

## NEW CLIENT INFORMATION

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Client Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Employer: \_\_\_\_\_ Work Location: \_\_\_\_\_  
Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell/Pager # \_\_\_\_\_  
Person Responsible for Payment: \_\_\_\_\_  
Referred by: \_\_\_\_\_

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### HOUSEHOLD MEMBERS

Name	Birth Date	Relationship	Are you legal guardian?
_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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### PERSONAL HISTORY

Highest level of Education: \_\_\_\_\_ School attended: \_\_\_\_\_

Leisure Activities/Hobbies: \_\_\_\_\_

Alcohol Use:  Never  Occasional  Weekly # of drinks/week: \_\_\_\_\_

Cigarette Use:  No  Yes # of packs/day \_\_\_\_\_

What concern(s) brought you to counseling? \_\_\_\_\_

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What changes do you want to see as a result of counseling? \_\_\_\_\_

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**MEDICAL HISTORY**

<b>Doctors involved in your health care</b>	<b>Specialty</b>	<b>Frequency Seen</b>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Current Health Problems:** \_\_\_\_\_

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**MEDICATIONS**     NONE

<b>Prescription Medication</b>	<b>Dosage</b>	<b>Dr who prescribed</b>	<b>Reason for taking</b>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

<b>Non-prescription Medication</b>	<b>Dosage</b>	<b>How Often</b>	<b>Reason for taking</b>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Past Hospitalizations (medical, psychiatric care, chemical dependency)**     NONE

<b>Dates</b>	<b>Reason</b>	<b>Hospital/Facility</b>
_____	_____	_____
_____	_____	_____

**PREVIOUS COUNSELING, EAP, or CHEMICAL DEPENDENCY SERVICES**     NONE

<b>Therapist/Facility Name</b>	<b>Dates Seen</b>	<b>Reason</b>	<b>Helpful?</b>
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

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**HOW MAY WE CONTACT YOU?** (please check all that are okay)

By mail:     at home         at work  
By phone:  at home         at work         on cell/pager

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## **CONSENT FOR TREATMENT**

I, the undersigned, hereby voluntarily request to receive clinical services from Vidisha A. Patel, Ed.D. I understand that these services may include individual, group, family and/or marital therapy. I acknowledge that no guarantees have been made to me as to the effect of therapeutic assessments, therapy, treatment or care of my condition. I further understand that before beginning any treatment procedure I will be given an explanation of the nature and purpose of such treatment and any probable risks involved. I may refuse any and all treatment at any time.

I understand that the information I share with the therapist will be held in the strictest confidence with the exception of the following reasons as outlined by Florida Statutes:

- (1) you consent in writing
- (2) someone's life or safety is seriously threatened
- (3) disclosure is required by law
- (4) you file a benefit claim and the claims payor requires information

I understand that I am responsible for the payment of all services and I agree to provide payment should my insurance carrier fail to do so.

Signature \_\_\_\_\_ Date \_\_\_\_\_

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