Acknowledgement and Authorization

CLIENT NAME: (printed) _______________________________ TODAY'S DATE: ________________

Disclosure Statement and Payment:
As shown by my signature below, I have read and understand the Disclosure Statement.
This includes understanding and agreeing to the exceptions to confidentiality, the 24 hour cancellation policy, and that the current rate is $80 per 50 minute session. Without 24 hours notice, I will be responsible for full payment ($80).
I acknowledge a copy has been made available to me at: http://www.minheejcho.com and is also available in hardcopy form from Min Hee J. Cho, LMFTA by request.

Client Signature: ____

Parent Signature: ____

Notice of Privacy Practices:
I hereby acknowledge receiving a copy of the Notice of Privacy Practices.
I acknowledge a copy has been made available to me at: http://www.minheejcho.com and also is available in hardcopy from Min Hee J. Cho, LMFTA by request.

Client Signature: ____

Parent Signature: ____

Insurance:
I do not bill insurance claims but can provide you with an invoice of my service. If your insurance provider will be covering the cost of your counseling then you need to make arrangements with them to reimburse you directly. You are responsible for obtaining and filing out any appropriate paperwork and submitting it to the insurance company.

Client or Authorized person's signature: ____

CLIENT INTAKE INFORMATION

Today's Date: ______________________________

1. Identification Information

Name: ____ Date of Birth: ______________________________

Address: ______________________________________ City: _________________ Zip: ________________

Phone: _______________________________________ Work Phone: _______________________________

Employer/ School: _____________________________ Occupation/ Studying: _______________________

2. Referral Information

Who gave you my name to call? ____

May I have your permission to thank this person for the referral? ☐ Yes ☐ No

3. Family Information

Relationship status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widow /Widower

This is my ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th marriage/ partnership

Number of children and their ages: ____

Were your parents: ☐ married ☐ never married ☐ divorced

Your birth order of siblings in family: ________________________

Family history of:

☐ Depression ☐ Suicide Attempts ☐ Anxiety ☐ Eating Disorder

☐ Mental Illness ☐ Violence ☐ Sexual Abuse ☐ Emotional Abuse

☐ Alcohol/ Drug/ Sexual Addiction ☐ Chronic Illness (please explain) ______________________

☐ Other ____

	Father	Mother	Step parents	Grandparents	Uncles/Aunts	Brothers	Sisters
First name							
Age							
Illness							
Education							
Occupation							

4. Medical Information

Primary Physician: __________________________ Phone: _________________ Last Exam: ____________

Major (or chronic) Operations/Illness/ Injuries/ Health concern: ___________________________________

Current Medication Dosage(s) Frequency Effectiveness Prescribing Physician

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Have you experienced any recent changes in:

□ Sleep □ Amount of Exercise □ Sexual Desire □ Eating /Appetite □ Weight

How you say your overall health? □ Fair □ Good □ Poor □ Excellent

Do you smoke? □ Yes □ No Smoke in the past? □ Yes □ No

Do you consume alcohol? □ Yes □ No, how much, often? _________________________

5. Treatment Information

How would you describe the concern(s) you are seeking to address today?

____

____

____

How have these concerns evolved over time?

____

Were there any precipitating/influential events or factors regarding the issue(s) that led you to seek counseling at this particular time in your life?

____

Please indicate your major life stressors of the past 12 months?

□ Serious illness or Injury □ Death of a close friend or family member □ Major illness in family

□ Gain of new family member □ Divorce/ separation □ Job change

□ Other ____

What solutions have you tried and how well have they worked?

____

What goals and outcomes do you hope to achieve through counseling?

____

____

____

Have you ever been to counseling before? □ Yes □ No

Name of Counselor: ____________________________ Approximate dates: ______________

Name of Counselor: ____________________________ Approximate dates: ______________

If you are comfortable doing so, please list and briefly describe the topics you covered in your previous counseling, even if they are the same issue(s) you are currently wanting to address:

____

How helpful was your previous counseling experience, and specifically why?

____

Have you ever been prescribed medication for a psychiatric or emotional problem? □ Yes □ No

When? Prescribing clinician? What medication? For what? Results?

____

____

Have you ever hospitalized for a psychiatric or emotional health? □ Yes □ No

When? Where? For what reason? Outcome?

____

Have you ever been in a drug alcohol treatment program? □ Yes □ No □ Inpatient □ Outpatient

When? Where? How long? Outcome?

____

6. **Social/ Relationship Information**

Please indicate any of following that you have experienced?

□ Death of family member □ Divorce of parents □ Suicide Attempts □ Mental Illness

□ Chronic Illness □ Drug/Alcohol addiction □ Violence in family □ Sexual Abuse

□ Major change in living situation (e.g.: immigrant, refugee) □ Social isolation

How do you get along with your present spouse or partner?

____

How do you get along with your children?

____

How do (did) you get along with your family of origin members?

Mother? ____

Father? ____

Siblings? ____

Please list your significant friends and indicate how long you have had these relationships?

Name How long? How often do you see this person?

____

____

7. **Employment Information**

What is the nature of your employment? ______________________ How long at current job?__________

How satisfied are you in this job? □ Very Satisfied □ Comfortable □ Somewhat satisfied □ Not very satisfied

Are you satisfied that the income from your job?□Very Satisfied □Comfortable □Somewhat satisfied □Not very satisfied

8. **Spiritual Resources**

What is the nature of your religion? ____

How significant a role does spirituality play in your life? □ Significant □ Significant □ Somewhat Significant □ none

9. **Other**

Is there anything else you think I should know about prior to our beginning your treatment?

____

____

*If you have any questions then please let me know. Thank you.