

Live Oak Counseling & Associates, PLLC

3806 Park Avenue, Unit D
Wilmington, NC 28403
Website: www.liveoak-counseling.com

Phone: 910-636-5100
Fax: 910-636-5101
E-mail: info@liveoak-counseling.com

Welcome! We are pleased that you have chosen to entrust us with your care. Please provide the following information for our records. Leave blank any question you would rather not answer.
Information you provide here is held to the same standards of confidentiality as our therapy.

CLIENT INFORMATION

Name: (First) _____ (M.I.) _____ (Last) _____

Name of Parent/Guardian (if you are a minor): _____

Birth Date: ____ / ____ / ____ Age: ____ Gender: Male ____ Female ____ SSN: _____

Local Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Permission to leave message? Yes ____ No ____

Cell Phone: _____ Permission to leave message? Yes ____ No ____

Permission to text message? Yes ____ No ____

Email: _____ Permission to email? Yes ____ No ____

How did you learn about our practice? Internet ____ Friend/Family ____ Pastor/Church ____ Other ____

Marital Status: Single ____ Partnered ____ Married ____ Separated ____ Divorced ____ Widowed ____

Spouse's Name (if applicable): _____

If married, how long? _____ If separated, divorced, or widowed, how long? _____

Do you have any children/step-children? If so, please tell us about them:

Name	Birth Date	Sex	Relationship	Living at Home?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

EMERGENCY CONTACT (In the event of an emergency, who should we contact?)

Name: (First) _____ (M.I.) _____ (Last) _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

PRESENTING CONCERNS

Please describe the issue(s) that lead you to seek counseling at this time:

How long have you had this/these issue(s)? _____

Please list any important events in your life that may relate to this issue:

What have you tried to do to solve this issue?

What has been successful?

Please identify and rate any additional problems or symptoms you may be experiencing.

0= None

1= Mild

2= Moderate

3= Severe

- | | | | |
|---|--|---------------------------------------|---|
| <input type="checkbox"/> Marriage | <input type="checkbox"/> Sexual Issues | <input type="checkbox"/> School | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Divorce/Separation | <input type="checkbox"/> Codependency | <input type="checkbox"/> Parents | <input type="checkbox"/> Food/Nutrition |
| <input type="checkbox"/> Child Custody | <input type="checkbox"/> Intimacy | <input type="checkbox"/> In-Laws | <input type="checkbox"/> Weight Control |
| <input type="checkbox"/> Singleness | <input type="checkbox"/> Pornography | <input type="checkbox"/> Stress | <input type="checkbox"/> Aging/Dependency |
| <input type="checkbox"/> Past Hurts | <input type="checkbox"/> Loneliness | <input type="checkbox"/> Fear/Anxiety | <input type="checkbox"/> God/Faith |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Self-Esteem | <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Church/Ministry |
| <input type="checkbox"/> Grief/Loss | <input type="checkbox"/> Communication | <input type="checkbox"/> Disability | <input type="checkbox"/> Work/Career |

CRISIS INFORMATION

Are you having any current suicidal thoughts or feelings? Yes _____ No _____

If yes, please explain: _____

Are you having any anger-control problems or feelings? Yes _____ No _____

If yes, please explain: _____

CURRENT AND PREVIOUS COUNSELING/PSYCHIATRIC SERVICES

Counseling Services

Are you currently receiving professional counseling elsewhere? Yes _____ No _____

If yes, for what reason(s)? _____

Name of Clinician: _____

Permission to contact this clinician for treatment purposes? Yes _____ No _____ Please initial: _____

Have you had any previous counseling experiences? Yes _____ No _____

If yes, when? _____ For what reason(s)? _____

Name of Clinician: _____

Permission to contact this clinician for treatment purposes? Yes ____ No ____ Please initial: _____

What was helpful about the experience? _____

What was *not* helpful about the experience? _____

Psychiatric Services

Are you currently receiving psychiatric services? Yes ____ No ____

If yes, for what reason(s)? _____

Name of Clinician: _____

Permission to contact this clinician for treatment purposes? Yes ____ No ____ Please initial: _____

Have you received psychiatric care in the past? Yes ____ No ____

If yes, when? _____ For what reason(s)? _____

Name of Clinician: _____

Permission to contact this clinician for treatment purposes? Yes ____ No ____ Please initial: _____

MEDICAL INFORMATION

Primary Care Physician: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

Permission to contact this clinician for treatment purposes? Yes ____ No ____ Please initial: _____

Are you currently taking any medication? Yes ____ No ____

If so, please list any medications and reasons for which you are taking them:

Medication:	Dosage:	Reason:	Prescribing Physician:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

How would you describe your current physical health?

