MANN
COUNSELING GROUP

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CLIENT REGISTRATION

Today's Date _____

Client Name _____ Date of Birth _____

Street Address _____

City _____ State _____ Zip _____

Cell Phone _____

Is it okay to leave a message/text? Y N

Email to be used for communication of appointments and other counseling related communication

_____

If you are a member of Aetna, please provide a copy of your card and the date of birth of the primary insured (if primary insured is not a client) ____ /____ /____

In case of emergency notify _____ Relationship _____

Cell Phone _____

IF A MINOR:

Parent's/Guardian's Name

_____

Parent's/Guardian's Email

_____

Parent's/Guardian's Cell Phone _____

Is it okay to leave a message/text? Y N

Siblings Names/Ages _____

What school do they attend?_____

IF MARRIED/COUPLED:

Spouse/Partner Name _____ Occupation _____

Cell Phone _____ Email _____

Children's Names/Ages _____

ALL CLIENTS:

Who referred you to this practice? _____

May I thank them for the referral? (If so, please sign) _____

Any previous counseling/psychiatric care? With whom? _____

List all medications _____

_____

Primary Care Physician _____

Phone _____ Fax _____

PERSONAL HISTORY:

Indicate any of the following that you have experienced:

ADHD/ADD	Yes	No
Adoption	Yes	No
Alcohol/Substance Abuse	Yes	No
Anxiety	Yes	No
Bipolar Disorder	Yes	No
Child Abuse/Neglect	Yes	No
Chronic Pain	Yes	No
Depression	Yes	No
Divorce	Yes	No
Domestic Violence	Yes	No
Eating Disorders	Yes	No
Gaslighting (Crazy-making communication)	Yes	No
Obsessive Compulsive Behavior	Yes	No
Schizophrenia	Yes	No
Sexual Harassment	Yes	No
Sexual Abuse (childhood)	Yes	No
Sexual Assault (18 years & older)	Yes	No
Sexual Issues	Yes	No
Spiritual Abuse	Yes	No
Suicide Attempt or Contemplation/Planning	Yes	No
Self-Injury	Yes	No

LIFE RHYTHMS:

How would you rate the quality of the following?

Sleep	Poor	Fair	Good
Appetite	Poor	Fair	Good
Mood/Emotional Regulation	Poor	Fair	Good
Self-Awareness (what you think/feel)	Poor	Fair	Good
Physical Health	Poor	Fair	Good
Exercise	Poor	Fair	Good
Family Support	Poor	Fair	Good
Friend Support	Poor	Fair	Good
Career/School	Poor	Fair	Good
Significant Other Support	Poor	Fair	Good
Spiritual/Faith Life	Poor	Fair	Good

What do you consider to be some of your strengths?

_____

_____

_____

_____

What do you consider to be some of your weaknesses?

_____

_____

_____

_____

What would you like to accomplish during your time in therapy?

_____

_____

_____

_____

CONFIDENTIALITY: The confidentiality of your discussions with the therapist is protected by ethical standards of practice and by law. The law does require, however, that the therapist must notify relevant others if a client expresses the intention to harm himself/herself or others. Instances of child abuse, neglect or molestation against a minor must also be lawfully reported.

PAYMENT POLICY: PAYMENT OF ALL FEES ARE EXPECTED AT THE TIME OF SERVICE. Medically coded receipts can be provided at the time of session.

CANCELLATIONS OR MISSED APPOINTMENTS *(Please initial at the end of each bullet where indicated.)*

• Mutual consideration and respect are assumed. THEREFORE, ANY CANCELLATIONS MUST BE MADE A MINIMUM OF 48 HOURS PRIOR TO THE APPOINTMENT. Any missed appointments or appointments cancelled without adequate notice will lead to a full charge for the missed appointment. **Please initial _____**

• In the event of illness or inclement weather, we can arrange to hold the session via Skype, Facetime, or voice call. If you don't desire to do this, there will be a half-fee charge to the credit card on file. **Please initial _____**

• Please note that you can contact me directly at 303.881.0854 via text 48 hours prior to your appointment to cancel your appointment. You may also cancel your appointment on the online calendar provided by Schedulicity; this is a scheduling system that connects to my practice, via my website: www.MannCounselingGroup.com. It allows you to set up an account with your email and password so that you can arrange, reschedule or cancel appointments at your convenience. I can assist setting up your account during session if desired. **Please initial _____**

INSURANCE: Insurance coverage represents a contract between you and your insurance company. You are responsible for payment of service at the regular fee whether your insurance coverage applies. Monthly statements with all the information needed to process your claim will be provided.

RELEASE AND STATEMENT OF RESPONSIBILITY I have read the above information and understand the payment policy. I authorize the release of information concerning my treatment to my insurance company. I understand that I am responsible for the full amount of my bill for services provided.

Client (or guardian, if client is a minor) Name _____

Signature _____ Date _____