BALANCE 4 LIFE

CLIENT CONFIDENTIALITY STATEMENT / AGREEMENT

Professional ethics and the laws of this state prevent us from telling anyone else what we discuss in counseling sessions unless you give us written permission to do so. These rules and laws are the ways our society recognizes and supports the privacy or "confidentiality" of counseling.

There are limits on our confidentiality. There are times when the law requires us to reveal certain information. Specifically:

1. When, in the professional opinion of the counselor, disclosure is necessary to protect against an imminent or likely risk of serious harm to self or others.
2. When there is suspicion of abuse of children or vulnerable adults.
3. When there is a court order. If you are involved in a legal case, a judge has the authority to issue a court order for your counseling records.

We may, at your request, share information with others about your counseling sessions with your authorization via a signed release of records form.

Any information that you choose to share outside of therapy, willingly and publicly, will not be considered protected or confidential.

The signatures below show that we each have read, discussed, understand, and agree to abide by the statements presented above.

_____ _____

Signature of client Date

_____ _____

Signature of counselor Date

BALANCE 4 LIFE

CLIENT INFORMATION SURVEY

Please provide the following information for our records. Leave blank any question you would rather not answer or would prefer to discuss in person. Information provided here is subject to our confidentiality agreement.

PLEASE PRINT ALL RESPONSES

Name: _____ Date of -Birth: _____

Complete Address: _____

Email Address: _____ Mobile Number: _____

TREATMENT HISTORY

Are you currently receiving psychiatric services, professional counseling, or psychotherapy elsewhere? ☐ no ☐ yes

Have you had previous psychiatric services, professional counseling, or psychotherapy?

☐ no ☐ yes, with (previous therapist's name) _____

Are you currently taking any prescribed psychiatric medication (antidepressants or others)?
☐ no ☐ yes

If yes, please list: _____

Prescribed by: _____

HEALTH AND SOCIAL INFORMATION

Do you currently have a primary physician? ☐ no ☐ yes

If yes, who is it? _____

Are you currently seeing more than one medical health specialist? ☐ no ☐ yes

If yes, please list: _____

When was your last physical? _____

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.: _____

_____

Are you currently on medication to manage a physical health concern? If yes, please list below:

_____

_____

Are you having any problems with your sleep habits? ☐ no ☐ yes

If yes, check where applicable: ☐ Sleeping too little ☐ Sleeping too much

☐ Poor quality sleep ☐ Disturbing dreams ☐ other _____

How many times per week do you exercise? _____

Approximately how long each time? _____

Are you having any difficulty with appetite or eating habits? ☐ no ☐ yes

If yes, check where applicable: ☐ Eating less ☐ Eating more ☐ Bingeing ☐ Restricting

Have you experienced significant weight change in the last 2 months? ☐ no ☐ yes

Do you regularly use alcohol? ☐ no ☐ yes

In a typical month, how often do you have 4 or more drinks in a 24-hour period? _____

How often do you engage recreational drug use?

☐ daily ☐ weekly ☐ monthly ☐ rarely ☐ never

Do you smoke cigarettes or use other tobacco products? ☐ no ☐ yes

Have you had suicidal thoughts recently?

☐ frequently ☐ sometimes ☐ rarely ☐ never

Have you had suicidal thoughts in the past?

☐ frequently ☐ sometimes ☐ rarely ☐ never

Are you currently in a romantic relationship? ☐ no ☐ yes

If yes, how long have you been in this relationship? _____

On a scale of 1-10 (10 being the best), how would you rate your current relationship? _____

In the last year, have you experienced any significant life changes or stressors? ☐ no ☐ yes

If yes, please explain: _____

_____

_____

Have you ever experienced any of the following?

Extreme depressed mood	☐ no ☐ yes
Dramatic mood swings	☐ no ☐ yes
Rapid speech	☐ no ☐ yes
Extreme anxiety	☐ no ☐ yes
Panic attacks	☐ no ☐ yes
Phobias	☐ no ☐ yes
Sleep disturbances	☐ no ☐ yes
Hallucinations	☐ no ☐ yes
Unexplained losses of time	☐ no ☐ yes
Unexplained memory lapses	☐ no ☐ yes
Alcohol/substance abuse	☐ no ☐ yes
Frequent body complaints	☐ no ☐ yes
Eating disorder	☐ no ☐ yes
Body image problems	☐ no ☐ yes
Repetitive thoughts (e.g. obsessions)	☐ no ☐ yes
Repetitive behaviors (e.g. frequent checking, hand washing)	☐ no ☐ yes
Homicidal thoughts	☐ no ☐ yes
Suicidal attempts If yes, when?	☐ no ☐ yes

OCCUPATIONAL INFORMATION

Are you currently employed? ☐ no ☐ yes

If yes, who is your currently employer/position? _____

If yes, are you happy with your current position? _____

Please list any work-related stressors, if any: _____

_____

_____

RELIGIOUS/SPIRITUAL INFORMATION

Do you consider yourself to be religious? ☐ no ☐ yes

If yes, what is your faith? _____

If no, do you consider yourself to be spiritual? ☐ no ☐ yes

FAMILY MENTAL HEALTH HISTORY

Has anyone in your family (immediate family members and/or relatives) experienced difficulties with the following? (Check all that apply and list family member, e.g. sibling parent, uncle, etc.)

Difficulty		**Family member**
Depression	☐ no ☐ yes	
Bipolar disorder	☐ no ☐ yes	
Anxiety disorder	☐ no ☐ yes	
Panic attacks	☐ no ☐ yes	
Schizophrenia	☐ no ☐ yes	
Alcohol/substance abuse	☐ no ☐ yes	
Eating disorders	☐ no ☐ yes	
Learning disabilities	☐ no ☐ yes	
Trauma history	☐ no ☐ yes	
Suicide attempts	☐ no ☐ yes	
Chronic illness	☐ no ☐ yes	

OTHER INFORMATION

What do you consider to be your strengths? _____

_____

What do you like most about yourself? _____

_____

What are effective coping strategies that you have learned? _____

_____

_____

What are your goals for counseling?

_____

_____

_____

_____

_____