Client History Form

Name of Client_____ _____
First Middle Last Date of Birth

Address_____
Street City State Zip

Home Phone_____Cell Phone_____Other_____

Form Completed By_____

Occupation_____

Student Yes No Highest level of education:_____

Occupation_____

Martial or partnership status:_____

In case of emergency, please contact_____

#_____Relationship to emergency contact_____

Referred By_____

May I send a letter of gratitude to this professional for your referral? Yes No

_____
Signature Date

Primary Care Physician:_____

Name_____phone _____

Psychiatrist or other mental health care provider:

Name_____Phone_____

What is your level of physical activity at this time_____

Is there a history of mental illness or substance abuse in your family ___Yes ___No
If
Yes_____
_____.

Primary reason(s) for seeking services:_____

_____.

Past experiences with therapy/counseling/mental health care_____

_____.

Prior mental health or medical diagnosis_____

Prior psychological or psychiatric evaluation_____

Prior or current medications taken_____

Please list any significant medical
problems:_____
_____
_____

Have any of the following been sources of distress in your life:

____Abuse in childhood	___Anxiety	____Anger
____Career difficulties	____Chronic illness	____Friendships
____Coping with stress	____Depression	____Sleep
____Manic episodes	_____Grief and loss	____Relationships
____Divorce (parents)	_____Divorce(self)	_____Academics
____Hallucinations	_____Parenting	______Career
____Recent move	_____Sadness	

_____Self Harm/Self abuse _____Suicidal thoughts _____Isolation

_____Suicide attempts _____Family violence _____Social withdrawl

____Decrease concentration _____Change in energy level

____Phobias _____Obsessions(intrusive thoughts)

____ Binging/purging _____Compulsions(Repetitive behaviors)

____Weight _____Alcohol _____Lying

____Emotional eating _____Compulsive Shopping _____ Skin picking

____Repetitive Hair pulling _____Selective Mutism _____Panic attacks

Who or what do you consider to be your greatest source of support during difficult times?

Please provide any other information that you believe might be relevant to our work together?_____

Consent for Treatment

I give my consent for the completion of my initial evaluation and provision of treatment as necessary by Alicia Kruger, LPC. I understand that no promises have been made to me as to the result of treatment by Alicia Kruger, LPC. If I have questions about any aspect of my treatment or therapy I will discuss them with Alicia Kruger, LPC

Signature below indicates consent for treatment. The following information is required for consent for treatment for Children, adolescents and vulnerable adult with guardians, as well as adults.
Name of Client_____

Name of Person Giving Consent/Relationship to Client_____

By my signature below, I consent to treatment and agree to terms above.

Signature_____

(Date)

Cancellation Policy

Your scheduled appointment time is time reserved just for you. Missed or cancelled appointments without a 24 hour notice will be charged to the client at the full office rate of $180 for that appointment. Should you need to cancel your appointment time please call 24 hours in advance to avoid being charge. Insurance is not responsible for and will not pay for missed or late cancelled appointments . Clients may cancel/reschedule an appointment by calling (512-658-7704).

Client Signiture_____Date_____

Client Acknowledgment of Understanding and Agreement

Client Name:_____
Parent/Guardian Name:_____

1. HIPAA.

I acknowledge that Alicia Kruger, LPC has provided me with a written copy of Client Policy. I have reviewed this policy and by signing below acknowledge both my understanding of and agreement with the policy.

Client signature or Parent/Guardian signature_____

(Date)

2. Notice of Privacy Practices

I acknowledge that Alicia Kruger, LPC has provided me with a written copy of Notice of Privacy Practices. I have reviewed this notice and by signing below acknowledge both my understanding of and agreement with the policy.

Client signature of Parent/Guardian Signature_____

Patient Confidential Communications

The Health Insurance Portability and Accountability Act (HIPAA) gives you the right to request that Alicia Kruger, LPC communicates financial and/or medical information to you in confidence by a particular method or certain locations.

In order to protect the privacy and confidentiality of your information; please complete the following which tells me how you would like to be contacted.

I wish to be contacted in the following manner (check all that apply):

Phone Communications

____ Home Telephone Number _____

____ Work Telephone Number _____

____ Cell Phone Number _____

____ Leave message with your name and call-back # on answering machine

____ Leave message with medical information on answering machine

Written Communication

___ Mail information to my home address on file

___ Mail information to other address:

******(to request for communication via E-mail or Text message please read and sign Consent for Unencrypted Communication document)******

CONSENT TO USE UNECRYPTED E-MAIL OR TEXT

It is very important that you are aware that computer e-mail, texts, and e-fax communication, can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. E-mails, texts, and e-faxes, in particular, are vulnerable to such unauthorized access due to the fact that servers or communication companies may have unlimited and direct access to all e-mails, texts and e-faxes that go through them. While data on Alicia Kruger, LPC laptop is encrypted, e-mails and e-faxes are not. It is always a possibility that e-faxes, texts, and e-mail can be sent erroneously to the wrong address and computers. . E-mail messages on your computer, your laptop, IPad, phone or other devices have inherent privacy risks – especially when your e-mail access is provided through your employer or when access to your e-mail messages is not password protected.

Alicia Kruger, LPC laptop is equipped with a firewall, a virus protection and a password, and all confidential information from the computer is backed up on a regular basis onto an encrypted harddrive. Please, note that e-mails, faxes, and texts are all part of your clinical records. Please notify Alicia Kruger, LPC if you decide to avoid or limit, in any way, the use of e-mail, texts, cell phone calls, phone messages, or e-faxes. If you communicate confidential or private information via unencrypted email, texts or e-fax or via phone messages, it will be assumed that you have evaluated the risks and made an informed decision, Alicia Kruger, LPC will view it as your agreement to take the risk that such communication may be intercepted, and your desire to communicate on such matters will be honored. Please do not use texts, e-mail, voice mail, or faxes for emergencies.

Patient's Name: _____
Cell Phone Number: _____
E-mail Address: _____
Patient's Signature: _____

Alicia Kruger, LPC will continue to communicate with you according to your above response(s) until you change your preferences. You may do so by completing a new form.

By your signature below, you agree to be communicated in the above manner.

Patient Signature _____Date_____

Patient Name _____