GUIDELIGH COUNSELING

Personal Information Sheet

Please complete information that is relevant to your situation. Use the back of this page if necessary.

Name _____ Date_____

Address_____

_____ Zip _____

Cell Phone _____ ☐ Work Phone _____ ☐

Home Phone _____ ☐ Email _____ ☐
**Check preferred method of contact*

PERSONAL INFORMATION

Date of birth _____ Age _____Marital Status _____

Soc. Sec. # _____Religious Preference_____ No. Children_____

Your occupation _____

Your employer _____

Spouse/Significant other's name_____

Spouse/Significant other's address (if different) _____

_____ Zip _____

EMERGENCY CONTACT INFORMATION

Name/Relationship_____ Phone (1)_____

Phone (2)_____ Email_____

Primary care physician _____

Address _____

_____ Zip _____

GUIDELIGH COUNSELING

Personal Information Sheet

INSURANCE INFORMATION
If you plan to file Insurance, please provide the following information.

Insurance Co. _____ Policy # _____

Subscriber/Insured Name _____ Group # _____

Subscriber DOB _____

Insurance Co. address _____

_____ Zip _____

Phone # _____ Fax # _____

REQUEST FOR COUNSELING

Please describe your reason(s) for requesting counseling at this time: _____

_____

_____

Who referred you? _____

Is there anything you think I should know before we begin? _____

_____

_____

The information above is correct to the best of my knowledge:

_____ _____
Signature Date

GUIDELIGH COUNSELING

Clinical History Form

Client Name: _____ **Birthdate (client):** _____

Please describe your Chief Complaint: _____

_____

_____

Was the onset: Sudden ☐ Gradual ☐

History of Presenting Problem(s) (include your symptoms, when they began, how often they occur, etc.)**:**

_____

_____

_____

_____

Safety, Suicide and Self-Harm History:
(If you are filling this out on behalf of the patient, please answer from the patient's perspective)

1. **Are you currently feeling suicidal?** ☐ Yes ☐ No
2. **Are you currently afraid for your safety?** ☐ Yes ☐ No
3. **Have you ever tried to kill yourself?** ☐ Yes ☐ No
    a. If yes, how many times? _____
    b. If yes, was your intent to die? ☐ Yes ☐ No
    c. If yes, were you hospitalized ☐ Yes ☐ No
    d. If yes, was hospitalization helpful? ☐ Yes ☐ No
4. **Have you ever tried to self-harm?** ☐ Yes ☐ No
    a. If yes, how many times? _____
    b. If yes, please describe the most recent occurrence_____

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Clinical History Form

Past Psychological & Psychiatric Treatment History (Both Inpatient and Outpatient):

Provider or Facility	Dates of Treatment	Reason(s) for seeking treatment (symptoms & diagnosis)	Effective? Yes or No	How long did treatment last? How long did you see this provider?

Trauma & Abuse History: (physical/sexual/emotional/verbal abuse, loss, suicide, witness of domestic violence)

Nature of trauma/abuse	Time frame	Description, persons involved, etc.	Describe any treatment you received:

Family Psychiatric History:

Family Member (i.e., mother, brother, grandmother, uncle, cousin, etc.)	Psychiatric Problem(s) (i.e., depression, anxiety, bipolar, substance use, trauma, ADHD, etc.)

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Clinical History Form

Substance Use History:
(If you are filling this out on behalf of the patient, please answer from the patient's perspective)

Substance Used	√ if "Yes"	Still Using?	Age of first use	Age of last use	Amount per day	Days per month
Marijuana/Hashish/etc	☐					
Opiates	☐					
Prescription pain killers	☐					
Heroin	☐					
Cocaine	☐					
Amphetamines/Speed	☐					
Benzodiazepines	☐					
Alcohol	☐					
Others, please describe	☐					

Consequences of Substance Use:
(If you are filling this out on behalf of the patient, please answer from the patient's perspective)
Please check all consequences that apply because of alcohol consumption or abuse of substances

