Lee's Place
216 Lake Ella Drive
Tallahassee, FL 32303

CLIENT INFORMATION FORM (DE)

Name: _____ **Age** _____ **Date of Birth**: _____

Address: _____

Street City State Zip

Phone (H): _____ **Phone (W):**_____ **Phone (Cell):** _____

Email Address: _____

Invoices will be emailed unless requested otherwise

Your occupation and employer: _____ How Long? _____

Our fee is based on a sliding scale, please use the attached grid to determine your fee for each session:_____.

Do you have health insurance? ___ Yes ___ No
Does your insurance cover mental health services? ___ Yes ___ No
(*Answering these questions does not commit you in any way to using your insurance.)

Relationship status: Single ___ Married ___ Divorced ___ Widowed ___ Separated ___ Partnered ___
If married, how long? ___ How many times? ___ If divorced, how long? ____ If separated, how long?____
If partnered, how long? ____

Spouse/Partner Information:
Name: _____Date of Birth: _____
Occupation: _____
Employer's Name: _____ How Long? _____

Emergency Contact: _____ Phone number: _____

How did you hear about Lee's Place? _____

Please answer the following questions so we can better understand your experience:

Full name of person who died: _____Age: _____ Date of Death: _____

What other deaths have you experienced and the approximate dates?

_____
_____
_____

What other changes have you experienced (moved, changed jobs, schools, etc.)?

_____

_____

_____

_____

Persons Living in Your Home:

Name	Relationship	Age	Special Concerns/Problems?

Have you ever been in a relationship where there was (check all that apply):

_____ physical violence (slapping, punching, biting, throwing objects, etc.)?

_____ name calling or put downs?

_____ controlling or jealous behaviors?

_____ fear for your own safety or that of your children?

_____ none of the above

Please answer the following general health questions so I may better understand your medical history:

How has your health changed since the loss? _____

_____

Please indicate current health concerns: _____

_____

Please indicate past health concerns: _____

_____

Are you now under the care of a doctor? __No __Yes If "Yes," state the problem/condition being treated:

_____

Physicians Name: _____Phone: _____

What medications are you currently taking? (please list) _____

_____

_____

Past Hospitalization – Medical, Psychiatric, and/or Chemical Dependency: ___ None

Date(s)	Reason(s)	Hospital/Facility
_____	_____	_____
_____	_____	_____

Have you ever attempted suicide? ____Yes ____No

Please circle the following conditions/problems you are currently experiencing:

Dizziness/Fainting	Breathing difficulty	Unexplained pain/body aches
Rage	Nausea/Vomiting	Frequent Headaches
Tired most of the time	Irritability	Sleeping too little/ too much

Indigestion/Reflux	Difficulty concentrating	Shaking of hands, arms, or legs
Chills, fever, night sweats	Over/Under eating	Constipation/Diarrhea
Mind racing	Chest tightness	Suicidal Thoughts
Loss of interest in activities	Recent weight change	Jittery/Nervousness
Outbursts of anger	Loss of the will to live	Feeling threatened
Blackouts/Seizures	Violence in the home	Other: _____

BEHAVIORS:

Do you or anyone in your family have addictive behaviors such as gambling, eating, shopping, sex, or excessive computer use? ____ yes ____ no If yes, please explain each addictive behavior:

_____

_____

_____

Is there, or has there ever been, any substance abuse among any members or your household (ex. Cocaine, alcohol, marijuana, prescription drugs, inhalants, etc.)? ___ yes ___ no

If yes, please explain:_____

_____

_____

Have you had previous counseling and/or chemical dependency services? None

Facility/Counselor Name	Date(s)	Why Seen?	Helpful?
_____	_____	_____	Y N
_____	_____	_____	Y N

Is there anything else you would like us to know about you or your family?

_____

_____

_____

_____

_____

What changes would you like to see as a result of counseling?

_____

_____

_____

_____

_____

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CLIENT AGREEMENT FORM / INFORMED CONSENT

1. I agree to attend my sessions regularly. **I agree to call at least 24 hours in advance when I am unable to attend. I understand that I will be charged for that session without 24 hour notice of cancellation.**

2. I agree to be on time for each session. It is important to those who will be dropping off and picking up a client that they do so at the appropriate times.

3. Parents agree to provide supervision for any children in the waiting area.

4. I agree to pay for each session at the time of service. If I am utilizing insurance, Lee's Place will not bill my insurance directly, but they will be happy to provide me with a receipt for payment.

5. I understand that Lee's Place therapists and staff are only available during regular business hours and that Lee's Place does NOT have 24 hour emergency phone service. Crisis assistance can be obtained by going to the nearest emergency room, calling Telephone Counseling and Referral Service at 211 (or 850.617.6333 if using a cell phone), or by calling 911.

6. The greatest risk of counseling is that it may not by itself resolve my problem or concern. While the staff at Lee's Place will do their best to help me, they may at times, with my consent, team with other medical and mental health professionals to seek the best approach to care.

7. **I have read and understand the statements above. My signature indicates that I give full and informed consent to receive services for myself and/or for my minor child/children.**

Signature of Each Adult Printed Name of Each Adult

_____ _____

_____ _____

Date _____

_____

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LEE'S PLACE CONFIDENTIALITY POLICY

Our work with you and your family at Lee's Place is confidential. The information you share with the staff, volunteers and other participants is private. Your right to privacy will be strictly maintained. There are, however, some important **exceptions** to confidentiality that are explained below. Please read the seven exceptions to confidentiality before signing this form.

EXCEPTIONS TO CONFIDENTIALITY

1. Florida law requires our staff to report to the appropriate authorities any suspected physical, sexual or emotional abuse or neglect of a child, elderly person or disabled person.
2. If we believe you have a specific intent to harm yourself, we reserve the right to inform other family members and/or make appropriate referrals if necessary, including seeking hospitalization for you.
3. If we believe you intend to harm someone else, we will take steps to protect the intended victim, including contacting law enforcement and informing the intended victim.
4. If information is ordered by the Court, including a subpoena, we will assert to the Court that the information is privileged. Additionally, we will attempt to contact you about the order. If you oppose the release, the Court may require compliance with the order and information would be released.
5. If we come to believe there is drug and/or alcohol use or abuse by a child or a teen, we reserve the right to inform the parent. If we suspect a participating adult is using drugs and/or alcohol before an appointment, we reserve the right to decline further services.
6. These rights and exceptions to confidentiality apply to information disclosed in support groups. All group members are encouraged to keep such information confidential, but Lee's Place cannot guarantee they will do so.
7. At times, Lee's Place uses case examples of children or teens and their families in publishing journal articles, conducting professional training and in fundraising efforts. We may anonymously refer to your situation in those circumstances. However, your names will never be used without specific written approval.

IN SIGNING THIS DOCUMENT, I ACKNOWLEDGE THAT I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE LEE'S PLACE CONFIDENTIALITY POLICY. I HAVE READ AND UNDERSTAND THE CONFIDENTIALITY POLICY.

Today's Date _____

Signature of Parents/Legal Guardian _____

Signature of Adult Client_____