Client Information

Phoenix Therapeutic

Phoenix ID# (Office use only) _____

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Name _____ _____ ___ _____
Last First MI

Street Address_____ City_____ State____ Zip_____

Mailing Address_____ City_____ State____ Zip_____

Social Security Number _____-_____-_____ Gender? (circle one) F M

Telephone *Home* _____*Work* _____*Mobile*_____

Other _____ Email _____

Where can I leave messages? _____

Emergency Contact Phone_____ Relationship to client_____

Education / Training (Highest Level or Grade Attained)_____

Military Service ▫ Yes ▫ No Dates _____Did you serve in combat? ▫ Yes ▫ No

Birth Date _____Age _____Childhood Nicknames _____

Sexual Orientation ▫ Heterosexual ▫ Gay/Lesbian ▫ Bisexual

Relationship Status ▫ Married ▫ Never Married ▫ Widowed ▫ Single ▫ Divorced ▫ Separated ▫ Living together as partners

Spouse / Partner's Name _____ Age_____ _____

If married, duration of present marriage _____Are there children living at home? ▫ Yes ▫ No

Previous Marriages (Date / How ended) _____

Previous Marriages (Date / How ended) _____

Names and ages of children Age_____ Age_____ Age Age

Names and ages of children Age_____ Age_____ Age_____ Age_____

Have you had previous therapy? ▫ Yes ▫ No Spiritual or Pastoral Counseling? ▫ Yes ▫ No

When? _____ With whom? _____

Are you presently seeing a therapist? ▫ Yes ▫ No If yes, whom? _____

How did you hear about me?

▫ Clergy Person ▫ Social Service Agency ▫ Family
▫ Friend ▫ Employer ▫ Advertisement (where?)_____
▫ School ▫ Former Clients ▫ Physician or Other
Please include specific name if appropriate_____

Insurance Company _____ Policy #_____Group #_____ Primary Insured (name)_____
Name of and address of Person Responsible for payment of services if other than above:
_____
___
Your Physician's Name _____
Date of last medical exam_____
Are you currently on medication? ▫ Yes ▫ No
If so, which medication(s)?_____
Prescribed by _____
Major surgeries in the past five years? ▫ Yes ▫ No
For which condition(s)? _____
Other health related conditions_____
What is your current physical condition? ▫ Poor ▫ Fair ▫ Average ▫ Good ▫ Excellent
What is your current emotional condition? ▫ Poor ▫ Fair ▫ Average ▫ Good ▫ Excellent
Which of the following describe or relate to the concerns that bring you here?
Relationship with: _____
Loss of: _____

▫ Aging Issues ▫ Mid-Life Issues
▫ Anger ▫ Suicidal Feelings ▫ Partner ▫ Self-Respect
▫ Anxiety ▫ Religious Doubts ▫ Parents ▫ Identity
▫ Frequent Crying ▫ Legal Issues ▫ Children ▫ Faith
▫ Eating / Food ▫ Finances ▫ Others ▫ Meaning
▫ Alcohol / Drugs ▫ Vocation/Career ▫ Love ▫ Loneliness
▫ Physical Health ▫ Self Doubt ▫ Self Esteem ▫ Abuse Issues
▫ Life Transition ▫ Poor Appetite ▫ Sexual ▫ Guilt
▫ Self Loathing ▫ Physical ▫ Sexual Concerns ▫ Sleep Disturbances
▫ Emotional ▫ Fear ▫ Hopelessness ▫ Verbal
▫ Grief ▫ Weight Loss

Please make an "X" next to all the Alternative Treatments you have tried for your condition(s)?

▫ Verbal

▫ Grief ▫ Weight Loss

Please make an "X" next to all the Alternative Treatments you have tried for your condition(s)?

▫ None	▫ Colonics	▫ Nutritional Therapy	▫ Environmental medicine
▫ Naturopathic medicine	▫ Massage	▫ Yoga	▫ Homeopathy
▫ Acupuncture	▫ IV (chelation) therapy	▫ Hypnosis	▫ Light therapy
▫ Chiropractic	▫ Rolfing	▫ Biological Dentistry	▫ Meditation
▫ Iridology	▫ Reiki	▫ Ayurveda	▫ Other:

State in your own words the concerns that bring you to therapy:_____

_____

How will you know when your current concerns are resolved?

_____

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain right to privacy regarding my protected health information. I understand that this information can and will be used to:

- *Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment, directly and indirectly*
- *Obtain Payment form third party payers*
- *Conduct normal healthcare operations such as quality assessments*

I have been informed by Phoenix Therapeutic and Consulting Services of our Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact Phoenix Therapeutic and Consulting Services to obtain a current copy of this notice.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand Phoenix Therapeutic and Consulting Services is not required to agree to my requested restrictions, but if Phoenix Therapeutic and Consulting Services does agree, then they are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that Phoenix Therapeutic and Consulting Services has taken action relying on this consent.

Check all that apply to this consent:

▫ Please do not phone me at home. Use this alternate phone number: _____

▫ Please do not phone me at work. Use this alternate phone number: _____

▫ Please do not leave messages on my answering machine.

▫ Please do not contact me by e-mail.

▫ Please send me mail, including my bills, to this alternate address: _____

▫ Other request: (please describe)_____

AUTHORIZATION TO RELEASE INFORMATION:

I have read and I accept this policy for my testing and/or treatment with Phoenix Therapeutic and Consulting Services. In obtaining payment for services, I authorize my healthcare provider to furnish information from my medical records to any company that may be responsible for payment for all or part of my provider charges, including my insurance companies and their representatives, and my employer or union if they are involved in processing the claim. I understand that Phoenix Therapeutic has the right to bill for missed and late-cancelled appointments.

I have read the above information and fully understand my obligations and relationship with Phoenix Therapeutic and Consulting Services

_____ _____

Signature *Date*

_____

Print Name

Print Name