Real Life Solutions Counseling, Inc.

Laurie Shoats L.M.F.T.

954-802-1601

Client Information

Name:___________________________ Date:_________ Home Phone: _______________ Cell: _____________

Address:______________________________________City:___________________ State:______ Zip:___________

Age:_______ Birth Date:___________ Marital: M S W D

Occupation:__________________________ Employer:____

Spouse/Partner:______________________ Age____

Cell___________________Occupation:________________ Employer:________________________________

Emergency Contact____

How many children?____________Names and Ages of Children:____

____

How were you referred to our office? Internet____ Personal Referral ____ Facebook___

Which Internet site? (circle): Psychology Today, Theravive, Good Therapy, Google, Not Sure

Have you served in the Armed Forces? _______

HISTORY OF PRESENT PROBLEM:

Purpose of this appointment:____

____

Have you ever had the same or a similar condition? ____ Yes ____ No If yes, when and describe:

____

____

PAST HISTORY

Do you ever have: (Place a check mark by conditions that apply to you)

__ Anxiety	__ Eating Disorder	Jealousy___	Feelings of guilt___
__ Depression	__ Post Traumatic Stress Disorder	Affairs____	Compulsive Bx____
__ Anger	__ Adoption Issues	Phobias____	Controlling Bx____
__ Abandonment	__ suicidal ideations/attempt	HIV positive __	Low Self-Worth___
__ Alcoholism	__ Drug Addiction	Mood Swings__	Sexual Problems ___

Have you been treated for any health condition by a physician in the last year? ____ Yes ____ No

If yes, describe: ____

What medications or drugs are you taking? (List name and dosage)

____

____

Please list any other health problems you have, no matter how insignificant they may be: ____________________

____

____

Client Name: ______________________________ Date: _____________

SOCIAL HISTORY:

What is the highest level of education you have completed?________________

Do you drink alcoholic beverages?______ If so, how much per week?______________________________

Do you use any tobacco products?______Do you smoke?____ If so, packs per day: ____________________

Do you consume caffeine?_____ If so, how much per day:____________________________________

Do you exercise?_____ If yes, what is the frequency and type of exercise?___________________________

Do you sleep well at night? _____ If no, why not? ____

What are your hobbies?____

What percentage of time during the day do you spend:
Under normal stress load: _____% Under considerable stress: _____% Resting or relaxed: ____%

FAMILY HISTORY:

Parents:
Father: living ___ deceased ____ (check one) Current age if still living:______ Cause of death and age at death if deceased:____

Mother: living ___ deceased ____ (check one) Current age if still living:______ Cause of death and age at death if deceased:____

Siblings: (names, ages, locations) ____

____

FAMILY DISEASES (if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):

__ Anxiety
__ Depression
__ Anger
__ Abandonment
__ Alcoholism
__ Drug Addiction
__Eating Disorder
__ Post Traumatic Stress Disorder
__ Adoption Issues
__ Other. List: _________________________
__ Other. List: _________________________
__ HIV Positive

How hopeful are you that you will get your concern resolved? _________________________

Do you make decisions based on your emotions? _____ How well does that work for you? ______

Have you received counseling in the past? (yes or no) If yes, briefly describe nature, duration and outcome___

____

Case History **Name** ___________________________________ **Date** ________________

1. What is your major concern? ____

____

____

____

Other concerns: ____

____

____

2. If this is a recurrence, when was the first time you noticed this problem?_______________________

How did it originally occur?____

____

Has it become worse recently? Yes ___ No ___ Same ___ Better ___ Gradually Worse _____

If yes, when and how? ____

____

3. Is there anything you can do to relieve your major problem? Yes ___ No ___. If yes, describe:

____

If no, what have you tried to do that has not helped? _____________________________________

____

NO SYMPTOMS/STRESS ____ EXTREME SYMPTOMS/STRESS

Please place an “X” on the line above to indicate level of problem.

Therapist's Signature ____ Date _____________

Real Life Solutions Counseling, Inc.
7401 Wiles Rd. Suite 239
Coral Springs, FL 33067
Laurie Shoats LMFT

CONFIDENTIALITY: Everything you say is these sessions and the written notes I take are confidential and may not be released to anyone without your written permission except where disclosure is required by law. . **I will never publicly acknowledge working with you if I see you out in public**

WHEN DISCLOSURE IS REQUIRED BY LAW: **Disclosure is required or may be required by law when there is a reasonable suspicion of child, dependent,; where a client presents a danger to self, to others, to property, or is gravely disabled; or when a client's family members communicate to me that the you present a danger to others**. Disclosure may also be required by the courts. I will not release records to any outside party unless I am authorized to do so by all adult parties who were part of the therapy.

CANCELLATION/LATE POLICY: I reserve the timeslot for you. Please try to arrive a few minutes early. There is a waiting list. Please be courteous and give at least a 24 hour notice to cancel or reschedule your appointment. There is a **$75 for less than 24 hour** notice of canceling or rescheduling appointments. If you are late please be aware that as a courtesy to others, we will need to **keep to your scheduled time**. It is not fair to make the next client wait as it would not be fair to make you wait. There is a **$25 fee for checks with insufficient funds**.

TELEPHONE & EMERGENCY PROCEDURES: If you need to contact me between sessions, please call us at 954-802-1601. If I do not answer, I will return your call as soon as possible. Phone calls over 5 minutes will be prorated. If an emergency situation arises, indicate it clearly in your message **and if you need to talk to someone right away call 911 or go to your nearest emergency room.**

THE PROCESS OF THERAPY/EVALUATION AND SCOPE OF PRACTICE: Therapy can affect you in many ways. You may resolve the problem you came in for but it takes effort on your part. **I want you to be open and honest** to get the most out of your time. We may also talk about unpleasant events which may cause you discomfort and I may challenge some of your ways of thinking. You must also know that while we expect change, there is no promise that this therapy will yield a positive result. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. I do not prescribe drugs.

TREATMENT PLANS: On approximately your third visit, I will discuss with you my working understanding of the problem, treatment plan and therapeutic objectives. **.**

SOCIAL NETWORKING: I do not accept friend requests from current or former clients on social networking sites, such as Facebook. <u>I believe that adding clients as friends on these sites is likely to COMPROMISE their privacy and confidentiality.</u>

I have read the above policies. I understand them and agree to comply with them:

Client's Signature ____ Date ________________

Client's Signature ____ Date ________________

Therapist Signature____ Date _________________

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Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used.

The patient understands and agrees to allow this office to use their Patient Health Information (**PHI**) for the purpose of treatment, and coordination of care.

The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.

1. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
2. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
3. Our office may contact you periodically regarding appointments.
4. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
5. This notice is effective on the date stated below.
6. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the therapist has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Signature of Client ___________________ Print___________________ Date______

Signature of Client __________________ Print ___________________ Date _________

Witness ______________________________ Date _______________________