Center For Family Counseling
Tia M. Bach, LCSW

Client Name:_____ **Age**:_____ **Birth date**: _____

Address: _____

City: _____**State:**_____**Zip:**_____

E-mail:_____ Home Phone:_____

Work (optional):_____ **Cell**_____

Preferred method of contact home phone__ cell phone__ work phone__

Can we leave a message/voicemail? yes__ no__

Occupation:_____

Employer:_____

If client is a minor, name of responsible adult:_____

Emergency Contact: _____**Phone**:_____

Address:_____ **City:**_____

State: _____**Zip**:_____

INSURANCE

Name of insurance_____

Name of policy holder_____ **Policy holder's date of birth**___/___/___

Policy number_____

Group number_____ **Plan number/plan code**_____

Provider phone number_____

REASON FOR COMING TO THERAPY

Please describe the problem(s) that you want help with:_____

_____

_____

_____

_____

How long have you had this problem?_____

Please describe how has this problem affected your life in the following areas:

Family_____

_____

_____

_____

Work/School_____

_____

_____

_____

Social_____

_____

_____

_____

Health_____

_____

_____

_____

Have you had prior counseling/therapy? yes__ no__

Name of past therapist_____

Approximate start and end date of last therapy_____

Discuss briefly how past therapy was helpful and/or not helpful_____

_____

_____

_____

CURRENT FAMILY SITUATION

Names of people currently living in the home (indicate each person's title, for example: Terry-mother)

_____

_____

_____

_____

_____

Relationship status: married__ single__ widowed__ divorced__ domestic partnership__

Current family stressors_____

_____

_____

_____

_____

FAMILY HISTORY

Who raised you?_____

If there were changes, please list and indicate the age you were when these changes occurred:_____

_____

_____

Please list names and ages of siblings

_____

_____

_____

Which members of your family are you close to?

_____

_____

Briefly describe any family members who are a problem for you_____

_____

_____

Please indicate other people in your life that are good sources of support_____

_____

_____

Please check any problems that family members currently have or had and briefly describe:
depression__ anxiety__ alcoholism__ drug addiction__ prone to violence__ convictions/arrests__
suicidal ideation__ attempted suicide__ completed suicide__

_____

_____

_____

_____

_____

_____

Check any of the following that apply to your childhood/adolescence:

☐ Happy childhood ☐School problems ☐Medical problems

☐Unhappy childhood ☐Family problems ☐Alcohol use

☐Drug use ☐Arrests/convictions

EDUCATIONAL HISTORY:

Highest level of education completed _____

Problems:_____

_____1

Strengths:_____

_____

WORK HISTORY:

Occupation:_____

Are you currently employed: ☐Yes ☐No

Length of time at current position:_____

If you have changed jobs during the last five years, give duration of employment and reason for leaving job:_____

PHYSICAL AND MENTAL HEALTH:

How would you rate your current health?
Very poor 1 2 3 4 5 6 7 8 9 10 Very good

List current health/emotional problems for which you are seeking treatment or have sought treatment

_____

_____

List medical/emotional problems you are currently experiencing or have experienced in the past

_____

_____

Please list current medical doctor and/or any specialists you are currently seeing

Name **Phone #** **Reason**

_____

_____

_____

_____

_____**2**

Please list all medications you are currently taking:

Medications/dosages **Prescribing Doctor** **Reason**

_____

_____

_____

_____

What past/present medications have helped?_____

_____

What past/present medications have not helped?_____

_____

Indicate with a check mark if any of the following apply to you currently or in the past

	current	**past**
Thoughts about suicide	_____	_____
Attempted suicide	_____	_____
Thoughts of hurting someone else	_____	_____
Plan for suicide	_____	_____
Self harming behavior	_____	_____
Plan for harming someone else	_____	_____

Have you have a history of past alcohol/drug use? Yes__ No__

If yes, please describe substance type and frequency of usage:

_____

_____

_____

_____3

Are you currently using any drugs or alcohol? Yes __ No __

If yes, please describe substance type and frequency of usage:

_____

_____

_____

_____

Have you been arrested for alcohol/drug related offenses? □Yes □No

Have you had treatment for drug abuse/dependency? □Yes □No
If yes, where/when?

