BRIGHT HORIZON COUNSELING LLC
REENA SHARMA LPC, CRADC, LCPC
1010 Carondelet Drive
Kansas City, MO
64114

This information is confidential

DEMOGRAPHIC INFORMATION

Person completing this form _____

Relationship to patient _____

Patient Information:

Date of Birth _____/_____/_____

Social Security #_____-_____-_____

Circle: Female Male

Relationship Status: (circle) Single Married Divorced Separated
Mailing Address_ _____

Home Phone _____

Work Phone _____

Cell Phone _____

Phone number that you would like to be reached at: (circle) Home Work Cell

Email _____

In case of Emergency contact _____ Phone_____

Highest Degree of Education_____

Occupation _____

Name of Primary Care Physician _____

Phone _____

Address_____

How did you hear about my practice?_____

CLINICAL INFORMATION

The patient is requesting the following: (circle)…

Individual **Adult Counseling** **Adolescent Counseling**
Group Counseling **Stress Management**

What are the reasons for seeking counseling services at this time?

_____

_____

What is the nature of your situation?

_____

_____

What would you like to experience that is different from what you are experiencing now?

_____

_____

How long has this been a problem for you?

_____

_____

Please state what you would like to work on in therapy.

_____

_____

Do you have any physical disabilities, limitations, or health problems?
If Yes, please describe: _____

_____

Do you take any medications? Please list current medication(s), dosages, and frequency of administration

Name of the Medication	Dose	Frequency of Administration
_____	_____	_____
_____	_____	_____

Have you ever been hospitalized for physical illness or surgery? Yes No

If Yes, please describe _____

Have you ever been hospitalized for mental illness? Yes No

If Yes, please describe _____

Have you ever received psychological help of any kind in the past? Yes No

If Yes, what issues were addressed? _____

Name(s) of previous mental health provider(s) & dates of service:

Provider's Name	Reason	Dates of Service
_____	_____	_____
_____	_____	_____

Please circle any of the following items that may pertain to you for seeking mental health counseling services at this time:

Have you ever had thoughts of suicide? Yes No
If Yes, Explain _____

Have you ever attempted suicide in the past? Yes No
If Yes, Explain _____

Have you ever-experienced thoughts of harming others? Yes No

If Yes, Explain _____

Have you ever attempted to harm others in the past? Yes No

If Yes, Explain _____

Do you drink alcoholic beverages? Yes No

If Yes, How many? _____ How often? _____

Do you use illicit/street drugs? Yes No

If Yes, What kind? _____ How often? _____

When was the first time you used or experienced this drug? _____

What was the reason for the use? _____

PERSONAL AND FAMILY HISTORY

Has a close relative ever been hospitalized for a psychiatric illness? YES NO

Does anyone in your family have a mental illness? YES NO

Has anyone in your family every attempted or committed suicide? YES NO

Does anyone in your family have a substance abuse problem? YES NO

Are you currently employed? YES NO

1) How well you are doing on your job:

Cannot Function	Serious Problem	Moderate Problem	Mild Problem	No Problem

2) How well you are doing in your marital/significant other relationship:

Cannot Function	Serious Problem	Moderate Problem	Mild Problem	No Problem

3) How well you are doing in your family relationships:

Cannot Function	Serious Problem	Moderate Problem	Mild Problem	No Problem

4) How well you are doing in relationships with people outside your family:

Cannot Function	Serious Problem	Moderate Problem	Mild Problem	No Problem

5) Please rate your current physical health:

Very Poor 1 2 3 4 5 6 7 8 Excellent

6) Please rate your general happiness and well-being:

Very Poor 1 2 3 4 5 6 7 8 Excellent

LEGAL DATA:

Have you ever been incarcerated (Jail or Prison)? Yes _____ No_ ___ Dates_____

Reason_____Where_____

Have you ever had a DWI (Driving While Intoxicated)? Yes _____ No_____ How Many:_____

Are you currently on Probation? Yes _____No_____ Explain_____

Symptom Assessment

Please give as accurate account as you can and if you have any questions or concerns, we invite you to discuss them with your intake counselor

Your Concerns:

I AM EXPERIENCING…	Seldom	Often	Always	Never	For how Long?
Frequent worry or tension					
Fear of many things					
Discomfort in social situations					
Feelings of guilt					
Phobias: unusual fears about specific things					
Panic Attacks: Sweating, trembling, shortness of breath, heart palpitations					
Recurring, distressing thoughts about a trauma					
"Flashbacks" as if reliving the traumatic event					
Avoiding people/places associated with trauma					
Nightmares about traumatic experience					

I AM FEELING…	Seldom	Often	Always	Never	For how Long?
Decreased interest in pleasurable activities					
Social Isolation, Loneliness					

Suicidal Thoughts					
Bereavement or Feelings of Loss					
Changes in sleep (too much or not enough)					
Normal, daily tasks require more effort					
Sad, hopeless about future					
Excessive feelings of guilt					
Low self-esteem					

