experienced any type of health concern over the last 2 years?

____Yes _____No If yes, please explain: _____

Do you want to hurt yourself? ___Yes, with thoughts only___Yes, with a plan___No

Do you want to hurt someone? ____Yes, with thoughts only___Yes, with a plan___No

Do you have friends? ____None ____Few ____Many

Are you taking any medications? __Yes, please list name, dosage, and doctor ___No

Medication	Dosage	Doctor

Please let us know about your family's background:

Estimated yearly household income: (Financial information is used for clients without insurance and to seek outside funding to keep counseling fees affordable)

___Under $10,000 ___$10,000-$19,999 ___$20,000-$29,999 ___$30,000-$39,999
___$40,000-$49,999___$50,000-$59,999 ____$60,000-$69,999 ___$70,000 and over

Religion: ___Christianity ___Jehovah's Witness ___Buddhist ___Muslim ___Other

Importance of religion to you/your family:

___Very important ___Somewhat important ___Not Important

What are your goals for counseling?

1.

2.

3.

INSURANCE, PRIMARY CARE PHYSICIAN AND REFERRING PSYCHIATRIST AUTHORIATION

I understand that if therapy is being paid for using insurance, Be Well Therapy will release any and all records pertaining to treatment to the insurance company, the primary care physician, or your referring psychiatrist electronically, or by mail if such disclosure is necessary for claim processing, case management, and coordination of

treatment or utilization review purposes. I hereby authorize payments for medical services rendered to myself to be made whether to me or on my behalf to Be Well Therapy. I understand that I am responsible for any amount not covered by my insurance.

Client/Legal Responsible Person Signature:_____

Thank you for taking the time to complete this form. This information will help us understand your situation better and will allow us to assist you in reaching your goals as quickly as possible.

CONSENT FOR TREATMENT, OFFICE POLICIES, & GENERAL INFORMATION

Consent for Treatment

I give Be Well Therapy, PLLC permission to conduct assessment, treatment, and/or diagnostic procedures for myself or for my family member. By signing this form, I understand the counseling and therapeutic treatment methods will be explained to me upon my request and subject to my agreement. I acknowledge that this consent is truly voluntary and is valid until revoked. I understand that I may revoke this consent at any time.

Client Name (please print): _____

If client is a minor, name of legal guardian: _____

_____

Client's Signature Date

_____

Parent/Legal Guardian/In-Loco Parentis Signature Date

___ _____

Therapist's Signature Date