Patty L. Yule, LPCC (LPC #177)
New Client Information and History

Date of Intake _____ Client's Date of Birth _____

Name of Client(s) _____

Address _____

City _____ State _____ Zip Code _____

Home Phone (___) _____ Cell (___) _____ Email _____
Is it okay to contact you at home? (Circle) Yes No

Occupation _____ Employer_____ Education _____

Marital Status (Circle): Single; Shared Living; Married; Divorced; Widowed; 2nd Marriage. Years Married ___

Previous Counseling/Hospitalization (Circle): Yes/No Approximate Date(s) _____ Duration _____

Medical doctor: _____ (___)_____ _____
Name Phone Date of last physical

Current Medical Conditions: _____

Current Medications: _____

In Emergency contact: _____
Name & Relationship Phone

Medical Insurance or EAP _____ Plan or Group #: _____

Primary Insured's Name _____

Primary Insured's Insurance ID # _____ Date of Birth _____

Client's Relationship to Insured (Circle): Self Spouse Child Other

Client's Insurance ID# _____ Authorization #_____

Secondary Insurance Carrier/Other Person Responsible for Bill _____

Address _____ Phone (___) _____ ID # _____

How were you referred? _____

For what concerns are you seeking counseling at this time? How long has this been a concern for you?

Current sources of stress:

Describe the events or interactions that precipitated your concerns?

Please check those that apply:

__ Depressed mood	__Panic attacks	__High stress
__Eating disturbance	__Anger/temper	__Social skills problems
__Physical abuse	__Gender issues	__Relationship issues
__Hallucinations	__Alcohol/drug abuse	__Low energy/fatigue
__Low self-esteem	__Sleep disturbance	__Co-dependency
__Phobia/fears	__Sexual abuse	__Sexual disturbance
__Chronic pain	__Aggressive Behaviors	__Obsessive/Compulsive Issues
__Avoidant behaviors	__Suicidal thoughts	__Grief/Loss

__Other (please specify)_____

__Present/past substance use (please specify substance(s) _____

How often do you use the substance: ___/day ___/week ___/month

Current Household Members (Name, Age, Relationship):

_____ _____

_____ _____

_____ _____

_____ _____

Who were the members of your childhood family? List names and relationship (mother, brother, sister etc)

_____ _____

_____ _____

_____ _____

_____ _____

Patty L. Yule, M.S., LPCC #177
Licensed Professional Clinical Counselor

Did anyone in your childhood family have a substance abuse problem? (Please describe)

Was there a history of mental illness in your childhood family? (Please describe)

Was there a history of physical or sexual abuse in your childhood family? (Please explain)

How do you hope that counseling will improve your relationships?

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INFORMED CONSENT & OFFICE POLICIES

Welcome. I hope you find our time together worthwhile. Please read this outline of my policies which should answer some initial questions. Your understanding of this part of our professional relationship is important. I will be happy to answer any of your questions.

1. Fees: The fee for each 50-minute session is $130 for individuals and $150 for couples and families. However, you are responsible for determining what is covered, and will be responsible for the bill if your insurance company denies payment. Please discuss any concerns you have about fees with me at any time. Make checks payable to Patty Yule. Fees and co-payments are payable at the beginning of each session. Please have your payment ready when you come into the session so that we minimize use of your therapy time for business transactions.

2. Appointments: The 50 minutes that has been reserved is your time. If you do not use the time, except in the case of an emergency, the regular fee will be charged (or the rate contracted with your insurance carrier) unless you cancel the appointment 24 hours in advance. If you arrive late, you will receive the remainder of your time at the full fee. Insurance companies do not pay for missed appointments, late cancellations or appointments less than 30 minutes in duration. If you choose to commit to a regular standing appointment with me, please keep changes and cancellations to a minimum.

4. Confidentiality: By law you have the right to confidentiality and I, as therapist, am prohibited from revealing to any other person what you have said to me without your written permission. I do take notes and some of the information you share with me will be in your files. I am the only one who has access to those files and they are stored in a locked file cabinet. There are some circumstances in which your right to privacy must be set aside without your permission:

- If I have knowledge or "reasonable suspicion" that child abuse/neglect, elder abuse, or abuse of a dependent adult has occurred, I am mandated by law to report the abuse to the appropriate agency.
- If you threaten to harm yourself, and I believe your threat is serious, I am obligated to take whatever actions seem necessary to protect you from harm and see that you receive adequate care.
- If I believe, from information you disclose, that you intend to perpetrate violence upon an identifiable victim(s), the law requires me to notify local authorities and the person(s) in danger.
- If one of your family members communicates to me that you have expressed a serious intent to harm yourself or another, I am required by law to take whatever actions are necessary to protect people from harm.

- If you (or someone representing you) introduce your mental health into legal proceedings, then your right to privileged communication is automatically waived and I could be court ordered to testify or release my records.
- When you request that your insurance be billed, they will require disclosure of information.

5. Emergencies: Please call me at (916)508-5507 for all routine and urgent matters. On weekdays, I check my messages often and will respond as soon as possible. I will respond to messages left on weekends on Monday. **In a life threatening emergency, call 911 or go to the nearest hospital emergency room.** For an urgent matter, call the Sacramento Crisis line at (916) 368-3111, or Suicide Hotline (800) 827-7571 or Sutter Center for Psychiatry at (916) 386-3077. **For an urgent matter or emergency, do call me at 916-508-5507 and leave a message. However, in a life threatening emergency, do not wait for a response from me since I may not receive your message.**

6. Gold River Christian Counseling Associates (GRCCA) is an unincorporated association of licensed therapists who are individual proprietors. Each therapist is solely responsible for his/her own business. I have no responsibility for the business activities or practices of any other therapist practicing in this suite at this business address.

I/We have read the above statements and agree to these policies and procedures.

Signature: _____ Date: _____

Signature _____Date: _____