Smithson Counseling

CLIENT INFORMATION

First Appt. Date: _____
Name:_____ Gender: _____
DOB: _____ Age: _____ E-Mail: _____
OK to E-Mail? oYES oNO
Preferred Phone: _____
Alternate Phone: _____
OK to Leave Messages? oYES oNO
Mailing Address: _____
Preferred Way to Contact: _____

Occupation:_____
Education: (highest level attained)_____
Are you satisfied with your work/education? oYES oNO
Comments: _____

(circle all that apply:)
SPOUSE/PARTNER/PARENT/ EMERGENCY CONTACT:_____
Gender: _____ DOB: _____ Age: _____ Phone: _____
(Wk) _____ E-Mail: _____
Home: _____ (Wk) _____
E-Mail: _____ OK to Leave Messages? oYES oNO
OK to E-Mail? oYES oNO
Occupation:_____
Education: (highest level attained_____

Significant health problems:
_____
_____
_____

Significant Family: Including yourself, list the significant members of your family, from oldest to youngest. (Use the back if necessary). Name Relationship Age Where this person lives (i.e. with me, elsewhere--list where) State of the relationship (i.e. good, neutral, conflicted, etc.)_____
_____
_____
_____
_____

What are you hoping to achieve through therapy?

_____

_____

_____

_____

Do you have any concerns you would like me to know about?

_____

_____

_____

Previous Treatment (Use back page if necessary) YES NO InPt/OutPt
When?_____
HELPFUL?

_____

Counseling YES SOME NO PSR
Drug/Alcohol:_____
Psychiatric Services/ Medications:

_____

_____ _____

Hospitalization:_____
Self Help:_____
Have you or are you currently thinking of harming yourself? oNO oYES
Comment: _____
Have you or are you currently thinking of ending your life? oNO oYES
Comment: _____
Has anyone in your immediate family attempted or thought of attempting suicide? oNO oYES
Comment:

_____

How did you find me?

_____

Health History Primary Physician:

_____

Phone: _____

Primary Psychiatrist: _____
Phone: _____

Significant health
problems:_____

_____

Current Medications/Supplements (use back of page if necessary) Name of Medication Dosage Frequency Purpose Prescribing Physician Concerns/Questions

Past Medical Conditions (use back page if necessary) What When Treatment/Outcome

Andy Smithson, LCSW
Phone: (208) 312-3648, www.smithsoncounseling.com, andsmithson@truparenting.net

PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE

(Unless other specific arrangements have been made with Andy Smithson, LCSW directly)

Sessions are $95 per 50-60 minutes. You may pay with cash or checks. Payment is required upon close of each counseling/coaching session. (Electronic accounts may be utilized and charged as arranged between client and therapist if it is available). Sessions not canceled 24 hours in advance will be charged the full session fee and will be required to be paid before the following therapy session. $25 will be charged for all returned checks and declined credit/debit cards. Any payment information is securely stored in your file and may be updated upon request. I agree, by my signature on this form, to pay $95/50-60 min. for all scheduled appointments. I authorize Andy Smithson, LCSW to charge me for sessions attended as well as those scheduled but not canceled 24 hours in advance, across multiple dates of service. I certify that my signature below authorizes each individual charge for all dates of service. I agree that this financial agreement will continue for as long as services are provided or until I inform Andy Smithson, LCSW in person or by certified mail that I wish to end it. I agree to pay for all services rendered prior to the date/time I end the relationship. I agree that I am responsible for payment, although other persons may make payments on my (or client's) account. I agree to pay $25 for returned checks or declined credit/debit cards and understand that unpaid balances may be sent to collection.

I, _____, request that Andy Smithson, LCSW, provide services to
Person Responsible for Payment oMyself oAnd/or to _____,
who is my: _____
SS # of person responsible for payment: _____
Phone Number: _____

Signature of Person Responsible for Payment Date :

_____