

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: _____

Problem Areas: Please check items applicable to you

<input type="checkbox"/> Self Esteem	<input type="checkbox"/> Marital	<input type="checkbox"/> Mood
<input type="checkbox"/> Sexual Dysfunction	<input type="checkbox"/> Physical Abuse	<input type="checkbox"/> Sexual Abuse
<input type="checkbox"/> Depression	<input type="checkbox"/> Suicidal Ideation	<input type="checkbox"/> Relationships
<input type="checkbox"/> Financial	<input type="checkbox"/> Spiritual	<input type="checkbox"/> Parent/Child
<input type="checkbox"/> Drug or Alcohol Abuse	<input type="checkbox"/> Health	<input type="checkbox"/> Eating Disorder
<input type="checkbox"/> Suicide Attempts	<input type="checkbox"/> Stress level	<input type="checkbox"/> Obsessions
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Problems in school	<input type="checkbox"/> Self harm
<input type="checkbox"/> Body image issues	<input type="checkbox"/> Grief	<input type="checkbox"/> Emotional Abuse
<input type="checkbox"/> 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:

Physical Health History:

Please check and date any of the following that apply:

<input type="checkbox"/> Serious Accident	<input type="checkbox"/> Vision Problems	<input type="checkbox"/> Insomnia
<input type="checkbox"/> Hormone Imbalance	<input type="checkbox"/> Impotence	<input type="checkbox"/> Thyroid trouble
<input type="checkbox"/> Heart Trouble	<input type="checkbox"/> Sterility	<input type="checkbox"/> Sinus Infection
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Miscarriage
<input type="checkbox"/> Hearing Problems	<input type="checkbox"/> Menstrual Pain	<input type="checkbox"/> Major surgery
<input type="checkbox"/> Asthma	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Headaches
<input type="checkbox"/> Alcohol abuse	<input type="checkbox"/> Aids/HIV+	<input type="checkbox"/> Fainting
<input type="checkbox"/> Depression	<input type="checkbox"/> Eating disorder	<input type="checkbox"/> Drug Abuse
<input type="checkbox"/> Blood sugar problems	<input type="checkbox"/> Cancer	<input type="checkbox"/> Nervous tics
<input type="checkbox"/> Panic attacks	<input type="checkbox"/> Addictions	<input type="checkbox"/> Abortion
<input type="checkbox"/> Hearing Problems	<input type="checkbox"/> Menstrual Pain	<input type="checkbox"/> Major surgery
<input type="checkbox"/> Anemia	<input type="checkbox"/> Tension/stress	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Suicidal Ideation	<input type="checkbox"/> Issues with sleep	
<input type="checkbox"/> 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 \$140.00 and for the recurring charges of: \$120.00 per each additional individual session, \$160 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