CORE HEALING CENTER

Date _____

Name _____

Street Address _____ **City** _____ **Zip** _____

Home Phone _____ **Work Phone** _____

Cell Phone _____ **Calling Restrictions?** _____ **If "yes" explain:**

_____

Email Address _____

Date of Birth _____

Emergency Contact _____ **Phone Number** _____

Referred By _____

Spouse/Partner _____ **Age** _____

Previous Mental Health Treatment:

Have you seen a counselor before? _____ If "yes":

How long ago? _____

Name of Counselor _____

At the time sought treatment for _____

Any other family members in counseling? _____

Medical History: Physician _____

Last seen (approx. date) _____ For _____

Taking Any Medications? _____ If "yes":

Medication _____ For _____ Dosage _____

Medication _____ For _____ Dosage _____

Medication _____ For _____ Dosage _____

Family History

Father _____ Age _____ If deceased date _____

Mother _____ Age _____ If deceased date _____

Step Parent (s) names (s) _____

Brothers/Sisters Names Age Sex Occupation Where living Deceased?

_____

_____

_____

_____

Children's Names Age Sex School & Grade Lives at home? Step?

_____

_____

_____

_____

Personal History: Have you ever been a victim of: sexual abuse _____ physical abuse _____

verbal/emotional abuse _____

Who was the abuser(s) _____

Social History: How many friends do you have? _____

How well do you get along with co-workers? _____

What do you like to do socially? _____

Education: Highest grade achieved _____ Date of graduation _____

Degree _____

Employment: Current employer _____

Been there for _____ years. Duties _____

Substance Use: Have you used drugs/alcohol in the past week? _____ Past month? _____

Type _____ Amount _____

Has alcohol/drug use ever caused a problem? _____ If "yes" please explain: _____

_____

Have you ever been treated (residential/out patient) for substance abuse? _____

Where and when _____

Have you ever attended a 12-step program? _____

Parents or grandparents with alcohol/addiction problems? _____

Siblings with alcohol/addiction problems? _____

Daily Routine: How well do you sleep? _____ Fall asleep OK? _____

Stay asleep? _____ Feel rested in the AM? _____

Any changes in the last six months? _____

How is your energy level during the day? _____

Does you life feel sufficiently organized? _____

Do you currently have any homicidal thoughts? _____

Do you currently have any suicidal thoughts? _____

Check the items that relate to you

___bereavement
___depression
___anxiety
___nervousness
___marriage problems
___sexual concerns
___infidelity of spouse
___sexual identity
___sexual orientation
___fear
___anger
___work/career
___guilt
___suicidal feelings or thoughts
___relationship with parents
___relationship with children
___spiritual issues
___loss of hope
___loss of meaning
___loss of self respect
___loss of love
___helplessness
___hopelessness
___low self-esteem

Signature: _____ Date _____

CORE HEALING CENTER

CONSENT FOR TREATMENT

I am voluntarily seeking treatment from Violet Eden of the Core Healing Center. I understand that there is no guarantee concerning my treatment outcome. My therapist and I shall develop the treatment plan in accordance with my presenting problems. The fee for therapy sessions are $140 unless a lesser fee has been agreed upon. Sessions are 53-55 minutes in length. I understand that all fees are due in full at the beginning of each session, and that I may request a receipt to submit to my insurance company. If I need to cancel an appointment, I understand that a 24-hour notice is required. Should I cancel without notice, I will be charged the full fee for the session. I reserve the right to terminate treatment anytime I wish, but I will discuss termination of treatment with my therapist before discontinuing. I understand that all personal information will be considered confidential and can only be released with my written consent, unless there is a "Duty to Warn."

I have read this notice, understand and agree to it.

_____ _____

Client's Signature **Date**

CORE HEALING CENTER

NOTICE OF PRIVACY PRACTICES SIGNATURE SHEET

I acknowledge that I have received for review a copy of the Core Healing Center Notice of Privacy form.

_____ _____

Signature Date

_____

Print Patient Name