I NOTICE……	Seldom	Often	Always	Never	For how Long?
I am Angry, Irritable, hostile					
I feel euphoric, energized and highly optimistic					
I have racing thoughts					
I need less sleep than usual					
I am more talkative					
My moods fluctuate: go up and down					

I HAVE	Seldom	Often	Always	Never	For how Long?
Memory problems or trouble concentrating					
Trouble explaining myself to others					
Problems understanding what others tell me					
Intrusive or strange thoughts					
Obsessive Thoughts					
Been hearing voices when alone					
Problems with my speech					

I USE THE FOLLOWING	Seldom	Often	Always	Never	For how Long?
Alcohol					
Nicotine (Cigarettes)					
Marijuana					
Cocaine					
Opiates					
Sedatives					
Hallucinogens					
Stimulants					
Methamphetamines					

MY EATING INVOLVES	Seldom	Often	Always	Never	For how Long?
Restriction of food consumption					
Bingeing and Purging					
Binge Eating					
A lot of weight loss or gain					

I HAVE…	Seldom	Often	Always	Never	For how Long?
Concern about my sexual function					
Discomfort engaging in sexual activity					
Questions about my sexual orientation					

EMPLOYMENT & SELF-CARE	Seldom	Often	Always	Never	For how Long?
I have problems getting/keeping a job					

I have problems paying for basic expenses					
I am afraid of becoming homeless					
I have problems accessing healthcare					

List 3 Strengths you believe you have:

1. _____

2_____

3. _____

List 3 Weaknesses you believe you have:

1. _____

2_____

3. _____

List 3 Support Systems you have in your life right now:

1. _____

2. _____

3. _____

Client's Signature_____ Date_____

Personal Agreements

I understand that I may be asked to do certain "homework exercises" such as reading, praying, changing behaviors, and otherwise acting in my own best interest. I understand that I am entirely responsible for my own actions and I will always make my own final decisions regarding counseling.

I further understand that much of the work done will be to resolve issues and will depend on my honesty, and willingness to do the things I need to do to move forward even if it is painful and difficult.

I understand that whatever I say in a session is strictly confidential and will not be released to anyone without my consent unless I am violating codes of abuse, harm to others or myself.

I understand that I will pay in full for appointments not canceled with 24 hours notice. The rate is $125/hr.

_____(Client signature and date)

As your therapist/counselor, you honor me by sharing your life and growth with me. I will not hide myself behind silence or position and will have high regard for you as a person. I will bring the best that I know from my study and experience. I will bring you the highest of my insight, wisdom, and spiritual guidance.
I will keep a holistic perspective in our work together because I believe that the Physical, Spiritual, and Soul (mind, will, emotions) all work together to form the wholly healthy person.

You can expect truth from me even when you may not want to hear it. I will always have compassion and empathy for you in all that we do. I value you as a person in need of care. I will do my best to honor that.

Consent To Use Or Disclose Health

INFORMATION FOR THE TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

Patient Name: _____

Patient Address: _____

Patient Phone Number: _____

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our office.

We have a comprehensive Notice of Privacy Practices that describes these uses and disclosures in detail. You are free to refer to this Notice at any time before you sign this consent document. As described in our Notice of Privacy Practices, the use and disclosure of your health information for treatment purposes not only includes care and services provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health care professional. Similarly, the use and disclosure of your confidential information for purposes of payment may include the submission of your personal information to a billing agent or vendor for processing claims or obtaining payment; our submission of claims to third-party payers of insurers for claims review, determination of benefits and payment; or our submission of your personal information to auditors hired by third-party payers and insurers, among other aspects of payment described in our Notice of Privacy Practices. Our Notice of Privacy Practices will be updated whenever our privacy practices change. You can get an updated copy here at our office.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services, and to perform mental health treatment. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services, or performed health care operations in reliance upon our ability to use or disclose your information in accordance with this consent. We can decline to serve you if you elect not to sign this consent form.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or mental health treatment, but as described in our Notice of Privacy Practices, we are not obligated to agree to these suggested restrictions. If we do agree, however, the restrictions are

binding on us. Our Notice of Privacy Practices describes how to ask for a restriction.

I HAVE READ THIS CONSENT AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY CONFIDENTIAL INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

Patient Signature: Date:

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient: Print Name:

Authorization for Release/Exchange of Information

This form provides your therapist with written permission to communicate with other individuals regarding your treatment (e.g., previous therapist, current health care providers, parent).

I _____authorize_____ to release and/or exchange

my case with the following parties:

Name_____

Address_____

Phone Number_____

Information to be Released or Exchanges (Check all that apply)

-------- Intake and history

-------- Diagnosis and Treatment Plan

------- Verbal Consultation

-------- Other (Specific) _____

_____

------ Progress notes

------ Discharge Summary

------ Billing and Payment

----- All of the above

The release shall be valid until the termination of treatment or until withdrawn in writing by the patient during the course of treatment.

Print Name: _____

Signature: _____

Parent Signature if under 18 _____

Date: _____