# New Patient Information Form

**Abundant Life Counseling**
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404-788-0002

## INFORMATION, AUTHORIZATION, & CONSENT TO TREATMENT

This document is intended to inform you about what you can expect from your counselor or group leader, policies regarding confidentiality and emergencies, and other details regarding your counseling. This document is part of an ethical obligation to our profession as well as our commitment to keep you informed of every part of your therapeutic experience. Your relationship with your counselor is a collaborative one; thus, we welcome any questions, comments, or suggestions regarding your counseling at any time.

Client Participation & Viewpoints

To make the most of your counseling, we encourage you to take an active role. This will include a commitment to work through what is recommended by your counselor both during and between sessions. This also means avoiding any mind-altering substances like alcohol or non-prescription drugs for at least eight hours prior to your therapy sessions and in sessions. Furthermore, we see clients in which we feel competent to help and who are benefiting from the counseling relationship. If counseling is not beneficial to the client, we will provide you with other resources that will be helpful to you. Please feel free to inform your counselor of your needs and if you desire a referral.

Your Counselor

Eddie Capparucci is a licensed in the State of Georgia as a Professional Counselor. He is a Nationally Certified Counselor recognized by the National Board for Certified Counselor and a member of the following professional organizations:

- American Association of Christian Counselors
- American Counseling Association
- Georgia Christian Counseling Association
- Georgia Licensed Professional Counselors Association

Eddie received his master's in Mental Health Counseling from Liberty University. He is certified in pornography and sexual addiction by the AACC and IACSAS. He also is certified in marriage counseling by the AACC and is certified as a pre-marital counselor in the Prepare and Enrich program.

Confidentiality & Records

Your communications with your counselor will become part of a clinical record of treatment, and it is referred to as Protected Health Information (PHI). Your PHI will be kept in a secure location. Additionally, your counselor will always keep everything you say to him or her completely confidential, with the following exceptions: (1) you direct your counselor to tell someone else and you sign a "Release of Information" form; (2) your counselor determines that you are a danger to yourself or to others; (3) you report information about the abuse of a child, an elderly person, or a disabled individual who may require protection; or (4) your counselor is ordered by a judge to disclose information. In the latter case, your counselor's license does provide him or her with the ability to uphold what is legally termed "privileged communication." Privileged communication is your right as a client to have a confidential relationship with a counselor. If for some unusual reason a judge orders the disclosure of your private information, this order can be appealed. We cannot guarantee the appeal will be sustained, but we will do everything in our power to keep what you say confidential.

## COSTS OF SESSIONS

I consent to receive counseling and pay all fees for my intake, counseling sessions, and other customary charges in accordance with the terms set below. I acknowledge that my initial intake session will cost $125; all additional couples sessions are $110 and individual sessions are $90. Exact cash payments; checks made to Abundant Life Counseling; and most major credit cards are accepted. **All fees are due at time of service.** A charge of $40 will be incurred for any checks that do not clear the bank. All counseling fees are subject to review and/or change. Your intake session will be one hour; all other sessions are 45 minutes. I am on many insurance panels, please inquire if I accept your insurance.

## OFFICE POLICY INFORMATION

**Cancellation Policy:** If you are unable to keep an appointment, you must notify the counselor **at least 48 hours in advance**. If advance notice is not received, you will be financially responsible for the **full session fee** that you missed.

**Late Policy:** If you are late for your appointment, please note that your appointment time will be cut short. As well, if your intake paperwork is not filled out by your scheduled appointment time, then you will be asked to complete it during your session time. This will entail a shorter session, so please make every effort to be on time. Sessions will still end 45 minutes on the hour (i.e, a 5 pm scheduled appointment will end at 5:45 pm).

**Discharge:** If you are no show for 2 appointments in a row or cancel 3 appointments late you may be discharged from our counseling services.

**In Case of an Emergency:** A counselor will return your phone call within 24-48 hours, excluding weekends. If you have a mental health emergency, we encourage you not to wait for a call back, but to do one or more of the following: Call Ridgeview Institute at 770.434.4567; call 911; or go to your nearest emergency room.

Please print, date, and sign your name below indicating you have read and understand the contents of this form, you agree to the policies of your relationship with your counselor and are authorizing us to begin counseling with you.

_____

**Client Name (Please Print)** **Date**

_____

**Client Signature**

□ **By checking this box, I acknowledge that I have read and received the Notice of Privacy Practices**

_____

**Parent's or Legal Guardian's Name (Please Print)** **Date**

_____

**Parent's or Legal Guardian's Signature**

The signature of the Counselor below indicates that she or he has discussed this form with you and has answered any questions you have regarding this information.

