Information Form

Date: _____

Name: _____

Address: _____

City:_____State: _____ Zip: _____

Phone # _____Birth Date: _____

Marital Status:

❑ Single ❑ Partner ❑ Married ❑ Separated ❑ Divorced
❑ Widowed ❑ Engaged ❑ Other _____

Employer:_____Occupation: _ __ _____

Referred by: _____

Emergency Contact (Name, Phone Number): _____

Your Family

Relationship	Name	Age	Substance or Mental Health Concerns?

Are you providing care for a chronically or terminally ill family member? ❑ Yes ❑ No

Your Health Information

History of Mental Health Services

(inpatient, outpatient, hospitalization, therapy)

Date	Provider	Type of Treatment	How Long?	Diagnosis?	

Psychiatric Medications: _____

Psychiatrist (Name, Address, Phone): _____

Physician (Name, Address, Phone): _____

History of Physical Health Services

(inpatient, outpatient, hospitalization)

Date	**Provider**	**Type of Treatment**

Sleep Patterns:

- ❑ I have trouble falling asleep.
- ❑ I have trouble staying asleep.
- ❑ I sleep during the day instead of at night.
- ❑ I sleep more than 7-9 hours most nights.
- ❑ I sleep less than 7 hours most nights.

Medications:

Any Medical Conditions?

Do You Exercise? ❑ Yes ❑ No

If yes, how often? _____

Any problems with appetite or eating patterns/behaviors?

Substance Use

Do you have a problem with alcohol or drugs? _____

Have others said you drink/use too much? _____

How often do you drink/use drugs? _____

Ever been told to cut back? Do you want to stop? _____

How long have you been drinking/using? _ _____

Have you had legal problems related to drugs and/or alcohol (When, Type):

_____

Do you smoke cigarettes? ❑ Yes ❑ No

If yes, how many cigarettes do you smoke per day? _____

Do you use dipping tobacco? ❑ Yes ❑ No

If yes, how often? _____

Please check current concerns you have:

- ❑ Alcoholism
- ❑ Drug Abuse
- ❑ Relationship Issues
- ❑ Legal Issues
- ❑ Assertiveness
- ❑ Divorce
- ❑ Depression
- ❑ Grief & Loss
- ❑ Trauma
- ❑ Addiction (other than alcohol / drugs)
- ❑ Low Self Esteem
- ❑ Codependency
- ❑ School
- ❑ Anger
- ❑ Suicidal Ideas
- ❑ Unemployment
- ❑ Work
- ❑ Other: _____
- ❑ Abuse: physical, emotional, sexual
- ❑ Managing Medical Diagnosis/Treatment

Anything else you want me to know?

Confidentiality

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person, the mentalhealth professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies aplan for suicide, the health care professional is required to notify legal authoritiesand make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances

Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the rightto access the clients' records.

Insurance Providers (when applicable)

Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes type of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

Client Signature (Client's Parent/Guardian if under 18)

_____

Today's Date _____

Springer Counseling
Dr. Gary Springer
100 High Ridge Circle
San Marcos, TX 78666
512-754-6175

I, _____, understand that if I miss an appointment, without letting my counselor know in advance, or **if my insurance company does not fully reimburse for a session attended, I am responsible for paying the entire fee of $150 for each session**.

_____ _____
Patient's Signature Date