CLARISSA I. PEARCE, LMHC 360-393-9015

PLEASE COMPLETE AND BRING TO FIRST APPOINTMENT

CONTACT INFORMATION

Name: _____ Date: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ OK to leave message ? Y ___ N ___

Home Phone: _____ OK to text? Y ___ N ___

Email: _____ OK to email? Y ___ N ___

Occupation: _____

Date of Birth: _____ Age: _____

Emergency Contact: _____ Phone: _____

Relationship to you: _____

COMPLETE THIS SECTION IF YOU ARE USING INSURANCE

- PRIMARY INSURANCE (Info found on card)

Insurance Company: _____ Phone: _____

Subscriber's Name: _____ Subscriber's Birthdate: _____

Subscriber's Relationship to Client: _____

ID# _____ Group/Plan # _____

- SECONDARY INSURANCE (Info found on card)

Insurance Company: _____ Phone: _____

Subscriber's Name: _____ Subscriber's Birthdate: _____

Subscriber's Relationship to Client: _____

ID# _____ Group/Plan # _____

- HEALTH INFORMATION Current or past health problems:

Have you ever been hospitalized for psychological reasons? NO ____ YES _____

Have you ever attempted suicide? NO ____ YES _____

Have you had serious thoughts of ending your life recently? NO ____ YES _____

Have you ever intentionally injured yourself? NO ____ YES _____

Are you receiving care or treatment for any health problems at this time? _____

_____

Have you had life experiences you would consider traumatic? (You may simply answer yes/no to this question, or briefly list the experiences here.) _____

_____

_____

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Please list any medications you are taking (including birth control)

Medication: _____ Date Started: _____

Medication: _____ Date Started: _____

Medication: _____ Date Started: _____

Prescribing Doctor: _____ Last Visit: _____

WHAT ARE THE MAIN CONCERNS THAT BRING YOU TO COUNSELING?

_____

_____

_____

ARE THERE ANY SPECIFIC GOALS OR CHANGES YOU HOPE WILL COME ABOUT AS A RESULT OF COUNSELING?

_____

_____

_____

PLEASE INDICATE AREAS OF CONCERN FOR YOU

sleep * physical health * living situation * education * occupation* body-image * appetite nutrition * relationships * anxiety * occupation * living environment * parenting * worry * culture substance use * loneliness * creative expression * discrimination * physical pain or discomfort friendships * meaning and purpose * boundaries * gender * sexuality * spirituality * impulsiveness anger * boredom * low energy * decision making *self-worth * guilt * distressing thoughts authenticity * feeling disconected * stress management * safety * communication

* other _____

CONSIDER YOUR STRENGTHS, RESOURCES, AREAS OF SUPPORT

(This list is NOT exhaustive! Please feel free to add your own.)

sense of belonging * curiosity * joy * competence * connection to others * physical strength faith/spirituality * courage * connection to nature * connection to culture * connection to family creative expression * humor *emotional awareness * passion * determination * honesty * routine self-acceptance * honesty * inspiration * communication * empathy * playfulness * dedication willingness to ask for help * enjoyment * physical nourishment * movement and physical activity gentleness * compassion * relaxation * sexuality * meaning and purpose * connection with animals connection with children * humor * assertiveness * service

* other_____

We will have a chance to go into detail when we meet in person. Is there anything that I have not asked about on this form that you would like me to know about you before we meet?

_____

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AGREEMENT AND CONSENT FOR SERVICES

By signing below, I attest that I have read, understood, and agreed to the Office Policies and Disclosure Statement. I understand that it is my responsibility to reimburse my therapist for any services provided on my behalf. In the event that my insurance does not cover costs for services rendered or I do not have insurance coverage at this time, I agree to pay any and all costs of counseling. Costs may include any missed appointments, fees for written reports, phone calls on my behalf, or any other costs of providing services on my behalf.

_____ _____

Client's Signature Date

I understand that there are fees for missed appointments and late cancellations. The fee for a missed appointment is $130 and the fee for cancelling within 24 hours of my appointment is $65. I understand that insurance does not cover these fees, and I will be responsible for these charges.

_____ _____

Client's Signature Date

By signing below, I attest that I have received a copy of the notice of privacy practices. I understand that I can request an additional copy of this notice at any time, and that I can access the privacy notice at clarissapearce.weebly.com

_____ _____

Client's Signature Date

- IF USING YOUR INSURANCE TO PAY FOR SERVICES, SIGN THIS SECTION

I authorize the release of any medical or other information necessary to process this claim through any insurance company. I authorize payment to Clarissa I. Pearce, LMHC, LLC for services rendered as stated on claims submitted to my insurance company. I also understand that it is my responsibility pay for any services provided on my behalf. In the event that my insurance does not cover costs for services rendered, I agree to pay any and all costs of counseling or services provided on my behalf.

x_____ _____

Client's Signature Date

x_____ _____

Parent's Signature Date

PRINT NAME: _____