Today's Date:______________________________

Schroeder Family Counseling

Dale Schroeder,
LPC, LMFT, LCDC, DAPA, CART, CPCE

15303 Huebner Rd #10, San Antonio, TX 78248

CONFIDENTIAL CLIENT INFORMATION

Client Information

____
CLIENT Name: First Middle Last

Address (Street/Apt #):

____

____
: City State Zip

( )______________( )______________( )______________
Phone: Home Cell Work

It is okay to leave a message at: ☐ Home ☐ Cell ☐ Work ☐ Email

_______/_______/_______ _______ ____________________
Date of Birth Age Driver's License Number

____________________ ____________________
Employer Occupation/Job Title

_______/_______/_______ ____________________
Social Security Number Email Address

____________________ ____________________
Highest level of Education If currently in school, Name of School

Gender: ☐ Male ☐ Female

☐Single ☐Married ☐Separated ☐Divorced ☐Widowed ☐ Other:

Spouse (or Guardian Information)

____
Name: First Middle Last

Address (Street/Apt #):

____

____
: City State Zip

( )______________( )______________( )______________
Phone: Home Cell Work

It is okay to leave a message at: ☐ Home ☐ Cell ☐ Work ☐ Email

_______/_______/_______ _______ ____________________
Date of Birth Age Driver's License Number

____________________ ____________________
Employer Occupation/Job Title

_______/_______/_______ ____________________
Social Security Number Email Address

____________________ ____________________
Highest level of Education If currently in school, Name of School

Gender: ☐ Male ☐ Female

☐Single ☐Married ☐Separated ☐Divorced ☐Widowed ☐ Other:

If client is under 18, Information on other guardian/parent:

____
Other parent/guardian's Name: First, Middle, Last name

____
Address: Street State Zip

( )______________( )______________( )______________
Phone: Home Cell Work

It is okay to leave a message at: ☐ Home ☐ Cell ☐ Work ☐ Email

_______/_______/_______ _______ ____________________
Date of Birth Age Driver's License Number

____________________ ____________________
Employer Occupation/Job Title

_______/_______/_______ ____________________
Social Security Number Email address

____________________ ____________________
Highest level of Education If currently in school, Name of School

Gender: ☐ Male ☐ Female Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed ☐ Other: ________

Other family members living in home of client (use reverse side of this page for additional info):

______________________________ __________
1. Name: First/Last DOB (or age)
Relationship to client: ______________________________

______________________________ __________
2. Name: First/Last DOB (or age)
Relationship to client: ______________________________

______________________________ __________
3. Name: First/Last DOB (or age)
Relationship to client: ______________________________

______________________________ __________
4. Name: First/Last DOB (or age)
Relationship to client: ______________________________

______________________________ __________
5. Name: First/Last DOB (or age)
Relationship to client: ______________________________

Billing Information

Responsible Party for Payment ____________ Relationship to Client ____________ Phone ____________

Address ________ City ________ State ________ Zip ________ Additional Phone ________

Indicate method of payment for services: Clients & all responsible parties understand they're responsible for any/all services provided through our offices, including but not limited to counseling, consultations, School ARD's, telephone or emergency calls, late cancels, no-shows, fees related to collection of account due to non-payment, including fees added by collection agencies. By seeking services client indicates intent to keep account in good standing (paid in full).

√ Self-Pay--I will pay in full at the time of service.

√ If I have or obtain insurance, I will bill my own insurance & pay at the time of service (re New Client Info brochure for additional information. Request forms from Mr. Schroeder to include with your insurance filing and expedite your insurance company's reimburse directly to you.)

Payments made by: ☐ Cash ☐ Credit Card ☐ Check ($35 returned check fee)

Insurance Information (We must have copy of back & front of insurance card to bill insurance)

PRIMARY		**Secondary**	
PRIMARY Insurance Name	Insurance Phone #	**Secondary** Insurance Name	Insurance Phone #
Insurance Billing Address	City, State, Zip	Insurance Billing Address	City, State, Zip
Member ID #	Policy Number	Member ID #	Policy Number
Name of Insured	Social Security # of Insured	Name of Insured	Social Security # of Insured
Address of Insured (if different from above)	City, State, Zip	Address of Insured (if different from above)	City, State, Zip
Insured Employer:	Work Phone # of Insured	Insured Employer:	Work Phone # of Insured
☐ Male ☐ Female Gender of Insured	Date of Birth	☐ Male ☐ Female Gender of Insured	Date of Birth

Financial Agreement (By seeking services, I agree to the following)

By seeking services….**I agree and understand I will be charged a $100 fee for the first missed session not cancelled 24 hours in advance, and full fee for all other late cancel/no show appointments.

**Individual sessions are 50 minutes . Family/Marital is 50 minutes-1 hour. Additional fees apply if sessions exceed allowed times.

**I received, read and agree to terms listed in the New Client Brochure for this professional's office.

**If provider's office files insurance claims, I authorize billing entities to release necessary information to insurance carrier to process claims.

**I understand I am responsible for any & all payments. I certify information provided on this form is accurate, true and complete.

Client Signature ________ **Date** ________ **Parent/Guardian/Spouse Signature** ________ **Date** ________

Receipt of HIPPA NOTICE OF PRIVACY PRACTICES

I acknowledge notice of availability of Notice of Privacy Practices (displayed on wall in reception area). I understand a copy of this document can be provided upon request. I certify I have reviewed the Federal HIPPA Ruling provided by this office.

