TAMPA BAY CLINICAL COUNSELING GROUP

Welcome! As part of beginning the therapy process, please take a few minutes to fill out this form. This information will help me better understand your situation and will help us both find solutions to the situations that are creating difficulties. Please note that this information is confidential.

Type of services sought: Child: Adolescent: Adult: Family:
Name of person filling out form: Date:
Name of Primary Patient:
Age DOB: Sex M F Phone
Address:
Email address:
Current Occupation:
Current Insurance Company:
Current Insurance Member ID:
Insurance Group Policy Number:
Person to contact in an emergency:
Address: Phone:

Primary Concern: What are the primary issues for which you are seeking therapy?

What are the most important things you think I should know about these issues?

In what ways have you attempted to cope with these issues?

Do you have any concerns or fears regarding therapy?

What are your goals for therapy?

Religious or spiritual preference:

Importance of religion to you / your family: Very important Somewhat important Not important

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Mental Health and Social History:

Have you or anyone in the family attended therapy previously, or are currently in treatment?

Any psychiatric Hospitalizations? No Yes

If yes, please briefly explain:

Have you or anyone in the family had suicidal thoughts / attempts / self-harm (cutting, etc.) recently? No ¸Šă

If yes, please briefly explain:

Have you or anyone in the family been a victim of, or perpetrator of, child abuse (physical, sexual, emotional, neglect), domestic violence, rape, or other violent act? No Yes

If yes, please briefly explain:

Have you or anyone in the family had trouble with alcohol or other substances, now or in the past? bƨ ¸Šă

If yes, please briefly explain:

Has anyone in the family been involved with the legal system (probation, parole, jail, prison, DUI)? Any present or pending civil lawsuits? No Yes

Were you adopted? No Yes If yes, do you have a relationship with your biological parent(s)?

Medical History:

Physician(s) currently treating self / family members:

Date of most recent visit, primary concern:

Is anyone in the family being treated for a medical problem(s) and / or disability?

If yes, please briefly explain:

Current medications (for primary patient):

Name Medication / Dosage Prescribing physician Reasonă

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Please check any past, present, or impending issues for you or your family.

- o Suicidal thoughts / attempts /
- o Cutting or other self-harm
- o Depression / hopelessness
- o Anxiety / worry
- o Anger issues
- o Chronic pain or illness
- o Sleep problems
- o Eating problems
- o Loss /grief
- o Legal issues
- o Job issues /unemployed /financial
- o Partner violence / abuse
- o Sexual abuse /rape
- o Alcohol / drug concerns
- o Other addiction issues
- o Couple concerns
- o Marital affairs / infidelity
- o Communication problems
- o Sexuality / intimacy concerns
- o Divorce adjustment
- o Remarriage adjustment
- o Major life changes

Complete for Children

- o Adjustment to divorce
- o School failure
- o Truancy / runaway
- o Fighting with peers
- o Hyperactivity
- o Wetting / soiling
- o Isolation / withdrawal
- o Child abuse / neglect
- o Parent / child conflict
- o Other:

Personal and Family Strengths and Resources:

Please indicate the strengths that you and others in your family have (write in names below):

Strength / Resource	Self			
Is willing to seek help				
Gets along well with other family members				
Is physically healthy				
Is generally liked and respect at work / school				
Is a hard worker				
Has family members or friends who are supportive				
Copes well with disappointment				
Uses anger constructively				
Thinks before he / she acts				
Feels good about who he / she is				
Makes friends easily and is kind to others				
Stands up for him / herself				
Follows through on tasks				
Is able to compromise				
Has a spiritual practice that helps in difficult times				

List the people, activities, groups and hobbies that are supportive to you / your family:

Thank you for taking the time to complete this form. This information will help me to understand your situation better and will help us to reach your goals as quickly as possible. When we meet, please feel free to ask me any questions about this form, or to tell me anything else that you would like me to know.

Thank you,

Dr. Joel M. Laatsch

Clients Informed Consent

I have chosen to receive treatment services under a benefit plan managed by Tampa Bay Clinical Counseling Group PLLC.

My choice has been voluntary, and I understand that l may terminate treatment at any time, and I will give at least 24-hour notice.

I understand that there is no assurance that I will feel better. Psychotherapy is a cooperative effort between my therapist and me. I will work with my therapist in a cooperative manner to resolve my difficulties.

I understand that during my treatment, material may be discussed which will be upsetting in nature and that this may be necessary to help me resolve my problems.

I understand that record and information collected about me will be held or released in accordance with state laws regarding confidentiality of such record information.

I understand that state and local laws require that my therapist report all cases of abuse or neglect of minors or disabled adults.

I understand that state and local laws require that my therapist report all cases in which there exists a danger to self or others.

I understand that I may be contacted by my insurance company to ensure the continuity and quality of my treatment and /or after the completion of treatment to assess the outcome of treatment.

I have read and had explained to me the basic rights of individuals in treatment. These rights include:

1. The right to be informed of all carious steps and activities involved in receiving serv1ces.
2. The right to confidentiality, under federal and state laws relating to the receipt of services.
3. The right to humane care and protection from harm, abuse, or neglect.
4. The right to make an informed decision whether to accept or refuse treatment.
5. The right to contact and consult with counsel at my expense.

I understand that my therapist may disclose any and all records pertaining to my treatment to my insurance company, (and my primary care physician), if such disclosure is necessary for claims processing, case management, coordination of treatment, quality assurance, or utilization review purposes. I understand I may revoke this consent at any time, except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent. If I do not revoke this consent, it will expire in one year.

_____ _____

Client's/Guardian 's Signature Date