



Personal
Groups
Training

1612 S. Big Bend Blvd. St. Louis, MO 63117
(314) 529-1391

Personal Information Form

Today's Date: _____ How did you hear about us? _____
Client's Name: _____ Date of Birth: _____
Home Phone #: (____) _____ Cell Phone #: (____) _____
Address: _____
E-mail address: _____
Education: High School College Other _____
Employer: _____ Position: _____ How Long Employed? _____
Do you attend church? Y/N Church Name _____ Member? Y/N
Relational Status: Single / Married / Divorced / Separated / Widowed / Committed Relationship / Engaged

Spouse/Partner Information

Name: _____ Date of Birth: _____
Home Phone #: (____) _____ Cell Phone #: (____) _____
Address (if different than above): _____

Emergency Contact Information

Name: _____ Phone: _____ Relationship: _____

Information About Children

Please list: *Name, Age, Sex, Living at home, and whether they are your Step Child*

What is happening in your life that has caused you to seek out counseling?

Health and Family History

Your current health: Very good Good Average Declining
Approximate date of your last comprehensive medical exam: _____
Current medical problems: _____

<u>Medication</u>	<u>Reason For Medication</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Prescribed By</u>
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Are you currently meeting with any of the following: Counselor | Psychologist | Psychiatrist | Dietitian | Other: _____ | If so, please list their name and reason: _____

Have you previously sought counseling or psychiatric help? ___ Yes ___ No | If so, please tell me a bit about it and how satisfactory your experience was: _____

Please describe any family history of medical and / or psychological problems: _____

Have you ever experienced: *(Place a check mark by conditions that apply to you)*

- Anxiety Eating Disorder Depression Anger Abandonment
- Addiction (drugs, alcohol, sex, gambling, pornography, etc.) Adoption Issues
- Post Traumatic Stress Disorder HIV Positive Postpartum Depression

Please describe any current or past addiction(s) (i.e., drug, alcoholic, sexual, etc.): _____

Please describe any current or past violence or abuse in the home: _____

Please describe any family history (the family you grew up in), which might be pertinent to the concerns that bring you to counseling (your relationship with your parents, their relationship with each other, significant losses and / or events): _____

Social History

How satisfied are you with your social support system? _____

Do you drink alcoholic beverages? Y/N If so, how much per week? _____

Do you use drugs (illegal/any drug)? Y/N If so, how often and which drug? _____

Please circle any symptom you have had in the past **six months**:

Change in appetite	Problems concentrating
Difficulty sleeping	Low Motivation
Sleeping too much	Isolating from others
Fatigue/low energy	Frequent anger
Low self-esteem	Depressed mood/sadness
Tearful/cry spells	Anxiety/Fear
Hopelessness	Panic



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Consent for Treatment

Client Name: _____ Date of Birth: _____

I give permission to **LIANNE JOHNSON, LPC (License # 2003031565)** to provide counseling to me. As a client of Avenues Counseling it is your right to have the content of your therapy sessions held in confidence with these exceptions in which we are mandated to report: (1) if you sign a release form for us to divulge any or all information, (2) if you intend suicide, or if you intend to do serious physical harm to yourself, (3) if you intend homicide, (4) if a child, elderly person, or disabled person is being abused or has been abused, or (5) in the case of exploitation by a mental health professional.

In some cases, the Missouri courts have held that if an individual intends to take harmful or dangerous action against another individual, it is the counselor’s duty to warn the person and/or family of the person who is likely to suffer the results of harmful behavior. Every effort will be made to resolve these issues before such a violation of confidentiality takes place. Every effort will be made to prevent an attempted suicide or a dangerous action against another person. In following ethical and professional standards, our therapists consult with other professionals to gain other perspectives and ideas on how to best serve you. Unless you have signed a release, no identifying information is shared during these consultations.

I have read and agree to the above policies, procedures and statements.

Signature of Client

Printed Name of Client

Date

Signature of Counselor

Date

Contact *Please INITIAL each statement to which you consent*

____ I grant permission for general information (events and other information) to be sent to my home address.

I grant permission for my therapist and the administrative staff to leave a message for me at
___ home phone ___ cell phone ___ business phone

I recognize that e-mail & text is not a secure means to transmit data. I voluntarily waive my rights provided by federal and state laws regarding confidentiality in order to send to, or receive communications (and / or invoices) from Avenues Counseling via e-mail or text. I voluntarily give my permission and will not hold Avenues Counseling or my counselor, Lianne Johnson, legally responsible for the transmission of this data.

Client Signature _____ Date _____

____ I grant permission to send and receive communication from my therapist and Avenues administrative staff at my email address.

Privacy Policy *Please INITIAL*

____ I acknowledge that the Notice of Privacy Practices has been made available to me.



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Financial Policy *Please INITIAL all statements*

_____ I understand that counseling sessions are 50 minutes long. The fee for a 50 minute session, either face-to-face, by phone, or Skype (e.g. telehealth) is \$_____ as determined by you and your counselor. **Your counselor charges in 15 minutes increments for all phone sessions.**

_____ I agree to make payment at the beginning of the session. I understand that my counselor receives a percentage of the fee I pay to Avenues for our time together and is not compensated for his/her time with me unless and until I make payment for a session. Fees per session are subject to change. If changes are forthcoming, you will be given 30 days notice prior to the implementation of the change.

_____ I understand that Avenues Counseling prefers payment to be made in the form of cash or check. As a convenience Avenues also accepts credit cards, for which there is a convenience charge.

_____ I agree that in cases of returned checks and bank fees, to pay for all service charges associated with my account and for all returned checks. There is a \$20 fee for all returned checks.

_____ I understand that if I have an outstanding balance billing information will be sent to my primary address unless another address is supplied.

Missed Appointment Policy *Please INITIAL*

_____ I understand that **24 hours notice** is required for the cancellation of an appointment. Appointments canceled with less than 24 hours notice will be charged your full fee. If you have a credit card on file, your missed appointment will be charged to your credit card.