Good Company Christian Counseling
& Life Coaching, LLC
2475 Collingwood Blvd.
Toledo, Ohio 43620
419-822-7319

CLIENT INFORMATION AND POLICY STATEMENT

Welcome! As a new client, it is important that we provide you with information relevant to treatment, confidentiality, and office policy. Please read, sign and date the following Client Information and Office Policy statement. The therapist working with you will be pleased to respond to any questions you may have regarding treatment, confidentiality or office policy during your initial session.

APPOINTMENTS: Our entire staff makes every effort to be on schedule and to respect the busy lives of our clients. Appointments are usually scheduled for 50-minute sessions. Your appointment time is reserved especially for you and implies obligation of your presence. Both you and your therapist need to evaluate the process and progress of therapy periodically and renegotiate the need for further appointments. It is in your best interest to do so. It is the therapist's ethical responsibility to end the relationship when it is reasonably clear that the client is not benefiting from treatment.

CONFIDENTIALITY: Ohio law requires that issues discussed during the course of therapy with a psychologist or therapist be confidential, meaning that information you reveal will not be discussed with others without your knowledge and written consent. Information will not be sent or disclosed to others without a signed release from you. Exceptions to confidentiality include the following: situations of potential harm to oneself (suicide) or others (homicide); suspected child abuse or neglect; in the instance where the court may subpoena records, the release of confidential materials is, or maybe, required of your therapist.

PAYMENT FOR PROFESSIONAL SERVICES RENDERED: Please refer to Counseling Fees form.

CANCELLATIONS AND MISSED APPOINTMENTS: If you need to change your appointment, please allow 24-48 hour notice. This will allow us to schedule another client, needing care, in your reserved time. ***ALL MISSED APPOINTMENTS WITHOUT A 24 HOUR NOTICE ARE SUBJECT TO A $70.00 BROKEN APPOINTMENT FEE!***

OVERDUE ACCOUNTS: We understand that financial hardships may occur to all of us. If you cannot pay your bill because of unforeseen circumstances, individual payments can be arranged. If more than ninety days elapses without payment, unless arrangements have been made, we reserve the right to turn the account over for collection.

STAFF: Some therapists in this office are directly supervised by **R Carter Thomas, LISW-S** as required by Ohio law. She will have access to your case and file. You have the right to ask foran appointment with her at any time.

TELEPHONE: There is a 24-hour answering service that receives our calls. The telephone is listed at the top of this page.

Date _____ Signature _____

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Release of Confidential Information
To Managed Care Organizations

I _____ understand that Good Company Christian
(parent/guardian)
Counseling, LCC., will be discussing my case with

_____, Managed Care Organization. The purpose of the clinician's consultation with my Managed Care Organization will be to discuss diagnosis, goals for treatment and progress toward those goals. As a part of the release of information, issues to be discussed will be my family history, current personal liabilities and assets, which includes strengths and my physical, medical condition. The medical condition will involve reporting what medical treatment I am currently receiving including medications. The family history will involve issues such as composition of family of origin, illness in family of origin and my relationship to my family of origin. The issues to be discussed are my personal liabilities and assets which include my employment, access to a support network and ability to draw on other support networks for the purpose of reducing the reoccurrence of the current problem presented in therapy.

While the above information is an estimate of topics to be discussed, please keep in mind that it is not a limit to the topics discussed with your Managed Care Organization. In an effort to reserve some privacy, I **R Carter Thomas, LISW-S** will attempt to share only the information necessary for the approval of counseling sessions, reserving the right to not discuss the intimate details of counseling sessions.

Signed _____ Date _____
(parent/guardian)

PATIENT INFORMATION (please print clearly & complete ALL information front & back)

Name: _____ (first) (M.I.) (last)

Address: _____ (street) (city) (state) (zip)

Home Phone: (___) _____ Work Phone: (___) _____ Cell: (___) _____

Date of Birth: _____ Social Security Number: _____

Gender: ___ Male ___ Female

Marital Status: ___ Married - Spouse's Name: _____ Work Phone: (___) _____
___ Single
or
___ Minor - Parent/Guardian Name: _____ Work Phone: (___) _____

Patient's Employer or School _____ Status: _____
Address: _____

Primary Care Physician (PCP) _____ (name)
Complete Address: _____ (phone)

In Case of Emergency, contact: _____ (name) (phone) (relationship to patient)

BILLING INFORMATION

Person responsible for charges for this patient? ___ Patient = Sign at bottom AND turn over to complete.
(other than insurance) or ___ Other = Please complete the following information.

