Jeffrey Cohen, LPC

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NEW CLIENT INFORMATION

(Please print.)

Name _____ Date _____

Phone numbers: *(home)* _____ *(business)* _____ *(other)* _____

Address *(street)*_ _____

_____

(city) *(state)* *(zip code)* *(county)*

Email Address _____ May I contact you at this address? Y / N

Date of birth _____ Height _____ Weight _____

Race/ethnicity_____

Highest level of education _____

Place of employment _____

Occupation _____

How did you hear about us?_____

Relationship Status *(check one)* :

___Single ___Married/Committed Relationship ___Widowed ____Divorced/Separated

How long in married/committed relationship? _____ Partner's age_____

Partner's business or position _____

Number of children _____ Ages and genders_____

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MEDICAL HISTORY

Local physician _____

Current physical problems, symptoms or concerns

_____

Current prescription medications (name & dosage)

_____

Prescribed by (physician name & number)

_____

Date and nature of previous significant physical problems

_____

_____

Currently in counseling or psychotherapy? _____ Yes _____ No

If yes, name of therapist_____

Previous counseling or psychotherapy? _____ Yes _____ No

For how long? _____ When ? _____

Medication prescribed:

_____

Previous psychiatric hospitalization (where/when)

_____

Length of sta y _____

Have any family members been hospitalized for psychiatric purposes? _____ Yes _____ No

If yes, who? _____ When? _____ How long? _____

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FAMILY HISTORY

Parental Status: Living together _____ Separated/Divorced _____

Father's age _____If deceased, age and year of death _____

Mother's age _____If deceased, age and year of death _____

Highest educational level attained by: Father _____Mother _____

Father's last business or position _____

Mother's last business or position_____

Ages and Genders of siblings: _____

Are/were either of your parents alcoholic or drug addicted? _____ Yes _____ No

Are/were any of your siblings alcoholic or drug addicted? _____ Yes _____ No

Are/were any of your grandparents alcoholic or drug addicted? _____ Yes _____ No

Are/were any other family members alcoholic or drug addicted? _____ Yes _____ No

Contact in case of medical or psychological emergency:
(Note: This person would only be contacted upon your consent, or upon life threatening circumstances.)

Name _____ Relationship_____

Address _____

Home phone _____Work phone _____Other phone _____

Briefly describe why you are seeking therapy at this time: _____

_____

_____

_____

What else might be important for your therapist to know?_____

_____

_____

Please complete the following checklist. Check only those items which are TRUE or mostly true for you.

_____1. A life transition is causing me stress.

_____2. I have just had a major loss.

_____3. I have feelings of overwhelming panic and/or anxiety.

_____4. I am afraid that I'm losing my mind.

_____5. My mind keeps racing, and it is hard to shut out thoughts.

_____6. I am (or have been) seeing or hearing things that others don't see or hear.

_____7. I have disturbing nightmares.

_____8. I have done things to hurt myself physically (suicide attempts, self-mutilation, etc.).

_____9. I have serious thoughts of suicide.

_____10. My future seems hopeless.

_____11. I am very depressed.

_____12. My appetite is not like it used to be.

_____13. I have recently lost/gained a significant amount of weight.

_____14. I have sometimes vomited, fasted, or used laxatives or vigorous exercise in order to control my weight.

_____15. I have been told by a physician that I was too thin.

_____16. I have had an intense fear of gaining weight or becoming fat.

_____17. I have felt fat even though others have said I was thin.

_____18. I have had recurring periods of binge eating (rapid consumption of a large amount of food in a short amount of time).

_____19. I used to sleep normally (e.g. 7-8 hours) every night but now I sleep too much/too little.

_____20. I am concerned about issues of sexuality.

_____21. I sometimes use too much alcohol/drugs.

_____22. I have sometimes felt like I ought to cut down on my drinking/drug use.

_____23. I have sometimes felt bad or guilty about my drinking/drug use.

Checklist *(continued)*

_____24. People have sometimes annoyed me by criticizing my drinking/drug use.

_____25. I have sometimes had a drink first thing in the morning to steady my nerves or get rid of my hangover.

_____26. I have had a sudden inability to recall important personal information (more than ordinary forgetfulness, not due to stroke, seizure, or alcohol-related blackouts).

_____27. I have (past or present) experienced sudden unexpected travel away from my home or work place with the inability to recall my past (not due to stroke, seizure, or alcohol-related blackouts).

_____28. I have (past or present) assumed a new identity, partial or complete (not due to stroke, seizure, or alcohol-related blackouts).

_____29. I have had a persistent or recurrent experience of feeling detached from reality, as if I were an outside observer of my mental processes or body.

_____30. I have (past or present) had a persistent or recurrent experience of feeling like an automaton or as if in a daydream.

_____31. I have felt like there were two or more very different personalities within myself, each of which is dominant at a particular time.

_____32. I feel I have some gaps in my memory after the age of five.

_____33. When I was a child or adolescent, an adult overly criticized me, focused on my failures, belittled, and/or swore at me.

_____34. When I was a child or adolescent, an adult punched, bit, kicked, burned, or beat me.

_____35. When I was a child or adolescent, someone fondled me, exposed themselves to me such that I felt frightened, exploited me sexually, and/or attempted sexual contact when I did not want to participate.

