

Gina R. Carter, LPC

5601 Democracy Dr., Suite 225, Plano, Texas 75024

Office: 469-224-0123 Fax: 469-214-0020

CLIENT INFORMATION

Client Name: _____ Date of Birth: _____

Address: _____ SSN: _____

City/State/Zip: _____

Employer: _____ Work Phone: _____

Home Phone: _____ Cell: _____

Is it ok to leave a message at these numbers? ____ yes ____ no

Email address: _____ May we send you emails? ____yes ____no

Preferred method of contact: ____E-mail ____Phone ____Text

PARENT/SPOUSE INFORMATION

(Please Check One) Spouse: ____ (or) Parent: ____

Name: _____ Date of Birth: _____

Address: _____ SSN: _____

City/State/Zip: _____

Contact Number: _____

INSURANCE INFORMATION

Name of Insurance Company: _____ ID#: _____

Insured Name: _____ Policy/Group #: _____

Insurance Phone Number (for benefits) _____

Insured DOB: _____ Authorization Number _____

MARITAL STATUS

Single _____ Married _____ Separated _____ Divorced _____

List children and their ages: _____

List any other individuals living in the home:

Is there any family history of mental illness or substance abuse? Give brief explanation:

Spiritual Background _____

How much influence does your faith have in your day-to-day living?

1 2 3 4 5 6 7 8 9 10

Not at all

Neutral

High Priority

Reasons for seeking counseling:

ASSESSMENT

Please list family, friends, support groups, or community groups that are helpful to you:

History of alcohol/drug abuse? _____ yes _____ no

Quantity of current alcohol consumption daily: _____

List any family history of abuse and the nature of the abuse (substance abuse, verbal, sexual, physical, emotional, etc.)

MEDICAL HISTORY & INFORMATION

Are you currently being treated by a physician for any **medical conditions**? If so please explain and list **medication** you are currently taking.

PREVIOUS OR CURRENT COUNSELING

Have you ever seen a psychiatrist or any mental health provider? _____ yes _____ no

When were you treated and what was the primary focus of the sessions?

EMERGENCY CONTACT

Emergency contact person: _____

Relationship to contact person: _____ Contact phone: _____

Do I have permission to contact above person in the event that you require emergency assistance? _____ yes _____ no

REFERRAL SOURCE

How did you learn about this office? Please print name of referral.

Friend _____ Family _____ Internet _____
Physician _____ Insurance _____ Other _____

APPOINTMENT REMINDERS

I understand that, and consent to, the following appointment reminders that may be used by the Provider:

___ Yes ___ No *An e-mail to the e-mail address provided by me.

___ Yes ___ No *Telephoning my home phone/cell and leaving a voice message or with the individual answering the phone.

___ Yes ___ No *Sending a text message to the cell number provided by me.

RELEASE OF INFORMATION

*I authorize the release of any medical or other information necessary to process insurance claims to Gina Carter, LPC, in relation to treatment and/or counseling services.

Accept ___ Decline ___

*My signature below acknowledges receipt of Notice of Privacy Practices/Office Policies for Gina Carter, LPC.

Client (or guardian)

Signature: _____ Date: _____

Initial Visit Check List

Indicate which of the following areas are currently problems for you and are reasons for you coming in for counseling.

- Feeling inferior to others
- Under too much pressure and feeling stressed
- Feeling down or unhappy
- Feeling lonely
- Experiencing guilt feelings
- Suspicious feelings toward other people
- Experiencing loss/grief
- Dealing with a serious illness
- Afraid of being on your own
- Angry feelings
- Feeling down on yourself
- Feeling you don't belong here
- Concern about finances
- Feeling cut-off from your emotions
- Difficulty expressing emotions
- Concerns about physical health
- Experiencing nightmares or flashbacks
- Lacking self-confidence
- Feeling the need to lose weight
- Thinking constantly about food or body shape
- Use of alcohol
- Use of non-prescription/prescription drugs
- Lacking assertiveness in some situations
- Having difficulty being open with other people
- Difficulty communicating with boyfriend/girlfriend
- Communication difficulties with spouse
- Difficulties making or keeping friends
- Difficulties communicating with parents
- Thoughts of taking your own life
- Wondering "Who am I?"
- Feeling confused about right and wrong
- Difficulty living up to religious beliefs
- Difficulty making decisions
- Confused about how far to go sexually
- Feeling guilty about sexual activities
- Confused about what to do with sexual feelings
- Difficulties in sexual relations with boyfriend/girlfriend
- Disagreements with spouse concerning sex
- Feeling sexually attracted to members of your own sex
- Feelings related to having been sexually molested
- Other (specify) _____

Name _____