Marie Caterini Choppin, LCSW-C & Associates
LOTUS POINT WELLNESS, INC.

LOTUS POINT Wellness

NEW CLIENT INFORMATION FORM
Couples Form

CLIENT INFORMATION- Each partner will fill out their own Information Form

Client Name: _____ Today's Date:_____
Date of Birth: _____ Spouse's Name:_____
Full Address: _____
_____ Marital Status:
_____ ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Partnered
Emergency Contact Name: _____ Home Phone: _____
Emergency Contact Email:_____ Cell Phone: _____
Referred by: _____ Work Phone: _____
Would you like to receive our FREE Newsletter? Yes ☐ No ☐

WHO ELSE LIVES IN YOUR HOUSEHOLD?

Name: _____ D.O.B._____ Relationship: ☐ Child ☐ Sibling ☐ Relative
Name: _____ D.O.B._____ Relationship: ☐ Child ☐ Sibling ☐ Relative
Name: _____ D.O.B._____ Relationship: ☐ Child ☐ Sibling ☐ Relative
Name: _____ D.O.B._____ Relationship: ☐ Child ☐ Sibling ☐ Relative

---

DEVELOPMENTAL HISTORY

How did you come into your family of origin? ☐ Birth ☐ Adoption/Foster Care ☐ Surrogacy ☐ Fertility Treatment
Any issues with developmental milestones that you are aware of (Walking, talking, potty training.) ☐ Normal ☐ Delayed, Explain_____
If so, did you receive any treatment/interventions? ☐ No ☐ Yes, Explain
_____
List any history of seizures, prolonged high fevers, head injuries, poisoning, serious illness/injury?
_____

EDUCATIONAL/ACADEMIC /EMOTIONAL HISTORY

Have you ever had any ☐ Academic challenges ☐ Social challenges ☐ Emotional challenges
If so, Please explain: _____
Did you have an IEP or 504 Plan? ☐ Yes ☐ No
If yes, can you explain_____
Highest level of education completed _____

TRAUMA HISTORY

Have **you** ever experienced any physical or sexual abuse? ☐ No ☐ Yes, When/By whom/How long?_____
Was this reported? ☐ NO ☐ YES What was the outcome of the report?_____

13200 New Hampshire Avenue
Silver Spring, MD 20904

Lotus Point Wellness, INC.
mchoppin@lotuspointwellness.com
301-960-1198

4405 East West Highway Suite 508
Bethesda, MD 20814

Marie Caterini Choppin, LCSW-C & Associates
LOTUS POINT WELLNESS, INC.

NEW CLIENT INFORMATION FORM
Couples Form

FAMILY HISTORY OF SIGNIFICANT MEDICAL ISSUES ☐ NO ☐ YES

RELATIONSHIP TO CLIENT	TYPE OF ILLNESS	TREATMENT	RELATIONSHIP TO CLIENT	TYPE OF ILLNESS	TREATMENT
SISTER			FATHER		
BROTHER			PATERNAL GRANDMOTHER		
MOTHER			PATERNAL GRANDFATHER		
MATERNAL GRANDMOTHER			PATERNAL UNCLE		
MATERNAL GRANDFATHER			PATERNAL AUNT		
MATERNAL AUNT			OTHER		
MATERNAL UNCLE			OTHER		

FAMILY HISTORY OF PSYCHIATRIC DISORDERS ☐ NO ☐ YES

RELATIONSHIP TO CLIENT	TYPE OF ILLNESS	TREATMENT	RELATIONSHIP TO CLIENT	TYPE OF ILLNESS	TREATMENT
SISTER			FATHER		
BROTHER			PATERNAL GRANDMOTHER		
MOTHER			PATERNAL GRANDFATHER		
MATERNAL GRANDMOTHER			PATERNAL UNCLE		
MATERNAL GRANDFATHER			PATERNAL AUNT		
MATERNAL AUNT			OTHER		
MATERNAL UNCLE			OTHER		

Marie Caterini Choppin, LCSW-C & Associates
LOTUS POINT WELLNESS, INC.

