Judy Figura, LCSW
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Asheville NC 28801

Client Information Questionnaire

Please feel free to leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy.

Personal Information

Name: _____ Today's Date: _____

Prefer to be called: _____ Gender: _____

Date of Birth: _____ SSN: _____

Address:_____

Home Phone: _____ May we leave a message? Yes ____ No _____

Cell Phone: _____ May we leave a message? Yes ____ No _____

Email: _____ May we contact you via email? Yes ___ No ___
(please be aware that email may not be confidential)

Marital Status: Never Married __ Married __ Coupled __ Separated __ Divorced __ Widowed __

Name of Spouse/Partner: _____

Names and ages of children: _____

Employer/ School: _____ Occupation: _____

If a minor: name of parent of guardian: _____

Emergency Contact: _____ Phone:_____

Contact Preferences

I prefer to be contacted by: Home phone____ Cell phone____ Text _____ Email _____

I DO ___ DO NOT____ Give permission for my spouse/partner to coordinate my appointments.

Referral Information

How, or from whom, did you learn about this office? _____

Your permission to thank them for your referral? Yes_____ No_____

HEALTH AND SOCIAL INFORMATION

1. How is your physical health at present? Poor____ Fair____ Good ___ Very good___

2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

_____

3. Please list any past major illnesses or injuries:

_____

4. Please list any medications you are currently taking:

_____

5. How many times per week do you exercise? _____

6. Are you currently in a romantic relationship? No_____ Yes ____
If yes, how long have you been in this relationship? _____

7. Are you having any problems with your sleep habits? No_____ Yes _____

If yes, which ones: Sleeping too little____ Sleeping too much_____ Poor quality sleep___
Disturbing dreams_____ Other _____

8. Are you having any difficulty with appetite or eating habits? No___ Yes ___
If yes, which ones: Eating less___ Eating more___ Binging___ Restricting___

Have you experienced significant weight change in the last 2 months? No____ Yes___

9. Do you regularly use alcohol? No__ Yes__
In a typical month, how often do you have 3 or more drinks in a 24-hour period? _____

10. How often do you engage recreational drug use? Daily____ Weekly___ Monthly___
Rarely___ Never ___

11. Have you had recent suicidal thoughts?
Frequently___ Sometimes____ Rarely____ Never___
Have you had them in the past?
Frequently ___ Sometimes____ Rarely____ Never___

12: Have you ever engaged in self-harming behaviors: No ___ Yes___
If yes, when? _____

Other Personal Information

In the last year, have you experienced any significant life changes or stressors:

_____

Please give a brief description of your favorite coping skills to manage stress:

_____

How do you describe your spiritual / religious life?

_____

Mental Health History

Have you had previous mental health/family/marriage counseling? Yes_____ No_____
***If yes: When: _____ Was it helpful? Yes_____ No_____

Have you ever been under the care of a psychiatrist: Yes_____ No_____
***If yes: When: _____ Was it helpful? Yes_____ No_____

Have you ever had a psychiatric hospitalization? Yes_____ No_____
***If yes: When: _____ Was it helpful? Yes _____No_____

Issues and Concerns: In your own words, please give a brief description of your goals for therapy: _____

_____

In the sections below, please check the items that apply, currently or in the past six months.

Mood

___ Anxiety, Worries
___ Stress, tension
___ Panic attacks
___ Fears, phobias
___ Depression, low mood, sadness
___ Crying spells
___ Guilt
___ Grieving deaths, losses
___ Anger, irritability
___ Mood swings
___ Loss of control, outbursts
___ Low self-esteem
___ Fatigue, tiredness, low energy
___ Loneliness
___ Withdrawal, isolating
___ Suicidal thoughts

Issues and Concerns (con't)

Problems with thinking

___Attention, concentration, distractibility
___Decision making, indecision, mixed feelings, putting off decisions
___Obsessions, compulsions (thoughts or actions that repeat)
___Memory problems
___Confusion
___Delusions (false ideas)

Relationship Problems

___ Children / parenting
___ Child custody / visitation
___ Marital / Significant Other conflict
___ Family conflict
___ Friendships
___ Interpersonal Conflicts

Abuse History

___Physical
___Neglect (of child or elderly)
___ Emotional
___ Sexual

Employment/Career Problems

___ Career goals / choices
___ Unemployment
___ Over-working
___ Extreme stress at work

Financial/Legal Problems

___ Consumer debt
___ Impulsive spending
___ Legal issues
___ DWI/DUI

Other Problems

___ Perfectionism
___ Low motivation
___ Judgment problems, risk taking
___ Impulsivity

Additional concerns or issues: _____

_____

Please look back over the concerns you have checked off and choose the one which you most want help with: _____

_____

Financial Agreement

If you are insured with a company with whom this office has a negotiated contract, we will bill your insurance company. Your co-payment or deductible (if applicable) will be requested at the end of each session. (Please know that for reimbursement by insurance companies, a diagnosis is required. You will be informed of the diagnosis given to you during our work together.)

If this office is out-of-network for your insurance, we will provide you with a suitable receipt that you can mail to your insurance company for claiming your reimbursable portion. For those who will not be using insurance, a sliding scale is available.

Please note: If you are unable to keep an appointment, it is requested that you ***cancel at least 24 hours before the appointment time***. It is fine to leave a message on the office voice mail. Unexpected emergencies understandably arise. However, on other occasions of late cancelations or missed appointments, 50% of the normal fee may be charged. Such fees are not covered by insurance benefits.

Financial Agreement for Clients Using Insurance (*please sign, if applicable)*

I authorize a release of information to my health insurance company. I assign all benefits covering services rendered at this office to Judy Figura, LCSW. I agree to be responsible for any co-payments and deductibles, as stated by my insurance policy.

***Client Signature**: _____ **Date:** _____

Insurance co. _____ Subscriber Name: _____

Subscriber DOB: _____ Subscriber SSN: _____

Subcriber Employer _____ Phone # for pre-cert: _____

Policy ID # _____ Group # _____

Secondary Insurance co. _____ Subscriber Name: _____

Subscriber DOB: _____ Subscriber SSN: _____ Subcriber Employer: _____

Policy ID # _____ Group # _____

Financial Agreement for Private Pay Clients (*please sign, if applicable)*

I understand that my fee for therapy is due at the end of each session, unless other arrangements are made in advance. Payment amount will be discussed with my therapist and agreed upon before entering into therapy.

*** **Client Signature:** _____ **Date:** _____

Confidentiality / Consent to Treatment

Our conversations and my records will be held in the strictest confidence, as protected information according to my professional code of ethics and by law. A few exceptions to this rule exist, which are important to understand. Confidentiality is not guaranteed in cases of: 1) a person's intent to harm him/herself or intent to harm another; and 2) when there is current or future threat of abuse of a child or elderly person. Also, in rare circumstances, a court may be able to order a professional therapist to release information. Please know that this is an extremely rare circumstance. In any other situation, you will be asked to sign a "Consent to Release" form when you desire that certain information be released to another party.

Please note that texting and emails cannot be protected information due to the nature of the internet. Also, you should know that cyber communication you send to me becomes part of the clinical record.

Upon your request, a thorough Privacy Policy Notice which closely details the rules and regulations of HIPAA law is available to you.

Consent to Treatment *(please sign)*

I attest that I have read and sufficiently understand the material enclosed in this New Client Information Packet. I understand that no promises have been made to me as to results of treatment. I am aware that the full Privacy Disclosure of the HIPPA law is available to me, upon request. I do hereby seek and consent to treatment with Judy Figura, LCSW.

*****Signature:_____ Date: _____**