Rock Landing Psychological Group
Adult Client Information

Please Print
Name: _____ Date: _____

Marital Status: ▢ Single ▢ Married ▢ Domestic Partner ▢ Separated ▢ Divorced ▢ Widowed

Date of Birth:_____ ▢ Female ▢ Male Race:_____

Address:_____

City/State/Zip: _____

Preferred Contact Method:
(Cell/Home) _____Secondary (Cell/Home) _____

Email_____

Occupation:_____ SSN: _____
Emergency Contact: _____ Phone:_____

If different than above, Guarantor Information (Responsible Party)

Relationship to Client: ▢ Spouse ▢Parent ▢ Guardian
Name:_____
Address: _____
Date of Birth: _____ ▢Female ▢ Male
SSN:_____
Employer: _____ Occupation:_____
Home Phone: _____ Work/Other Phone: _____

Insurance Information

Primary Insurance:_____Subscriber Date Of Birth: _____

Subscriber Name: _____ Subscriber SSN:_____

Policy ID#: _____ Group #: _____

Subscriber's Employer: _____ Work Phone: _____

Secondary Insurance: _____Subscriber Date of Birth:_____

Subscriber Name: _____ Subscriber SSN:_____

Policy ID#:_____ Group #:_____

Subscriber's Employer:_____ Work Phone:_____

Treatment Contract

Insurance and Financial Policy Statement

Thank you for choosing Rock Landing Psychological Group for counseling. As part of providing high-quality services, we need to clarify our financial policies. Should you have any questions regarding the practice policies, please ask a member of the staff for clarification.

If you are using your health insurance benefits, we will bill your insurance company. To do so, we need you to provide us with accurate and timely information regarding your insurance. **All co-pays, deductibles, and denied payments are your responsibility.** Your health insurance company may require you to make a co-payment and/or satisfy a deductible. The co-payment is determined by your health insurance company and is due at the time of service. If you have a deductible which has not been met, then full fee is due until the deductible has been met.

I authorized a release of information to my health insurance company and I assign all benefits to Rock Landing Psychological Group.

Late Cancellation/No Show Fee

Rock Landing Psychological Group requires 24 hours notice for routine cancellations. Late cancellations and no shows will incur a $65.00 charge for a missed appointment with your therapist and $75.00 charge for missed appointment with your psychiatrist to be paid at your next scheduled session. Please note that your health insurance company will not cover this fee. Repeated cancellations and/or missed appointments may result in being disengaged from this practice. The practice has a 24 hour voice mail system to take your cancellations. Please call (757) 873-1736 and the service will take the message and fax to the office. At the time of check-out you are given a card with the date of your next scheduled appointment. Upon request the staff will be glad to give you an appointment card. Our office does not make reminder calls for appointments.

Late Cancellation/No Show Fee for Psychological Testing

The psychologist needs 72 hours for cancellation for testing. Late cancellations and no shows will incur a $65.00 charge for each hour the individual was scheduled for testing. Please note the health insurance company will not cover this fee. Please be aware it will also be at the discretion of the examiner as to whether or not the individual will be rescheduled for testing.

Client Signature: _____ Date: _____

Consent to Treatment

I do hereby seek and consent to take part in the treatment provided by Rock Landing Psychological Group.

I understand that developing a treatment plan with my provider(s) and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures rendered by my provider(s).

I am aware that I may stop treatment with my provider(s) at any time. I will still be responsible for payment of services I have already received.

Signature:_____

Coordination of Treatment

If I am referred to any other clinician or physician at Rock Landing Psychological Group, I give my consent for those clinicians to obtain and release pertinent information to each other for the purpose of coordinating my care.

Signature: _____

I give permission to the following to schedule and/or speak with the office about my appointment.

1. _____
2. _____

Agreement

I hereby attest that all information contained in these pages is current and correct. I understand that I am responsible for informing Rock Landing Psychological Group of any changes. Failure to do so may delay processing of insurance claims, in which case I will incur responsibility for those unpaid claims. Falsification of this information is punishable under Federal Law.

I have received a copy of the Notice of Privacy Information Practices (HIPAA) pertaining to this practice.

Client Signature:_____ Date: _____

Responsible Party Signature:_____ Date:_____

Referral Information

Who referred you to this practice: _____

May we have permission to thank them for your referral? ☐ Yes ☐ No

Have you been seen here before? ☐ Yes ☐ No If "yes" please give approximate date and reason for seeking counseling: _____

Additional Information

Name of Spouse/Partner: _____ Age: _____

Name of Children	Age of Children

Your Education & Training:
☐ Pre-School to High School Grade ___
☐ High School Diploma/GED
☐ Vocational/Technical School
☐ College
☐ Graduate/Professional School

Client Signature: _____ Date: _____

Health Information

1. List all medications you take:

Medication/Drug	Dose	Taken for

2. List all diseases, illnesses, significant accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, seizures, and any other medical conditions you have or have had.

