CLEAR BROOK COUNSELING SERVICES

75 Gilcreast Road
Londonderry, NH 03053
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charles@clearbrookcounseling.com

Date: _____

Name: _____

Street Address: _____

City and State: _____ Zip: _____

Phone: Home: _____ Work: _____ Cell: _____

E-mail Address: _____

Date of Birth: _____ Referred by: _____

Place of Employment: _____

Work Address: _____

Emergency Contact:
Name: _____

Phone: Home: _____ Coll: _____

Insurance Information:

Insurance Company: _____

Address: _____

Phone: _____

Insurance I.D. Number: _____

Insurance Group Number: _____

Insured's Name: _____

Insured's Date of Birth: _____

Client's relationship to Insured: _____

Insured's address if different from client's: _____

If you and your spouse are in couple's therapy and participate in individual sessions with your therapist, what you disclose in the individual sessions may be considered part of the couple's therapy. Treatment records of couple's sessions contain information about each person. Therefore, both clients agree that treatment records will be only released by joint consent. In the event of a disagreement, the records will not be released without a court order. There are many precedents of court orders being obtained in pending divorce or custody cases.

Unmarried individuals in couple's therapy do not have the privilege to the same extent that married individuals have due to the legal status of their relationship. However, each person is required to maintain the confidentiality of the other.

If a court order is issued for the release of your records, your therapist will request, but does not require, your signed authorization.

You have a right to your intake paperwork, treatment plan, and other information shared for billing purposes. Psychotherapy notes from each session are the property of and confidential to the therapist and will not be released to the client.

As a professional therapist, your psychotherapist hires or participates in a supervisory group. He/she may consult with an individual licensed therapist for case review. The prerogative and responsibility of privilege exists between your therapist and the hired or participating supervisory group. If you object to this, please notify your therapist prior to beginning treatment. If you object to your case being reviewed or discussed, please again discuss this with your therapist prior to beginning treatment.

Any information related to substance abuse or STD, including HIV, will only be released after the signer on that particular section acknowledges that category on the release form.

Once information is sent outside this office, Clear Brook Counseling cannot control and is no longer responsible for its distribution.

Any clinical, clerical, or administrative staff member who is checking messages, etc. may read or listen to a recorded message on an incoming phone line, fax or e-mail. A phone message, fax, or e-mail may become part of a client's permanent record and may also be used in court proceedings.

If translators are needed due to language issues, professional translators who are bound by confidentially mandates will be arranged for and paid for by the client. If the client at any time is uncomfortable with the translator, the client will inform the therapist.

CLIENT NAME ____ DATE __________

FAMILY HOUSEHOLD MEMBERS

All members must be listed legibly, including address and birth dates. Therapy will not be provided without this information. You may use the back side of this sheet if needed.

Name: ____ DOB: _______________

Address: ____Apt. or P.O.Box #: _____

City: _____________________________________ State: ________ Zip: _____________

Cell Phone Number: ____

Name: ____ DOB: _______________

Address: ____Apt. or P.O.Box #: _____

City: _____________________________________ State: ________ Zip: _____________

Cell Phone Number: ____

Name: ____ DOB: _______________

Address: ____Apt. or P.O.Box #: _____

City: _____________________________________ State: ________ Zip: _____________

Cell Phone Number: ____

Name: ____ DOB: _______________

Address: ____Apt. or P.O.Box #: _____

City: _____________________________________ State: ________ Zip: _____________

Cell Phone Number: ____

Name: ____ DOB: _______________

Address: ____Apt. or P.O.Box #: _____

City: _____________________________________ State: ________ Zip: _____________

Cell Phone Number: ____

MARITAL STATUS:

Unmarried	_____	How many years?	_____
Living together	_____	How many years?	_____
Married	_____	How many years?	_____
Number of times married:	_____		
Separated	_____	How many years?	_____
Divorced	_____	How many years?	_____
Widowed	_____	How many years?	_____

Who lives in your home? _____

Who raised you? _____

Number of brothers/sisters? _____ # living? _____ # older than you? _____

Family members you are close to now: _____

What RECENTLY HAPPENED to make you decide to seek help now? _____

_____

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

_____

CIRCLE or CHECK any of the following that apply to you (or your child) now or in the past (feel free to explain on back of page)

Depression
Crying spells
Hopelessness
Relationship break-up
Loneliness
Emptiness
Loss of appetite
Sleep disturbance
Nightmares
Thoughts of harming self
Thoughts of harming others
Suicide attempts/injuries
Hearing voices
Bereavement/Grief
Unusual thoughts
Fire Setting

Increased alcohol use
Increased drug use
Black-outs/memory loss
Withdrawal symptoms
Financial worries
Loss of control in:
- alcohol/drug use
- overeating/bingeing
- purging
- yelling/breaking
- hitting people
- endangering self
- endangering others
- spending
- gambling

Court Proceedings

Anxiety
Panic attacks
Can't concentrate
Confusion
Mood swings
Racing thoughts
Fear of dying
Job stress
Decreased activity
Not seeing friends
Feel controlled
Feel talked about
Guilt/shame
Sexual problems
School problems
Restraining order

CLIENT NAME _____ DATE _____

PHYSICAL HEALTH

Circle the number for each item that applied to you in the past or does now, and then explain below.

