FIFE COUNSELING
Providing Guidance, Hope, and Healing

Client Information

Please fill out the information below. The information will help me understand better who you are and what you are seeking from counseling and/or life coaching. Please fill out this form as completely as possible. If you have any questions, please feel free to ask.

SECTION I: IDENTIFYING INFORMATION Today's Date: _____

Name_____ Age____ Date of Birth_____ Gender __M, __F
Address_____ City_____ Zip_____
Home Phone_____ Cell Phone_____ Is it OK to leave a message at home? __Yes, __No
Occupation_____ Work Phone_____ Contact at work? __Yes, __No

Marital Status: ___Single, ___Married, ___Co-habiting, ___Separated, ___Divorced, ___Widowed

Name of Spouse/Partner_____ Age____ Date of Birth_____

Children:
Name: _____ Age: ___ Lives with you? __Yes, __No
Name: _____ Age: ___ Lives with you? __Yes, __No
Name: _____ Age: ___ Lives with you? __Yes, __No
Name: _____ Age: ___ Lives with you? __Yes, __No
Name: _____ Age: ___ Lives with you? __Yes, __No
Name: _____ Age: ___ Lives with you? __Yes, __No

Among your friends and family, whom do you count on for support?
_____

In case of an emergency: Emergency contact person_____
Phone_____ Relationship to you_____

Referred to Stephen Fife for counseling/life coaching by: _____

Section II: PREVIOUS COUNSELING AND MEDICAL HISTORY

Have you ever had treatment by a psychiatrist, psychologist, or counselor in the past? _____ Yes, _____No
If yes, please describe the reasons for treatment.
_____
_____
_____
What treatment helpful? _____ Yes, _____No

Please list any current or previous health problems.
_____
_____
_____

Please list any medications that you are currently taking (including daily dosage).
_____
_____

8200 Nashville Ave, Suite 203, Lubbock, TX 79423
Fifecounseling@gmail.com 806.482.1293

SECTION III: DESCRIPTION OF PRESENTING PROBLEM

Please describe your primary reasons for seeking counseling/therapy.

_____
_____
_____
_____

How long has this been a concern/problem for you?

_____
_____

Are any events that are associated with or led to this concern/problem (traumatic event, relationship ending, etc.):

_____
_____
_____
_____

In the past/present, what has been helpful to you in dealing with this problem?

_____
_____
_____
_____

Are you currently suffering from any of the following? Please check **all** that apply:

__overeating	__restless	__rapid heart rate	__thoughts of suicide
__taking drugs	__depressed mood	__sweating	__fears/phobias
__crying	__trembling/shaking	__anxiety	__recent weight loss or gain
__shortness of breath	__excessive drinking	__low motivation	__causing harm/pain to self
__muscle tension	__distrust	__social withdrawal	__difficulty concentrating
__aggressive behavior	__outbursts of temper	__nervous	__sexual dysfunction
__nightmares	__dizzy or lightheaded	__chest pain	__feelings of worthlessness
__stomach problems	__easily distracted	__fatigue/loss of energy	__can't fall asleep
__sleeping too much	__obsessions	__compulsive behavior	__decreased need for sleep
__poor self-esteem	__family problems	__financial problems	__abusive home situation
__problems with school	__housing problems	__marital problems	__pain
__death of a loved one	__childhood trauma	__problems at work	__other traumatic events

other(s):_____

What substances do you regularly use? ___Alcohol, ___Tobacco, ___Marijuana, ___Meth, ___Cocaine, ___ Pain Medications, Others: _____

Please describe any other information that you feel is important for the therapist to know.

_____
_____
_____
_____
_____
_____
_____

FIFE COUNSELING

Providing Guidance, Hope, and Healing

Authorization for Treatment

Confidentiality:
The information on this form as well as the contents of therapy conversations will be kept confidential, unless you (the client or parent/guardian) give written consent for their release. In certain situations, therapists are required by law to inform certain individuals or agencies. Situations in which the therapist is required by law to report include: when a therapist has a knowledge of or reasonable cause to believe that child/elder abuse or neglect is occurring (report to Child Protective Services (CPS) or a law enforcement agency), and when a therapist has a knowledge of or reasonable cause to believe that there is intent to harm self or others (report to law enforcement agency).

Payment:
Payment is collected at the time of each appointment. Appointment fees are $140 per 50 minute session conducted via phone, video, or office visit, (paid by cash or check; checks should be made out to "Stephen Fife"). Additionally, clients will be billed for the therapist's time spent (beyond 10 minutes) reading lengthy client emails or documents, responding to client emails, talking on the phone, or preparing written documents as requested by clients (see Electronic Communication Policy document for policy and guidelines about email and electronic communication). The fee for a double session is $280 for 100 minutes. The therapist does not accept or bill insurance. However, a summary statement of appointments and payments is available upon request.

Appointments and Cancellation Policy:
Typically, appointments are made weekly for 50 minutes. However, this can be modified to meet your needs. If you cannot make it to an appointment, please contact Stephen Fife. Cancellation of an appointment must occur at least 24 hours before the appointment. Clients will be billed $70 for appointments that are cancelled with less that 24 hours notice or if clients fail to attend the appointment.

Successful Outcomes:
The success of your therapy or life coaching depends greatly on your own ability, desire, and efforts. The therapist cannot offer any guarantee of the success of your treatment. However, you can expect that the therapist will come prepared for each session with the purpose of addressing your needs and the goals you have set for yourself in counseling. You have a right to be informed about the counseling process. Please inform the therapist if you are unclear about something or if you feel that the counseling is not meeting your needs.

Questions:
Please ask if you have any questions regarding the information on this form or therapy policies or procedures.

Consent for Treatment:
Your signature indicates your consent for Stephen Fife to provide treatment to you and/or family members. Your signature indicates that the information you provided above is accurate and that you have read, understood, and agreed to the terms described above.

_____ _____
Signature Date

_____ _____
Signature Date

_____ _____
Parent or Guardian Date

_____ _____
Therapist Signature Date

8200 Nashville Ave, Suite 203, Lubbock, TX 79423
Fifecounseling@gmail.com 806.482.1293