_____

SOCIAL OUTLETS/ACTIVITIES/SUPPORTS (note specifics, frequencies, increases /decreases in involvement)

Exercise_____

Religion/Spiritual Affiliation_____

Social Activities/Interests_____

Check any of the following that may apply to you (client):

- ☐ Inferiority Feelings
- ☐ Traumatic event
- ☐ Anxiety
- ☐ Depression
- ☐ Avoidance of associations with traumatic event
- ☐ Troubling thoughts
- ☐ Unable to relax
- ☐ Afraid of people
- ☐ Under-eating
- ☐ Over-eating
- ☐ Fears and phobias
- ☐ Panic Attacks
- ☐ Obsessions
- ☐ Self-harm behaviors
- ☐ Bowel disturbances
- ☐ Suicidal thoughts
- ☐ Racing thoughts
- ☐ Stomach trouble
- ☐ Isolation
- ☐ Hyper vigilance
- ☐ Always tired

- ☐ Problems concentrating
- ☐ Difficulties sleeping
- ☐ Drug problems
- ☐ Flashbacks
- ☐ Legal problems
- ☐ Loved one has alcohol or drug problem
- ☐ Nightmares
- ☐ Alcohol problems
- ☐ Financial problems
- ☐ Difficulties sleeping
- ☐ Heightened Startle Response
- ☐ Health problems
- ☐ Grief/loss
- ☐ Difficulties with intimacy/sexual relations
- ☐ Work problems
- ☐ Anger management
- ☐ Sexual abuse/assault
- ☐ Survivor
- ☐ School problems
- ☐ Feelings of guilt/shame
- ☐ Marital stressors
- ☐ Conflict with parent/child
- ☐ Other:_____

What do you wish to achieve through the process of therapy?_____

_____

_____

_____

How were you referred to Tia M.Bach, LCSW?_____

Upon my signature below, I hereby attest that all the information furnished is true and correct. By signing I agree to be responsible for all fees that my insurance does not cover. I agree to receive therapy services from Tia Bach and for her to bill my insurance for services rendered.

_____ _____

Signature of Client or Responsible Party **Date**

Cancellation Policy

I agree to provide a **minimum of 24 hours notice** if I need to cancel or reschedule an appointment with Tia M.Bach, LCSW.

- ☐ I understand I will be allowed **one** missed appointment free of charge.

- ☐ I understand that **failure to provide 24 hours notice** for future appointments will result in being charged the full session fee.

- ☐ I understand I will not be allowed to schedule future appointments before missed session fee is paid in full.

Signature_____ Date _____

Consent to Treatment

I do hereby seek and consent to take part in treatment by Tia M. Bach, LCSW. I understand that developing a treatment plan with her and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by Tia M. Bach, LCSW.

I am aware that I may stop my treatment with Tia M. Bach, LCSW at any time. The only thing I will still be responsible for is paying for the services I have already received. I am aware that any outstanding balances due will be charged interest at 1.9% monthly. I understand that I may lose other services or may have to deal with other problems if I stop treatment.

I understand that Tia M. Bach, LCSW may disclose information about me in consultations with other professionals in order to provide the best possible treatment. In such cases, my name or any identifying information about me is not disclosed. Only clinical information is discussed.

I know that I must call to cancel an appointment at least 24 hours before my scheduled appointment time. I do not cancel or do not show up, I will be charged the full session fee for that appointment. Any cancellation/no-show fees MUST be paid before future appointments can be scheduled.

I am aware that an agent of my insurance company or other third-party payer may be provided protected health information (PHI) about the type(s), cost(s) and date(s) of any services or treatments I receive as well as my diagnosis and treatment progress. I hereby authorize payment of medical benefits to Tia M. Bach, LCSW. I understand if payment for the services I receive here are not made, Tia M. Bach, LCSW may stop my treatment.

My signature below shows that I understand and agree with all of these statements.

_____ _____

Client's signature (or person acting for client) Date

_____ _____

Printed name Relationship to client if necessary

I, Tia M. Bach, LCSW have discussed the issues above with the client (and or his/her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent to treatment.

_____ _____

Tia M. Bach, LCSW Date

Tia M, Bach, LCSW
307 Lafayette Blvd. Suite 202, Fredericksburg, VA 22401
Work: 540-361-1556 EXT 712 Fax: 540-361-1557

Consent to Share Information and/or Disclosure of Records

I,_____ hereby authorize exchange of information relating to my mental health treatment between **Tia M. Bach, LCSW** and the individuals/organizations listed below:

(1) Name of individual or organization

_____

Address

_____

Phone_____Fax_____E-mail_____

(2) Name of individual or organization

_____

Address

_____

Phone_____Fax_____E-mail_____

(3) Name of individual or organization

_____

Address

_____

Phone_____Fax_____E-mail_____

for the following purpose, use or need:

- ☐ Coordination of treatment
- ☐ Provision of information to other professionals
- ☐ Other_____

The following information from my records may be disclosed:

- ☐ Verbal exchange of protected health information (PHI)
- ☐ General PHI (Demographic data, dates of service, diagnosis, psychological evaluation, treatment plan, global assessment of treatment progress)
- ☐ Psychotherapy notes
- ☐ Other_____

I understand that this authorization may be withdrawn by me at any time. Revocation of this authorization will not affect any information already released. I hereby certify that I am 18 years of age or older. Unless this form is revoked in writing, this release of information will remain in effect for one year from date of signature.

_____ _____

Client /Legal guardian signature (if client is a minor) Date

_____ _____

Witness Date