**Client Information Form**

**I assure you that I read every bit of the information you give me. Thank you for your time and information.**

**Also, Failure to provide 24-hour notice or no shows will result in a $45 charge.**

If you are part of any current or up and coming legal proceedings or court cases, including divorce or separation please specify:

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|  |
|  |  |
| Name: | Date of Birth: |
| Client Name if Different than person completing this form: | Date of Birth: |
| Address: | City: | State: | Zip: |
| BCBSTX PPO Member ID: | Group ID: |  | Age: |
| I agree that Chris Quaglino can bill my insurance company and understand that if my insurance company requests mental health updates he may be required to supply this information. | Initial Here: |

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| **\*Optional Demographic Information** |
| Gender: | Female: | Male: | Self: | Preferred pronouns:  |
|  |  |  |  |
| **Client Contact Information and Permissions:****You are responsible if others access your electronic communication with me or if they look over your shoulder.****Also note that electronic communication can be subpoenaed and is a permanent record.** **Please complete the Client Communications Agreement at the bottom of page 4.** |
|  |
| Please check all that apply: | Single | Married/Partnership | Divorced/Separated | Widowed |
| **Emergency Contact** |
| Name: | Relationship to you: |
| Best Phone Number (Daytime): | Best Phone Number (Nighttime): |
| Address: | City: | State: | Zip: |
| **Family Information** |
|  | Name(s) | Age(s) | Name(s) | Age(s) |
| (Ex)Spouse/Partner |  |  |  |  |
| Children |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| Siblings |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| Parents |  |  |  |  |
|  |  |  |  |  |
| Are there other family members in the home? | Yes | No | Explain: |

Symptom Checklist: Please check the symptoms that you are experiencing and indicate the severity and frequency. Please check all that apply. And know that I do read every page. Thank you.

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| --- | --- | --- | --- |
|  | Indicate Severity(mild, moderate,severe) | Indicate Frequency (daily, weekly, monthly)  |  |
| Symptoms  | Comments |
|  |  |
| Depressed mood  | Low | Med | High | Daily | Weekly | Monthly |  |
| Grief / bereavement  | Low | Med | High | Daily | Weekly | Monthly |  |
| Hopeless / helpless  | Low | Med | High | Daily | Weekly | Monthly |  |
| Decreased energy / Fatigue  | Low | Med | High | Daily | Weekly | Monthly |  |
| Hyperactivity  | Low | Med | High | Daily | Weekly | Monthly |  |
| Mood Swings  | Low | Med | High | Daily | Weekly | Monthly |  |
| Weight or Appetite Change  | Low | Med | High | Daily | Weekly | Monthly |  |
| Irritability / Restless  | Low | Med | High | Daily | Weekly | Monthly |  |
| Sleep Disturbances  | Low | Med | High | Daily | Weekly | Monthly |  |
| Obsessive/Compulsive Behavior  | Low | Med | High | Daily | Weekly | Monthly |  |
| Flashbacks  | Low | Med | High | Daily | Weekly | Monthly |  |
| Paranoia  | Low | Med | High | Daily | Weekly | Monthly |  |
| Anxiety/panic attacks/ worrying | Low | Med | High | Daily | Weekly | Monthly |  |
| Suicidal Thoughts  | Low | Med | High | Daily | Weekly | Monthly |  |
| Impaired concentration  | Low | Med | High | Daily | Weekly | Monthly |  |
| Loss of interest in activities  | Low | Med | High | Daily | Weekly | Monthly |  |
| Self-Harm-Cutting/Burning/Other  | Low | Med | High | Daily | Weekly | Monthly |  |
| Binging/Purging/Restricting Food  | Low | Med | High | Daily | Weekly | Monthly |  |
| Anger Issues  | Low | Med | High | Daily | Weekly | Monthly |  |
| Current Abuse  | Low | Med | High | Daily | Weekly | Monthly |  |
| Delusions / Bizarre Beliefs  | Low | Med | High | Daily | Weekly | Monthly |  |
| Hallucinations  | Low | Med | High | Daily | Weekly | Monthly |  |
| Impaired Memory  | Low | Med | High | Daily | Weekly | Monthly |  |
| Gambling Problem  | Low | Med | High | Daily | Weekly | Monthly |  |
| Sexual Issues  | Low | Med | High | Daily | Weekly | Monthly |  |
| Internet or porn addiction  | Low | Med | High | Daily | Weekly | Monthly |  |
| Other:  | Low | Med | High | Daily | Weekly | Monthly |  |
| Anything else I need to know:  |  |
|  List strengths: |  |

