Phone: (480)704-3474 Fax: (888)221-2541

CONFIDENTIAL

Client Information Form

Please answer all of the questions below to the best of your ability.

Name _____ **Today's Date**:_____

Birthdate: _____ **Age**: _____

Address: _____

City:_____ **Zip Code:**_____

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

E-mail: _____

Primary Insurance:_____

Policy Number/ID Number:_____**Group Number**:_____

Policy Holder: _____

May I contact you by mail? *Yes*_☐_ *No*_☐_ **Cell?** *Yes*_☐_ *No*_☐_ **E-mail?** *Yes*_☐_ *No*_☐_

What is your preferred method of contact?_____

Occupation: _____

Relationship Status:

Single _☐_ **Partnered** _☐_ **Married** _☐_ **Separated** _☐_ **Divorced** _☐_ **Widowed** _☐_

In case of emergency, please notify the following:

Name	Relationship to You	Phone Number
1.		
2.		

The following questions in *italics* are optional.

Spouse/Partner Name: _____

Spouse/Partner Age: ____ *Occupation:* _____ *Length of relationship:* _____

Names and ages of children: _____

Names and ages of any other family members who reside with you:

_____

Number of sisters: _____ *Ages:*_____

Number of brothers:_____ Ages: _____

Ethnicity: _____

Do you have a disability? Yes☐ No☐

If yes, Learning ☐ Hearing ☐ Visual ☐ Physical ☐ Other ☐

Sexual Orientation: ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Transgendered

Religious/spiritual preference: _____

How important is your spirituality to your daily life? _____ (on a scale of 1 to 10)

(Not important) 1 2 3 4 5 6 7 8 9 10 (Extremely important)

Primary Care Physician: _____ **Phone: _____**

Are you receiving other services for your overall personal wellness? *Yes☐ No☐*

If yes, please list provider's name:_____

(I will not contact your providers or physician without your prior written consent)

List any health problems for which you currently receive treatment:

_____

_____

List the medications you are currently taking be specific, including supplements, alternative medicines, treatments or herbal remedies):

_____

_____

Exercise: How much? How often? Type of exercise?

_____

How often and how much alcohol do you use?

_____

How often and how much do you use other drugs?

_____

Is there a history of alcohol or substance abuse in your family? If yes, explain:

_____

_____

_____

Is there a history of emotional or psychiatric problems in your family? If yes, explain:

_____

_____

_____

Are there any current stressors or changes in your life? (moving, loss, finances, etc.)

_____

_____

Have you received counseling services in the past? *Yes*☐ *No*☐

When?_____ **With whom?** _____

Reason?_____

Was it helpful? *Yes*☐ *No*☐

Please describe your reason for seeking counseling at this time. Please be as specific as possible. What are your concerns? Please also estimate the severity of the problem (mild, moderate, severe, very severe)

_____

_____

_____

Have you ever tried to kill or seriously hurt yourself? *Yes*☐ *No*☐

Have you recently been thinking about hurting or killing yourself? *Yes*☐ *No*☐

Have you recently been thinking about hurting or killing someone else? *Yes*☐ *No*☐

Please check any of the following that are currently a concern for you and put a "✶" next to the issues that are the most difficult at this time :

Relationship Difficulties
- ☐ Marital / Partner problems
- ☐ Communication problems
- ☐ Remarried family problems
- ☐ In-laws
- ☐ Problems with your parents
- ☐ Brother / Sister problems
- ☐ Sexual relationship problem
- ☐ Separation
- ☐ Divorce
- ☐ Dating
- ☐ Premarital issues
- ☐ Withdrawing from others

Physical / Health Problems
- ☐ Headaches
- ☐ Stomach / intestinal problems
- ☐ Not hungry or not eating
- ☐ Throwing up after eating
- ☐ Difficulty falling asleep
- ☐ Unwanted waking up
- ☐ Sleeping too much
- ☐ Ongoing physical pain
- ☐ Fatigue–low energy

Children
- ☐ Child's misbehavior
- ☐ Child having problems
- ☐ Parenting issues
- ☐ Parent-child conflict
- ☐ Parent-child conflict

Work / School Related Issues
- ☐ Unemployed
- ☐ Job / school problem
- ☐ Finances
- ☐ Career / Education choices
- ☐ Learning disability

Emotional Difficulties
- ☐ Depression
- ☐ Sadness/Unhappiness/ Crying
- ☐ Extreme worry or fears
- ☐ Panic attacks
- ☐ Anger / Temper
- ☐ Loss of interest in things

