



**Family of Origin**

Please list your mother, father, brothers, sisters, stepfamily and/or relatives who had a significant effect upon your life (positive or negative).

Name	Sex	Age/Year of death	Relationship to you	Describe him/her

Please identify any of the following you experienced in your family:

- Physical Abuse   
  Emotional Abuse   
  Sexual Abuse   
  Abortions   
  Gambling  
 Drug/Alcohol Addiction   
  Religious Upbringing   
  Major Losses   
  Multiple Marriages

Please describe the kind of family you grew up in: \_\_\_\_\_  
 \_\_\_\_\_

**Counseling History**

If you have had any previous counseling, psychiatric treatment, substance abuse treatment, or residential/in-patient care, please list the name of the therapists and/or programs (use back of this sheet if necessary):

Name of Therapist/Program	Issues Addressed	Dates in Treatment

Has anyone in your family ever been treated or hospitalized for substance abuse, mental health issues, or psychiatric conditions?  Yes  No

If yes, please describe: \_\_\_\_\_

Have any of your family or friends ever attempted or committed suicide?  Yes  No

If yes, who and when: \_\_\_\_\_

**Medical History**

Name and Town of Current Physician: \_\_\_\_\_

Date and outcome of last physical exam: \_\_\_\_\_

Please list any conditions, illnesses or surgeries that might be relevant to your reason for seeking counseling:

\_\_\_\_\_

Please list current medications you are taking even if use is seldom or as needed (use back of sheet if necessary):

Name of Medication	Dosage	Reason for taking medication





## Informed Consent for Counseling Services

I am willingly entering into a counseling relationship with the understanding of the following conditions:

- 1) I understand that my counseling records are kept confidential, except where disclosure is required by law (e.g., child abuse/elder abuse reporting requirements, serious threat of harm to self or others) or I have signed the appropriate release of information forms.
- 2) Counseling will cover emotional, physical and spiritual aspects of my life and may sometimes be distressing and difficult. However, I understand working through my issues will enable me to achieve increase health both personally and relationally.
- 3) I have the right to ask questions pertaining to my treatment and may discontinue therapy at any time. I understand terminating counseling is best decided after consulting with my therapist.
- 4) I understand that *Life Counseling Center* does not accept insurance for partial or full payment of services rendered. I agree to pay \$ \_\_\_\_\_ at the conclusion of each appointment.
- 5) Barring emergencies, I understand I must cancel and/or reschedule my appointments by notifying the office **at least 24 hours** prior to the scheduled appointment hour. There will be a **charge** if appointment is cancelled within 24 hours of appointment time. If you do not call and do not show up for your appointment, the **full charge** will apply. In the evenings and on weekends, you may leave a message on our voice mail, which will accurately record the date and time of your call.
- 6) In consideration of the benefits to be derived from the counseling, the receipt whereof is hereby acknowledged, I hereby release, remise and forever discharge and covenant not to sue or hold legally liable *Life Counseling Center*, or employees of the aforesaid from any and all claims, demands, actions or causes of action of whatsoever kind and nature related to the counseling process.

*I have read and understood the preceding information and agree to the policies of Life Counseling Center as stated. I understand that these comments are prerequisite to my receiving and continuing counseling through Life Counseling Center.*

\_\_\_\_\_  
Client's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Therapist's Signature

\_\_\_\_\_  
Date