NWA Premier Therapy
Your path to a better life

Client Information

Name:____
Date of Birth: ____________________
Address:____
____

Preferred means of communication ( ) Phone ( ) Email ( ) Text (check all that apply)
Cell Phone: ______________________ Home phone _____________ Work phone ____________
Email Address:____
Referred by:____

Emergency Contact Name:___________________________________ Relationship: ___________
Phone number__________________________________

PRESENT STUATION
Work: ( ) Full-Time ( ) Part-Time ( ) Student ( ) Unemployed ( ) Retired
May we contact you at work? ( ) Yes ( ) No
May we leave a message for you at home? ( ) Yes ( ) No
Relationship Status: ( ) Single ( ) Partnership ( ) Married ( ) Separated ( ) Divorced

Children names and ages: ____

Who lives in your home: ____

Please provide the following information for our records. Leave blank any question you would rather not answer, or would prefer to discuss with your therapist. Information you provide here is held to the same standards of confidentiality as our therapy.

TREATMENT HISTORY
Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? ( ) Yes ( ) No
Have you had previous psychotherapy? ( ) Yes ( ) No, if yes, with (previous therapist)
____
Are you currently taking prescribed psychiatric medication? ( ) Yes ( ) No
If yes, please list:
____
____
Prescribed by:
____
Prior Hospitalizations or Substance Abuse Treatment: ________________________________
Date(s): ____

Do you currently have a primary physician? ( ) Yes ( ) No

If yes, who is it? ____

Are you currently seeing more than one medical health specialist? ( ) yes ( ) no

If yes, please list: ____

Date of last physical? ______________________________________

Are you having any difficulty with appetite or eating habits? ( ) Yes ( ) No

If yes, check where applicable: ( ) Eating less ( ) Eating more ( ) Bingeing ( ) Restricting

Have you experienced significant weight change in the last 2 months? ( ) Yes ( ) No

Have you had suicidal thoughts recently?

( ) frequently ( ) sometimes ( ) rarely ( ) never

Have you had them in the past?

( ) frequently ( ) sometimes ( ) rarely ( ) never

How often do you engage recreational drug use?

( ) daily ( ) weekly ( ) monthly ( ) rarely ( ) never

In the last year, have you experienced any significant life changes or stressors? If yes, please explain:

____

____

Have you ever experienced any of the following?

Depression	Yes / No
Dramatic mood swings	Yes / No
Racing thoughts	Yes / No
Anxiety	Yes / No
Panic attacks	Yes / No
Risky Activity (speeding, sexual behavior)	Yes / No
Irritability	Yes / No
Avoidance of :	Yes / No
Sleep disturbances	Yes / No
Hallucinations	Yes / No
Impulsivity	Yes / No
Suspiciousness	Yes / No
Alcohol/substance abuse	Yes / No

Eating disorder	Yes / No
Body image problems	Yes / No
Repetitive thoughts (e.g. obsessions)	Yes / No
Repetitive behaviors (e.g. frequent checking, hand washing	Yes / No
Homicidal thoughts	Yes / No
Fatigue	Yes / No
Suicidal attempts	Yes / No If yes, when?

FAMILY MENTAL HEALTH HISTORY

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g. sibling parent, uncle, etc.)

Difficulty	**Yes / No**	**Family member**
Depression	Yes / No	
Bipolar disorder	Yes / No	
Anxiety disorder	Yes / No	
Panic attacks	Yes / No	
Schizophrenia	Yes / No	
Alcohol/substance abuse	Yes / No	
Eating disorders	Yes / No	
Learning disabilities	Yes / No	
Trauma history	Yes / No	
Suicide attempts	Yes / No	
Chronic illness	Yes / No	

SUBSTANCE HISTORY

Have you ever tried the following (check all that apply add last date used)

Alcohol ( ) ___/___	Tabacco ( ) ___/___	Marijuana ( )___/___	LSD ( ) ___/___
Heroin ( ) ___/___	Meth ( ) ___/___	Cocaine ( ) ___/___	Stimulants ( ) ___/___
Ecstacy ( ) ___/___	Methadone ( ) ___/___	Tranquilizers ( ) ___/___	Pain Killers ( ) ___/___

Informed Consent rights & Confidentiality and the exceptions.

We are bound by ethical principles to keep your information confidential, there are exceptions to these principles that you should understand prior to entering into a therapeutic relationship.

1. In case of suspected child abuse, I am required to report this to the appropriate county authorities.
2. If at any point, I believe that your life or someone else's life is endangered by actions you are about to take, I may break confidentiality to warn or prevent harm to you or another person.
3. If you are using a third party payer (private insurance) I may be required to submit records to your insurer.
4. In some cases, records may be subpoenaed by a judge in custody or litigation.
5. If you are a minor and engage in behaviors that are seriously threatening to your health, this information may be shared with your guardian. I will try to inform you of any decision to divulge this inform before the disclosure of information.
6. To allow any other communication, a written release must be completed and signed by you.
7. Only the custodial or joint custodian can consent to treatment of minors.

I have read the Informed Consent rights

____ ______________________

Client Signature Date

I have read the Informed Consent rights

____ ______________________

Guardian Signature Date

Financial Agreement

I agree to authorize payment of insurance benefits to provider, authorize release of information necessary to process my claims, and accept payment responsibility for the portion of the bill insurance doesn't pay within 60 days. I agree to pay in full for all services received. I understand that I am responsible for all charges not covered by my insurance.

____ Date: ______________________

Patient or Guardian Signature

Clinic Policies

I agree to provide notice of cancellations within 24 hours prior to my appointment. If I fail to provide adequate notice I will be charged full fee with the exception of agreed upon emergencies.

____ Date:______________________

Patient or Guardian Signature

Insurance Information

Services are billed by the hour. In accordance with standards of practice. Your insurance is a contract between you and your insurance company. Please present insurance cards to be photocopied.

Primary Insurance Provider ____

Member ID ______________________________Group ID______________________________________

Policy Holder Full Name ____

Relationship to client:____________________   Policy Holder DOB __________________________

Policy Holder Phone number________________________ Policy holder SSN: ______/______/____

Policy Holder Employer____

Insurance contact phone ____

Responsible Party if other than patient: (who is responsible for payment of all costs)

First Name: ____________Middle__________ Last: _____________________________________

Address: _______________________ City: ________________State; ____________Zip;_______

Phone: ________________ SSN: _____/_______/______ Employer:___________________________

Relationship to client:____

Method of Payment

Name on Card____

Card Number____

Expiration Date______________________________ CVV ______________________________

Card Type: Visa / Mastercard / AmEx

Address attached to card____

____