Maui Counseling Group

Master Signature Form

Your signature below indicates that you have read and agree with the paperwork provided to you today, including the:

Consent for Services and Office Policies, which describes

- Therapeutic services provided by Maui Counseling Group, including possible risks and benefits;
- Therapist Assignment and Evaluation Process;
- Choice of Therapist and Therapist Transfer Requests;
- Appointments and No-Show Policy;
- Professional Fees;
- Insurance and Billing Policies;
- Court Involvement;
- Professional records and documentation;
- Confidentiality;
- Parents and Minors;
- Contacting Your Therapist; and
- Other Client Rights.

Plus the **Notice of Privacy Practices** form.

Please request a copy of any of these documents at any time for your records, if you wish.

By signing below, I agree to the policies and practices described in the above paperwork.

Printed Name of Client_____

Client DOB_____

Signature of Client or Guardian _____

Printed Name of Guardian (if applicable) _____

Today's Date _____

Maui Counseling Group

New Client Information

Thank you for sharing this information with us. It will help us choose the best possible provider for you.

Name: _____ Date of Birth: _____ Gender: M or F

What do you hope to gain from counseling? _____

_____

Who referred you to Maui Counseling Group (MCG)? _____

Would you like us to send a note to your doctor to coordinate information about your counseling? Y N (please circle one)

If yes, provide the doctor's name and signature indicating consent to speak to him/her:

_____ _____

Doctor's Name & Number **Client Signature and Date**

Medical Insurance Information

Primary Type of Insurance: _____ (i.e. HMSA, QUEST, etc.) Insurance# _____

Primary subscriber of the insurance? Name: _____ DOB: _____

Secondary Insurance Type and # _____

Name, Phone and Address of person responsible for bill _____

_____

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SSN: ____-____-____ Marital Status: _____ Height: _____ Weight: _____

Home Address: _____

City:_____ State:_____ Zip Code:_____

Mailing Address: _____
(if different from above)

City:_____ State:_____ Zip Code:_____

Home Phone: (____)_____ Cell Phone: (____)_____ Email Address:_____

Do you authorize the clinic's receptionist to leave messages regarding appointments? Y N

Preferred way of contacting you: ___Home Phone ___Cell Phone ___Text ___Email (email address, if you would like us to contact you that way:

Emergency Contact Person: _____ Telephone# _____

Relationship to Client: _____ Other # _____

Ethnicity: (optional)_____Language spoken: _____

Employed? Y N Employer: _____Work Phone: (____)_____

Have you received mental health services in the past 2 years? Y N

If yes, when did services start? _____ end? _____ Name of Doctor: _____

Any allergies?_____

Additional Comments/Information:

_____

_____

_____

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CLIENT QUESTIONAIRE

Thank you for sharing the following information. This will help your counselor support you most effectively.

YOUR CURRENT PROBLEMS/ISSUES (please check all that apply)

___Anxious, worried
___Anger, aggression
___Depressed/sad mood
___Relationship issues
___Parenting Issues
___Grief/Loss
___Money management
___Alcohol Abuse
___Drug Abuse
___Eating/Food problems
___Perfectionist
___Unwanted Behaviors/Habits
___Withdrawn
___Employment/Job Issues
___Legal Problems
___Living Arrangement Issues
___Shy/Uneasy with others
___Suicidal thoughts
___Confusion
___Difficulty being alone
___Fatigue, exhaustion
___Guilt feelings, shame
___Memory/concentration problems
___Mood swings
___No energy/Low motivation
___Obsessive thoughts
___Panic Attacks
___Weight Changes
___Victim of Abuse (past or present)
___Low self-esteem
___Sexual problems
___Sleep problems
___Not Assertive
___Unusual Thoughts
___Other
_____

Medical History

Date of last physical exam _____ Name of Doctor:_____Results_____

_____

Chronic/Major Illnesses? Y N If yes, please list:_____

_____

Surgeries? Y N If yes, please list and provide dates:_____

_____

Disabilities? Y N If yes, please list:_____

Current Medications/Reasons Prescribed:_____

_____

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Psychological History

Previous Counseling

Dates (From/To)	Clinic/Therapist	Reason

Psychiatric Hospitalizations

Dates (From/To)	Hospital/Therapist	Reason

Substance Use

Have you ever had any trouble with alcohol/drinking or drugs? Y N
If yes, please explain:_____

_____

_____

Any DUI or DWI or other legal problems from substance use? Y N
If yes, please explain:_____

_____

_____

_____
Client's Name

_____
Client (or Parent/guardian) Signature Date

Mahalo for sharing this information with us!
Rev 1/14

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