_____

**Counselor's Signature** **Date**

## CLIENT INFORMATION

**NAME:** _____
**(Please Print)**

**Date of Birth:** ____/____/_____ **Gender:** ▲ Male ▲ Female

**Marital Status:** ▲ Married ▲ Divorced ▲ Widowed ▲ Single

**Street Address:** _____ **City:** _____

**State:** _____ **Zip Code:** _____ **Email:** _____
**(Please Print)**

**Home:** _____ **Cell:** _____ **Work:** _____
Can Leave Message: ▲ **Yes** ▲ **No** ▲ **Yes** ▲ **No** ▲ **Yes** ▲ **No**

_____
**Mobile Carrier Provider** (so we can send appointment reminders)

## CREDIT CARD INFORMATION

We require a credit card be placed on file. Thank you for your cooperation.

**Credit Card Number:** _____ **Exp. Date** _____ **Code #:** _____

## REFERRAL INFORMATION

▲ Internet Site: _____ ▲ Insurance Plan

▲ Physician: _____ ▲ Friend: _____

▲ Pastor: _____ ▲ Other: _____

## STUDENT/EMPLOYMENT INFORMATION

**Student Status:** ▲ F-T ▲ P-T ▲ Not a Student **College Name:** _____

**Occupation:** _____ **Employer:** _____

## EMERGENCY CONTACT

**Contact Name:** _____ **Relationship:** _____

**Cell Phone:** _____ **Other Phone:** _____

## INSURANCE INFORMATION

**Insured Name:** _____

**Client's Name:** _____

**Relationship with Insured:** **Self** ○ **Spouse** ○ **Child** ○ **Sibling** ○

**Client's Date of Birth:** _____

**ID Number:** _____ **Group Number:** _____

**Insurance Co. Name:** _____ **Phone Number:** _____

**Insurance Company Address:** _____

## LIFE EVENTS

**I/We made this appointment because:**

_____

_____

Please check any and all life events that you have experienced over the last 12 months:

| | | | |
|---|---|---|---|
| ☐ Death of a spouse | ☐ Family member ill | ☐ Foreclosed on mortgage | ☐ Change of work hours |
| ☐ Divorce | ☐ Pregnancy of self/partner | ☐ New work responsibilities | ☐ New residence |
| ☐ Marital separation | ☐ Sexual difficulties | ☐ Child leaving home | ☐ Change of school |
| ☐ Death of a close relative | ☐ New addition to the family | ☐ Trouble with in-laws | ☐ Recreational change |
| ☐ Personal injury or illness | ☐ Change in finances | ☐ Partner begins/stops work | ☐ Church activity changed |
| ☐ New marriage | ☐ Death of a close friend | ☐ Began/Finished school | ☐ Social activities changed |
| ☐ Fired from work | ☐ New job | ☐ Living conditions changed | ☐ Change in sleep patterns |
| ☐ Marital Problems | ☐ Arguing with spouse | ☐ Change of personal habits | ☐ Change in eating habits |

**Presenting Symptoms:**

Please check any symptoms you have experienced over the last two weeks:

| | None | Mild | Moderate | Severe | | None | Mild | Moderate | Severe |
|---|---|---|---|---|---|---|---|---|---|
| Suicidal Thoughts | ☐ | ☐ | ☐ | ☐ | Homicidal Thoughts | ☐ | ☐ | ☐ | ☐ |
| Hallucinations | ☐ | ☐ | ☐ | ☐ | Delusions | ☐ | ☐ | ☐ | ☐ |
| Feelings of Hopelessness | ☐ | ☐ | ☐ | ☐ | Obsessive Thoughts | ☐ | ☐ | ☐ | ☐ |
| Feelings of Worthlessness | ☐ | ☐ | ☐ | ☐ | Extreme Fears | ☐ | ☐ | ☐ | ☐ |
| Difficulty Concentrating | ☐ | ☐ | ☐ | ☐ | Hyperactivity | ☐ | ☐ | ☐ | ☐ |
| Lost Interest in Activities | ☐ | ☐ | ☐ | ☐ | Elevated Mood | ☐ | ☐ | ☐ | ☐ |
| Decreased Energy | ☐ | ☐ | ☐ | ☐ | Racing Thoughts | ☐ | ☐ | ☐ | ☐ |
| Social Isolation | ☐ | ☐ | ☐ | ☐ | Feelings of Guilt | ☐ | ☐ | ☐ | ☐ |
| Sexual Dysfunction | ☐ | ☐ | ☐ | ☐ | Feeling Distracted | ☐ | ☐ | ☐ | ☐ |
| Change in Sleep Pattern | ☐ | ☐ | ☐ | ☐ | Anxious Thoughts | ☐ | ☐ | ☐ | ☐ |
| Appetite Loss/ Gain | ☐ | ☐ | ☐ | ☐ | Depressed Mood | ☐ | ☐ | ☐ | ☐ |
| Weight Loss/ Gain | ☐ | ☐ | ☐ | ☐ | Paranoia | ☐ | ☐ | ☐ | ☐ |
| Self-Injurious Behaviors | ☐ | ☐ | ☐ | ☐ | Mood Swings | ☐ | ☐ | ☐ | ☐ |