Situation Difficulties
- ☐ Death of a loved one
- ☐ Violence (real or threatened)
- ☐ Physical abuse (past or current)
- ☐ Sexual abuse (adult or child)
- ☐ Stress
- ☐ My past
- ☐ Friends
- ☐ Religion
- ☐ Decision making

Individual Concerns
- ☐ Low self-esteem
- ☐ Feeling guilty, worthless, or hopeless
- ☐ Loneliness
- ☐ Shyness
- ☐ Sexual Identity/orientation
- ☐ Guilt
- ☐ Confusion
- ☐ Assertiveness
- ☐ Relaxation

☐ My Thoughts

Problems Coping with Life

☐ Use of Alcohol / Drugs to cope
☐ Compulsive gambling
☐ I cut / burn / hit myself
☐ Difficulty concentrating
☐ Problems remembering
☐ Disturbing thoughts I can't stop
☐ Repeated actions I can't stop
☐ I hear/see things that are not real
☐ Unhealthy coping strategies

Your Goals in Counseling: Goals provide us with a focus for our time together. Please list the goal(s) that you hope to achieve in our work together. Please be as specific as possible.

1) _____
2) _____
3) _____

How will you know if you are meeting your goals? What would you see yourself doing differently?

_____
_____
_____
_____
_____
_____
_____
_____

Do you have any concerns or questions about counseling?

_____
_____
_____
_____

Were you referred to Paper Cranes Behavioral Health Services? *Yes*_____ *No*_____

By whom or where did you hear about us?_____

Consent and Agreement to Treatment

Please read the following and initial each section as a notation that you have read and fully understand the information. Please sign at the end of this agreement to state that you are in full agreement with this Consent and Agreement toTreatment.

CLIENT/THERAPIST RELATIONSHIP: The relationship between you and your counselor is a professional relationship exclusive for therapeutic treatment. The therapeutic relationship is most effective when it remains strictly professional and therapeutic. _____*(client initials)*

AVAILABLE SERVICES: Paper Cranes Healthcare offers a wide array of Behavioral Health Services including individual counseling, family counseling, couples counseling, group therapy, consultative services, and wellness workshops. You have the opportunity for a free initial 20 minute consultation with our provider. _____*(client initials)*

RISKS AND BENEFITS: There are benefits to counseling and psychotherapy, as well as inherent risks. Risks and benefits come with all forms of treatment. Throughout counseling, uncomfortable emotions, feelings and thoughts may surface due to the discussion and encounter of personal issues. Overall, the benefits of counseling outweigh the risks and those may include improved personal relationships and emotional regulation, conflict resolution and overall enhanced wellness and life enjoyment. Your counselor will "walk with you at your pace" towards the attainment of your personal goals. _____*(client initials)*

COUNSELING: Paper Cranes Healthcare Behavioral Health Services provides outpatient counseling services and wellness programs intended to focus on many of the personal and life issues our clients encounter. The completion of initial paperwork prior to appointment is recommended however if the client chooses to complete at the initial appointment then the first session will allow for about 10 minutes of paperwork and a 40 minute session. The initial session consists of a discussion on what has brought you to counseling and what you would like to accomplish. Some questions will be asked about your current circumstances, life history and counseling goals. A treatment plan will be established. The counseling schedule will be planned and the next appointment will be set.
Counseling sessions will then be 50 minutes and will focus on your goals and issues that you would like to address. This is a time for you to safely talk and explore issues and experiences that are important to you. With your counselor, you will move in the direction of your goals at a pace that you are comfortable with. Factors that influence the session style and duration of therapy include:

- ~Your therapy goals and what you would like to accomplish in therapy.
- ~Action-oriented sessions vs. space to talk openly and honestly
- ~Individual acceptance and transparency in therapeutic process

If you and your therapist decide that other services would be more appropriate, we will assist you in finding a provider to meet your needs. The goal of our services are to provide our community with a place for a positive integration of their mind, body, and life in effort of optimal health and well being _____*(client's initials)*

FEE SCHEDULE: For providers that accept insurance, you will be responsible for the amount determined by your insurance provider. Copays and balances are due at the time of service. Fees for insurance billing providers will vary based on your insurance plan. We ask that all cancellations are communicated to Paper Cranes Behavioral Health by the end of business day prior to your appointment otherwise you will incur a fee of $50 depending on length of session. If you are more than 15 minutes late to your appointment, your appointment will be cancelled and you will be subject to the cancellation fee. _____*(client's initials)*

ADDITIONAL FEES: An additional fee will occur for client initiated or requested time outside of a counseling session and beyond the normal scope of direct counseling practice, including but not limited to: phone or email consultations, documentation review and preparation, time required for court hearings, legal proceedings, IEP meetings. The fee incurred will be billed at $100/per hour in 15 minute increments. I understand that I will be billed for these services and it is at the discretion of Paper Cranes Behavioral Health _____(*client's initials)*

