ALVIA M. BALDWIN Ph.D., LPC-S, NCC 11200 Westheimer, Suite 202 Houston, TX 77042
Office (713)780-0142 Ex. 2 Voice Mail (281)352-5534 Fax (713)780-0504

CLIENT INFORMATION

Client's Name: ______________________________ Date:_______________________

Birthdate: ______________________ Age: ________Soc. Sec. #: ___________________

Male ___ Female ___ Single ___ Married ___ Divorced ___ Separated ___ Widowed ____

Address: ____

City, State, ZIP: ______________________________________ Referred by: ___________

Employer: _________________________________ Occupation: ____________________

Home Phone: ______________________________ Work Phone: _____________________

Cell Phone: ___________________________ Email: ______________________________

Where would you like us to leave reminder messages: Home ____ Work ____ Cell Phone ____

In the event of an emergency, whom should we contact: Name: ___________________________

Relationship: _______________________ Cellular Number______________________

Work Number ______________________ Home Number________________________

Who Is Responsible for this account? Who is the insured?

Name: ___________________________ Relationship to Client: _______________________

Birthdate: _____________________________ SSN: __________________________

Address: ____

City, State, Zip: ____

Employer: ______________________________ Occupation: _______________________

Work Number________________________ Home Number _______________________ Cell Number _______________________

AUTHORIZATION AND RELEASE

- I authorize the release of necessary information to third party payers/insurance companies and/or other health practitioners.
- I authorize and request my insurance company to pay directly to the provider of care insurance benefits otherwise payable to me.
- I agree to be responsible for payment of all services rendered on my behalf or for my dependents including but not limited to, deductibles, copays, coinsurance amounts.

X____

Signature of Client or Responsible Party **Date**

Copay and/or any outstanding balance may be charged to my credit card (circle card): VISA MASTERCARD

Card Number _____________________ *Security Code* ________ *ExpirationDate* __________

*Name on Card*____

X____

Signature of Card Holder ***Date***

PLEASE PROVIDE YOUR INSURANCE CARD & PHOTO ID TO OFFICE STAFF FOR VERIFICATION OF BENEFITS.

CLIENT'S INFORMED CONSENT

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Your treatment is conditional on your signing this consent without modification.

- I understand that my therapist is a Licensed Professional Counselor and has earned a Master's degree in Counseling and a Ph.D. in Psychology and Christian Counseling.
- I understand that my therapist abides by state and federal regulations regarding health and medical record keeping and confidentiality (most commonly referred to as HIPAA regulations) and that a copy of this document has been provided to me to review.
- I understand that my therapist counsels from a Christian perspective meaning that Spirituality and related assignments may be included in the sessions.
- I understand that if any assignment is given that I disagree with morally, ethically, spiritually, or emotionally, I have the right not to proceed with that assignment.
- I understand that if I am concerned about slow progress or lack of progress I have the right to speak about my concerns.
- I understand that there are some occasions when confidentiality can/must be breached. These are: a) I sign a Release of Information Form or I verbally direct my therapist to tell someone else, b) my therapist determines that his client poses a threat to self or others, c) my therapist is ordered by a court to disclose information, or d) my therapist suspects child/elder abuse has taken place and will notify Child/Adult Protective Services.
- I understand that counseling can improve as well as upset the equilibrium in any person or family.
- I understand that if I have a complaint I cannot resolve with my counselor and I wish to file a formal complaint I may contact the Texas State Board of Examiners of Licensed Professional Counselors at 1-800-942-5540.

FEES

- I understand that I am responsible for all fees that my insurance denies, rejects, or fails to pay and understand that sessions are 45 minutes in duration, cost $120.00 per session (or the insurance contracted rate), and that all co-pays are due at the time of service.
- I understand that there is a returned check fee of $30.00 and that if a returned check is not cleared up in 30 days my therapist will file a suit with the Harris County District Attorney's Office.
- I understand that if I do not give at least 24 hours notice in canceling an appointment I will be charged a fee of $90.00 and I must pay this fee before additional sessions may be scheduled. I may pay by check, cash, Visa or MasterCard.
- I understand that my therapist is not a psychiatrist, she is a Licensed Professional Counselor (LPC), and as such cannot recommend or prescribe medications but can encourage clients to see an M.D. for a medical evaluation.

By signing below I confirm that I have read, agree to, and received the above information.

