JOHN WALSH

LICENSED MENTAL HEALTH COUNSELOR

561-644-2100

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Name:_____Phone#:(C)_____(W)_____
Address:_____E-Mail:_____(H)_____
City:_____Zip:_____
Age:_____DOB:_____Social Security #:_____
Marital Status:_____Name of Spouse:_____
Number of Marriages:_____
Referred By:_____
Insurance Company:_____
Policy Number:_____Group Name & Number_____
Insured's Name:_____Insured's ID#_____
Mental Health Coverage Conditions:_____
Emergency Contact Name & Phone #:_____

EDUCATION:

High School Graduate ( ) AA Degree ( ) BA/BS Degree ( )
MA/MS Degree ( ) Major:_____
Doctorate ( ) Major:_____

PLEASE INCICATE IF ANY OF THE FOLLOWING APPLY OR HAVE APPLIED IN THE LAST SIX MONTHS:

Loss of appetite ( )	Unkempt Appearance ( )	Withdrawn ( )
Sleeplessness ( )	Apathy ("Blahs") ( )	Loss of sex drive ( )

FAMILY:

Mother Living? Yes ( ) No ( )
Father Living? Yes ( ) No ( )
Describe your relationship with your parents: _____

_____

Describe your relationship with your in-laws: _____

_____

Number of siblings and gender of each: _____
Where are you in the birth order? Oldest ( ) 2nd ( ) 3rd ( ) 4th ( ) Youngest ( )
Has anyone else had a key role in your upbringing? Explain:_____

_____

MARRIAGE:

How long have you been married?_____

Describe how you met your spouse?_____

_____

How long did you date?_____

How long was your engagement?_____

Did your parents approve of this marriage?_____

Names of children: Ages:

_____ _____

_____ _____

_____ _____

_____ _____

HEALTH:

Very Good ( ) Good ( ) Average ( ) Poor ( )

Are you currently under a doctor's care? Yes ( ) No ( )

If yes, please describe:_____

Primary Dr. Name_____Phone#_____

Are you currently taking medication? Yes ( ) No ( )

Please describe your use of prescription and non-prescription drugs:

Never ( ) Occasionally ( ) Please indicate times per week_____

Name of Drug(s)_____

MEDICAL HISTORY:

1. Past or current History of:

Stroke	Seizures	Migraines	Chronic Fatigue
Anemia	Diabetes	Chronic Pain	Eating Disorder
Asthma	Hepatitis	Tuberculosis	Cardiac Problems
Cancer	Hypertension	Liver Damage	Thyroid Problems
STD	AIDS	Urinary Tract Infection	
Persistent flu-like symptoms		HIV	

2. Have you had a physical in the last year? Yes ( ) No ( )

3. Do you have any food or drug allergies? Yes ( ) No ( )

Do you use drugs? Yes ( ) No ( )

Drug of choice?_____

Please describe your use of alcoholic beverages:

Never ( ) Occasionally ( ) Please indicate times per week_____

Additional Comments:_____

_____

EMPLOYMENT:

Dates, types and length of employment:

(1)_____

(2)_____

(3)_____

CURRENT EMPLOYMENT AND COMPANY NAME:_____

Do you live within your financial means? Yes ( ) No ( )

How would you describe your financial status?

Above Adequate ( ) Average ( ) Fair ( ) Poor ( )

PERSONAL:

What books, written material, tapes, CD's/DVD's, workshops, seminars, ect., have you studied that deal with the reason you are seeking therapy?

_____

_____

_____

RELIGIOUS BACKGROUND:

Denomination:_____

Participation?:_____

How do you express your spirituality?:_____

_____

PLEASE CHECK ANY OF THE FOLLOWING THAT YOU ARE CURRENTLY EXPERIENCING

( ) Anger
( ) Anxiety
( ) Drug use/self medications
( ) Change in lifestyle
( ) Challenges with Children
( ) Guilt/Shame
( ) Recent Death/Loss
( ) Violence/Rage
( ) Rebellion
( ) Impotence
( ) Suicidal Thoughts
( ) Loneliness
( ) Issues with Mother
( ) Relationships
( ) Judgment Problems
( ) _____

( ) Depression
( ) Envy/Jealousy
( ) Fear
( ) Unforgiveness
( ) Eating Disorder
( ) Sexual Concerns
( ) Health
( ) Adult Child of Alcoholic/Addict
( ) Dishonesty
( ) Attention Deficit
( ) Psychotic Episodes
( ) Spouse/Partner Abuse
( ) Issues with Father
( ) Headaches, other kinds of pain
( ) Motivation, laziness

Describe further what is troubling you:_____

_____

_____

_____

Who have you discussed this with? _____

_____

What was their response? _____

_____

List any insult, injury, hurt, or rejection you are suffering. Be as specific as possible: _____

_____

How did you hear about this therapist?