Name: _____ Relationship to Patient: _____

Address: ___ Same as patient
___ Other: _____ (street) (city) (state) (zip)

Home Phone: (___) _____ Work Phone: (___) _____ Cell/Pager: (___) _____

Date of Birth: _____ Social Security Number: _____

Marital Status: _____ Gender: ____ Male ____ Female

Employer: _____
Address: _____ Employment Status: _____

I UNDERSTAND THAT (regardless of my insurance status) I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE OF MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED. I HAVE READ ALL THE INFORMATION PROVIDED ON R CARTER THOMAS & ASSOC. OFFICE POLICIES FORM AND HAVE COMPLETED THE ABOVE ANSWERS. I CERTIFY THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY YOU OF ANY CHANGES IN MY HEALTH STATUS OR THE ABOVE INFORMATION.

_____ _____
atient Signature Date Parent/Guardian Signature (If Minor) Date

NAME: _____ DATE: _____

Please list your **PRESCRIPTION MEDICINES and ALLERGIES:**
(IF NONE-please write N/A large over applicable section/s)

Start Date	Name of Medicine	How Much I Take	When I Take It	Used For	Refills
3-1-02	Example	1 tablet/400mg	3 times a day	Arthritis	2

ALLERGIES: (IF NONE-please write N/A over this entire section)

KEEP THIS ON HAND TO SHOW TO DOCTORS, PHARMACISTS,OR NURSES!!

ADULT PERSONAL HISTORY
(Ages 18 & older)

CASE # _____

CLIENT'S NAME: _____ AGE: _____ DATE: _____

Person completing form for Client: _____ Relationship to Client: _____

Please take your time and complete this entire form. The information that you give will help your therapist understand you better. You may also use the back of this form if necessary. Thank you!

	FULL NAME	AGE	LIVING WITH YOU?	IF DECEASED, YEAR & CAUSE
FATHER:				
MOTHER:				
SPOUSE/PARTNER:				
CHILDREN: 1				
2				
3				
4				
5				
6				
7				
8				
9				

Who else lives with you other
Than he ones checked above?

CURRENT MARITAL STATUS	MONTHS/YRS	CURRENT MARITAL STATUS	MONTHS/YRS
UNMARRIED		SEPARATED	
LIVING TOGETHER		DIVORCED	
MARRIED		WIDOWED	

Who were you raised by? _____ Were you adopted? _____

Age first married: ____ Number of times married: ____ or lived with a partner: ____ Number of times divorced: ___

Number of Brothers Living: ___ Deceased: ___ Sisters Living: ___ Deceased: ___ How many are older than you? ___

Which family members are you close to now? _____

What recently happed to make you decide to seek help now? _____

_____

_____

What would you like this clinic to do for you? _____

_____

_____

SYMPTONS: CIRCLE THE NUMBERS OF ALLITEMS THAT APPLY TO YOU NOW OR WITHIN PAST MONTH:

1) Depression
2) Crying Spells
3) Hopelessness
4) Relationship problems
5) Relationship breakup
6) Loneliness
7) Emptiness
8) Loss of appetite
9) Sleep Disturbance
10) Nightmares
11) Hearing Voices
12) Feeling Controlled
13) Feeling talked about
14) Seeing things others don't
15) Unusual thoughts
16) Increased alcohol use
17) Increased drug use
18) Blackouts/memory loss
19) Withdrawal symptoms

LOSS OF CONTROL IN:

20) alcohol use
21) drug or medication use
22) food bingeing
23) purging
24) yelling or breaking
25) hitting
26) endangering self
27) endangering others
28) gambling
29) spending
30) Nervous/anxious
31) Panic attacks
32) Can't concentrate
33) Confusion
34) Mood swings
35) Racing thoughts
36) Fear of dying
37) Job stress
38) Decreased activity
39) Decreased activity
40) Not seeing friends
41) Guilt/Shame
42) Financial worries
43) Sexual problems
44) School problems

Please explain each item that you circled (You may also write on the back of this page):

_____

_____

_____

_____

Do you have any thoughts now or recently of wishing you were dead? _____

Do you have any thoughts now or recently of harming yourself? _____

Have you ever attempted to commit suicide or seriously harm yourself? _____ When? _____

