Juniper Campbell, LPC

Patient Name:_____ Date of Birth:__/__/__ Age:_____

Home Address:_____

City_____ State_____ Zip Code_____

Home Phone Number:_____ May I leave a message? [ ] Yes [ ] No

Work Phone Number:_____ May I leave a message? [ ] Yes [ ] No

Cell Number:_____ May I leave a message? [ ] Yes [ ] No

If the above patient is a minor complete the following:

Name of Guardian:_____

Address of Guardian:_____

City_____ State_____ Zip Code_____

Guardian's Home Phone Number:_____ May I leave a message? [ ] Yes [ ] No

Guardian's Work Phone Number:_____ May I leave a message? [ ] Yes [ ] No

Guardian's Cell Number:_____ May I leave a message? [ ] Yes [ ] No

Emergency Contact:

Name of contact:_____ Relation to patient:_____

Phone number:_____

Referral Source:

Who referred you to my office, or how did your learn about my practice:_____

Gender: [ ] Male [ ] Female

Marital Status: [ ] Single [ ] Married [ ] Separated [ ]Divorced [ ] Widowed [ ] Other

Children: [ ] M [ ] F Name:_____ Age:_____

[ ] M [ ] F Name:_____ Age:_____

[ ] M [ ] F Name:_____ Age:_____

[ ] M [ ] F Name:_____ Age:_____

Were you raised by: [ ] Both parents? [ ] Single parent? [ ] Relative? [ ] Adopted? [ ] Other?

How many siblings do you have and where do you fall in the birth order: _____

_____

In your family is there a history of: [ ] Alcoholism [ ] Drug Addiction [ ] Mental Illness [ ] Prolonged physical illness

_____

_____

Current Medications and Dosages:_____

_____

_____

Do you have any significant medical problems:_____

_____

Have you had previous psychiatric care and/or counseling: [ ] Yes [ ] No
Name of Clinician:_____ Sessions from: _____to_____

Have you ever received a formal mental diagnosis: [ ] Yes [ ] No

If yes, please provide diagnosis:_____

_____

Have you ever been hospitalized for substance abuse, alcoholism, eating disorders or other psychiatric disorders:

_____

_____

SUPPLEMENTAL INFORMATION (this is to support a holistic approach to mental health):

How many times a week do you exercise and what type of exercise do you prefer: _____

_____

Describe your eating habits (do you eat three meals a day, vegetables, fruits, meat, snacks, late night eating...):

_____

_____

What junk food do you love to eat (soda, chocolate, chips...) and how often do you eat these foods: _____

_____

If you drink alcohol, what are your drinking habits: [ ] rarely drink [ ] 1-3 times per week [ ] 3-5 times per week

[ ] everyday [ ] don't intend to drink as much as I do sometimes [ ] black out when drinking [ ] drink to get drunk

How much sleep do you get: [ ] 3-5 hrs per night [ ] 5-7 hrs [ ] 7-9 [ ] 9-12

What supplements do you take: _____

_____

How much television do you watch: [ ] none [ ] 1-2 hrs. a day [ ] 2-4 hrs. a day [ ] 4-6 hrs. a day [ ] 6+ hrs. a day

How much time do you spend playing video games: [ ] none [ ] 1-2 hrs. a day [ ] 3+ hours a day

How much time do you spend on social media: [ ] none [ ] 1-2 hrs. a day [ ] 3+ hours a day

How do you sabotage yourself and your goals: _____

_____

What are 3 goals that you would like to work towards:

1. _____

2. _____

3. _____

Name 3 of your strengths:

1. _____

2. _____

3. _____

I, _____(person responsible for payment), understand and agree to pay Juniper Campbell, LPC, the contracted amount at the conclusion of each 50 minute session or to cover the insurance copayment at the time of services should the client be eligible for insurance coverage. Payment for services is rendered at the conclusion of the session unless other agreements have been made.

I hereby authorize the clinician to furnish information to insurance carriers concerning my treatment. I understand that I am responsible for all payments. Any monies received by the clinician from the above insurance companies over and above my indebtedness will be refunded to me when my bill is paid in full.

Delinquent bills will be sent to collections after three notices are sent. The third notice will be stamped final notice and will then be sent to collections on the next billing cycle.

I understand that I am responsible for payment for sessions not canceled 24 hours in advance. The fee for appointments canceled prior to 24 notification is $70.

Standing appointments are weekly appointments that are allocated for treatment. If more than two standing appointments are missed (illness and vacation are exceptions) then the standing appointment time will forfeited and sessions will be based upon weekly availability.

Client's Signature:_____ Date:_____

Guardian's Signature:_____ Date:_____