Poor ____ Unsatisfactory ____ Satisfactory ____ Good ____ Very Good ____

When was your last physical? _____

Please list any persistent physical symptoms or health concerns that you would like us to know about:

(e.g. chronic pain, headaches, hypertension, diabetes, etc.)

Any problems with *sleep*? Yes ____ No ____

If yes, please check where applicable:

- ___ Sleep too little
- ___ Sleep too much
- ___ Difficulty falling asleep
- ___ Frequent waking
- ___ Poor quality of sleep
- ___ Disturbing dreams
- ___ Other: _____

Any problems with *eating*? Yes ____ No ____

If yes, please check where applicable:

- ___ Eating less
 - ___ Eating more
 - ___ Binging
 - ___ Restricting
- Significant weight change in last two months?
 ___ Gain ___ Loss Approx. how much? _____

How many times per week do you exercise? _____ For how long? _____

SUBSTANCE USE

Do you currently drink alcohol (e.g. beer, wine, liquor)? Yes ____ No ____
In a typical week, how often do you drink? _____ How much? _____

Do you currently engage in recreational drug use (e.g. prescription or street drugs)? Yes ____ No ____
If yes, how often do you use? Daily ____ Weekly ____ Monthly ____ Rarely ____
If yes, please list which recreational drugs you use: _____

Have you ever received treatment for alcohol/drug abuse? Yes ____ No ____ If so, when? _____
Have you ever lost a job or relationship due to alcohol/drug use? Yes ____ No ____

HISTORY OF SYMPTOMS

Please indicate which of the following apply to you:

Current	Past		Current	Past	
_____	_____	Thoughts of Suicide	_____	_____	Sleep Disturbances
_____	_____	Plan for Suicide	_____	_____	Hallucinations
_____	_____	Suicide Attempt	_____	_____	Unexplained Losses of Time
_____	_____	Self-Harm	_____	_____	Unexplained Memory Lapses
_____	_____	Thoughts of Hurting Others	_____	_____	Traumatic Brain Injury
_____	_____	Hurting Others	_____	_____	Pornography
_____	_____	Extreme Depressed Mood	_____	_____	Alcohol/Substance Abuse
_____	_____	Extreme Mood Swings	_____	_____	Eating Disorder
_____	_____	Rapid Speech	_____	_____	Body Image Problems
_____	_____	Extreme Anxiety	_____	_____	Repetitive Thoughts (Obsessions)
_____	_____	Panic Attacks	_____	_____	Repetitive Behaviors (e.g. Frequent
_____	_____	Phobias	_____	_____	Checking, Hand Washing, etc.)

In the last year, have you experienced any significant life changes or stressors? If so, please describe:

OCCUPATIONAL INFORMATION

Are you currently employed? Yes ____ No ____ If yes, are you satisfied in your work? Yes ____ No ____
If yes, who is your current employer? _____
What is your current role/position? _____
Please list any work-related stressors: _____

RELIGIOUS/SPIRITUAL INFORMATION

Do you consider yourself to be religious? Yes _____ No _____

If yes, what is your faith? _____

If no, do you consider yourself to be spiritual? Yes _____ No _____

FAMILY HISTORY

Who raised you? _____

If there were changes, please list and indicate the age you were when these changes occurred:

Number of siblings: _____ Number of brothers: _____ Number of sisters: _____

Which members of your family are you close to?

Are there any family members who are a problem for you?

Has anyone in your family (either immediate or extended family members) experienced difficulty with the following? If so, please identify which family member(s) (e.g. Father, Mother, Aunt, Uncle, Grandmother, Grandfather, Sibling).