☐ Felt that you needed to cut down on your drinking
☐ Felt guilty about drinking
☐ Increased tolerance
☐ Withdrawal sx (i.e., shakes, sweating, nausea, rapid heartbeat)
☐ Effects on physical health
☐ Unintentional overdose
☐ Physical fights or assaults
☐ Problems with money
☐ Been annoyed by others criticizing your drinking
☐ Needed a drink first thing in the morning
☐ Blackouts
☐ Seizures
☐ Using or consuming more than you intended
☐ DUI/DWI or Arrests
☐ Relationship conflicts
☐ Job loss or problems at work or school

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Clinical History Form

Medical Conditions & History: (past and present, use back if needed)

Medical Condition/Surgery	Treatment history	Was the condition resolved? Is it still problematic? Any other info?

Medications: (past & present – include prescribed, over-the-counter, herbal supplements & vitamins)

Medication	Dosage and Frequency	Dates Taken	Prescribed by	Effective?	If no longer taking, reason for stopping?

Current Living Situation: Other Family Members or Persons Living in the Home

Name	Is the person living inside or outside the home?	Relationship	Is the person biologically related? (Yes or No)	Gender	Age	Describe Job or Grade in school

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Clinical History Form

Biological Parents:

Please provide the following information about your biological parents (or your child's, if they are the client)	Mother	Father
Name		
Living or Deceased?		
Age (current or when deceased)		
Birthplace		
Occupation (current or previous)		
Number of hours away from home per day. (If not in the home, leave blank)		

Developmental & Educational History:
(If you are filling this out on behalf of the patient, please answer from the patient's perspective)

1. **During your mother's pregnancy and your birth, did your mother have any problems with any of the following?** (check all that apply)

☐ Exposure to drugs or alcohol during pregnancy
☐ A difficult pregnancy
☐ Problems with delivery
☐ Exposure to cigarettes (direct/indirect)
☐ Any complications after your birth? (i.e., premature birth, jaundice, breathing difficulties)

Please describe: _____

2. **Did you have any delays or difficulties in reaching the following developmental milestones?**
(check all that apply)

☐ Walking
☐ Talking
☐ Toilet training
☐ Sleeping alone
☐ Being away from parents
☐ Making friends

3. **Which options below best describe your childhood home atmosphere?** (check any/all that apply)

☐ Normal
☐ Supportive
☐ Parental fighting
☐ Financial difficulties
☐ Parental violence
☐ Frequent moving

GUIDELIGH COUNSELING

Clinical History Form

4. Which of the following challenges did you experience during your childhood? (check any/all that apply)

- ☐ Tantrums
- ☐ Fighting
- ☐ Property damage
- ☐ Animal cruelty
- ☐ Depression
- ☐ Enuresis (bed wetting)
- ☐ Stealing
- ☐ Fire setting
- ☐ Victim of bullying
- ☐ Parental divorce
- ☐ Eating/weight issues
- ☐ Running away from home
- ☐ Separation anxiety
- ☐ Engaged in bullying
- ☐ Death of a parent/caregiver

5. Which of the following best describes problems you may have had in school? (check any/all that apply)

- ☐ Fighting
- ☐ Detentions
- ☐ School refusal
- ☐ Special education
- ☐ School phobia
- ☐ Suspensions
- ☐ Class failures
- ☐ Remedial classes
- ☐ Truancy
- ☐ Expulsions
- ☐ Repetition of grades

6. Did you have additional schooling outside of the standard classroom setting? (check any/all that apply)

- ☐ Speech classes
- ☐ Tutoring
- ☐ Accommodations

7. Please select your highest level of education

- ☐ Less than High School
- ☐ Two-year degree
- ☐ High School
- ☐ Four-year degree
- ☐ Some college
- ☐ Graduate degree

General Social History: (If you are filling this out on behalf of the patient, please answer from the patient's perspective)

1. Which options below best describes your social situation? (check any/all that apply)

- ☐ Family conflict
- ☐ Few friends
- ☐ No friends
- ☐ Supportive social network
- ☐ Distant from family of origin
- ☐ Substance-use based friends

2. What is your current marital status?

- ☐ Single, never married
- ☐ Divorced
- ☐ Married
- ☐ Widowed
- ☐ Committed relationship

