# SANTOS COUNSELING P.L.L.C

3300 Battleground Avenue Ste 303 | Greensboro, NC | 27410 | 336.707.1723
3410 Healy Drive Ste 203 | Winston-Salem, NC | 27103 | 336.707.1723
www.santoscounseling.com | juansantos@santoscounseling.com | @santoscounseling

## CLIENT INFORMATION

First Name_____ Middle _____ First Visit _____

Last Name_____ Gender _____

Address _____ Date of birth _____

City, State & Zip _____ Employer _____

Primary Phone _____ Martial Status _____

Email _____

*Can we leave a text/email for appointment reminders?* ☐ Yes ☐ No

*Can we leave a voice message?* ☐ Yes ☐ No

*Can we email you?* ☐ Yes ☐ No

How were you referred? ☐ Website ☐ Google ☐ Psychology Today ☐ Social Media (i.e., Facebook)

☐ Friend/Family _____ ☐ Other _____

Would you like to receive our FREE monthly e-newsletter? Yes _____ No _____

## EMERGENCY CONTACT

*Per Santos Counseling PLLC ethical code and guidelines, we will contact the legal guardian and/or emergency contact if the patient is in danger to themselves or someone else. Parents/legal guardians are required to remain on premises during each session for adolescents.*

First Name_____ Middle _____ Last Name _____

Relationship to Client_____ Contact # _____

First Name_____ Middle _____ Last Name _____

Relationship to Client_____ Contact # _____

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## EDUCATION

Level of education:

☐ None ☐ Elementary School ☐ Middle School ☐ High School ☐ GED ☐ Vocational Training
☐ Some College ☐ College Degree ☐ Graduate/Professional School

## ETHNICITY

☐ Other ☐ American Indian or Alaskan Native ☐ Black ☐ African American ☐ Hispanic
☐ Multiracial ☐ Pacific Islander ☐ White

## SEXUAL ORIENTATION

☐ Lesbian ☐ Gay ☐ Bisexual ☐ Transgendered ☐ Other ☐ Heterosexual ☐ Unknown

## CLIENT HISTORY

*The following questions are for gathering initial background information to save time for your first session. Please feel welcome to skip questions that do not apply to your situation or that you are not comfortable answering. Please note that the more information you provide, the better your counselor will understand your situation. You will be able to discuss questions in more detail during your session(s). Thank you.*

**Primary Concern:**

## SYMPTOM CHECK-LIST

| | | | |
|---|---|---|---|
| ☐ Poor Concentration | ☐ Impulsive | ☐ Negative Thoughts | ☐ Aggressive |
| ☐ Angry | ☐ Headaches | ☐ Recurring Thoughts | ☐ Inferior Feelings |
| ☐ Anti-Social | ☐ Sick Often | ☐ Regretful | ☐ Lonely |
| ☐ Anxious | ☐ Worry | ☐ Sexual Addiction | ☐ Body Image |
| ☐ Dizziness/Light headed | ☐ Restless | ☐ Internet Addiction | ☐ Unattractive |
| ☐ Inferior | ☐ Guilty | ☐ Drug Addiction | ☐ Sexual Difficulties |
| ☐ Incompetent | ☐ Tired | ☐ Alcohol Addiction | ☐ Empty |
| ☐ Alcohol Dependency | ☐ Hateful | ☐ Sleep Problems | ☐ Irritable |
| ☐ Avoid People | ☐ Restless | ☐ Other Addiction | ☐ Withdrawal |

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**If you are experiencing symptoms not listed above, please explain:**

**What are your counseling goals (things you would like to achieve/change)?**

**Please list strengths/positive influences in your life:**

## MEDICAL HISTORY

**Personal History of Counseling/Therapy?** ☐ Yes ☐ No

If so, please provide details (with whom, dates, purpose, etc.):

**Family History of Counseling/Therapy?** ☐ Yes ☐ No

If so, please provide details (with whom, dates, purpose, etc.):

**Are you currently under the care of a Psychiatrist?** ☐ Yes ☐ No

If, so, details?

Doctors Name:

Address:

Phone Number:

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**Are you taking medication?** ☐ Yes ☐ No

If, so please provide medication details:

| Medication | Dose | Start Date | Who Prescribes? | Purpose |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Anything else we should know about your medications (side effects, other supplements, etc.)**

If so, please explain:

**Have you ever attempted suicide or had a plan to harm yourself?** ☐ Yes ☐ No

If so, details:

**Current thoughts/feelings/ideations of wanting to physically harm yourself?** ☐ Yes ☐ No

If so, details:

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**Previous treatment for alcohol/drug abuse?** ☐ Yes ☐ No

If so, details:

**Have you ever experienced any of the following forms of abuse?**

☐ Verbal ☐ Emotional ☐ Sexual ☐ Other

If so, please explain:

**Do you have a previous (formal) diagnosis from a mental health professional?** ☐ Yes ☐ No

If so, please explain:

## LEGAL

Are you involved in any active legal cases (traffic, civil, criminal)? ☐ Yes ☐ No

If so, please explain:

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## Primary Insurance Information

*Having insurance is not a substitute for payment. Many insurance carriers have fixed allowances or percentages based upon your contract with them, not our office. It is your responsibility to pay the deductible, co-insurance and any other balances not paid by your insurance.*

Insurance Carrier_____ Insured's Name_____

Policy ID _____ Insured's date of birth _____ Gender _____

Group # _____ Address _____

Claims Address _____ City, State & Zip _____

_____ Employer _____

Patient relationship to insured: Phone _____

Self _____ Spouse _____ Child_____ Domestic Partner _____ Other _____

**My signature below indicates that I am consenting to treatment/services at Santos Counseling, PLLC. I have received and understand the contents of the professional disclosure, Notice of Privacy Practices (HIPAA), Electronic Communications Agreement and specific policies of Santos Counseling, PLLC. This information has been explained or summarized for me and any question or concerns have been addressed.**

**Signature:**

**Printed name:**

**Date:**

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## COORDINATION OF TREATMENT

It is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician, psychiatrist, and/or other service providers. Your consent is valid for the term of treatment. If you prefer to decline consent, no information will be shared.

____You may inform my physician(s) ___ I decline to inform my physician.

Physician Name _____ Clinic Name, if applicable _____

Address: _____

Phone: _____

**Signature:**

**Date:**