Age	Illness	Treatment	Treated By	Result

3. Are you now being treated for any medical condition? ☐ Yes ☐ No

4. When was your last medical exam? _____

5. Your health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

6. Describe any allergies you have: ___ No Allergies/Adverse Reactions

To What	Reaction You Have	Allergy Medication You Take

Health Information (continued)

7. Health Habits

Do you use any tobacco products? ▢ No ▢ Yes per day: ____ Do you wish to quit? ▢ No ▢ Yes

Do you drink alcohol? No ____ Yes ____ Drinks per: Day _____ Week _____

Has your drinking ever been a problem? No ____ Yes ____
Previous Treatment? _____

Do you use street drugs? No ____ Yes ____ What _____
Has your drug use every posed a problem? No ____ Yes ____
Treatment? No ____ Yes ____

How many cups of caffeinated beverages do you drink each day (coffee, tea, cola)?
▢ None # ___ ▢ 1-3 ▢ 4 or more

Do you frequently take over-the-counter medications? ▢ No ▢ Yes
What _____

Do you take vitamins/food supplements? ▢ No ▢ Yes
What?_____

How often do you exercise? Never ▢ times a week _____
Are you aware of the physical and mental health benefits of regular exercise? No ____ Yes ____

What do you do to manage stress? ▢ Social Support ▢ Hobbies ▢ Support/Interest Group
▢ Spiritual Pursuits ▢ Nothing

Client Signature: _____ Date: _____

Mental Health History

Have you ever had a psychiatric hospitalization? ☐ No ☐ Yes

If the answer is yes: Date(s): _____

Facility: _____

Reason: _____

Was it helpful? ☐ Yes ☐ No

Have you ever had mental health/family/marriage counseling? ☐ No ☐ Yes

If the answer is yes: Date(s): _____

Counselor: _____

Was it helpful? ☐ Yes ☐ No

Have you ever been under the care of a psychiatrist: ☐ No ☐ Yes

If the answer is yes: Date(s): _____

Provider: _____

Was it helpful? ☐ Yes ☐ No

Have you ever thought a lot about trying to harm or kill yourself? ☐ No ☐ Yes

If the answer is yes: When: _____

Where: _____

Have you ever tried to harm or kill yourself? ☐ No ☐ Yes

If the answer is yes: When: _____

Where: _____

Client Signature: _____ Date: _____

Name _____ Date _____

Please mark all of the items below that apply, and add any others at the bottom of the next page under "Additional concerns or issues."

Mood

- Anger
- Aggression, violence
- Nervousness, panic/anxiety attacks
- Crying spells
- Depression, low mood, sadness
- Emptiness
- Failure
- Fatigue, tiredness, low energy
- Fears, phobias
- Grieving deaths, losses, divorce
- Guilt
- Hopelessness
- Loss of control, outbursts
- Inferiority
- Loneliness
- Low self-esteem
- Mood swings
- Irritability
- Pessimism
- Shyness
- Stress, tension
- Suspiciousness
- Suicidal thoughts
- Withdrawal, isolating
- Worry

Relationship Problems

- Children, child management, child care, parenting
- Childhood issues (own childhood)
- Child custody/visitation
- Dependence
- Marital conflict, infidelity/affairs
- Sexual issues, dysfunctions, desire differences, etc.
- Family conflict
- Friendships
- Interpersonal conflicts
- Divorce, separation

Health Problems & Concerns

- Overeating
- Under-eating/food restriction
- Binging
- Vomiting
- Illness/injury
- Laxative Use
- Physical problems
- Headaches
- Menstrual problems
- PMS
- Menopause
- Self-neglect, poor self-care
- Sleep too much
- Sleep too little
- Insomnia
- Nightmares

Adult Checklist of Concerns (continued)

Problems with thinking
- ▭ Attention, concentration, distractibility
- ▭ Decision making, indecision, mixed feelings, putting off decisions
- ▭ Obsessions, compulsions (thoughts or actions that repeat)
- ▭ Delusions (false ideas)
- ▭ Memory problems
- ▭ Confusion

Abuse
- ▭ Physical
- ▭ Sexual
- ▭ Neglect (of child or elderly)
- ▭ Emotional

Employment/Career Problems
- ▭ Career goals
- ▭ Career choices
- ▭ Over-working
- ▭ Problems with co-workers
- ▭ Unemployment
- ▭ Can't keep a job

Other Problems
- ▭ Over sensitivity to rejection
- ▭ Perfectionism
- ▭ Procrastination
- ▭ Self-centeredness
- ▭ Impulsive spending
- ▭ Gambling
- ▭ Low motivation, laziness
- ▭ Judgment problems, risk taking
- ▭ Irresponsibility
- ▭ Consumer debt
- ▭ Low income

Additional concerns or issues: _____

_____

Please look back over the concerns you have checked off and choose the one which you most want help with. It is: _____