_____

Have you sought counseling before? Yes ( ) No ( )

If yes, who and what counseling did you receive? _____

_____

What goals do you want to accomplish with this present counseling/therapy?:_____

_____

_____

FEES ARE PAYABLE AT EACH SESSION. PLEASE MAKE YOUR CHECKS TO: **JOHN WALSH**. WE WILL GLADLY PROVIDE YOU WITH A RECIEPT WHICH YOU MAY FILE WITH YOUR INSURANCE COMPANY IF NEEDED.

DO YOU UNDERSTAND THE POLICY ABOUT FEES FOR COUNSELING AND PENALTY FOR CHARGES FOR CANCELLING AN APPOINTMENT WITHOUT 24 HOUR NOTICE?

Yes ( ) No ( )

I give my consent for services with **JOHN WALSH** and associated professional staff to include evaluation, psychotherapy, testing (if indicated) and involvement in the treatment planning process.

Signed_____Date_____

John Walsh, LMHC

PURPOSE:

To offer the service of professional counseling to individuals and couples in order that relationships may be restored in a beneficial manner. Further, to offer holistic therapy in an objective, understanding, and non-judgemental atmosphere.

RESPONSIBILITY OF THE CLIENT:

Counseling sessions are $155.00 due and payable at the beginning of each session. Checks are made payable to JOHN WALSH.

Insurance companies we are currently accepting will be billed by us. However, the client is ultimately responsible for the amount due if not paid by insurance company.

Appointments must be cancelled 24 hours prior to the session in order to avoid being charged a the full fee. It is the client's responsibility to reschedule.

A client will not be rescheduled after two consecutive missed appointments. Clients will only be reinstated after paying the fee for missed appointments. Managed Care clients will be charged a $155.00 penalty fee for missed appointments that do not meet the above criteria.

All checks returned for non-payment will incur a $100.00 service charge.

If a counselor receives a witness/records subpoena the client will be notified so that his/her attorney can take whatever action is deemed necessary.

If a client desires that the subpoena be honored, a signed release is then required. Therapeutic fees affiliated with any court proceeding are $200.00 per hour with a minimum of 2 hours. If court date is cancelled less than 24 hours, then a fee of $200.00 will be charged.

Therapists will work according to the State of Florida. Mental health counseling results cannot be guaranteed. Client agrees that texting and email communication shall be utilized.

RESPONSIBILITY OF THE THERAPIST:

The therapist will listen, analyze, evaluate and suggest alternate course of action in any given difficulty.

As required by your managed care insurance, copies of your treatment plans will be submitted to your primary care physician with signed Release of Information only. Please be advised that clients who are utilizing managed care benefits may be required to release information otherwise kept confidential in order to receive further benefits and therapy.

The counselor/client relationship is one of trust and confidentiality. Therefore, all records shall be accessible only to the counselor unless ordered by the Court. Under ethical standards, the therapist will break confidentiality if a client is in danger to self or others; is involved in criminal action; if ordered by the Court; or when it is in the best interest of a child or senior who is a victim of abuse.

Counseling sessions shall be held to 45-50 minutes.

The acceptance of clients will be at the sole discretion of the counselor and in accordance with the policies herein.

Outside assignments may be made by the counselor for the express purpose of directing the client toward development of the physical, psychological, and spiritual body and are regarded as a necessary part of healing.

Client Signature_____ Date_____

John Walsh, LMHC
Palm Beach Gardens, FL 33410
Phone: 561-644-2100
Secure Fax: 800-471-0025

AUTHORIZATION FOR THE RELEASE OR EXCHANGE OF INFORMATION

Client Name:_____DOB:_____

Information To/From_____

Address:_____

Phone Number:_____Fax Number:_____

Information To Be Released By Or Exchanged:

--History and Physical Exam	--Court/Agency Documents	--Family Systems Eval
--Discharge Summary	--Nursing Notes	--Educational Records
--Psychiatric Evaluation	--Mental Status	--Consultation Reports
--Psychological Test Results	--Treatment Plans	--Educational – Tests/Reports
--Chemical Recovery History	--Progress notes	--Therapist Orders
--Crisis Intervention Reports	--Attendance Record	--Attorney
--Psychosocial Report	--Lab results	--Medical Records
--Custody Evaluations	--Diagnoses	--Dates of Hospitalization

Other (specify)_____

IF NO LONGER THAN 90 DAYS; expires on_____(date)

_____Date:_____
Patient Signature