Joni Branham, LCSW
Psychotherapist
Counseling and Consulting

PATIENT INFORMATION
(Please print clearly)

Patient's Last Name: First: Middle:

Date of Birth: Age: Gender: M F (Circle one) Social Security #:

Street Address: City: Zip:

Cell Phone: Home Phone:

May I leave a message? ☐ Y ☐ N May I text you? ☐ Y ☐ N May I leave a message? ☐ Y ☐ N

E-Mail Address: May I E-mail you*? ☐ Y ☐ N

*Please note E-mail correspondence is not considered to be a confidential medium of communication.

Relationship Status: ☐ Single ☐ In Relationship ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Employer/School: Occupation:

Who Referred You?

INSURANCE/BILLING INFORMATION

Primary Insurance: Policy ID #: Group #:

Claims Address: Phone Number:

Policy Holder Name: Date of birth:

Social Security #: Employer:

Effective Date of Insurance: Co-Payment:

Patient's relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: Please list

Person responsible for account: ☐ Patient ☐ Parent ☐ Other: Please list

Name: Phone #:
(If different from patient or insured)

Secondary Insurance: Policy ID #: Group #:

Claims Address: Phone Number:

Policy Holder Name: Date of birth:

Social Security #: Employer:

Effective Date of Insurance: Co-Payment:

Patient's relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: Please list

Authorization and Confidentiality

Patient or Authorized person's signature: I authorize Joni Branham, LCSW, to submit claims on my behalf. I authorize the release of any medical or other information necessary to process my claims

Signature: _____ Printed name: _____ Date: _____

CANCELLATION POLICY: Once an appointment is scheduled, you will be expected to provide at least 24 hours advance notice of cancellation. Please be aware that if you miss an appointment or cancel within 24 hours of your scheduled appointment, you will be responsible for paying an $80.00 out-of-pocket fee, as insurance/Medicare will not cover such costs.

Signature: _____ Printed name: _____ Date: _____

Limits of Confidentiality

Under the state laws that govern the conduct of mental health professionals, there are specific times when therapists are required to violate the privacy or confidentiality of treatment. It is very important that you fully understand these exceptions or limits.

1. Any situation where you are in danger of harming yourself or another;
2. Any suspected current or previously unreported incident of child abuse (neglect, emotional, physical, or sexual abuse), whether the harm is caused by you or someone you know or whether someone else hurts you or someone you know;
3. In the case of active duty military members, there are times when the commanding officers can request access to your information.

Your signatures here are to verify that you understand that these exceptions or limits, by law, apply to you or any other family member or extended family member involved in your treatment.

_____ _____

Client Signature Date

_____ _____

Parent or Authorized Signature Date

_____ _____

Witness Signature Date

Symptoms and Treatment History

Patient's Name:	Date of Birth:
Name of person completing this form (if different from patient):	
Reason for seeking therapy:	
What do you hope to achieve in therapy?	

Please rate the severity of the following symptoms over the last two months according to the following scale:

0 = No difficulty 1 = Mild 2 = Moderate 3 = Severe

- ☐ Decreased appetite
- ☐ Increased Appetite/eating more
- ☐ Binging and/or purging
- ☐ Weight change? +/- ____ lbs.
- ☐ Depressed mood
- ☐ Decreased energy/fatigue
- ☐ Sleep changes, trouble falling asleep; trouble staying asleep; trouble waking up

Average number of hours sleep ____

- ☐ Decreased sexual desire
- ☐ Difficulty with sexual functioning
- ☐ Loss of interest in activities
- ☐ Crying
- ☐ Feelings of hopelessness
- ☐ Feelings of helplessness
- ☐ Decreased attention span
- ☐ Inattentive/Distractible
- ☐ Memory problems; long term; short term
- ☐ Self injurious behavior
- ☐ Thoughts of suicide
- ☐ Thoughts of hurting others
- ☐ Impulsivity
- ☐ Hyperactivity
- ☐ Anxiety/Nervousness
- ☐ Worry/Fear
- ☐ Flashbacks of traumatic event
- ☐ Nightmares
- ☐ Hyper vigilance (Jumpy/over aware)
- ☐ Obsessive thoughts
- ☐ Compulsions
- ☐ Spending sprees
- ☐ Racing thoughts
- ☐ Rapid heart beat
- ☐ Trouble breathing
- ☐ Sweating
- ☐ Phobia
- ☐ Police/Probation involvement
- ☐ Stealing
- ☐ Lying
- ☐ Truancy
- ☐ Violent behavior toward others
- ☐ Destruction of property
- ☐ Harming animals
- ☐ Fire setting
- ☐ Opposition
- ☐ Anger outbursts
- ☐ Irritability

Military Service: ☐ No ☐ Yes Number of years served: _____ Deployments: _____

Injuries sustained:

SYMPTOMS AND TREATMENT HISTORY (Continued)

Personal and/or family history of substance abuse problem?

How many alcoholic beverages do you consume in an average week?

List street drugs taken in last 2 months (Type/frequency/amount):

Previous psychological or psychiatric treatment, including hospitalization (List dates & provider):

Psychiatric medications (current and past):

Family mental health history (depression, anxiety, Bi Polar, etc.):

Patient medical history/conditions:

Current medications and doses:

Name of prescribing physician:

Current stressors:

Any other information you would like your therapist to know?