Client Signature ________ **Date** ________ **Parent/Guardian/Spouse Signature** ________ **Date** ________

CLIENT NAME: ______________________

CREDIT CARD: REQUIRED if:

1/"Zero $0 Balance" is not retained on account. 2/Payment is being made for others (college student, friend, spouse) 3/or if any Checks are written for your sessions. (Credit card not required if using cash or credit cards & signing @time of session. Only required if checks are written for payment. At initial session, cash or credit card is required.)

☐ Charge my credit card for payments on balances on acct (or to pay for a student/dependent/spouse/other)

Credit Card Number ______ We accept: ( )MasterCard ( )Discover/Novus ( )Visa

Zip Code (Where Stmt is mailed) ______ Expiration Month/Year ______ CVS code (3 digit code on card back) ______ Name (printed) on credit card: ______

Signature ______ Date ______

Reason(s) for seeking counseling ______

How did you hear about this professional? ☐ Friend ☐ Family Member ☐ Former Client ☐ Physician ☐ Phonebook ☐ Other Professional ☐ Pastor ☐ Website (Website name): ______ ☐ Other: ______

Please list name of referral source: ______

Medical and Emergency Information

Name of Primary Physician ______ Doctor's Phone Number ______ Date of last Visit ______

Contact in Case of Emergency: Name ______ Address ______ Phone Numbers ______ Relationship to client ______

Do you have any serious medical conditions? ☐ No ☐ Yes, Please list: ______

Are you currently taking any medications? ☐ No ☐ Yes, Please list: ______

Have you been hospitalized in the last 10 years? ☐ No ☐ Yes, Please explain: ______

Have you been in counseling within the last 10 years? ☐ No ☐ Yes, Reason for Treatment: ______

Name of Clinician: ______

Dates of Treatment: ______

Medications: Please list current medications: (Use reverse side of page if needed)

Medication Name	Dosage/# of times taken per day	Prescribing Physician Name

CLIENT NAME: -- Person filling out this form: ______

If you aren't the client, but want to share your assessment of the situation with Mr. Schroeder, please make additional copy of this page, fill out this form's top section & give to Dale Schroeder at beginning of initial appointment.

Current Symptoms: Please rate all that apply from 0 to 3 (0-None 1-Low, 2-Moderate, 3-High Concern)

☐ Family problems	☐ Feel sad or depressed	☐ Anxiety/worry	☐ Hear strange things
☐ Marital/relationship issues	☐ Cry often	☐ Stress	☐ See strange things
☐ Trouble communicating	☐ Feel hopeless	☐ Extreme fear	☐ Wanting to hurt others
☐ Physical or sexual abuse	☐ Anger problems	☐ Panic attacks	☐ Suicidal thoughts
☐ Domestic violence	☐ Frustration	☐ Aggressive behaviors	☐ Others are out to get me
☐ Sexual problems	☐ Trouble concentrating	☐ Nightmares	☐ Thoughts of Death
☐ Intimacy issues	☐ Trouble sleeping	☐ Upset stomach	☐ Wanting to hurt myself
☐ Divorce	☐ Feel guilty	☐ Health Problems	☐ Legal problems
☐ Pre-marital counseling	☐ Low self-esteem	☐ Severe pain	☐ Financial problems
☐ Grieving	☐ Loss of appetite	☐ Headaches	☐ Smoke cigarettes
☐ Lack of sex drive	☐ Dramatic weight changes	☐ Sweating	☐ Alcohol use
☐ Spiritual Issues	☐ Feel tired or low energy	☐ Trouble breathing	☐ Drug use
☐ Can't make friends	☐ Lack of motivation	☐ Quick mood changes	☐ Restless/Can't sit still
☐ Feel Lonely	☐ Problems at work	☐ Can't stop thinking	☐ Impulsive
☐ Withdrawn from others	☐ Problems at school	☐ Eating Disorder	☐ Other:

YES	**NO**	Any Major Illnesses:
YES	**NO**	Has client exhibited physical aggression or threats of harm toward others?
YES	**NO**	Has client exhibited behaviors cruel to animals? If yes, please explain:
YES	**NO**	Has client shown destructive tendencies toward property (setting fires, vandalism, property/home destruction)?
YES	**NO**	Has client had history of employment changes (repeated job losses, difficulties, etc.)?
YES	**NO**	Has client been in trouble with the law repeatedly or with law enforcement groups?
YES	**NO**	Has client been truant from school on repeated occasions?
YES	**NO**	Does client have addictions? (drug, alcohol, pornography, gambling, computer, or other addictions)
YES	**NO**	Does client smoke? If yes, how much per day?
YES	**NO**	Does client drink alcoholic beverages? If yes, how much per day?
YES	**NO**	Has client used inhalants not medically prescribed (now or in the past)?
YES	**NO**	Military history? (list military service/discharge type) Post Traumatic Stress?
YES	**NO**	List major traumas (Abuse, Violence, Loss of child/spouse/ friend, Robbery, Feared Death Experiences)
YES	**NO**	Has client had legal issues, past & present which may affect service?
YES	**NO**	Has client exhibited inappropriate sexual behaviors?
YES	**NO**	Developmental problems in infancy, childhood or adolescence? (Hearing/speech problems, difficulty walking, surgeries, pre-mature birth, learning disabilities, etc.)
YES	**NO**	Other situations, experiences or concerns of which therapist should be aware?