GUIDELIGH COUNSELING

Clinical History Form

General Employment History: (If filling this out on behalf of the patient, please answer from the patient's perspective)

1. **Which is your current occupation status?** (check any/all that apply)

☐ Unemployed ☐ Employed part-time ☐ Employed full-time ☐ Retired ☐ Disabled

☐ Full-time student ☐ Part-time student

Lifestyle and Wellness History: (If you are filling this out on behalf of the patient, please answer from the patient's perspective)

1. **How many hours of sleep do you get, on average, each night?** ☐ 5h or less ☐ 6-7h ☐ 7-8h ☐ 8h+
   a. Do you have difficulty falling/staying asleep? ☐ Yes ☐ No
   b. If yes, explain:_____
2. **Do you exercise regularly?** ☐ Yes ☐ No
   a. If yes, how often? _____
   b. If yes, what form(s) of exercise do you do? _____
3. **How would you describe your nutrition?** ☐ Excellent ☐ Average ☐ Not great ☐ Terrible
   a. How many meals & snacks do you eat/day?_____
   b. Do you have any dietary restrictions or special diets (Gluten Free, Vegetarian, etc.?) ____Yes ____No
4. **What are your leisure and recreational hobbies?** _____

   _____
5. **Do you have any physical restrictions or disabilities?** _____
6. **How do you identify your gender?** ☐ Male ☐ Female ☐ Gender Fluid ☐ Other: (describe)_____
7. **How do you identify your sexuality?** ☐ Heterosexual ☐ Lesbian ☐ Gay ☐ Bisexual ☐ Transgender ☐ Questioning
8. **Are you in a relationship?** ☐ Yes ☐ No ☐ Not Applicable (child)
   a. Are you satisfied with your relationship? ☐ Always ☐ Most of the time ☐ Sometimes ☐ Rarely
   b. Are you sexually active? ☐ Yes ☐ No ☐ Not Applicable (child)
9. **Is religion/spirituality important to you?** ☐ Yes ☐ No
   a. Do you participate in an organized religion? ☐ Yes ☐ No If yes , which one? _____
10. **How do you identify your race/ethnicity/cultural background?** _____

GUIDELIGH COUNSELING

Clinical History Form

11. Have you ever experienced discrimination, including sexism, racism, ageism, etc. ☐ Yes ☐ No

a. Please describe: _____

12. Do you have any past or present legal troubles? ☐ Yes ☐ No

a. If yes, any arrests? ☐ Yes ☐ No

13. What outcome do you most hope to get from therapy? _____

_____

Given the list of categories below, how much stress is each currently causing you?

	No Stress	Mild Stress	Moderate Stress	Severe Stress
Family	☐	☐	☐	☐
Friends	☐	☐	☐	☐
Relationships	☐	☐	☐	☐
Educational	☐	☐	☐	☐
Economic	☐	☐	☐	☐
Occupational	☐	☐	☐	☐
Housing	☐	☐	☐	☐
Legal	☐	☐	☐	☐
Health	☐	☐	☐	☐

Is there anything else you want me to know? _____

_____

GUIDELIGH COUNSELING

Consent for Treatment of a Minor Child

Child's Name: _____Date of Birth: _____

I, _____, give my consent to LCSW to provide treatment and therapy determined to be necessary or advisable for my child who is named above. I understand that I may stop treatment for my child at any time and that Carol L. Videtti, MSW, LCSW may also stop treatment after discussion of the reasons for termination and referral to other professionals, if needed.

I realize that my child's treatment is confidential. Information may not be released without my written consent except a) in the event that an issue is raised which, in the therapist's judgment, would endanger my child's welfare, or b) another exception to Confidentiality occurred (See "Statement of Confidentiality"). If my child is 14 years or older, I understand that s/he must sign a Release of Information for me to receive information about the treatment unless the child is at risk (See "Statement of Confidentiality") in which case the therapist will notify the proper authorities.

My child's therapist may determine with my child that my participation is needed to treat a specific problem. In that event, I am prepared to participate in my child's treatment as requested.

If I am separated or divorced from my child's other parent, I will provide legal documentation of my authority to sign this Consent for Treatment of a Minor Child. In addition, I agree to work cooperatively with the therapist to deal with issues related to this matter.

