***Positive Attributes Counseling and Consulting***

***Phyllis Crawford, MC LPC***

***1480 East Bethany Home Road Suite 230, Phoenix AZ 85014***

***P (602) 689-5012 F (602) 714-5051***

**CLIENT DEMOGRAPHIC INFORMATION**

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI\_\_\_\_\_ Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AGE: \_\_\_\_\_\_ Gender: (F) (M)

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AZ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: ( ) Ok to call? ( ) yes ( )no

Work Phone: ( ) Ok to call? ( ) yes ( )no

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (optional. This information is kept confidential and will not be distributed. You may received appt. reminders or newsletters from this office).

Cell Phone: ( ) Ok to call? ( ) yes ( )no

Marital Status:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer/School:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Doctor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number (s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION:**

Mental Health Plan:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Benefits Phone No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Insurance Plan:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Co-Pay $\_\_\_\_\_\_\_\_\_\_

**Is this an EAP referral: ( )yes ( )no Name of EAP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Authorization No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of Sessions Authorized \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Subscriber Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Subscriber’s SS # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship to patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CHILD/ADOLESCENT PATIENTS ONLY:**

Parent’s marital status:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pt resides with:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parents Names: (F)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (M)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additional Information counselor should know regarding pt’s legal status:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing below, I authorize my insurance company to pay directly to Phyllis Crawford MC LPC or Positive Attributes Counseling and Consulting, L.L.C., services rendered to me, my children, ward or spouse. I authorize the release of information pertinent to my case to any insurance company or adjuster involved in this case. A photocopy of this assignment shall be considered as effective and valid as the original. *This is a direct assignment of my rights and benefits under the policy.* I also authorize the Facility to initiate a complaint to the Insurance Commissioner for any reason on my behalf. I authorize the release of any medical or other information necessary to process my claims. I also request payment of government benefits to either myself or Phyllis Crawford or Positive Attributes Counseling and Consulting, L.L.C. I understand the filing of a claim is a courtesy to patients.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Client or Representative Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additional Participants Date

***Positive Attributes Counseling and Consulting, L.L.C.***

***Tel: (602) 689-6012 Fax: (602) 714-5051***

***TREATMENT AGREEMENT***

***Please review this information and ask about anything you do not fully understand.***

**BENEFITS AND EMOTIONAL RISKS:** The majority of individuals and families that obtain psychotherapy counseling benefit from the process. Self-exploration, gaining insight, exploring options for dealing with problems behaviors, learning new skills, or venting difficult feelings experiences are generally quite useful, but some risks do exist. As counseling is begun, please understand that some experience unwanted feelings and that examining old issues may produce unhappiness, anger, guilt, or frustration. These feelings are a difficult, but natural part of the psychotherapeutic process and often provide the basis for change. Important personal decisions are often an outcome of counseling and are likely to produce new opportunities and as well as unique challenges. Sometimes, a decision that is positive for one family member will be viewed quite negatively by another. Don’t be hesitant to discuss treatment goals, procedures, or your impressions of the services that are being provided. If ever you are not comfortable with suggestions or comment that has been made, please ask for clarification.

**CONFIDENTIALITY:** A client’s confidentiality is important and is legally protected. See Notice of Privacy Practice for complete information. **Information may be shared with medical/behavioral health providers involved in your care.** Confidentiality will be waived if a client sues the provider for breach of duty. In the event the group, family or couple’s counseling services are provided, information may be disclosed by the provider to another individual if it appears advisable for the treatment process. In such cases the provider or practice will not be held responsible for breach of confidentiality. In addition the provider or practice will not be held responsible for breach of confidentiality by other participants.

**Availability:** The offices are normally open from 9:00 am to 7:00 pm Tuesday, Wednesday and Thursday. Saturday appointments are available on the 1st and 3rd of each month. Calling the main phone number provides instructions and telephone numbers for non-business hours and emergencies.

