

# 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



**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? \_\_\_\_\_

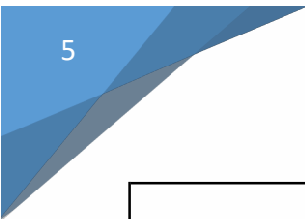
Do you use dipping tobacco?    Yes    No

If yes, how often? \_\_\_\_\_

**Please check current concerns you have:**

- |   |   |
|---|---|
| <input type="checkbox"/> Alcoholism                           | <input type="checkbox"/> Drug Abuse                             |
| <input type="checkbox"/> Relationship Issues                  | <input type="checkbox"/> Legal Issues                           |
| <input type="checkbox"/> Assertiveness                        | <input type="checkbox"/> Divorce                                |
| <input type="checkbox"/> Depression                           | <input type="checkbox"/> Grief & Loss                           |
| <input type="checkbox"/> Trauma                               | <input type="checkbox"/> Addiction (other than alcohol / drugs) |
| <input type="checkbox"/> Low Self Esteem                      | <input type="checkbox"/> Codependency                           |
| <input type="checkbox"/> School                               | <input type="checkbox"/> Anger                                  |
| <input type="checkbox"/> Suicidal Ideas                       | <input type="checkbox"/> Unemployment                           |
| <input type="checkbox"/> Work                                 | <input type="checkbox"/> Other: _____                           |
| <input type="checkbox"/> Abuse: physical, emotional, sexual   |   |
| <input type="checkbox"/> 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