FHL Center for Healing

ADULT REGISTRATION FORM

Client Name:_____ Preferred Name:_____

Gender: M or F DOB: _____SSN:_____ DLN#_____

Address: _____

Street City State Zip

Hm #: _____ Cell #: _____ Work #: _____

EMAIL _____ Marital Status: _____

Name of Next of Kin:_____ Relationship:_____

Emergency Contact:_____Phone #:_____

Primary Care Physician:_____Phone #: _____

Address:_____

How did you hear about our office? _____

EMPLOYMENT INFORMATION

Employed: Full time _____ Part Time ____ Unemployed_____ On Disability _____ Retired_____

Employer/Company Name: _____

Employers Address: _____

Street City State Zip

CLIENT'S GUARANTOR (Person responsible for Account/Insurance)

Guarantor Name:_____ Gender: M or F

DOB: _____SSN:_____ Relationship to patient_____

Address: _____

Street City State Zip

Home #: _____ Cell #: _____ Work # : _____

Employer:_____ Occupation: _____

PERSONAL HISTORY

Briefly describe your reason for seeking help or the circumstances which brought you to our office:

_____

_____

_____

FHL Center for Healing

EDUCATION What is your last grade completed in school?_____

Present marital status? Single_____ Married_____ Widowed_____ Divorced_____

Number of times you have been married, including common law marriages? _____

Spouse Name/s Marriage Date/s Separation/s Reason for separation, divorce, or dissolution?

_____

_____

_____

Please list any others that live with you:

Child(ren) Names, Ages, and Relationship to you:

_____ _____

_____ _____

_____ _____

MEDICAL HISTORY

Current Medications:

Name	Dosage	Purpose	Name	Dosage	Purpose
_____			_____		
_____			_____		
_____			_____		

Allergies:_____

Hospitalizations or Operations (Please list approximate dates):

_____

_____

FAMILY HISTORY Do or did any of your family members have a history of mental health problems or substance abuse? If yes, please explain: _____

_____

_____

Please place a check mark where your or a family member have had or are currently having problems:

You	Family		You	Family	
___	___	Ears, Nose, Mouth, or Throat	___	___	Back, Arm, or Leg Problems
___	___	Eyes	___	___	Arthritis/ Muscle Problems
___	___	Diabetes or Hormonal Problems	___	___	Heart
___	___	Lung Diseases (asthma, emphysema, TB)	___	___	Bleeding Disorders
___	___	Digestion (ulcers, gallbladder, colon, etc.)	___	___	Seizures or Strokes
___	___	Kidney, Bladder, or Urinary Problems	___	___	Gynecological Problems

Please provide a brief description to any boxes your checked: _____

_____

Do you have any problems sleeping? (If yes, complete the questions below)
Number of hours sleeping_____ Number of hours in bed_____

Do you wake up easily? Yes No
Do you have problems falling asleep? Yes No
Do you snore excessively? Yes No

Difficulties with Sex? (If yes, complete the questions below)
Do you have a decreased in sexual desire? Yes No
Do you have problems with impotency? Yes No
Do you have sexual thoughts or feelings that affect your everyday life? Yes No

Weight or Appetite Problems? (If yes, complete the questions below)
Have you had a recent weight gain? Yes No How much?_____
Have you had a recent weight loss? Yes No How much?_____
Do you use laxatives, water pills, or enemas to control your weight? Yes No
Have you been prone to overeating or binging? Yes No
Do you monitor your food intake? Yes No
Do you have little to no appetite? Yes No
Do you self-induce vomiting? Yes No
Do you use food as a comfort? Yes No

SUBSTANCE USE

Circle all drugs you have ever used:

Alcohol Amphetamines Barbiturates Benzodiazepines Cocaine Designer Drugs
Inhalants Hallucinogens Marijuana Opiates Steroids Mini-Thins/Caffeine Pills

Explain any circles: _____

Do you use Nicotine? Yes No Type: _____ Amount per day: _____

Do you consider yourself to be an Alcoholic or an Addict? Yes No

Why or Why not? _____

Have others told you that they thought you consumed too much of any of the above? Yes No
Please explain: _____
_____

Has your use of the above ever caused you to:
___Miss or be late to work? ___Have work related problems?
___Have financial problems? ___Have relationship problems?
___Have problems with the law? ___Other? If so explain:_____

MENTAL HEALTH HISTORY

Please list any previous treatment by a Mental Health Professional

Date Problem Outpatient/Inpatient Where

_____
_____
_____

Have you ever intentionally harmed yourself? Yes No (If yes, please explain)_____
_____

Do you presently have thoughts to harm yourself? Yes No (If yes, please explain)_____
_____

Have you taken actions or have a plan to take action to harm yourself? Yes No (If yes, please explain)_____

FHL Center for Healing

Have you attempted suicide? Yes No (If yes, complete section below)
Number of times_____ When & How? _____
_____
_____

Were you adopted? Yes No If yes, describe your feelings about being adopted:_____
_____
Briefly describe your childhood. Please include pertinent information related to physical, emotional, or sexual abuse. _____
_____
_____
_____