NEW CLIENT INFORMATION FORM
Couples Form

FAMILY HISTORY OF DRUG/ALCOHOL/TOBACCO USE ☐ NO ☐ YES

RELATIONSHIP TO CLIENT	TYPE OF ILLNESS	TREATMENT	RELATIONSHIP TO CLIENT	TYPE OF ILLNESS	TREATMENT
SISTER			FATHER		
BROTHER			PATERNAL GRANDMOTHER		
MOTHER			PATERNAL GRANDFATHER		
MATERNAL GRANDMOTHER			PATERNAL UNCLE		
MATERNAL GRANDFATHER			PATERNAL AUNT		
MATERNAL AUNT			OTHER		
MATERNAL UNCLE			OTHER		

FAMILY HISTORY OF ABUSE/NEGLECT ☐ NO ☐ YES

RELATIONSHIP TO CLIENT	TYPE OF ILLNESS	TREATMENT	RELATIONSHIP TO CLIENT	TYPE OF ILLNESS	TREATMENT
SISTER			FATHER		
BROTHER			PATERNAL GRANDMOTHER		
MOTHER			PATERNAL GRANDFATHER		
MATERNAL GRANDMOTHER			PATERNAL UNCLE		
MATERNAL GRANDFATHER			PATERNAL AUNT		
MATERNAL AUNT			OTHER		
MATERNAL UNCLE			OTHER		

CLIENT CURRENT MEDICAL HISTORY

Name of physician_____ Date of last physical_____

Address: _____ Phone: _____

Food Allergies or intolerances:

_____

Medical conditions/illnesses:

_____

May I contact? ☐ NO ☐ YES

13200 New Hampshire Avenue
Silver Spring, MD 20904

Lotus Point Wellness, INC.
mchoppin@lotuspointwellness.com
301-960-1198

4405 East West Highway Suite 508
Bethesda, MD 20814

Marie Caterini Choppin, LCSW-C & Associates
LOTUS POINT WELLNESS, INC.

NEW CLIENT INFORMATION FORM
Couples Form

How would you describe your health? ☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Excellent

Are you having problems sleeping? ☐ NO ☐ YES ☐ sleeping too much ☐ Sleeping too little ☐ Poor sleep quality
How many times per week do you get exercise? _____ What type of exercise? _____

Any difficulty with appetite or eating habits? ☐ NO ☐ Yes ☐ Eating less ☐ Eating More ☐ Binging ☐ Restricting

Any significant weight change in the last 2 months? ☐ NO ☐ YES ☐ Gaining ☐ Losing

Have you experienced any MAJOR life changes in the past 3-6 months? ☐ No ☐ Yes, explain:

_____

6-12 months? ☐ No ☐ Yes _____

Does spirituality or religion play a role in your life? ☐ No ☐ Yes

Have you experienced/Are you experiencing suicidal thoughts? ☐ No ☐ Yes In the past 2 weeks? ☐ No ☐ Yes

Do you have a history of suicide attempts? ☐ No ☐ Yes

Is there a family history of suicide? ☐ No ☐ Yes , if so by whom_____

Do you currently use alcohol? ____Yes, ____No

If yes, how often do you drink? ____Daily, _____Weekly, ____Occasionally, ____Rarely

If yes, how much do you drink? _____(#) per time

Do you currently use Tobacco? _____Yes, ____No

If yes, how much do you smoke/chew? _____

Do you currently use any other drugs? _____Yes, _____No

If yes, what drugs do you use? _____
If yes, how often do you use? ____Daily, _____Weekly, _____Occasionally, ____Rarely

Do you have access to firearms? ☐ No ☐ Yes explain,

_____

Are you using technology in a way that is negatively impacting their life? ☐ No ☐ Yes explain,

_____

Are there any legal issues impacting you or your family at this time? ☐ No ☐ Yes explain,

_____

If there is anything additional that you would like to share , please do so here:

_____

_____

13200 New Hampshire Avenue
Silver Spring, MD 20904

Lotus Point Wellness, INC.
mchoppin@lotuspointwellness.com
301-960-1198

4405 East West Highway Suite 508
Bethesda, MD 20814

Marie Caterini Choppin, LCSW-C & Associates
LOTUS POINT WELLNESS, INC.

