Coastal Care Counseling, Inc.

Dr. John Knight PhD & Associates 200 S. Emerald Bay Dr., Suite 300 Oldsmar, Florida 34677 727-483-9599

Client Information

Name _____ **Today's Date** _____

Social Security Number _____ **Date of Birth** _____

Address _____**City, Zip**_____

E-mail address _____

Home Phone_____ **Work Phone ***_____ **Cell Phone**_____

Place of Employment _____***May we contact you there?** _____

Reason for your visit today _____

_____

_____

Have you previously consulted with another Doctor for this complaint? _____

Name of Family Physician _____

Physician's Phone Number _____ **Physician's Fax Number**_____

How did you hear about us? _____

Name of Spouse/Significant Other (circle one) _____

Are they aware that you are here today? _____

Spouse/Significant Other's Birth Date_____ **How long have you been together?** _____

Married? _____ **How long?** _____ **Number of Children:** _____

Have you ever been divorced? _____ **How many times?** _____ **When?** _____

Has your spouse ever been divorced? _____ **How many times?** _____ **When?** _____

Have you ever had an abortion? _____ **How many?** _____ **When?** _____

Has your spouse had an abortion? _____ **How many?** _____ **When?** _____

Have you ever had an affair? _____ **How many?** _____ **When?** _____

Has your spouse ever had an affair? _____ **How many?** _____ **When?** _____

Have you ever attempted suicide? _____ **How many times?** _____ **When?** _____

Has your spouse ever attempted suicide? _____ **How many times?** _____ **When?** _____

Health Questionnaire

List all current medications and dosages. Please list all medicines including prescription and non-prescription._____

_____

_____

How much of the following do you consume on an average day?

Coffee _____ Tea _____

Soft Drinks _____ Water _____

Sweets of Candy _____ Salty Foods _____

Alcoholic Beverages _____

Have you recently had trouble with any of the following:

	Yes	No
Nausea or vomiting		
Have you had any recent weight or appetite change		
Do you have difficulties breathing		
Have you had any changes in your vision		
Have you had recent blackouts or memory loss		
Have you had any recent sexual problems		
Do you get dizzy or lose your balance		
Have you had difficulty with coordination		
Do your hands tremble sometimes		
Do you often feel fatigued, or ill		
Have you had a change in sleep patterns		
Do you laugh or cry for no apparent reason		
Do you have thoughts you can't seem to stop		
Do you experience headaches?		
Have you ever been advised to take medication for anxiety, depression, or other emotional issues?		
Have you ever heard voices or seen objects that others have not?		
Have you ever contemplated the details of suicide?		
Have you ever had nightmares or flashbacks of a traumatic event?		
Do you consider yourself to have fears or phobias? Heights, insects, social events, crowds, etc.		
Have you ever given in to an aggressive urge or impulse that has led to the harm of another or of property?		
Have you ever felt that others are against you without them necessarily saying so?		
Have you ever experiences emotional problems associated with you sexual interests?		
Do you find yourself often irritable and/or impatient?		
Do you have difficulty making decisions, often putting them off?		
Do you find yourself spending impulsively when angry, anxious, or tired?		
Do you find yourself spending impulsively when exceedingly happy?		
Would you consider yourself to be codependent?		
Do you ever feel overwhelmed with your life and/or responsibilities?		
Do you feel resentful of others in your life for no apparent reason?		
Do you enjoy social events?		
Do you often feel hopeless or like a failure?		
Do you feel that others often misinterpret your motives, feelings and/or actions?		

On a scale of 1 to 5 (1 being dissatisfied - 5 being satisfied) please rate the following areas of your life. Circle the rating that best applies:

	Least				Most
Emotions and Mental Health	1	2	3	4	5
Family Life	1	2	3	4	5
Finances	1	2	3	4	5
Marriage	1	2	3	4	5
Personal Relationships	1	2	3	4	5
Physical Health	1	2	3	4	5
Social Life	1	2	3	4	5
Spiritual Life	1	2	3	4	5
Quality of Sleep/Rest	1	2	3	4	5

Significant information you would like to make the doctor aware of:

_____

_____

_____

_____

X _____

Signature **Date**

HIPAA NOTICE OF PRIVACY PRACTICES

ALL three signatures are required for consultation and/or to commence treatment.

I, _____ Born on _____/_____/_____, have received and read the Notice of Privacy Practices from Coastal Care Counseling, Inc., and been offered a copy of the HIPAA Notice of Practices.

Signed: X _____ Date _____

---------- ***OR:*** ----------

Signature of authorized person if client is underage or impaired* _____ Date _____

*Relationship of authorized person to client _____ *Reason _____

*Witness _____ *Date _____

CONSENT TO RELEASE OF CONFIDENTIAL INFORMATION

I, authorize Dr. John Knight PhD and COASTAL CARE COUNSELING, INC., to the release of confidential information from my chart and file only for the purpose of aiding in the processing of Psychological/Developmental history, psychological test results & reports, medical and psychological diagnosis and treatment information, including but not limited to summary of treatment, therapy treatment plans, discharge information and/or insurance or payment claims assistance. To provide for continuity of care and treatment planning, I also authorize the verbal and written release of information to physicians and mental health professionals that we agree may be participating in my care. I understand that my therapist is mandated by law to report any intent of harm. I understand that I may have a copy of this form.

In addition, I authorize release to the following person(s)/family member(s) that may be participating in my/our therapy:

Name of person(s) _____

I authorize release to the following organizations and agencies:

Name of organization/agency _____

I understand that this authorization is in effect until I revoke it in writing.

Signed: X _____ Date _____

---------- ***OR:*** ----------

Signature of authorized person if client is underage or impaired* _____ Date _____

*Relationship of authorized person to client _____ *Reason _____

*Witness _____ *Date _____

CONSENT FOR PSYCHOTHERAPY, COUNSELING AND CONSULTING

I, by signing below I acknowledge I have received clear information the policies and procedures of Coastal Care Counseling, Inc. and all of my questions have been answered to my satisfaction. I agree to pay the current fee of $185.00 per **50-minute session** as well as fees for all other services I may receive in the future. I am aware that sessions may exceed 50 minutes at which time fees are calculated per minute based on the current rate. As a courtesy to our active patients, you will continue be charged at this rate regardless of any fee increases within the practice as long as there is no more than a six month interruption in treatment. I understand that I will be expected to pay for services at the time of the visit as well as any missed appointments cancelled without 24 hour notice. I understand my/my child's rights and responsibilities as a client, the confidentiality of my/my child's services and the exceptions, and I understand my therapist's responsibilities to me/my child. I agree to undertake therapy and/or counseling with COASTAL CARE COUNSELING, INC. **I am over the age of 18.**

Signed: X _____ Date _____

---------- ***OR:*** ----------

Signature of authorized person if client is underage or impaired* _____ Date _____

*Relationship of authorized person to client _____ *Reason _____

*Witness _____ Date _____

ALL three signatures are required for consultation and/or to commence treatment.