Peace and Purpose Counseling

Outpatient Services

Brittany Gilchrist, MA, LPC, CEDS
Licensed Professional Counselor
Certified Eating Disorders Specialist

PATIENT/CLIENT INFORMATION SHEET

PLEASE PRINT Date: _____

Patient Name_____MI _____ M_____ F_____ Age _____

DOB_____ S.S. #_____-_____-_____ DL#_____STATE_____Marital Status _____

Patient Address_____ City _____ ZIP_____

Home Phone # (_____)_____Patient Cell # (_____)_____

Email_____ Spouse Name_____Spouse # (____)_____

Patient Employer_____School District reside in_____

Work Address_____City_____ Occupation_____

Work # (_____)_____Ext._____Alternate # (_____)_____

IF PATIENT IS A CHILD (younger than 18):

Mother's Name_____DOB_____Home # (_____)_____

Cell # (____)_____Employer: _____

Email Address _____

Occupation_____Work # (___)_____

Father's Name_____DOB_____Home # (____)_____

Cell #(____)_____Employer_____

Email Address_____

Occupation_____ Work # (_____)_____

IF APPROPRIATE:

Which parent has legal custody of the child?_____

Which parent does not live with the child?_____

Stepmother's Name_____Tel.# (_____) _____

Stepfather's Name_____ Tel.# (_____)_____

RESPONSIBLE PARTY (if other than self):

Mr. / Mrs./ Ms./ Dr._____Relationship to Patient _____

Address_____City_____ ZIP_____

Home# (_____) _____ Work# (_____)_____Cell#(_____)_____

Email_____Employer_____Occupation _____

DOB_____ Driver's License #_____State_____Social Security #_____-_____-_____

Peace and Purpose, Social Medical Intake History

Patient:_____Age:_____Date of Birth:_____Date: _____

- List all present at the Diagnostic Session:
  Name:_____Relationship_____Age_____Occupation/Title:_____

  Name:_____Relationship_____Age_____Occupation/Title:_____

  Name:_____Relationship_____Age_____Occupation/Title:_____

  Name:_____Relationship_____Age_____Occupation/Title: _____

  List parents and siblings not present at this Diagnostic Session:

  Name:_____Relationship_____Age_____Occupation/Title:_____

  Name:_____Relationship_____Age_____Occupation/Title:_____

  Name:_____Relationship_____Age_____Occupation/Title:_____

  Name:_____Relationship_____Age_____Occupation/Title: _____

- You were referred to this office by _____

- Reason for referral: _____

- Has patient seen a Therapist in the past, ie, psychologist, social worker, psychotherapist, counselor or psychiatrist in the past? If yes, give name, address and approximate date(s)

  _____

  _____

- List anyone in household on medications:

Name: _____Medication(s): _____

Name:_____Medication(s): _____

- List other members of patient's family (including grandparents) who have experienced, been diagnosed or treated for, mental/ emotional distress or substance abuse:

- Does anyone listed drink alcohol to a degree that self or others have concern about it? YES _____
- Does anyone listed on this sheet have any drug involvement? YES _____
- Is patient or anyone listed currently involved in any judicial proceeding? YES _____

If yes, indicate name & nature of the proceeding(s):

_____

- Family doctor or pediatrician?_____
- Phone: _____
- Date of Patient's Last Physical Exam: _____
- School Counselor (if Patient is a child): _____
- School's Name:_____
- Phone: _____
- School District: _____

_____

- Formal Religious / Church Affiliation: ( ) Strong; ( ) Moderate; ( ) Mild; ( ) Very Little; ( ) None at All; ( ) Parents or spouses practice differently.

Church or Synagogue: _____

Credit Card Authorization Agreement

(PLEASE PRINT CLEARLY AND FILL OUT ALL FIELDS BELOW)

I,_____, authorize Peace and Purpose Counseling to charge the following Credit Card for ANY AND ALL PROFESSIONAL services for the following family members/patients; I further authorize said charges to be charged without my card being physically present.

As Guarantor for my teen's/ young adult's account and appointment fees, I realize that should s/he miss scheduled appointments without the appropriate notice, I will be charged for such cancelled or "no show" appointments. If I have not received a copy of the Office Policies and Procedures, the terms under which services at Peace & Purpose Counseling are provided, I realize that I may request a copy at any time. I acknowledge that this Financial/Payment/Guarantor's Agreement will remain in effect until withdrawn in writing.

Note: Credit card payment will be an additional $5 for processing fees.

Credit Card, Please Circle: Visa Master Card

Credit Card Number_____Exp. Date _____CVV_____

Cardholder's Signature_____Date_____

Billing Address_____

(Initial the following which apply)

____ Bill credit card directly

____ Left Credit Card on File but pays by cash or check at time of service