5934 South Business Drive
Sheboygan, WI 530-81

Client Information

Please print, sign and date. Thank you.

Date:_____

Client Name: LAST_____ FIRST_____ MI___

Date of Birth:_____/_____/_____ Age: _____ Gender: __M __F Marital Status:_____

Social Security #_____

Mailing Address:_____ City:_____ Zip:_____

Home Phone#:_____Work Phone #_____ Cell #_____

Emergency contact (in case of emergency or we can not reach you on the above phones)
#_____

E-Mail Address:_____

Client Employer Name:_____

Spouse Name:_____ Spouse DOB:_____

Spouse Social Security #:_____ Spouse Employer:_____

This therapist was recommended to me by:_____

Others who live with me at the above address:
Name:_____ Relationship_____ Age:_____
Name:_____ Relationship_____ Age:_____
Name:_____ Relationship_____ Age:_____
Name:_____ Relationship_____ Age:_____
Name:_____ Relationship_____ Age:_____
Name:_____ Relationship_____ Age:_____

Other Doctors or Treatment providers I see

Name: _____ Reason_____
Name: _____ Reason_____
Name: _____ Reason_____

You have my permission to coordinate my overall services with the above named doctors or therapists even though it may mean sharing confidential information: ____Yes ___No ___Does not apply

Signature: _____

Date: _____ Witness:_____

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New Client Health and Personal Information

Please complete every line; if statement or question does not apply to you write N/A Please print clearly; sign and date. Thank you.

Date:_____ Client Name: _____
Gender __M __F DOB:_____/_____/_____ Age:_____ Marital Status_____ Referred by:_____
Highest level of education completed_____ Occupation_____
Reason for Today's Appointment:_____

Please check one choice on each line

I experience these symptoms :

Yes	No	N/A	
___	___	___	Panic Attacks
___	___	___	Anxiety
___	___	___	Depression
___	___	___	Crying
___	___	___	Uncontrolled Anger
___	___	___	Irritability
___	___	___	Hopelessness
___	___	___	Sad/Down
___	___	___	Low Energy
___	___	___	Manic/ Very High Energy
___	___	___	Appetite Loss
___	___	___	Appetite Increase
___	___	___	Weight Loss _____#'s
___	___	___	Weight Gain _____#'s
___	___	___	Bingeing
___	___	___	Purging Behavior
___	___	___	Restricting food intake
___	___	___	Obsessive Behaviors
___	___	___	Paranoia
___	___	___	Hallucinations/Delusions
___	___	___	Increased tobacco use

Yes	No	N/A	
___	___	___	Nightmares
___	___	___	Difficulty Falling Asleep
___	___	___	Difficulty Staying Asleep
___	___	___	Loss of recent memory
___	___	___	Loss of distant memory
___	___	___	Confusion
___	___	___	Social Withdrawal
___	___	___	Loss of interest in usual activities
___	___	___	Mood Swings
___	___	___	Problematic Spending/shopping
___	___	___	Problems with gambling
___	___	___	High risk behavior
___	___	___	Alcohol or drug overuse/abuse
___	___	___	RX drug overuse/abuse
___	___	___	Suicidal thoughts
___	___	___	Wanting to hurt myself
___	___	___	Wanting to hurt others
___	___	___	Poor concentration
___	___	___	Overall poor judgment
___	___	___	Other symptom not stated:

_____

Please complete Family History

My Family's Mental Illness History

Mother Yes___ No___ Unknown___
Medications:_____
Diagnosis:_____
Father Yes___ No___ Unknown___
Medications:_____
Diagnosis:_____
Sibling Yes___ No___ Unknown___
Medications:_____
Diagnosis:_____
Sibling Yes___ No___ Unknown___
Medications:_____
Diagnosis:_____
Sibling Yes___ No___ Unknown___
Medications:_____
Diagnosis:_____
Extended Family Biological only
Relationship_____
Yes___ No___ Unknown___
Medications:_____
Diagnosis:_____

Please record major illness, injury or surgery you have had in the past 5 years. Begin with most recent:

Health Problem	Treatment	Physician Name	Outcome

Tobacco Usage: _____ Alcohol Usage: _____

Medications I currently use & dosage:

_____ _____ _____
_____ _____ _____

Do you use any illegal drugs? ___Yes___ No If yes, please itemize:_____
Current Family Doctor:_____Location:_____

I have been in counseling before: Name of Therapist:_____ What year?_____
How many sessions?_____ Was counseling helpful?_____ Why or why not?_____
I have seen a psychiatrist before: Name of Doctor:_____ What year?_____
Diagnosis_____ Are you still seeing this Doctor? ___Yes ___No

My support system for life's joys and problems is: ____ Excellent ____ OK ___ Not Good ____ I have no support system
Who are the primary people in your support system, if one exists?
Name: _____ Relationship to you: _____
Do you want any family member or others involved in your treatment or education and learning? ___Yes __No
If "yes", who_____
I have a spiritual belief system that may impact my recovery ___Yes ___No Specify:_____
I regularly do these wellness practices:_____
_____
_____

The information I have presented is a true representation of my health and health history.

