Olive Branch Counseling Associates, Inc.

Client Name _____ Age _____ Date of Birth_____

Address _____

City & State_____ Zip _____

Home Phone (___)_____Work Phone (___)_____
Cell Phone (____)_____ Email Adress: _____
Occupation: _____ Education Level:_____

How many hours a week do you work? _____Employer or School_____

Spouse/Partner _____ Occupation: _____

Names and Ages of Children _____
_____

Name of Physician _____ Date of Last Physical Exam _____

Would you like your therapist to contact your physician? _____ Phone # _____

Have you seen a therapist before? _____ How long ago?_____For how long?_____

Name of Therapist: _____

Do you have any diagnoses made by a physician or therapist? _____ With what have you been

diagnosed? _____

Please list any medications you take: _____

Names and Ages of Siblings _____

Is your mother living? _____If not, cause of death? _____

Is your father living? _____If not, cause of death? _____

How do you describe yourself culturally/ethnically? _____

Have there been any changes in your life recently? (death of a loved one, divorce, etc.)

_____

What kinds of difficulties bring you to our office? _____

Is there anything else you want your therapist to know about you right now?

_____

If you are paying for services out of pocket, do you require a Good Faith Estimate? _____

Please tell us how you found Olive Branch: “From a Friend” “My Doctor” “Google Search” “Church or Pastor” “YellowPages.com” “Facebook.com” “Psychology Today” “counselingmatters.live” Other:_____
_____

Symptom Checklist

Your Name _____ Todays Date_____

***Please rate the degree to which you have been experiencing the following problems during the LAST WEEK. **Make an X on or near the numbers that best describe the severity of the item listed below.

	Not a Problem										Very Severe Problem
1. Anxiety (Nervousness)	0	1	2	3	4	5	6	7	8	9	10
Panic Attacks	0	1	2	3	4	5	6	7	8	9	10
2. Depression	0	1	2	3	4	5	6	7	8	9	10
3. Disturbing Thoughts	0	1	2	3	4	5	6	7	8	9	10
4. Thinking about hurting yourself	0	1	2	3	4	5	6	7	8	9	10
How likely is it?	0	1	2	3	4	5	6	7	8	9	10
5. Thinking about hurting others	0	1	2	3	4	5	6	7	8	9	10
How likely is it?	0	1	2	3	4	5	6	7	8	9	10
6. Fears/Fearfulness	0	1	2	3	4	5	6	7	8	9	10
7. Repetitive thoughts/Obsessions	0	1	2	3	4	5	6	7	8	9	10
8. Impuslive thoughts, specify: _____											
9. Impulsive behaviors, specify: _____											
10. Loss of appetite/Not Eating:	0	1	2	3	4	5	6	7	8	9	10
11. Overeating	0	1	2	3	4	5	6	7	8	9	10
12. Binge Eating	0	1	2	3	4	5	6	7	8	9	10
13. Have you gained weight recently? **Y N** How Much? _____ In how much time?_____											
14. Have you lost weight recently? **Y N** How Much? _____ In how much time?_____											
15. Not sleeping enough	0	1	2	3	4	5	6	7	8	9	10
16. Sleeping too much	0	1	2	3	4	5	6	7	8	9	10
17. Waking up at night	0	1	2	3	4	5	6	7	8	9	10
18. Trouble falling asleep	0	1	2	3	4	5	6	7	8	9	10
19. Nightmares	0	1	2	3	4	5	6	7	8	9	10
20. Other sleeping problems	0	1	2	3	4	5	6	7	8	9	10
Specify:_____											
21. How many hours do you sleep most nights? _____											
22. Do you ever not sleep at night? **Y N** How often? _____ Why? _____											
23. Fatigue	0	1	2	3	4	5	6	7	8	9	10
24. Attention/Concetration Difficulties	0	1	2	3	4	5	6	7	8	9	10
25. Adjusting to change	0	1	2	3	4	5	6	7	8	9	10
26. Sexual Problems	0	1	2	3	4	5	6	7	8	9	10
Specify:_____											
27. Alchohol Problems	0	1	2	3	4	5	6	7	8	9	10
Specify:_____											
28. Drug Problems	0	1	2	3	4	5	6	7	8	9	10
Specify: _____											
29. Gambling problems	0	1	2	3	4	5	6	7	8	9	10
Specify: _____											