1. On average, how many hours of sleep do you get each night? _____Hours
2. On average, how much weight have you lost/ gained (circle one) in the past few months? _____Lbs.

## PREVIOUS COUNSELING HISTORY

In the past, have you received inpatient or outpatient mental health treatment? ☐ Yes ☐ No

In the past, have you ever experienced a traumatic head injury? ☐ Yes ☐ No

In the past, have you ever been treated for drug or alcohol abuse/dependence? ☐ Yes ☐ No

**If you answered yes to any of the previous three questions, please complete the following information:**

(Starting with the most recent treatment you have received)

| Treatment | Facility Name<br>Psychiatrist Name | Explanation of Treatment | Treatment Dates |
|---|---|---|---|
| ☐ Inpatient<br>☐ Outpatient | | | |
| ☐ Inpatient<br>☐ Outpatient | | | |

**Substance Abuse: If you have a history of substance abuse or dependence, please complete below:**

| | Current Use | Age Started | Last Used | Frequency | Comments |
|---|---|---|---|---|---|
| Alcohol | | | | | |
| Amphetamines/Diet Pills | | | | | |
| Methamphetamines | | | | | |
| Cocaine/Crack | | | | | |
| Heroin/Opiates | | | | | |
| Hallucinogens | | | | | |
| Marijuana | | | | | |
| Tobacco Products | | | | | |

Check all circumstances that apply to you regarding your use of drugs and/or alcohol:

| | | | | |
|---|---|---|---|---|
| ☐ Used to Sleep | ☐ Relieve Emotional Pain | ☐ Morning Use | ☐ To Avoid Withdrawal | ☐ To Get Rid of Hallucinations |
| ☐ Used to Relax | ☐ Relieve Physical Pain | ☐ Used Alone | ☐ To Function Socially | ☐ Other |

Check all consequences you have experienced due to your use of drugs and/or alcohol:

| | | | |
|---|---|---|---|
| ☐ Hangovers | ☐ Binges | ☐ Assaults | ☐ Legal Problems |
| ☐ Withdrawal Symptoms | ☐ Seizures | ☐ Loss of Job | ☐ Relationship Conflicts/Divorce |
| ☐ Sleep Disturbances | ☐ Medical Problems | ☐ Overdose | ☐ Suicidal Thoughts |

Do you consider your drinking or drug use a problem? ☐ Yes ☐ No
Are you currently attending support groups such as AA or NA? ☐ Yes ☐ No

If yes, how often do you drink/use drugs?_____

## FAMILY HISTORY

**Childhood exp**eriences with immediate and extended family members:

| | Degree of Contact in Childhood | Recollection of Relationship in Childhood |
|---|---|---|
| Mother | ☐ Much Contact ☐ Some Contact ☐ No Contact ☐ N/A | ☐ Good ☐ Fair ☐ Poor ☐ N/A |
| Father | ☐ Much Contact ☐ Some Contact ☐ No Contact ☐ N/A | ☐ Good ☐ Fair ☐ Poor ☐ N/A |
| Stepmother | ☐ Much Contact ☐ Some Contact ☐ No Contact ☐ N/A | ☐ Good ☐ Fair ☐ Poor ☐ N/A |
| Stepfather | ☐ Much Contact ☐ Some Contact ☐ No Contact ☐ N/A | ☐ Good ☐ Fair ☐ Poor ☐ N/A |
| Brother(s) | ☐ Much Contact ☐ Some Contact ☐ No Contact ☐ N/A | ☐ Good ☐ Fair ☐ Poor ☐ N/A |
| Sister(s) | ☐ Much Contact ☐ Some Contact ☐ No Contact ☐ N/A | ☐ Good ☐ Fair ☐ Poor ☐ N/A |
| Grandmother(s) | ☐ Much Contact ☐ Some Contact ☐ No Contact ☐ N/A | ☐ Good ☐ Fair ☐ Poor ☐ N/A |
| Grandfather(s) | ☐ Much Contact ☐ Some Contact ☐ No Contact ☐ N/A | ☐ Good ☐ Fair ☐ Poor ☐ N/A |