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| Pre-Service Questionnaire |
| The process of therapy can be stressful and sometimes overwhelming. To help this process to be as productive as possible, an important therapeutic partnership must be established between you and your therapist in which good self-care routines are established. Please help me to understand more about you by providing the information listed below: |
| Please list the top areas of current concern for you that you would like or need to work on: |
| Please tell me a little bit about your history (pertinent information concerning your family and relationships history, significant loss): |
| Do you feel like you have resolved any of these issues? How? |
| Have you suffered a traumatic event? Please Circle: Car Crash Natural Disaster Assault Deployed Military Service Other (describe). If yes, what and when? |
| What do you hope to get out of our sessions? |

**Informed Consent**

I understand that all statements made by me to my counselor are of a confidential nature and generally,

except as noted below, may not be disclosed by my counselor without my consent. I further understand and accept as a condition

of receiving counseling, that certain statements made by me or certain situations may require my counselor to take action or make disclosure when my counselor believes it is necessary for the protection of life or when my counselor may be required by law to disclose or report threats or past instances of harm to myself or threatened harm or past instances of harm to a third person. These disclosures will be made at the sole discretion of the Counselor I am seeing. I hereby acknowledge that I have read and understand the following six items concerning confidentiality of service provided. I understand that if I have any questions regarding privacy rights, I can contact Chris Quaglino, LCSW, LCDC.

**Client Communications Agreement Communication Policy**

The Health Insurance Portability and Accountability Act (HIPAA) gives you, the client, the right to request that your therapist communicates administrative and/or clinical information to you in confidence by a particular method. In order to protect the privacy and confidentiality of your information, please indicate how you wish to be contacted. **Check and fill in all that apply**:

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| **Phone Communication** |
|  Place an ‘X’ in each column that you choose |
|  | Home Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I understand Chris Quaglino will not leave a message that others may hear. |
|  | **Personal** Mobile Phone Number (NOT A WORK PHONE):  |
|  | Yes, Chris Quaglino may leave a message with his name and call-back # on my voicemail because I have my phone password protected and I don’t share the password with anyone. |
|  | I also agree to **only use text for appointment confirmation**. I will not use texting for discussion of any issues or concerns. I will call Chris Quaglino directly with this type of information, leave a message as needed, and Chris Quaglino will return my call. And finally, I know that **if I leave my phone or computer out and/or unlocked for others to see or use, I may compromise the privacy of my personal information. It is my responsibility to keep the information on my electronic devices private. This includes all electronic devises: iPad, Phone, Tablet, Computer, TV incoming calls notices, etc.** |
| **Email Communication** |
|  | I do not wish to communicate via email. |
|  | Yes, I wish to communicate via email. I will **ONLY USE** **the private, personal email address listed below. I will** **never** **use a shared or work email address**. I also understand that work email is the property of the company that I work for and con be used in court. My secure/personal email address is: |

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| **Acknowledgements** |
|  Please **initial each space** below acknowledging you have been given, read and understand the following: |
|  | **1 Informed Consent and Teletherapy WalknTalk** |
|  | **2 Notice of HIPAA NS** |
|  |  |
| Client Name (please print) Client Signature (or authorized representative\*) Date |

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| **Notice of Cancellation Policy**Your appointment time is held for you. If you need to make any changes to your appointment, please give at least 24-hour notice. **Failure to provide 24-hour notice or no shows will result in a $45 charge** which is one half of the full session rate. Please be on time for your appointments. Showing up more than 15 minutes late to the appointment may result in needing to reschedule the session. Your session starts at the time scheduled and typically ends 55 minutes from that time. If you are late, please understand that I must end the session as scheduled so that I can complete administrative tasks and start on time for the next client. Payments are due at the start of each session or can be paid in advance. Payment for services is an important part of any professional relationship. It shows that you value your healing and personal development. |

How did you hear about me? (please include name if appropriate)

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| --- | --- |
| www.itoiaustin.com | Conference/Seminar |
| Friend/Family | Yelp |
| Yahoo search | Psychology Today website |
| Google search | Yahoo search |
| M.D./Psychiatrist | Counselor |
| Other |