____

Client or Responsible Party Signature Date

Your treatment is conditional on your signing this consent without modification.

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GETTING TO KNOW YOU (THE CLIENT)

ABOUT YOUR EDUCATION

What was the last grade did you complete? ________________________

Where did you attend public school? ____

Did you attend college/professional school? When, where, degree earned? ____________________

____

Any plans to further your education? _______If so, when and what? _______________________

____

ABOUT YOUR RELATIONSHIPS

Please list your marriage(s) or other important "significant-other" relationships

	Spouse Name	Beginning Year	Ending Year	I was married to this person (Y/N)	Children from this Relationship and their ages
First					
Second					
Third					
Others					

Please list all people who are currently in your household and their relationship to you:

Person	Relationship	Age

ABOUT YOUR FAMILY OF ORIGIN

Please tell me about the people in your household growing up:

Person	Relationship	Still Living?	Age	Occupation

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ABOUT YOUR CONCERNS

Please check all of the items below that you are currently experiencing or having difficulty with.

Abuse – emotional		Impulsive spending		Self abuse – burning	
Abuse – neglect		Impulsiveness		Self abuse – cutting	
Abuse – physical		Indecision		Self abuse – other	
Abuse – sexual		Inferiority feelings		Self abuse – scratching	
Aggression		Inhibitions		Self-centeredness	
Anger		Interpersonal conflicts		Self-control	
Anxiety		Irresponsibility		Self-esteem	
Arguing		Irritability		Self-neglect	
Attention Problems		Judgment problems		Separation	
Career Concerns		Laziness		Sexual conflicts	
Childhood Issues		Legal matters		Sexual desire differences	
Children – care of		Loneliness		Sexual dysfunctions	
Children – custody		Loss of control		Sexual – other issues	
Children - management		Losses		Shyness	
Choices I have made		Low energy		Sleep – insomnia	
Codependence		Low frustration tolerance		Sleep – nightmares	
Compulsive spending		Low income		Sleep – too little	
Concentration problems		Low mood		Sleep – too much	
Confusion		Marital coldness		Step-parenting	
Crying		Marital conflict		Stress	
Deaths		Marital distance		Stress-management	
Debt		Marital infidelity/affairs		Suicidal thoughts	
Decision making		Medical concerns		Suspiciousness	
Delusions – false ideas		Memory problems		Temper problems	
Dependence		Menopause		Tension/stress	
Depression		Menstrual problems		Thought disorganization	
Distractibility		Mixed feelings		Threats of violence	
Divorce		Mood swings		Tiredness	
Drug abuse – over the counter		Motivation		Tobacco use	
Drug abuse – prescription		Mourning		Violence	
Drug abuse – street drugs		Obsessions		Violence – victim of crime	
Drug abuse – alcohol		Outbursts		Work problems	
Eating – poor appetite		Oversensitive to criticism		Weight and diet issues	
Eating – making myself vomit		Oversensitive to rejection		Withdrawal – isolating	
Eating – overeating		Panic or anxiety attacks		Employment problems	
Eating – under-eating		Parenting		Employment – lack of	
Emptiness		Perfectionism		Employment – overdoing	
Failure		Pessimism		Employment – termination	
Fatigue		Phobias		Other Concerns or Issues:	
Fears		Physical problems			
Financial troubles		PMS			
Friendship problems		Poor self-care			
Gambling		Procrastination			
Goals not being met		Relationship problems			
Grieving		Relaxation			
Guilt		Re-marriage			
Headaches, pains		Risk taking			
Health		Sadness			

Email: saltcounseling@sbcglobal.net Website: www.drsaltcc.com

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ABOUT YOUR HEALTH

Who is your Medical Doctor? ___________________________ Last Visit: ___________________

Phone/Address ____

Medical Concerns? ____

____

Prescribed Medications ____

____

Who is your Psychiatrist? ______________________________ Last Visit: ___________________

Phone/Address ____

Mental-Health Concerns? ____

____

Prescribed Medications ____

____

Have you previously seen a counselor/therapist? _________ If so, please tell who, when, and for what reasons.

____

____

____

____

Do you have any chronic medical conditions or concerns? _________. If so, please list:

____

____

List all diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness,

convulsions/seizures, and any other medical conditions you have had: ________________________

____

____

List all other medications or drugs (prescribed or street) you take or have taken in the last year:

____

____

____

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