LOTUS POINT Wellness

NEW CLIENT INFORMATION FORM
Couples Form

CURRENT REASON FOR SEEKING COUNSELING:_____

Family concerns (Check all that apply)

- ☐ Fighting
- ☐ Feeling distant
- ☐ Loss of Fun
- ☐ Lack of honesty
- ☐ Physical fights
- ☐ Financial problems
- ☐ Death of a family member
- ☐ Abuse/Neglect
- ☐ Feeling unsafe
- ☐ Alcohol Use
- ☐ Disagreeing about friends
- ☐ Drug use
- ☐ Divorce/separation
- ☐ Other _____

Are you satisfied with your current friendships? ☐ No ☐ Yes

Personal Concerns

- ☐ Sadness
- ☐ Crying
- ☐ Sleep disturbances
- ☐ Problems at home
- ☐ Hyperactivity
- ☐ Binging/purging
- ☐ Loneliness
- ☐ Irritability
- ☐ Social Anxiety
- ☐ Self harm/cutting
- ☐ Impulsivity
- ☐ Nightmares
- ☐ Hopelessness
- ☐ Mood Swings
- ☐ Disorganized
- ☐ Grief
- ☐ Phobias
- ☐ Headaches
- ☐ Weight changes
- ☐ Appetite Changes
- ☐ Social Isolation
- ☐ Paranoid thoughts
- ☐ Poor concentration
- ☐ Indecisiveness
- ☐ Low Energy
- ☐ Excessive worry
- ☐ Low self worth
- ☐ Anger issues
- ☐ Racing thoughts
- ☐ Drug use
- ☐ Easily distracted
- ☐ Alcohol use
- ☐ Obsessive thoughts
- ☐ Panic attacks
- ☐ Feeling anxious
- ☐ Suicidal thoughts
- ☐ Body image concerns
- ☐ Relationship issues
- ☐ Eating disorder concerns
- ☐ Sexual concerns

Other_____
_____
_

Marie Caterini Choppin, LCSW-C & Associates
LOTUS POINT WELLNESS, INC.

NEW CLIENT INFORMATION FORM
Couples Form

Relationship Concerns

- ☐ Feeling misunderstood
- ☐ Not feeling close
- ☐ Trouble communicating
- ☐ Not trusting partner
- ☐ Lack of respect
- ☐ Partner being secretive
- ☐ Lack of fairness
- ☐ Problems dividing tasks
- ☐ Disagreeing about children
- ☐ Lack of affection
- ☐ Unsatisfactory sexual relationship
- ☐ Lack of time together
- ☐ Lack of shared interests
- ☐ Lack of positive interaction
- ☐ Lack of time with other couples
- ☐ Jealousy in relationship
- ☐ Frequent arguments
- ☐ Trouble resolving conflict
- ☐ Partner being demanding/controlling
- ☐ Partner putting you down
- ☐ Violent arguments
- ☐ Emotional abuse
- ☐ Physical abuse
- ☐ Sexual Abuse
- ☐ Partner having drug/alcohol problem
- ☐ Self or partner having an affair
- ☐ Feeling uncommitted
- ☐ Wanting to separate
- ☐ Discussing separating or divorce
- ☐ Problems with in-laws
- ☐ Problems with ex-partner
- ☐ Problems with step parents
- ☐ Children having problems
- ☐ Worrying about getting pregnant
- ☐ Not being able to get pregnant
- ☐ Lack of sexual desire
- ☐ Wanting to have sex more often
- ☐ Feeling used sexually
- ☐ Not enjoying sexual affection
- ☐ Choice of birth control

Other_____
_____
_

13200 New Hampshire Avenue
Silver Spring, MD 20904

Lotus Point Wellness, INC.
mchoppin@lotuspointwellness.com
301-960-1198

4405 East West Highway Suite 508
Bethesda, MD 20814

Marie Caterini Choppin, LCSW-C & Associates
LOTUS POINT WELLNESS, INC.

NEW CLIENT INFORMATION FORM
Couples Form

CREDIT CARD OR DEBIT (ACH) AUTHORIZATION

Only one card needs to be on file for the couple.

I authorize **Lotus Point Wellness, Inc.** to use the credit card or ACH information below **to charge my credit card or debit my checking/savings account using an on-line system for the following purposes:**

1. **FOR EACH SERVICE AT THE TIME OF SERVICE** provided to me/and or my child or family by the provider of Lotus Point Wellness Inc.
2. **FOR A MISSED SESSION at the rate of my regular session if I cancel less than 48 hours in advance of my appointment.**
3. **IF AND WHEN MY PAYMENT BALANCE BECOMES PAST DUE.** The provider will inform me about this charge.