How would you describe your spiritual life? _____

"I have problems with the following…" (please check those that apply)

____ Trouble getting along with other people
____ Feeling suspicious and distrustful of others
____ Hearing things that others don't hear
____ Seeing things that others don't see
____ Feel or smell things that others don't
____ Constant mood swings
____ Losing my train of thought
____ Problems with energy
____ Socially withdrawn
____ Loss of interest in activities
____ Frequently recall unpleasant experiences
____ Feelings of sadness
____ Sweating spells
____ Feelings of hopelessness
____ Hyperventilation spells
____ Rapid thoughts
____ Panic attacks
____ Nervousness
____ Problems relaxing
____ Excessive anxiety w/ others or _____
____ Thoughts I can't stop
____ Binge and/or purging of food
____ Extreme exercising
____ Easily distracted
____ Problems concentrating
____ Trouble staying with task
____ Feelings of being better off dead
____ Sexual identity
____ Crying spells
____ Relationship concerns
____ Parenting concerns
____ Difficulties in dealing w/ children (mine/step) (please circle one)
____ Experiences of trauma (Child/Adult) (please circle one)

Information reviewed and discussed with client:

_____ _____
Signature of Client Date

_____ _____
Signature of Provider Date

Consent for Treatment

I authorize and request my practitioner to carry out psychological and/or psychiatric exams, treatment and/or diagnostic procedures which now, or during the course of my treatment become, advisable. I understand the purpose of these procedures will be explained to me upon my request and that they are subject to my agreement. I also understand that while the course of my treatment is designed to be helpful, my practitioner can make no guarantees about the outcome of my treatment. Further, the psychotherapeutic process can bring up uncomfortable feelings and reactions such as anxiety, sadness, and anger. I understand that this is a normal response to working through unresolved life experiences and that these reactions will be worked on between my practitioner and me.

Initial Here_____

FHL Center for Healing

RIGHTS AND RESPONSIBILITIES

Experience has shown that when the contract terms of the psychotherapy relationship or evaluation process are clear and explicit from the beginning, some common misunderstandings are avoided. Please read carefully and sign at the bottom.

1. Since you are an integral part of your evaluation and therapy, you have the right to ask questions at any point. You may refuse to participate in any evaluation task; however, an accurate evaluation is better achieved with your cooperation.

2. Questions concerning your therapist's qualifications and experience will always be answered. As well, you may refuse to participate in any intervention, strategy, or behavior suggested by your therapist.

3. Therapy is an interactive, reciprocal experience. The therapist will always attempt to meet the client where they are emotionally. Your cooperation in the relationship is central to the success of therapy.

4. Within certain legal and ethical limits, information revealed by assessment or treatment will be kept strictly confidential and will not be disclosed to another person or agency without your written permission. The limits to this policy are as follows:

    a. If a court of law issues a subpoena, we are required to provide the information required by the subpoena.

    b. If a court of law has ordered you to participate in therapy or to be evaluated by our staff, the results of the treatment or assessment must be revealed to the court.

    c. If you threaten physical injury or death to yourself or another person, we must take steps necessary to protect you or other involved individuals. (This includes disclosure to appropriate authorities or relevant individuals.)

    d. If you or your child discloses emotional/physical/sexual abuse of a minor, we are required by law to report this to the Department of Child Services.

    e. If you were sent here to be evaluated for an attorney, insurance agency, Social Security, or your employer, disclosure is required.

5. You have the right to be informed about policies regarding fees and services.

    a. Co-payment or deductible will be due at the time of service.

    b. Fees are based on the type and length of therapy you receive. You will also be responsible for charges incurred on your behalf with other professionals/agencies; court appearances; test scoring, interpretation or preparation.

    c. We reserve the right to terminate treatment for non-payment of fees and services provided.

    d. Any check that is returned for Non-Sufficient Funds (NSF) will be charged an additional $25.00 above the amount of the check.

    e. Unpaid accounts greater than one session will result in dismissal from the practice until payment is received.

6. You have the right to terminate therapy at any time.

7. If you cancel or do not show for a scheduled appointment and we do not hear from you for 30 days, then it will be assumed you are no longer under our care.

8. There will be an additional charge for processing forms other than medical insurance (i.e. court reports, reports for outside persons/agency).

9. It is your responsibility to become familiar with your own mental health benefits prior to entering into treatment with your therapist. Our staff may be able to provide you with some insurance information, but due to the various plans with each carrier and their confidentiality policies, we cannot guarantee the accuracy of information we receive from your carrier.

10. **APPOINTMENTS:** Your appointment time is set aside just for you. We look forward to meeting you at your reserved time. If you miss an appointment without notice, this means that another person is not able to use that appointment time. If you have an objection to being reminded of your appointment via text message please let your therapist know Repeated "no-show" appointments could result in referring you back to the insurance company for reassignment to another practitioner. Your insurance company cannot be billed for fees associated with missed or canceled appointments. The fee for a missed appointment is $100.