_____ _____

Signature of Parent/Legal Guardian Date

_____

Address

_____

_____ _____

Witness and Title Signature of Child (if 14 or older)

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Authorization Consenting to Release of Information

I, _____ , authorize Carol L. Videtti, MSW, LCSW to discuss and exchange, in verbal or written form, any relevant information to my child's treatment with the person, or any person(s) or staff of the institution, named below.

_____

Name / Institution Name

_____

Address

_____ /_____

Phone Number Fax Number

For the following reason(s):

☐ Psychological Assessment

☐ Medical Records

☐ Coordination of Care

☐ Other: _____

You may revoke this consent at any time. Unless otherwise revoked or renewed, this consent is in effect for one year from the date of the last session. This consent is subject to all conditions outlined in the Office Policies & Consent to Psychotherapy Services.

iiiiiiii

_____ _____

Client / Legal Guardian Signature Date

hhhhhh

_____

Client / Legal Guardian Printed Name

GUIDELIGHT COUNSELING

Authorization for Electronic Communication

As a convenience to me, I authorize Guidelight Counseling to communicate with me regarding my treatment via electronic communications (email or text message) and to transmit my protected health information electronically as described below.

I understand there are risks inherent in the electronic transmission of information by email or text message:

- Such communication does not provide a completely secure means of communication.
- Any protected health information transmitted via electronic communications pursuant to this authorizationSign may not be encrypted.
- Electronic transmission of information cannot be guaranteed to be secure or error-free.
- Data may be vulnerable to access by unauthorized third parties.

As such, Guidelight Counseling shall not have any responsibility or liability with respect to any error, omission, claim or loss arising from or in connection with the electronic communication of information by Guidelight Counseling to me.

Text Communication: ☐ Yes ☐ No
Authorized phone number(s):_____

Email Communication: ☐ Yes ☐ No
Authorized email address(es):_____

Other: ☐ Yes ☐ No
Authorized service(s): _____

Your treatment does not depend on your consent to this authorization. You have the right to terminate or amend this agreement at any time. **The use of more secure communication methods, such as messaging through your Patient Portal or through the Spruce App are available alternatives** should you elect to not give consent to any of the forms of communication listed above.

I understand that Guidelight Counseling may transmit my protected health information electronically as described above unless and until I revoke or amend this authorization by submitting notice to Guidelight Counseling in writing. This authorization does not allow for electronic transmission of my protected health information to third parties, and I understand I must execute a separate authorization for my protected health information to be disclosed to third parties.

_____
Patient Name

_____ _____
Signature of Patient Date

GUIDELIGHT COUNSELING

Credit Card Payment Authorization

Please complete and sign this form if you would like to have your co-payments, cancellation/missed appointment fees, and any other balances due to be charged to your credit card. Please note that payment by credit card is required for all telehealth sessions.

Credit Card Payment helps because:

- It's convenient
- It's secure (all credit card information is stored & processed by a secure financial institution)
- Your payment is on time
- It eliminates interruptions to the therapeutic environment

Here's How Credit Card Payments Work:

- You authorize Guidelight Counseling LLC to charge your session fees, copayments, coinsurance, cancellation/no-show fees, and balances due to your credit card.
- You will be charged on the day of your visit for the amount that is due. Please remember that Guidelight Counseling LLC does not allow for patients to carry balances.
- It is your responsibility to know when you have incurred a cancellation/no-show fee. Your card will be charged for the fee when the fee is due.
- The charge will appear on your credit card statement. A receipt can be sent to you upon your request.

Please complete the following information:

I _____ authorize Guidelight Counseling LLC to charge my credit card indicated below for payment of my applicable copayments, cancellation fees, and balances due.

Name on Card: _____ Expiration Date: _____

Credit Card #: _____ Please circle: Visa Amex MC

Security Code (from back of card): _____ Zip code: _____

_____ _____

Signature Date

By signing above, I certify that I am an authorized user of this card. I understand that this authorization will remain in effect until I cancel it. I agree to notify Guidelight Counseling of any changes in my account information, or termination of this authorization.