I acknowledge that I will be receiving an email with a receipt for the payment and the appropriate information needed to submit to my insurance company and/or for tax purposes.

CREDIT CARD OR ACH INFORMATION Type: ☐ Mastercard ☐ Visa ☐ ACH - for checking/savings account

_____ _____ _____

Credit Card number | 3 digit security code | Expiration

_____ _____

Email for receipts | Credit Card holder's name on card

_____

Address of Cardholder (if different than address listed on front)

ACH: Routing number_____ Account Number _____

_____ _____

SIGNATURE | **DATE**

13200 New Hampshire Avenue
Silver Spring, MD 20904

Lotus Point Wellness, INC.
mchoppin@lotuspointwellness.com
301-960-1198

4405 East West Highway Suite 508
Bethesda, MD 20814

NEW CLIENT INFORMATION FORM
Couples Form

I have been given or have been directed to the website of Lotus Point Wellness, Inc. and have read the materials provided by my treatment provider regarding Lotus Point Wellness, Inc. I/we have read and understand the background, philosophy and approach that have been disclosed in the statements for the practice AND for therapy, nutritional and/or yoga services, if applicable.

I/we also understand and accept the terms as outlined in the material provided regarding confidentiality, office policies and procedures, fees, and client rights and responsibilities, and the HIPAA policy.

I give permission for my provider of Lotus Point Wellness, Inc. to contact me and/or leave brief messages on any of my voice mails or answering machines confirming, changing or canceling an appointment with the EXCEPTION of (please initial) __home __work __cell.

I/we understand the fees as outlined in the material. Lotus Point Wellness, Inc. will provide a statement of services by e-mail or in-person at my/our session. If my/our insurance plan does not cover services provided, I/we are responsible for the payment. Extended appointments and phone consults will be charged at a pro-rated amount based on the fee for service. I/we also understand that we need to cancel appointments 48 hours in advance by phone in order to avoid a charge for the regular session fee, unless there are extenuating circumstances, as outlined in the material provided.

As a parent, I/we understand that I have the right to information concerning my minor child in therapy, nutrition counseling or yoga except where otherwise stated by law. I also understand that Lotus Point Wellness, Inc. believes in providing a minor child with a private environment in which to disclose himself/herself to facilitate services. I/we therefore give permission to my child's therapist to use his/her discretion, in accordance with professional ethics and state and federal laws and rules, in deciding what information revealed by my child is to be shared with me/us.

HIPAA POLICY CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS (TPO)Federal regulations (HIPAA) allow me to use or disclose Protected Health Information (PHI) from your record in order to provide treatment to you, to obtain payment for the services I provide, and for other professional activities (known as "health care operations."). Nevertheless, I ask your consent in order to make this permission explicit. The Notice of Privacy Practices describes these disclosures in more detail. You have the right to review the Notice of Privacy Practices before signing this consent. I reserve the right to revise our Notice of Privacy Practices at any time. If I do so, the revised Notice will be posted in the office. You may ask for a printed copy of my Notice at any time. You may ask me to restrict the use and disclosure of certain information in your record that otherwise would be disclosed for treatment, payment, or health care operations; however, I do not have to agree to these restrictions. If I do agree to a restriction, that agreement is binding. You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the consent prior to the revocation. This consent is voluntary; you may refuse to sign it. However, I am permitted to refuse to provide health care services if this consent is not granted, or if the consent is later revoked. I hereby consent to the use or disclosure of my Protected Health Information as specified above. I hereby acknowledge that I have received and have been given an opportunity to read a copy of Lotus Point Wellness, Inc. Notice of Privacy Practices. I understand that Lotus Point Wellness, Inc. is an S Corporation and that if I have any questions regarding the Notice or my privacy rights, I can discuss them with Marie Caterini Choppin, MSW, LCSW-C (Owner/Director). Further inquiries can be addressed to the Secretary of Health and Human Services, 200 Independence Avenue, SW, Washington, D.C. or by calling 202-619-0257.

Please sign below to acknowledge that you have read, understood and agree to the terms previously described.

_____ _____ Date _____
SIGNATURE of Client PRINTED NAME

_____ _____ Date _____
SIGNATURE of Client PRINTED NAME

_____ _____ Date _____
SIGNATURE of Therapist PRINTED NAME