1. Were you adopted? ☐ Yes ☐ No
2. Who were your primary care providers in childhood and adolescence?
3. As a child, how would you characterize your family's economic status? ☐ Wealthy ☐ Middle Class ☐ Poor

| |
|---|
| Briefly describe your mother as you remember her in childhood: |
| Briefly describe your father as you remember him in childhood: |

Check all descriptors that accurately characterize your childhood experience:

| | | | | |
|---|---|---|---|---|
| ☐ Loving/Supportive | ☐ Unstable | ☐ Emotional Abuse | ☐ Molestation | ☐ Rejected By Father |
| ☐ Chaotic | ☐ Parents Argued | ☐ Verbal Abuse | ☐ Spiritual Abuse | ☐ Rejected By Mother |
| ☐ Stable | ☐ Physical Abuse | ☐ Sexual Abuse/ Rape | ☐ Witnessed Violence | ☐ Little Memory |

**Substance Use/ Mental Health History of Family:** (X all that apply)

| | Mother | Father | Sister | Brother | Children | Others |
|---|---|---|---|---|---|---|
| Alcoholism | | | | | | |
| Amphetamines | | | | | | |
| Cocaine | | | | | | |
| Heroin/Opiates | | | | | | |
| Marijuana | | | | | | |
| Anxiety | | | | | | |
| Depression/ Mood Disorder | | | | | | |
| Eating Disorder | | | | | | |
| Schizophrenia | | | | | | |
| Suicide Attempt | | | | | | |
| Other | | | | | | |

**Check all that apply to your current relati**onship status:

| | | |
|---|---|---|
| ☐ Single, never married | ☐ Separated for _____ years/months | ☐ _____prior marriages for self |
| ☐ Engaged _____years/months | ☐ Divorce in the process _____months | ☐ Now in a serious relationship |
| ☐ Married for _____ years/months | ☐ Divorced for _____years/months | ☐ Not in any relationships right now |
| ☐ Live-in for _____years/months | ☐ Widowed _____years/months | ☐ Never been in serious relationship |

If applicable, note your current relationship satisfaction:

| | | | | |
|---|---|---|---|---|
| ☐ Excellent | ☐ Satisfactory | ☐ Somewhat Dissatisfied | ☐ Very Dissatisfied | ☐ Not Applicable |

If applicable, list the names of your children from oldest to youngest (including stepchildren):

| First Name | Age | Where they live | Occupation | Marital Status | Contact with them? |
|---|---|---|---|---|---|
| | | | | | ▲ Yes ▲ No |
| | | | | | ▲ Yes ▲ No |
| | | | | | ▲ Yes ▲ No |
| | | | | | ▲ Yes ▲ No |
| | | | | | |

## LEGAL HISTORY

Have you ever been incarcerated: ☐ Yes ☐ No When: _____

Are you currently on probation? ☐ Yes ☐ No ☐ County ☐ State ☐ Federal Date Ends: _____

| | | | |
|---|---|---|---|
| ☐ | I do not have any legal history | | |
| ☐ | Misdemeanor Offense | When? | ☐ Pending ☐ Probation ☐ Resolved |
| ☐ | Simple Battery | When? | ☐ Pending ☐ Probation ☐ Resolved |
| ☐ | DUI/DWI | When? | ☐ Pending ☐ Probation ☐ Resolved |
| ☐ | Drug Possession | When? | ☐ Pending ☐ Probation ☐ Resolved |
| ☐ | Theft/Shoplifting/B&E | When? | ☐ Pending ☐ Probation ☐ Resolved |
| ☐ | Child Abuse/Neglect | When? | ☐ Pending ☐ Probation ☐ Resolved |
| ☐ | Domestic Violence | When? | ☐ Pending ☐ Probation ☐ Resolved |
| ☐ | Felony Assault & Battery | When? | ☐ Pending ☐ Probation ☐ Resolved |
| ☐ | Felony Sexual Offense/ Sexual Assault | When? | ☐ Pending ☐ Probation ☐ Resolved |
| ☐ | Other _____ | When? | ☐ Pending ☐ Probation ☐ Resolved |

## HEALTH ISSUES

**Are you experiencing any current health conditions? ▲ YES ▲ NO**

**If YES, Please explain here**:

_____

_____

_____

_____

_____

**Current Medications** ▲ **None**

List all medications including birth control and thyroid medications.

| Current Medications | Dosage (mg) | Frequency | Physician's Name |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**What Other Information Would You Like to Share That You Believe Would Be Helpful:**

_____

_____

_____

_____

_____