<u>Issue:</u>	<u>Yes</u>	<u>No</u>	<u>Family Member(s):</u>
Depression	_____	_____	_____
Bipolar Disorder	_____	_____	_____
Anxiety Disorder	_____	_____	_____
Panic Attacks	_____	_____	_____
Schizophrenia	_____	_____	_____
Alcohol/Sub. Abuse	_____	_____	_____
Eating Disorder	_____	_____	_____
Learning Disability	_____	_____	_____
Trauma History	_____	_____	_____
Suicide Attempt	_____	_____	_____

Please identify other people in your life that provide support for you:

OTHER INFORMATION

What do you consider to be your strengths?

What do you like most about yourself?

What are effective coping strategies that you've learned?

What are your goals for therapy?

OFFICE POLICIES

Please read the following policies and sign.

With your signature, you are agreeing to the policies and take responsibility of being informed.

Copay and Deductibles. With a few exceptions, patients usually have a fee associated with their insurance that is due at the time of service. Please review your policy to fully understand your responsibility according to your insurance contract.

- Copays, co-insurance, and deductibles are due and expected at each appointment prior to being seen.
- If the patient is unaware of their benefits, the full fee will be taken to cover the visit until billing receives a response from your insurance. If this results in a credit, that amount will be applied to your account.
- Please call our office with your insurance information PRIOR to your appointment. If a patient arrives for an appointment without insurance information, that visit will be assessed as a self-pay appointment until insurance information can be verified and applied for additional visits.
- Patient balances are expected to be paid along with copay amounts where applicable.
- If the patient's insurance changes, it is advised that you call the office prior to your appointment, as not all providers are in network with all insurance carriers.
- The office does not process with Medicaid and Medicare. We can provide a "super bill" that you can submit to Medicaid or Medicare for your own personal reimbursement.

Missed Appointment Charge. If a patient fails to show for an appointment or if the appointment is canceled less than 24 hours prior to the appointment time (including after-hour messages left), a \$75.00 broken appointment fee will be assessed to the patient and must be settled prior to the next appointment. Continued broken appointments may result in the full fee. We have an office voicemail set up for the weekends for patients to cancel appointments scheduled for Monday. Emergencies are handled on a case by case basis and are left up to the provider for the final decision. As a courtesy, we will attempt to text an appointment reminder, but it is still the patient's responsibility to remember their appointment times. This does not waive the missed appointment fee. Please inform the office if you are going to be late for your appointment time. You may email your provider or call the office voicemail if needed. In some instances, a provider may have to reschedule the appointment based on scheduling and calendar demand as a session hour has been reserved for you.

Requests for Notes and Other Correspondence. If a patient requests records for notes to be sent to another entity (other than a healthcare provider of the patient), there is a fee per page, and the patient must sign a release of information in the office. Generally, we try to accommodate all requests within three to four business days if all paperwork has been signed and released.

Consent for Treatment.

I understand that I have chosen to be treated by _____ at Live Oak Counseling & Associates, PLLC. My signature below is my indication that I have read and agree to the Office Policies for Live Oak Counseling & Associates, PLLC <https://doxy.me/wendylaursenlcmhc>, understanding that my full participation with my counselor, as well as abiding by all office policies, means that I have made a significant investment in my personal mental health and will work hard with my counselor to meet treatment objectives.

Patient/Parent or Guardian/Legal Representative

Date

AUTHORIZATION FOR CREDIT CARD USE

I authorize my counselor to charge my credit card for counseling sessions, missed appointments, and payments on my account.

Name Printed on Card: _____

Card Type: _____

Card Number: _____

Exp. Date: _____

Zip Code for Billing Address: _____

CVC/CVV Code: _____

By signing below, I certify that my above information is true, accurate, and that I am an authorized user on the account. I authorize my counselor to keep my credit card information on file and charge any fees that are my responsibility listed on the intake paperwork. I understand and give permission to charge my card for any therapy appointments not canceled with full 24-hour notice. If I do need to cancel an appointment, I will call the office in advance and leave a message for my counselor.

My counselor agrees to ONLY charge for services rendered or for fees on appointments not canceled 24 hours in advance.

Client Signature: _____

Date: _____

Therapist Signature: _____

Date: _____