_____36. As an adult, someone overly criticized me, focused on my failures, belittled, and/or swore at me.

_____37. As an adult, someone punched, bit, kicked, burned, or beat me.

_____38. As an adult, someone fondled me, exposed themselves to me such that I felt frightened, exploited me sexually, and/or attempted sexual contact when I did not want to participate.

_____39. I have recently been sexually assaulted.

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Please review the following information carefully.

FEES: Payment is due at the time services are rendered unless other arrangements have been made in advance. My self–pay rate is 350.00 dollars per 50-minute individual session and 400.00 dollars per 70-minute couple session. Fees can be pro-rated if additional time is desired.

APPOINTMENT CANCELLATION: You will be billed our session fee for an appointment cancelled with less than 24 hours notice. Appointments not cancelled, or cancelled after the scheduled appointment time, will also be billed in full.

INSURANCE: I have chosen to limit contracts with managed care providers. Billing through insurance generally requires you to receive a psychiatric diagnosis. Future insurance providers may learn about this diagnostic label. Some people have been denied coverage for health or life insurance after filing claims for outpatient counseling. Many insurance providers require detailed personal information about the sessions. I encourage you to carefully weigh any economic benefits of using insurance against the privacy risks that arise from sharing the information described above. You will maintain much greater control over any potentially sensitive details of your life by paying privately for my services. If you decide to use your insurance, please check with your carrier to ensure that you have the benefit for mental health services and that you have met your deductible.

PHONE CONSULTATION: Occasionally you may need to contact me by phone (i.e. a crisis). Please remember that an extended telephone conversation is a billable service, but there is no charge for short calls to communicate specific information. All attempts will be made to return calls the same day. If you are in crisis, I will make every effort to see you as soon as possible. I generally will not call a client unless specifically asked to do so or unless there is a need to clarify or change a scheduled appointment. I may also use email correspondence if you prefer to schedule that way. In order to prevent miscommunication, I am often very brief in this type of communication.

RECORD KEEPING: I maintain a clinical record that includes information that we discuss. You may see this record if you like.

TREATMENT OF MINORS (Under 18): Patients under 18 years of age (who are not emancipated) and their parents should be aware that the law allows parents to examine their child's treatment records unless I believe that doing so would endanger the minor client. Because privacy in psychotherapy is ESPECIALLY important to progress with teenagers, it is my policy to require an agreement from parents that they consent to give up their access to their son or daughter's records. I will provide general information about the progress of a teen's treatment and his/her attendance at scheduled sessions–and nothing else. I will also provide parents with a summary of their son/daughter's treatment when it is complete. Any other communication will require the teen's consent, unless I feel that that s/he is in danger or is a danger to someone else, in which

case of course I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the minor client, if possible, and do my best to handle any objections s/he may have.

Parent Signature (If applicable) _____ Date: _____

CONFIDENTIALITY: I will not release any information that identifies you to anyone without your written permission. Exceptions include:

1. I will release information necessary to protect a child or aged individual who is unable to protect them selves from imminent danger of being physically harmed.
2. I will release information if ordered by a court of law.
3. I will release your information to protect you if I feel you are a danger to yourself.
   - *I am required by law to release the above information if such situations arise.*

TERMINATION OF SERVICES: You have the right to stop seeing me at any time, whether or not I feel it is advisable, with no obligation to me other than to pay for the services you have already received. Please tell me if you plan to stop therapy so that we can schedule a final appointment to review your progress and discuss any referrals that might be beneficial. If you repeatedly miss appointments, if I cease being reimbursed, if your needs do not match my ability to help you, or in the unlikely event that our relationships becomes too strained to continue, I will stop providing services to you unless you are in crisis. I will also offer to refer you to other sources of services.

YOUR RIGHT TO DIGNITY AND AUTONOMY: You have the right to be treated competently, ethically, and respectfully; to be informed about all aspects of your service, to ask questions about my approach and methods, to decline any recommendations I make, and to bring any questions or concerns to my attention.

Please sign below to indicate that you understand and agree to all of the above items and that you request my services:

Client Name: _____ Date: _____

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CONTRACT FOR SERVICES

I am hereby entering a contract for Jeffrey Cohen's professional time and services when I set an appointment. I understand that by entering this contract for Jeffrey Cohen's professional time I am specifically contracting for his services to prepare for my session in advance. I recognize that professional services are not only provided during my appointment but also during the 24 hours prior to and following my appointment time. I understand that these services involve preparation for my scheduled session, case review, case notes, and consultations with other professionals, as agreed in writing by me, to assist in treatment.

I understand Jeffrey Cohen's cancellation policy requires 24 hours advance notice in order to be released from the contract for his time and services of preparation for my session.

I understand that I will be charged a FULL SESSION FEE of no less than 75.00 dollars and a maximum of 350.00 dollars (for single) and 400.00 (for couples) if the appointment is missed or canceled with less than 24 hours notice, including emergencies: _____ (Initial)

I hereby authorize Jeffrey Cohen to charge my:

VISA / Mastercard / American Express *(circle one)*

Credit Card Number: _____

Expiration Date: _____

CV Code : _____ *(Four digits on the front of American Express, 3 digits on the back of Visa/Mastercard)*

Zip Code: _____

Email *(if you would like a receipt emailed)*: _____

Please sign below to indicate that you understand and agree to all of the above items and that you request my services:

Client Name *(Printed)*: _____ Date: _____

(or parent / legal guardian of minor client)

Client Signature: _____ Date: _____

(or parent / legal guardian of minor client)