**PAYMENT AND FEES:** You may pay for services at the time they are rendered or you may assign health insurance benefit, pay your deductible and pay only the part that is not covered by your insurance health benefit plan. Most insurance plans require a co-payment, which is payable at the time of each visit. While we assist you in filing insurance claims you are responsible for any amounts that your insurance or health benefit plan does not cover.

**A charge of $35 will apply to any appointment missed or cancelled without allowing a 24-hour advance notice.**

The following standard charges apply:

**MA**

Intake/Assessment $125.00

Individual/Family/Therapy $100.00

Group counseling (per individual) $40.00

Court //services (as arranged) $125.00

Court Testimony (as arranged) $150.00

**CONSENT/AGREEMENT:** I have read the above information and have had my questions answered to my satisfaction. I consent to participate in treatment. I certify that I am the legal guardian or custodial parent with the legal right to request and approve evaluation and treatment for my son/daughter/ward and hereby consent to their treatment.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SIGNATURE OF PRIMARY CLIENT OR REPRESENTATIVE Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additional Participant Consent to Treatment Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additional Participant Consent to Treatment Date

**New Patient Information/Consent Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**To be completed by the patient (or parent/guardian if patient is younger than 18 years)**

**PRESENTING CONCERN(S):**

Please describe your reasons for seeking treatment (include date/month the problem(s) started):

Was there any event that made these concerns or problems surface? \_\_\_\_\_Yes \_\_\_\_\_No

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE INDICATE HOW YOUR PROBLEMS ARE AFFECTING THE FOLLOWING AREAS:

No effect Little effect Some effect Much effect Significant effect Not Applicable

Marriage/Relationship 1 2 3 4 5 N/A

Family 1 2 3 4 5 N/A

Job/School performance 1 2 3 4 5 N/A

Friendships 1 2 3 4 5 N/A

Hobbies 1 2 3 4 5 N/A

Financial situation 1 2 3 4 5 N/A

Physical health 1 2 3 4 5 N/A

Anxiety level/nerves 1 2 3 4 5 N/A

Eating habits 1 2 3 4 5 N/A

Mood 1 2 3 4 5 N/A

Sleeping habits 1 2 3 4 5 N/A

Sexual functioning 1 2 3 4 5 N/A

Ability to concentrate 1 2 3 4 5 N/A

Spirituality 1 2 3 4 5 N/A

Ability to control your temper 1 2 3 4 5 N/A

**PSYCHIATRIC HISTORY:**

Have you ever received psychiatric or psychological treatment of any kind before? \_\_\_\_Yes \_\_\_\_NO

What type of care did you receive? \_\_\_Inpatient (hospital) \_\_\_\_Outpatient \_\_\_\_Both

When were you in treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where were you in treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did your doctor prescribe medicine at that time? \_\_\_Yes \_\_\_No

If yes, what was prescribed (include dosages if known)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**New Patient Information/Consent Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDICAL HISTORY:**

Please list any prescription medications you currently use: (Name, dosage, frequency)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any over-the-counter medications you currently use: (Name, dosage, frequency)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any past of present conditions that you have been or are being treated for including current reproductive or pregnancy status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did you last have a physical examination? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who did you see? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History:**

Describe any medical or psychiatric conditions of your parents or siblings \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Habits: Amount currently using Most ever used

Coffee (cups/day) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cigarettes (packs/day) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever felt you have abused drugs alcohol? \_\_\_Yes \_\_\_No

Have you ever felt you ought to cut down on your drinking? \_\_\_\_Yes \_\_\_\_No

Have people annoyed you by criticizing your drinking? \_\_\_\_Yes \_\_\_\_No

Have you ever felt bad or guilty about your drinking? \_\_\_\_Yes \_\_\_\_No

Have you ever had a drink the first thin in the morning

To steady your nerves of get rid of a hangover (eye opener)? \_\_\_\_Yes \_\_\_\_No

Other Substances Amount Frequency When? (First use, last use)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever received substance abuse treatment of any kind before? \_\_\_\_\_Yes \_\_\_\_\_No

Do you have a history of blackouts, seizures, or withdrawal symptoms? \_\_\_\_Yes \_\_\_\_\_No

Please describe anything else you would like your clinician to know:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_