CLIENT QUESTIONNAIRE FOR ADULTS

I am glad you are here. Thanks for your willingness to fill out this information.
If you have any questions, please ask me. ☺

Client Name:_____ **Date of Birth:**_____ **Gender:** ❑ Male ❑ Female

Current Address:_____

Current Phone:_____ **E-Mail Address:**_____

Insurance Co. & Plan: _____ **Group #:** _____
Co-pay _____

If employed, please list Employer:

Please describe your current living situation:_____

_____

Individuals Living in Household:

Name	Age	Sex	Relationship	Occupation

Medical History

Current Primary Care Physician:_____

Would you like me to contact your physician or a prior mental health provider? If so, please provide contact info:

_____

List any current medical problems or concerns:_____

_____

Current Medications (Please include prescription and over the counter medications):

Medication	Dose (mg)	Frequency	Reason for Taking	Date Started

Mental Health History

Previous Mental Health Services: ❑ Individual Counseling ❑ Family Counseling ❑ Couples Counseling

❑ Group Counseling ❑ Psychiatrist ❑ Psychiatric Medication ❑ Psychological Evaluation ❑ Other_____

Please Describe Previous Services:

Dates	Name of Professional	Reason for Treatment	How Was it Helpful?

Have You Ever Been Hospitalized For Any Emotional or Psychiatric Reason? ❑ Yes ❑ No
If Yes, Approximately How Many Times?_____ When?-
_____

Did You Take Any Medication For Psychiatric or Psychological Reasons in the Past? ❑ Yes ❑ No
If Yes, Please List Below:

Medication	Dose (mg)	Frequency	Reason for Taking	Date Started

Have You Ever Had Thoughts of Hurting Yourself? ❑ Current ❑ Past. When?_____

Have You Ever Attempted Suicide? ❑ No ❑ Yes When?_____

Have You Ever Had Thoughts of Hurting Someone Else? ❑ Current ❑ Past Who?_____
When?_____

Have You Ever Been Abused? ❑ Physically ❑ Emotionally ❑ Sexually ❑ Domestic Violence ❑ Neglected

Other than the above, please list traumatic situations you may have been exposed to in the past. If you are unsure about how to define trauma, please ask.

_____
_____
_____

Do you or have you ever had a problem with Drugs or Alcohol?

❑ Yes ❑ No

If yes, please include a brief description of problem. Amount and Specific drugs and alcohol you are currently using.

_____

_____

Psychological *(If the below list is too much-just skip it and tell me about it.)* ☺

Symptoms

Current	Past		Current	Past	
❑	❑	Depressed mood	❑	❑	Fear of dying or going crazy
❑	❑	Anxiety	❑	❑	Excess fear of persons, situations
❑	❑	Daily Irritability	❑	❑	Recurrent thoughts/behaviors
❑	❑	Lack of interest or pleasure in activities	❑	❑	Difficulty controlling anger/bad temper
❑	❑	Increase in appetite	❑	❑	Psychological abuse
❑	❑	Decrease in appetite	❑	❑	Physical abuse
❑	❑	Difficulty sleeping or poor sleep	❑	❑	Sexual abuse
❑	❑	Decreased need for sleep	❑	❑	Distressing memories that reoccur
❑	❑	Increased need for sleep	❑	❑	Recurrent distressing dreams
❑	❑	Restlessness or inability to concentrate	❑	❑	Hear or see things others don't
❑	❑	Difficulty making decisions	❑	❑	Unreasonable thoughts/beliefs
❑	❑	Fatigue or loss of energy	❑	❑	Compulsive shopping/spending
❑	❑	Feelings of worthlessness or guilt	❑	❑	Excessive computer/internet use
❑	❑	Feelings of hopelessness	❑	❑	Not able to control impulse to steal
❑	❑	Recurrent thoughts of death	❑	❑	Frequent gambling
❑	❑	Racing thoughts or ideas	❑	❑	Compulsive sexual behavior
❑	❑	Easily distracted	❑	❑	Sense of reliving traumatic events
❑	❑	Rapid mood swings	❑	❑	Periods of time you cannot remember
❑	❑	Shortness of breath/dizziness			
❑	❑	Accelerated heart rate or chest pain	❑	❑	Avoidance of thoughts or feelings
❑	❑	Trembling or shaking	❑	❑	Avoidance of activities/situations
❑	❑	Sweating/feeling flushed	❑	❑	Detachment from feelings & people
❑	❑	Choking	❑	❑	Binging/compulsive overeating
❑	❑	Nausea or abdominal distress	❑	❑	Intentional vomiting
❑	❑	Feeling unreal	❑	❑	Diuretics or laxative misuse
❑	❑	Numbness or tingling sensation	❑	❑	Compulsive exercising or dieting

Do you have a faith that is a source of strength for you? If so, please list. _____

Referred By: _____

Consent For Treatment

I hereby consent to treatment with Linda Sheehan, LCSW I understand that I am responsible for full payment of the fee regardless of my health insurance coverage or benefits. I understand that full payment (or payment of the applicable co-pay) is expected at each session; that if I need to cancel an appointment, I must provide at least 24 hours notice; and that if an appointment is cancelled without such notice, I will be responsible for a cancelation charge of $40 as canceled sessions cannot be billed to insurance. I understand that if my account is in arrears, my biller may contact you to set up a payment plan.

Phone calls over 15 minutes will be billed at the rate of $95 an hour. In some cases, insurance may cover these services. I will inform you if I need to bill for a phone conversation we have just had. My attendance at special meetings/ Psychosocial evaluations can be very informative and helpful in working with your child. I bill an hourly rate of $95 and do not charge travel time unless the location is more than 25 minutes from my office. Once again, sometimes these services are covered but often they are not.

Counseling is confidential. I will use and protect your information in compliance with applicable state and federal law. Information obtained during counseling sessions will not be disclosed to anyone outside the session without your knowledge and written consent, with the following exceptions: if I believe that you present an imminent, serious risk of injury or death to yourself or another; if I have reasonable cause to believe a child's well-being or safety is compromised; if I have reason to believe that an individual who is protected under the Illinois Elder Abuse and Neglect Act has been abused, neglected, or financially exploited; or if I receive a valid court order signed by a judge.

Important note regarding confidentiality: If this is court-involved/ordered therapy, the normal assurances of confidentiality do not apply. However, every effort will be made to seek releases of information and keep information on a need to know basis.

Fee Agreement:

I, _____have agreed to the mutually decided amount of $110 per 50 minute session, or $150 for initial evaluation. I understand that whatever is the contracted amount that my insurance panel pays will, of course, be accepted. However, I understand I will be responsible for co-pays and meeting my deductible. I have discussed this form with Linda and I understand and agree to the terms outlined above.

(Please know that arrangements can be made if Linda is not on your insurance panel or you have a high deductible.)

Communication Agreement:
I give Linda Sheehan permission to contact me to arrange appointments on the email address and phone I listed on the first page. Please initial here: _____

Please note: Email/text communication is not HIPPA compliant. I will not be sending you or your family any clinical information in this way, just appointment info.

No I do not give permission to use the communication info provided on page one.
I would prefer to be contacted in the following manner: _____

_____		_____	
Client's Signature	Today's Date	Parent/Guardian Signature (if client is under 18)	Date

Note: Confidentiality cannot be guaranteed in situations involving insurance or other third party reimbursement where consent is given for clinical information to be provided to the insurance or third party, with the handling and confidentiality of such information by insurance or third party being beyond the control of this office.