30. Work/School Problems 0 1 2 3 4 5 6 7 8 9 10
31. Marriage Problems 0 1 2 3 4 5 6 7 8 9 10
32. Child-rearing problems 0 1 2 3 4 5 6 7 8 9 10
33. Extended family problems 0 1 2 3 4 5 6 7 8 9 10
34. Problems getting along with others 0 1 2 3 4 5 6 7 8 9 10
35. Anger 0 1 2 3 4 5 6 7 8 9 10
36. Violence 0 1 2 3 4 5 6 7 8 9 10
    Specify: _____
37. Spiritual Problems 0 1 2 3 4 5 6 7 8 9 10
38. Do you attend church? If so, which one? _____
39. Health problems 0 1 2 3 4 5 6 7 8 9 10
    Specifiy: _____
40. Self-Esteem 0 1 2 3 4 5 6 7 8 9 10
41. Cultural/Ethnic Identity 0 1 2 3 4 5 6 7 8 9 10
42. Self Image (How you see yourself) 0 1 2 3 4 5 6 7 8 9 10
43. Legal Problems 0 1 2 3 4 5 6 7 8 9 10
    Specify: _____
44. Are there one or more firearms in your house **Y N**
    Specify:_____
45. Financial Problems 0 1 2 3 4 5 6 7 8 9 10
46. Spending too much money 0 1 2 3 4 5 6 7 8 9 10
47. Feeling hopeless 0 1 2 3 4 5 6 7 8 9 10
48. Feeling sad 0 1 2 3 4 5 6 7 8 9 10
49. Feelings of loneliness 0 1 2 3 4 5 6 7 8 9 10
50. Do you exercise? **Y N** What type of exercise? _____How often? _____
51. How much caffiene do you consume each day? _____
52. Do you drink energy drinks? **Y N** How often? _____
53. Other problems 0 1 2 3 4 5 6 7 8 9 10
    Specify _____

What kind of car do you drive? Make: _____ Model: _____ Year _____
Color: _____ License Plate Number:_____

Is there another car you drive sometimes? Make: _____ Model: _____
Year _____ Color: _____ License Plate Number:_____

Emergency contact: Name: _____Phone # _____
Address: _____

What are your three main concerns?

_____

_____

Olive Branch Counseling Associates, Inc.

6819 W. 167th Street, Tinley Park, Illinois 60477

The credit card information below is used for the purpose of service fees, insurance fees (including co-pays, deductible payments and co-insurance) and missed or late cancelled appointment payments incurred at Olive Branch Counseling Associates, Inc. Please complete the form below. This card will be kept on file and charged after each appointment or missed appointment, or when we receive information from your insurance company. A minimum of a 24-hour notice is required for rescheduling or canceling an appointment for reasons other than emergencies and illness. If proper notice is not given for the rescheduling or cancellation of any appointment, the full session fee will be charged. By signing, you are providing permission for payments to be charged to your credit card.

Therapist: _____

Client Name: _____

Name on Card: _____

Visa ____ Discover _____ MasterCard _____ AmEx_____

Card Number: _____

Expiration Date: _____

Security Code: _____

Zip Code: _____

Signature: _____ Date: _____

Printed Name: _____ Date: _____

Olive Branch Counseling Associates, Inc. has transitioned from the standard telephone land-line already being used to the use of "Google Voice" telephone numbers for more efficient communication between clients and their therapists.

Please read and sign below acknowledging your understanding of how this transition impacts you, our client:

I understand that using "Google Voice" does not provide a secure line according to the Health Insurance Portability and Accountability Act (HIPAA). Therefore telephone conversations and messages, either text or voice, should only be utilized for communication of setting, changing or confirming appointment times.

By signing below you agree to abide by this policy as it is designed to protect you, the client.

Signed_____ Date_____

Printed Name_____

Now, about how your therapist may contact you:

I give my permission for my therapist to leave a voice-mail message and/or a text message on my phone relating to appointment information only.

I agree to communicate with my therapist via email only for appointment changes or confirmations.

Olive Branch Counseling Associates, Inc. does not provide Internet counseling services.

I understand that giving permission for my therapist to leave a voice mail message or send a text message regarding appointment times is entirely voluntary and I am not obligated in any way to sign below. If I agree to any part of this agreement I may withdraw my decision at any time by filling out a new agreement form stating such. I hereby agree my therapist may leave voice or text messages on the following

Phone Number____-____-_____ Is this your Cell, Home, Work or Other number?_____

Phone Number____-____-_____Is this your Cell, Home, Work or Other number?_____

Email address: _____

Signed_____Date_____

Printed Name_____

I acknowledge that I have received the attached copy of the Notice of Privacy Practices and Social Media Statement.

Signed_____ Date_____

I give my consent to receive an evaluation and treatment that my therapist and I deem appropriate. I am entering into treatment voluntarily and am aware I can discontinue treatment at any time.

Signed_____ Date_____

I understand that I am responsible for the payment of professional services rendered to me, including any unpaid balance remaining after insurance benefits have been paid.

Should it become necessary for Olive Branch Counseling Associates, Inc. to employ the services of a collection agency or lawyer to collect my unpaid balance, I agree to pay the expenses associated with that collection process.

Signed_____ Date_____

When you schedule an appointment in our office, that time is reserved just for you. In an effort to be fair to our therapists who reserve that time for you, we ask you to sign below.

I acknowledge and agree to comply with the Policy of Olive Branch Counseling Associates, Inc. that a twenty-four (24) hour notice is required for sessions that will be missed for reasons other than emergencies.

If 24-hour notice is not given, I accept full financial responsibility for the session. I will either make the payment online, or mail cash or check payable to Olive Branch Counseling Associates, Inc. within one week of the missed session. No-show and late cancellation fees are the same full rate as session.

Signed_____ Date_____

Printed Name_____