Please explain (How, why): _____

Has anyone in your family attempted or committed suicide? _____ Who? _____

Do you have any thoughts now or recently of harming others? _____ Who? _____

Please explain: _____

Have you ever attempted to kill or seriously harm someone else? _____ Who? _____

Please explain: _____

Is our partner afraid of you sometimes? _____ Are your children? _____

Do you ever threaten, throw things, punch walls or slam doors, yell or scream at your partner or children? _____

Have you ever hit, slapped or choked any of your loved ones? _____ Who? _____

How do you feel about your behavior afterward? _____

Have you ever been the victim of physical, sexual or verbal abuse? _____

INTERESTS/ACTIVITIES (Check all that apply to you)

__Television
__ Movies/videos
__ Video games
__ Music listening
__ Play instrument
__ Sing
__ Dance
__ Read
__ Write
__ Draw

__ Be with friends
__ Be with family
__ Be alone
__ Cook
__ Eat
__ Go to museums
__ Volunteer work
__ Travel/sight-see
__ Pray/Read Bible
__ Church activities

__ Shop
__ Go to school
__ Study
__ Get high
__ Exercise
__ Play sports
__ Watch sports
__ Hike
__ Ride bike
__ Roller-blade/skate

__ Fix/repair things
__ Sew/knit/crochet
__ Build/decorate
__ Gardening
__ Photography
__ Car for elderly/ill
__ Child-care
__ Play cards
__ Gamble
__ Sex

Other interests/activities: _____

Have you recently lost interest in activities that you normally enjoyed? _____

Do you feel you spend enough time on your interests, hobbies (non-work activities)? _____

EMPLOYMENT: What do you do for a living? _____

Current employer: _____ Title: _____ Years on job: ____ Pay rate: _____

Have you ever been fired from a job? ____ How many times? _____ Reasons: _____

Do you currently have any problems on the job? _____

FINANCIAL: Do you have any financial problems? _____

What types of financial aid do you receive? _____ Monthly amount: _____

What types of aid do other household members receive? _____ Monthly amount: _____

LEGAL HISTORY:

ARREST DATE	CHARGE	CONVICTED?	SENTENCE

Are you currently on Probation? _____ Parole? _____ Ending Date: _____

Are you involved in any lawsuits? _____

Do you have any upcoming Court dates? _____ Reason: _____

MILITARY SERVICE: Type: _____ When? _____

Type of Discharge: (Explain if Dishonorable): _____

Describe any combat experience: _____

Are you troubled now by your military experience? _____

EDUCATION: Last grade completed: ____ Degree ____ In school now? _____

Special training or skills? _____

Hope or plan to go to school? _____

ETHNIC/CULTURAL BACKGROUND: _____

Do you have any ethnic or cultural concerns? _____

RELIGIOUS/SPIRITUAL BACKGROUND: _____

Current religious/spiritual involvement/activities: _____

Do you have any religious or spiritual concerns now? _____

SEXUAL/GENDER ISSUES (Describe any sexual concerns or gender issues that you might have):

_____

PREVIOUS MENTAL HEALTH OR ALCOHOL/SUBSTANCE ABUSE TREATMENT:

OUTPATIENT: Have you seen a therapist or counselor for personal or family problems or alcohol/drug treatment? ____

When, where? _____

Reason: _____

Any involvement in self-help **Support groups** such as AA, NA, ACOA, CODA, RR, EA, AIM, ISA, Recovery, etc? _____

When, where: _____

Reason: _____

INPATIENT: Have you been in hospital or Residential treatment for personal problems or alcohol/drug treatment? ____

When, where? _____

_____

_____

Reason: _____

Were any of your treatment experiences helpful? _____ Explain: _____

What medications were you prescribed? _____

Which of those medications were helpful? _____

Have any family members been hospitalized for personal or substance abuse problem? _____

Who, when, where? _____

PHYSICAL HEALTH

CIRCLE THE NUMBER OF ALL ITEMS THAT APPLY TO YOU NOW OR IN THE PAST:

