Bishop's Counseling FOR WOMEN

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Confidential Background Questionnaire

General Information (Client's Information):

Today's Date:_____ Referred by:_____
Client's Name:_____ Age:_____
Address/Zip Code:_____
Home Phone:_____ Work Phone:_____ Cell Phone: _____
*Please indicate with an * for number/s at which a message can be left. Please do not provide a phone number you do not wish to be called.*
Email address:_____Can I contact you by email? ____Yes ____No
Sex: M___ F___ Date of Birth:_____ Occupation:_____
Signature of Legally Responsible Adult:_____
Person to Notify in Case of Emergency: (Name)_____(Ph.)_____
Education Level: Please circle
>12 years GED High school diploma Bachelors Masters Doctorate Trade School
Presenting Problems:_____

General Information for Minors (17 and under):

Parent/Legal Guardian Name
Address_____
Home Phone_____Work Phone_____Cell Phone_____
Occupation_____ Education Level_____
(School Name)_____(Address)_____(Ph.)_____
(Status Please Circle) Active Suspended Detention Special Education
Please list grade level and behavioral issues, or learning disabilities:
_____
_____
_____

Insurance Information: Primary Policy

Policy Holder: _____ Insurance Company: _____
HMO PPO EAP POS Birth date of Policy Holder: _____
SS#: _____ Policy #: _____
Address to mail claims:_____

<u>Problem Areas:</u> Please check items applicable to you

_____Self Esteem	_____Marital	_____Mood
_____Sexual Dysfunction	_____Physical Abuse	_____Sexual Abuse
_____Depression	_____Suicidal Ideation	_____Relationships
_____Financial	_____Spiritual	_____Parent/Child
_____Drug or Alcohol Abuse	_____Health	_____Eating Disorder
_____Suicide Attempts	_____Stress level	_____Obsessions
_____Anxiety	_____Problems in school	_____Self harm
_____Body image issues	_____Grief	_____Emotional Abuse

_____Other_____

In your own words describe why you are seeking counseling. Please be detailed, as the more I know the better I can assist you:

_____
_____
_____
_____

<u>Physical Health History:</u>

Please check and date any of the following that apply:

_____Serious Accident	_____Vision Problems	_____Insomnia
_____Hormone Imbalance	_____Impotence	_____Thyroid trouble
_____Heart Trouble	_____Sterility	_____Sinus Infection
_____Epilepsy	_____Paralysis	_____Miscarriage
_____Hearing Problems	_____Menstrual Pain	_____Major surgery
_____Asthma	_____Arthritis	_____Headaches
_____Alcohol abuse	_____Aids/HIV+	_____ Fainting
_____Depression	_____Eating disorder	_____Drug Abuse
_____Blood sugar problems	_____Cancer	_____Nervous tics
_____Panic attacks	_____Addictions	_____Abortion
_____Hearing Problems	_____Menstrual Pain	_____Major surgery
_____Anemia	_____Tension/stress	_____Diabetes
_____Suicidal Ideation	_____Issues with sleep	

_____Other_____

Has anyone in your immediate or extended family ever received treatment for a mental, emotional or stress related disorder, or for alcohol or chemical addiction? _____
If yes, please indicate type of treatment and your relationship to family member.

_____

Do you smoke? Yes/ No How often _____
Do you drink? Yes/ No How often _____
Do you take any drugs other than over the counter or prescription? Yes/ No How often _____

Family History:

Parent's marital status: (if married to each other)

____very happy____ happy____average____unhappy____separated____divorced

If divorced, at what age, then explain:

_____

_____

Overall, how would you describe your family life growing up?_____

_____

_____

_____

Relationship History:

Single_____ Dating_____ Married_____ Separated_____ Divorced_____

Sexual Orientation: Heterosexual Homosexual Bisexual Transexual Other_____

If married, how long?_____ Your age when married?_____

If divorced, date:_____ Who filed for the divorce?_____

Dates of previous marriages & divorces:_____

Children: Your own (present & previous marriages) total #_____

Please list the names, ages and relationship of all individuals currently residing in your household:_____

_____

Previous Psychotherapy or Counseling:

Date:_____ Counselor or Center:_____

Presenting Problem:_____

Name of your Psychiatrist_____ date when started_____

Medical Diagnosis: _____

Results of Therapy: _____

Reason for Termination: _____

When was the last time you saw a doctor?_____ Reason for the visit:_____

What prescription or non-prescription medications are you taking currently, in what dosages, and for what reason?_____

_____

_____

Describe any recent or ongoing sleep or appetite changes or difficulties:_____

_____

Please use this space to share any other information you feel I need to know about you:

_____

_____

_____

_____

_____

Bishop's Counseling
FOR WOMEN

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Credit Card Authorization Form

I authorize Bishop's Counseling for Women, PLLC and Jennifer Bishop, LCSW to keep my signature on file and to charge my credit card account for the initial intake psychotherapy session charge of $160.00 and for the recurring charges of: $140.00 per each additional individual session, $180 for each additional relationship or family session, and $60 per person for each group therapy session. Should I have insurance I authorize my credit card to be charged for my portion of insurance payment. I understand that payment is due at the time service is provided.

I also understand this form is valid (even if I want to use a different credit card) for two years, unless I cancel the authorization in writing. I promise not to dispute charges for any appointments I have scheduled. I understand missed appointments or cancellations without 24 hour notice will be charged to my credit card on file for the full fee. I further authorize Bishop's Counseling for Women, PLLC and Jennifer Bishop, LCSW to disclose information about my attendance/cancellation to my credit card issuer if I dispute a charge.

Credit Card Authorization

_____ _____
Client Name Date of Birth

_____
Cardholder Name

_____
Cardholder Billing Address City State Zip Code

_____Visa _____MasterCard _____American Express _____Discover

Card Number: _____ Expiration Date:_____

Last 3 or 4 numbers from back of card:_____

My signature below signifies that I have read, understand, and agree to abide by the above policies.

_____ _____
Signature Date