_____ _____/_____/_____ _____
Patient Signature Date Witness

Psychotherapy
5934 South Business Drive
Sheboygan, WI 53081

(920) 459-9277

Consent for Treatment/Therapy of a Minor

I, _____ parent/guardian of

_____ hereby give my consents to treatment/therapy services to my (son) (daughter).

This consent specifically limits services to:

_____

_____.

And is in effect until such time that this file is closed and patient is discharged.

You may communicate about this minor in written, oral, e-mail, fax or other format to:

_____	_____
Name	Relationship to minor
_____	_____
Name	Relationship to minor
_____	_____
Name	Relationship to minor
_____	_____
Name	Relationship to minor
_____	_____
Name	Relationship to minor
_____	_____
Name	Relationship to minor
_____	_____
Name	Relationship to minor

_____ _____

Signature of Parent/Legal Guardian Date

_____ _____

Signature of Witness Date

Patient Rights & Informed Consent

PART ONE
Patient Rights

Treatment Rights and Personal Rights / Clients have the right to:

1. Receive prompt and adequate treatment
2. Complete and current information concerning their outpatient program
3. Confidentiality as it relates to their treatment program
    a. Legally, confidentiality may be broken when a client's actions or stated intent pose a risk to client or another person (in the therapists professional judgment.) Also note Informed Consent # 10 & 11.
4. Be informed of services available and their cost
5. Participate in the planning of their treatment program
6. Refuse to take medication. (Be informed that psychotherapists do not prescribe medication)
7. Refuse to participate in experimental research. (Be informed the WHC does not participate in experimental research programs)
8. Refuse to be filmed or taped. (Be informed the WHC does not use taping or video devices)
9. Sign an Informed Consent Document
10. Receive ongoing treatment from other staff or options/referrals should their therapist no longer be employed at WHCS, LLC.

Legal Rights / Clients have the right to:

1. Petition a court for a review of any civil commitment
2. Bring an action for damages against persons violating rights or confidentiality
3. Be considered to be legally competent unless a judge has found them to be incompetent

Other Rights / Clients have the right to:

1. See their treatment record after release. A client may also see parts of it during treatment, if the primary therapist agrees.
2. Have a grievance procedure available to them and to have an advocate present during the grievance process
3. Have the right to see or contact the Director or Clinical Director to discuss their treatment plan
4. Receive written notification if involuntary discharge occurs for behavior, non-compliance with treatment plan, non-compliance with payment plan and have the right to receive sources for ongoing treatment. In addition patients have the right to have the involuntary discharge reviewed by the Dept. of Health Services, Certification Unit, prior to the effective date of discharge.

PART TWO
Informed Consent Document

Clients have the right to know:

1. The proposed treatment and services
2. Benefits and risks of treatment and services
3. Administration of treatment and services
4. Side effects (if any) of treatment and services
5. Alternative programs and/or methods of treatment
6. Benefits and risks of alternative programs and/or methods of treatment
7. The right to receive no treatment or services
8. The benefits and risks of receiving no treatment or services
9. The right to withdraw the informed consent at any time in writing
10. Necessary records will be released to my insurance carrier for the purpose of billing and collection.
11. Bills not covered by my insurance carrier will be mailed to my home.

I understand that this Patient Rights & Informed Consent Document is in effect for one year or until I withdraw it in writing or until my case is closed. I will be required to sign a new form every 12 – 15 months.

I have read and understand these rights and I understand that a copy will be given to me upon my request.
If I am being prescribed medication by another provider/doctor not at this clinic, I attest that I have been completely informed of the benefits, risks, side effects, dosage, alternatives, benefits and risks of alternatives of those medications and know that I have the right to refuse medication and I have been informed of the benefits or risks to receiving no medication.
I give my consent for treatment

_____
Client Signature (Guardian for Minor) Date_____

_____ _____
Therapist Signature indicates that the points have been reviewed and explained Date