1) ALLERGIES
2) ASTHMA
3) ULCERS
4) SEIZURES
5) STOMACH PROBLEMS
6) PANCREATITIS
7) LIVER DISEASE
8) HEPATITIS
9) THYROID PROBLEMS
10) CHRONIC FATIGUE
11) INSOMNIA
12) VISION PROBLEMS
13) SPEECH PROBLEMS
14) HEARING PROBLEMS
15) HYPOGLYCEMIA (LOW BLOOD SUGAR)
16) DIABETES
17) LOW BLOOD PRESSURE
18) HYPERTENSION (HIGH BLOOD PRESSURE)
19) HEART DISEASE
20) BACTERIAL ENDOCARDITIS
21) PROLAPSED MITRAL VALVE
22) CIRCULATION PROBLEMS
23) LARGE WEIGHT GAIN
24) LARGE WEIGHT LOSS
25) APPETITE DISTURBANCE
26) SEXUALLY TRANSMITTED DISEASE
27) HIV POSITIVE
28) AIDS
29) CANCER
30) MAJOR SURGERY
31) MAJOR ACCIDENTS
32) HEAD INJURY
33) NECK/SHOULDER TENSION
34) SEVERE HEADACHE/MIGRAINE
35) CHRONIC PAIN
36) INJURY FROM ABUSE
37) BROKEN BONES
38) HIGH CHOLESTEROL
39) IMPOTENCE
40) IRRITABLE BOWEL
41) LUPUS
42) BACK PROBLEMS

FOR EACH ITEM CIRCLED GIVE DATE OF PROBLEM & THE TREATMENT RECEIVED (You may also write on back).

_____

_____

_____

_____

_____

_____

_____

Primary Physician's Name: _____

Physician's Address: _____ Phone: _____

Date of your last physical: _____ Results: _____

List all medications that you are on for medical reasons: _____

_____

_____

Do you skip meals often? _____ Eat a well-balanced diet? _____ Do you eat much junk-food? _____

Do you exercise regularly? _____ How often? _____ What do you do? _____

For women: Number of pregnancies: _____ Live Births: _____ Miscarriages: _____ Stillbirths: _____ Abortions: _____

Do you have a normal menstrual cycle? _____ Normal menstrual flow? _____ Are you pregnant? _____

Premenstrual syndrome? _____ Menopause? _____ Hormone therapy? _____

ALCOHOL AND DRUG USAGE (Please complete this section even if don't feel that your usage is a problem)

About how many days a week, on the average, do you drink beer or wine? _____

About how many days a week, on the average, do you drink liquor? _____

On the days that you drink, about how much do you consume? _____

About how many days a month do you drink a large amount in one day? _____

How much are you capable of drinking in one day? _____

How often do you become sick (nausea, stomach pain, hangovers) after drinking: _____

How many times a month, on the average, do you experience Blackouts (memory lapses) when drinking? ____

What is the longest period that you didn't drink? _____

What helped you to stay sober? _____

If you used to drink, when did you stop? _____ Why? _____

How many days a week, on the average, do you use illegal drugs? _____

On the days that you use illegal drugs, about how much do you use? _____

_____

Have you ever overdosed when getting high on drugs? _____

What is the longest period that you didn't use drugs? _____

What helped you to stay clean? _____

If you used to use drugs, when did you stop? _____ Why? _____

Do you ever take more of your prescription medication than you are supposed to? _____

Please explain: _____

Have any family members had an alcohol or drug problem? ____ Who? _____

Please describe: _____

_____

Has your drinking or drug usage ever caused you problems in any of the following areas:

____family ____employment ____legal ____emotional
____social ____financial ____behavior ____physical/medical

Does a relative, loved one, friend, court or employer feel that you have an alcohol or drug problem?

IF YOU ANSWERED YES TO EITHER OF LAST TWO QUESTIONS, COMPLETE NEXT PAGE.

TYPE OF DRUG	AGE OF 1ST USE	AT WHAT AGES WERE YOU USING IT REGULARLY?	AVERAGE NUMBER OF DAYS USED EACH WEEK	USUAL AMOUNT USED ON AN AVERAGE DAY	NUMBER OF DAYS USED IN PAST 30 DAYS	AMOUNT USED IN THE LAST 48 HOURS	DATE YOU LAST USED
Coffee, Cola Caffeine pills							
Cigarettes							
Beer, Wine							
Liquor							
Marijuana							
Crack Cocaine							
Cocaine powder							
Heroin: Snort							
Heroin: Shoot (IV)							
Methadone							
Pain Pills: Type:							
Codeine: Tylenol 3,4 Other:							
Muscle relaxers: Soma, Flexeril Other:							
Tranquilizers: Valium, Librium Other:							
Glue Poppers Aerosols							
PCP, LSD Mescaline							
Meth-amphetamine Speed, Ritalin							
Phenobarbital Sleeping pills							
Steroids							
Other:							
Other:							

What are your drugs of preference: 1) 2)

Therapist/Credentials: _____ Date: _____

Supervisor Signature _____ Date: _____