CARTER COUNSELING, PLLC

Gina R. Carter, LPC

6136 Frisco Square Blvd., Suite 400
Frisco, Texas 75034
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

SPOUSE/PARENT 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 #:_____

Insured DOB:_____ Authorization Number _____

Insurance Phone Number (for benefits)_____

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 describe:

_____

_____

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- 1) An e-mail to the e-mail address provided by me

___Yes ___No- 2) Telephoning my home/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 currently apply to you.

___ 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 _____