AUTHORIZATION TO TREAT/RELEASE INFORMATION: I hereby give my permission to Paper Cranes Healthcare to administer treatment and to perform procedures that may be deemed necessary in the diagnosis and treatment of

my health. I also hereby assign to the above-named practice all benefits provided by my insurance company policy or policies for medical care. **I understand that I am financially responsible for any balance due on my account.** I also authorize the above practice to release all of my information in the processing of my claims. _____(*client's initials)*

EMERGENCY SERVICE LIMITATION:: PaperCranes Healthcare Behavioral Health Services does not offer emergency services. If you are experiencing increased difficulty, please contact us during regular business hours to schedule an appointment with our Nurse Practitioner and/or Counselor. If you are experiencing an emergency, please call 911 or go to the closest Emergency Room. If you are in Crisis and need support prior to your next appointment, please call the Maricopa County Crisis Line at 1-800-631-1314._____ (*client's initials)*

SUPERVISION OF CLINICAL CARE AND RECORDS: Paper Cranes Behavioral Health's service providers receive clinical supervision towards independent licensure.The supervision includes clinical case, counseling plan and clinical notes. The purpose of clinical review is for professional training purposes and support of excellent services. Please speak to your counselor regarding any further questions about their individual clinical supervisor and supervision. I understand that their name and contact information is available per my request to my counselor or the office manager of Paper Cranes Behavioral Health _____ (*client's initials)*

DISABILITY PAPERWORK AND FMLA: Our team of therapists and counselors cannot and willnot sign FMLA or Disability paperwork. If you would like a referral to one of our Primary Care Providers or a Psychiatrist, one can be provided at your request. _____ (*client's initials)*

DISCHARGE CRITERIA:

Should you choose to discontinue your counseling services with Paper Cranes Healthcare, or if you are discharged based on the criteria below, a list of referrals and resources is available in office and on our website (www.papercraneshealthcare.com). It can also be emailed to you at any time.

1. When you and your counselor identify that your counseling goals have been met and you decide to end the therapeutic relationship.

2. When you request counseling to end, and your counselor offers a closing session or referrals as clinically recommended.

3.. If there is no contact or communication from you for a period of 30 days, after 2 missed appointments, or after 2 attempted contacts; I will assume that you no longer intend to remain active in this therapeutic relationship and your case will be closed. You can return to therapy in the future if you decide to continue treatment, but may be subject to current waiting lists. _____ **(***client's initials)*

CONSENT TO TREATMENT: By signing this Client Information and Consent Form as the Client or Parent/ Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given an appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receive a behavioral health assessment, treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time.

Print Name:_____Signature:_____Date:_____

Print Name:_____Signature:_____Date:_____

Provider Name:_____Signature:_____Date:_____

Client's Rights

The counseling services are confidential. This means that your information is not shared or released to any persons or agencies regarding the fact that you are receiving counseling nor the nature of your concerns without your written consent. Couples or families seen as clients maintain that the therapeutic process requires that information shared individually with the client may not remain confidential from the other partner/ family members, as the therapeutic process requires open communication between both partners and all family members in a safe environment. Danger to self or others (i.e., suicide or homicide) may necessitate the breaking of confidentiality. In addition, by law I must report suspected child abuse and/or neglect.

Client's Rights: You, the client, have the right to:

- have your personal dignity, privacy, and freedom of choice respected
- receive respectful treatment that is beneficial to you in a safe setting
- ask questions about counseling techniques and strategies
- participate in the establishment of your goals and the evaluation of your progress
- request and receive information on professional qualifications or your Behavioral Health Provider
- an explanation of services offered, time commitments, fee scales, billing policies and cancellation policies prior to receipt of services
- to refuse the disclosure of information
- know the limits of confidentiality and the circumstances in which a therapist is legally required to disclose information to others
- report unethical and illegal behavior by a provider
- be informed of clinical supervision provided specific to your care
- request and in most cases receive, a summary of your file, including a diagnostic impression, your progress, and type of treatment
- request the transfer of a copy of your file to any therapist or agency you choose
- receive a second opinion regarding your counseling and/or a referral to another provider

My signature below indicates that I,_____ have read and understand the Clients Rights and Confidentiality Statements. If I have any questions at any time regarding these statements and rights, I will speak to the Behavioral Health Provider of Paper Cranes Healthcare.

Print Name:_____Signature:_____Date:_____

Provider Name:_____Signature:_____Date:_____