Beautiful Autism

CLIENT INFORMATION SHEET

This is a confidential record of your personal history, it will not be released to anyone unless authorized by you or required by law.

Personal information			
Name(First/Last):		Birth Date:	Sex: M ❑ F ❑
Race:	Religion:	SSN:	
Street:	City:	State:	Zip:
Home #:	Cell #	Work #:	
May your therapist leave a message for you at home? Yes ❑ No ❑		On Cell? Yes ❑ No ❑	
Your e-mail address:			
Highest Education:			
Emergency Contact Name: (first/Last)			
Relation to patient:		Phone #:	

How can we help you?
Please state the nature of your problem, and what you would like to accomplish through counseling:
How serious does this problem feel to you? 1 2 3 4 5 Mildly upsetting ⟷ Extremely serious

For our records?
How did you hear about us?
Would you like to receive updates regarding Beautiful Autism via email? Yes ❑ No ❑

Occupational status		
Employer name:		Title:
Street:		
City:	State:	Zip:
Household gross monthly income: $		

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Family status
Marital status: Single ❑ Married ❑ Divorced ❑ Widow(er) ❑ Other ❑
Spouse Name (first/Last): Date of marriage: If married the age of spouse:
If separated the date of separation:
If divorced the date of marriage to ex-spouse: Date of divorce:
If divorced more than once, date of previous marriages:
Date of previous divorces:
If involved with a "significant other" his/her name:
If you live together since when: How long known:
Your children's names and ages:
Are your children living with you? Yes ❑ No❑
Other children living with you? Names, Ages & Relationship to you:
Other adults living with you:
If your therapist provides psychotherapy with your spouse, should your therapist use his/her own judgement in sharing information or observations from your therapy? Yes ❑ No ❑

Family History:
Father's age: Occupation: Mother's age: Occupation:
Did you grow up with both parents in the home? Yes ❑ No ❑
Are your parents still married? Yes ❑ No ❑ If No date of divorce:
Whom do you feel closest to? Mother ❑ Father ❑ Neither ❑
Briefly describe your relationship with your father:

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Family History Continued:
Briefly describe your relationship with your Mother:
Brothers' first names & ages: (Please describe relationship)
Sisters' first names & ages: (Please describe relationship)
Has any member of your family suffered from anything that could be described as an "emotional" or "psychological" problem (i.e. depression, suicide…):
Please mention any history of domestic violence, child abuse or sexual abuse in your family:
Please comment on any history of alcohol or drug use in your family:

Medical history: (Please mark your selection with an X)

	Never	**Seldom**	**Sometimes**	**Often**
Alcohol intake	❑	❑	❑	❑
Allergies	❑	❑	❑	❑
Asthma	❑	❑	❑	❑
Back pain	❑	❑	❑	❑
Caffeine consumption	❑	❑	❑	❑
Constipation	❑	❑	❑	❑
Depression	❑	❑	❑	❑
Drug use	❑	❑	❑	❑
Diarrhea	❑	❑	❑	❑

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Medical History Continued: (Please mark your selection with an X)				
Fatigue	❑	❑	❑	❑
Headaches	❑	❑	❑	❑
High blood pressure	❑	❑	❑	❑
Insomnia	❑	❑	❑	❑
Loss of appetite	❑	❑	❑	❑
Loss of temper	❑	❑	❑	❑
Mood swings	❑	❑	❑	❑
Nausea	❑	❑	❑	❑
Nervousness	❑	❑	❑	❑
Over-eating	❑	❑	❑	❑
Phobias(fears)	❑	❑	❑	❑
Smoking	❑	❑	❑	❑
Suicidal thoughts	❑	❑	❑	❑

Personal History:		
Have you ever attempted suicide? Yes ❑ No ❑ If Yes, How many times? Date(s):		
Current weight: One year ago: Maximum: When:		
Do you exercise regularly? Yes ❑ No ❑ If so how?		
Do you sleep well?	Amount (hours):	Easy to get to sleep? Yes ❑ No ❑
What recreation do you enjoy?		
Physician:	City:	Date of last physical:
The hardest time in your development was: Preschool ❑ Grade school ❑ Junior high ❑ High school ❑ College ❑ Now ❑		

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Medication and Treatment history:				
Please indicate with an "x" how often you use any of the following:				
	Never	**Occasionally**	**Frequently**	**Daily**
Appetite suppressants	❑	❑	❑	❑
Aspirin	❑	❑	❑	❑
Blood pressure medicine	❑	❑	❑	❑
Heart medicine	❑	❑	❑	❑
Sedatives/tranquilizers	❑	❑	❑	❑
Sleeping pills	❑	❑	❑	❑
Stimulants	❑	❑	❑	❑
Vitamins	❑	❑	❑	❑
Other :	❑	❑	❑	❑
Please list all current medications:				
Please list all street drugs used currently and in past: How often are these drugs used?				
Have you seen a therapist before? Yes ❑ No ❑		If yes, when?		
Length of therapy:		Was therapy successful? Yes ❑ No ❑		
Please comment:				
Have you ever been hospitalized for psychiatric reasons? Yes ❑ No ❑			If yes, when?	
Length of hospital stay:				
Have you ever been arrested? Yes ❑ No ❑ If **yes**, please explain and give dates: Are you currently on Probation/Parole?				

Name of Insurance Company:		
Insurance ID #:	Group #:	
Subscriber:	Subscriber birthdate:	Employer:
Subscribers address if different from patients:		
Secondary insurance:	ID#	
PLEASE PROVIED INSURANCE CARDS FOR SCANNING		

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Attendance Agreement

Attendance is very important for effective therapy. Therapy is generally once a week, or twice a month, based on the client's particular needs which will be determined by the therapist. Things such as late arrivals, missed appointments, late changes, and cancellations can and likely will impact the therapeutic process. Because of that, the following will be placed into effect as of August 1, 2018:

- 3 missed appointments, meaning no show and no cancellation, will lead to a cancellation of services.
- Any missed appointment will also be charged a $50 no show fee. This fee cannot be billed to insurance and is expected to be paid in full before the next session.
- If client arrives 15 minutes late for appointment, you may not be able to be seen and will be charged a no-show fee of $50.
- All late changes, including rescheduling and canceling, (within 24 hours of session) will be charged $50.
- All clients will be given 5 excused missed sessions a calendar year. These can be used for travel, other appointments, family engagements, illness, etc. As long as appropriate time is given for cancellation (more than 24 hours), no fee will be charged. After 5 missed sessions, a $50 fee will be charged for any cancelled session, even if more than 24 hours notice is given. This fee cannot be billed to insurance; the family is expected to pay this fee and needs to be paid before the next session. Rescheduling with the therapist to avoid missing sessions towards the 5 excused missed sessions can be looked into at the discretion of the therapist and according to their availability.
- Illness can happen at any time; we certainly appreciate clients not coming in when they are sick. If the client is feeling sick the day before the session, please call and let us know; you will not be charged the late fee even if it is within the 24 hours. If you call to let us know, but the client is well enough the following day, the client is more than welcome to come in for session. Please note that illness from a parent or sibling is not a reason to cancel for the client; Please seek alternative arrangements for the client to come for therapy. If a late cancellation needs to happen due to illness, it will go towards the 5 excused missed sessions per calendar year. The $50 late cancellation fee will not be charged for illness unless the 5 excused missed sessions have been used already.
- The 5 excused sessions are for each different therapy and/or each day. For example, if you see a behavior tech two days a week, you have 5 excused sessions for each day.

Name of client _____ Date _____

Signature of client (guardian) _____

Print Name _____