



NEW CLIENT INFORMATION FORM
Adult Form

CLIENT INFORMATION

Client Name: _____ Today's Date: _____
Date of Birth: _____ Email Address: _____
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? _____



NEW CLIENT INFORMATION FORM
Adult 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		



NEW CLIENT INFORMATION FORM
Adult 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



NEW CLIENT INFORMATION FORM
Adult 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 or self-harm? No Yes, when and what type of self-harm _____

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:



NEW CLIENT INFORMATION FORM
Adult Form

CURRENT REASON FOR SEEKING COUNSELING: _____

Family concerns (Check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Fighting | <input type="checkbox"/> Financial problems | <input type="checkbox"/> Disagreeing about friends |
| <input type="checkbox"/> Feeling distant | <input type="checkbox"/> Death of a family member | <input type="checkbox"/> Drug use |
| <input type="checkbox"/> Loss of Fun | <input type="checkbox"/> Abuse/Neglect | <input type="checkbox"/> Divorce/separation |
| <input type="checkbox"/> Lack of honesty | <input type="checkbox"/> Feeling unsafe | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Physical fights | <input type="checkbox"/> Alcohol Use | |

Are you satisfied with your current friendships? No Yes

Personal Concerns

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



NEW CLIENT INFORMATION FORM
Adult Form

CREDIT CARD OR DEBIT (ACH) AUTHORIZATION

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



NEW CLIENT INFORMATION FORM
Adult 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.

SIGNATURE of Client

_____ Date _____
PRINTED NAME

SIGNATURE of Therapist

_____ Date _____
PRINTED NAME