RECOARSE Counseling, PLLC

RECOARSE Integrative Therapies

612 S Creyts Road, Suite B, Lansing, MI 48917
(517) 285-0527 (Cell) & (517) 220-4694 (Fax)

All submitted information is confidential. If an item does not apply to you write "NA".

Adult History Today's Date: _____

Name: _____ Date of Birth: _____

Place of birth_____ Female ____Male____

Current Address:_____City_____State_____Zip_____

Best phone number(s) to reach you at: _____

Emergency Contact _____relationship_____

Phone No(s)._____

Please describe the reason for your appointment _____

_____

Is there anything that may interfere with counseling?

_____

_____

Hobbies/Interests:_____

_____

Describe yourself in 3 to 5 words: _____

_____

Family Composition

Married ____ Divorced ____ Never Married ____Single ____ Single with Partner ____Widowed____

Name of Spouse or partner?(Optional)_____

Children/Grandchildren ____Yes____ No. If so, please list names and ages below:

_____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____

Employment: Are you currently employed? Yes____ No____Part-Time____ Full-Time_____

Stay-at-home Parent_____ Student_____Retired_____Other____

Employer: _____ Position: _____ Length: _____

How would you describe your current work situation? _____

Responsible Party/Insurance information

Responsible party if minor, etc: _____

Phone number:_____

_____I give my consent for this office to discuss my financial account with the above party- please initial **(must have for clients over 18 and dependent upon parent's insurance, etc)**

Primary Insurance information (please present card)

Insurance:_____Employer_____

Subscriber or enrollee ID number: _____

Policy holder's name: _____DOB: _____

Phone number of policy holder_____

Secondary Insurance information (please present card)

Insurance: _____Employer: _____

Subscriber or enrollee ID number: _____

Policy holder's name: _____DOB: _____

Phone number of policy holder_____

Medical Information

PrimaryCarePhysician:_____Phone number:_____

Date of Last Physical: _____

Physical Concerns: (Please check any that apply)

_____ Depression _____ Anxiety _____ Stress

_____Headaches _____Sleep problems _____Stomach problems

_____Other_____

List any current medication, dosage, and reason for usage (including vitamins/herbs/over the counter medication) _____

_____

_____

Other Concerns: (Please check any that apply)

_____Nightmares _____Family Problems _____Problems with Child(ren)

_____ Fear _____Relationship Problems _____ Custody problems

_____ Anger _____ Suicidal thoughts or actions _____ Domestic Violence

_____Other _____

Symptoms:

In the last 3 to 6 months have you had any of the following symptoms that have lasted for more than a few weeks:

_____ mental confusion
_____ frequent arguments
_____ nervous habits/behavior
_____ grinds teeth
_____ hyperactivity
_____ too interested in sex
_____ little or no interest in sex
_____ difficulty concentrating
_____ seeing things not there
_____ tire quickly/easily
_____ little interest in activities
_____ worries a lot
_____ afraid/fearful
_____ short attention span
_____ am disorganized
_____ cry frequently
_____ think too much about my problems
_____ feel stressed at work
_____ hearing voices
_____ concerned about the future
_____ feel lonely
_____ feel hopelessness
_____ keep to myself most of the time
_____other (explain)_____
_____

Have you been or are you currently under the care of another mental health professional (i.e. psychiatrist, psychologist)? _____Yes _____No. If yes, please explain:

_____

_____

Do you or any family members have any history of depression or other similar problems (i.e. anxiety, manic depression, schizophrenia)? Yes _____No_____. If yes, please explain:

_____

_____

Do you or your family have any history of drug/alcohol abuse? _____ Yes _____ No. If yes, please explain:

_____

_____

Is there a history of any type of abuse towards you or around you? _____Yes _____ No. If yes, please explain:_____

Legal Involvement:

Is or was there ever any court involvement? _____ Yes _____ No. Please explain:

_____

_____

Optional Information:

Race and ethnicity:_____

Religious Affiliation: _____

Communication by Email/Texting

_____I disagree with sending or receiving communication through either of these forms of communication, except for appointment reminders.

_____I agree with sending or receiving communication through the following:

_____Email- address is: _____

_____Text- phone number is: _____

Notice of Privacy Practices Receipt and Acknowledgment

I, the undersigned, hereby acknowledge receipt of the Notice of Privacy Practices given to me by RECOARSE Counseling, PLLC / RECOARSE Integrative Therapies.

Cancellation Policy

I, the undersigned, understand that my therapist respects my time and ask that I respect hers as well. I understand that if I cannot give 24 hours' notice of a cancellation that I may be charged a $50 fee which is payable prior to resuming counseling services. This fee is not billable to my insurance company (third party payer).

Financial Responsibility

I, the undersigned, hereby authorize release of information necessary for RECOARSE Counseling, PLLC / RECOARSE Integrative Therapies to file a claim with my insurance company (third party payer) and assign benefits otherwise payable to me to the provider or group indicated on the claim. I understand that I am financially responsible for any balance not covered by a third party payer, i.e. co-payments, co-insurance, deductibles or non-covered services (may include requested letters written and/or consultations not billable to your insurance company). I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. If it is ever necessary for this office to employ collections counsel, I understand that I am responsible for those collection charges.

Consent to Treat

I verify that the information given is correct and I consent to receiving therapy services. I also agree that a copy of my signature is as valid as an original.

_____Date_____

Signature of client

_____Date_____

Signature of staff member