1. Allergies
2. Asthma
3. Ulcers
4. Cancer
5. Stomach problems
6. Pancreatitis
7. Chronic pain
8. Heart disease
9. Bacterial endocarditis
10. Seizures
11. High Blood Pressure
12. Low Blood Pressure
13. Diabetes
14. Hypoglycemia (Low blood sugar)
15. Thyroid Problems
16. Liver Disease
17. Vision problems
18. Hearing problems
19. Speech problems
20. Dental problems
21. Weight loss
22. Weight gain
23. Severe headaches/migraines
24. Frequent neck/shoulder pain
25. Head injuries/Concussion
26. Physical abuse
27. Sexual abuse
28. Premenstrual syndrome
29. Sexually transmitted diseases
30. Positive HIV
31. AIDS
32. Tuberculosis
33. Hepatitis
34. Major surgery
35. Chronic fatigue syndrome
36. Impotence
37. Mitral valve prolapse
38. Circulation problems
39. High cholesterol
40. Irritable bowel
41. Broken bones
42. Accidents
43. Concussion
44. Low vitamin D level _____
45. Feeling depressed/low in winter months
46. Mother had postpartum depression
47. Gastric bypass

#	At what ages?	Describe problem and treatment (include medications):
____	_____	_____
____	_____	_____
____	_____	_____
____	_____	_____
____	_____	_____

Forceps Delivery of Client? ☐Yes ☐ No

Birth Weight _____ Was client separated from mother by incubation, illness, etc.?

If yes, please describe:

_____

Remarks about Delivery:

_____

Have you ever experienced a traumatic event or events?_____

FOR WOMEN: Number of pregnancies _____ Live births _____ Adoptions _____

Do you have a normal menstrual cycle? _____ Are you pregnant now? _____

Premenstrual syndrome? _____ Menopause? _____ Hormone therapy? _____

ALCOHOL AND DRUG HISTORY

How many days a month do you drink? _____ or use non-prescribed drugs? _____

On the days that you drink or use drugs, about how much do you drink (in ounces)_____ or use in drugs? _____

How many times a month do you drink more than you planned to? _____

Do you ever experience black-outs (memory lapses) when drinking? _____

Have you ever overdosed or experienced withdrawal symptoms? _____

What's the longest period you remained totally alcohol/drug-free? _____

Have you ever received HOSPITAL or RESIDENTIAL treatment for an alcohol or drug-related problem? _____ How many times? _____

When/Where? _____

Have you ever received any OUTPATIENT alcohol/drug treatment? _____

When/Where? _____

Has any family member/loved one ever had a drinking or drug problem? _____

Who? _____ Please describe: _____

CLIENT NAME _____ DATE _____

SAFETY HISTORY

Have you (or your child) had any suicide attempts in the past? _____ If yes, please indicate in a few sentences the approximate dates, time, and means:

_____

_____

_____

Do you have any history of self-injurious behavior such as cutting? _____
If yes, please indicate the approximate dates, time and means:

_____

_____

_____

Do you have any guns or other weapons in your home, or access to such? _____
If yes, please indicate below and tell if weapons and ammunition are locked in separate, secure cabinets:

_____

_____

_____

Are you or is anyone in your household on the Sexual Offenders List? _____
Who? _____

Are there any other safety issues you are concerned about for either yourself or your child? Does your child make statements of self harm? _____

_____

_____

_____

Is your child being bullied or bullying at school?

_____

_____

_____

Do you have any other safety concerns for yourself or your child?

_____

_____

_____

_____

☐ I understand that at times I may be reached by text, voicemail, E-mail, or fax. I understand that these communications are confidential, and that it is my responsibility to safeguard my electronic devices. I agree that the clinician may leave messages on all phone numbers or electronic devices that are listed. If you wish to limit the manner of communication and messaging, please indicate below:

_____

☐ Clients who do not show up for appointments or who cancel without 24 hours notice will be charged a minimum of $140.00, which must be paid prior to attending or booking their next appointment.

☐ I have read this statement in full and have had sufficient time to be sure that I considered it carefully. I have asked questions about any section I did not understand fully or that I had concerns about.

Signature of Client or Guardian: _____

Date of Birth of Client: _____

Printed name of Client or Guardian: _____

Date of signature _____

Witness signature _____

Date of signature _____