Client Intake and Consent to Treatment

Contact Information

Name: _____ Age: _____ Date of Birth: _____
First M.I. Last

Address: _____ Referred By: _____
Street Address Apt./Unit #

_____ Home Phone #: _____
City State Zip Okay to Call/Leave Message at Home? _____

E-Mail: _____ Cell Phone #: _____

Person to Contact in Case of an Emergency: _____
Name Phone Number

Family Information

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Living with Partner

Name/Age of Spouse/Partner: _____

Names/Ages of Children: _____ _____ _____

Names/Ages of Siblings: _____ _____ _____

_____ _____ _____

Are your parents living? Mother ☐ Yes ☐ No (Cause/date of death _____)
Father ☐ Yes ☐ No (Cause/date of death _____)

Employment/Education Information

High School: _____ College (if applicable): _____

Other: _____

Current Employer: _____ Position: _____

Medical/Psychological Information

Presenting Problem (Why are you seeking counseling?): _____

_____

_____

Past Counseling/Psychotherapy (For this or other condition) _____

_____

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Medical History (Please describe current medical condition and any past history of disease, surgery, etc.):

_____

Current Medications (if any) _____

Primary Care Physician: _____
Name City Phone Number

Psychiatrist (if any): _____
Name City Phone Number

Religious/Spiritual Information

What is the role, if any, of faith and spirituality in your life? _____

_____

Insurance Information

Policy Holder (Member) Name: _____ Relationship to Client: _____

Policy Holder (Member) D.O.B: _____

Insurance Company: _____
Name Phone Number

Member ID #: _____ Group/Plan #: _____

Consent to Treatment

I hereby consent to treatment with Thomas M. Gorey, JD, LCPC. I understand that I am responsible for full payment of the fee, regardless of my health insurance coverage or benefits, and that full payment (or payment of the applicable co-pay) is expected at each session. **I understand that, if I need to cancel an appointment, I must provide at least 24 hours' notice, and that if an appointment is cancelled without such notice, I will incur a missed session fee of $50.** I understand that if my account is in arrears, a collection agency or attorney may be retained to collect any past due amount, and that I will be responsible for any and all fees associated with such collection, including but not limited to attorney's fees, court costs, and collection agency fees.

Counseling is confidential. We will use and protect your information in compliance with applicable state and federal law. Information obtained during counseling sessions will not be disclosed to anyone without your knowledge and signed written consent, with the following exceptions: if your therapist believes that you present an imminent, serious risk of injury or death to yourself or another; if your therapist has reasonable cause to believe a child's well-being or safety is compromised; if your therapist has reason to believe that an individual who is protected under the *Illinois Elder Abuse and Neglect Act* has been abused, neglected, or financially exploited; if your therapist believes it is in your best interests to consult with another licensed mental health professional; or if your therapist receives a court order signed by a judge.

I have discussed this form with my therapist, and I understand and agree to the terms outlined above:

_____ _____
Client's Signature Date Parent/Guardian Signature (if client is under 18) Date