Client: ____

Leslie A. Campbell, LCSW
Five Tribes Therapy
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PATIENT INFORMATION

Date ______ DOB _______ Age _____ SS# __________________ DL # ______________

Name ____

Street Address ____

City ____________________ State __________ Zip ______________

Phone (Home) ________________ OK to leave voice mail/text message _____________

Phone (Work) ________________ OK to leave voice mail/text message _____________

Phone (Cell) ________________ OK to leave voice mail/text message _____________

Email Address ____

Married ( ), # *of times* __. Single ( ). Divorced ( ), # *of times* __. Separated ( ). Other ( ).

Name of spouse *(or parent if a minor)* ______________________________

Emergency Contact _________________ Relationship __________ Phone ______________

Patient's *(or parents)* employer & address ______________________________

____

FAMILY HISTORY

With whom do you live? ____

Children's names and ages ____

Parent's names and ages *(if a minor)* ______________________________

MEDICAL HISTORY

Personal Physician and Contact Information ______________________________

____

Client: ____

Psychiatrist and Contact Information ____

____

Other Medical Providers and Contact Information ______________________________

____

Medication ____________________ Dosage ______________ Frequency ______________

Medication ____________________ Dosage ______________ Frequency ______________

Medication ____________________ Dosage ______________ Frequency ______________

Medication ____________________ Dosage ______________ Frequency ______________

Medication ____________________ Dosage ______________ Frequency ______________

Date of Last Medical Exam ____

Results ____

Current Nonprescription Drug Use/Frequency ___________________________________

Do *(or did)* your parents use drugs/alcohol? ___________________________________

Have you had mental health treatment before? ________ Dates ________________________

With whom, where and why?____

____

____

What brings you to therapy now? _______________________________________

____

____

What else would you like me to know? ___________________________________

____

____

Client: ____

What would you like to achieve in therapy? _________________________________

____

____

Who referred you to me? ____

RESPONSIBLE PARTY FOR BILL *(if other than patient)*

Name ____

Street Address ____

City ________________________ State __________ Zip ____________________

EMPLOYER

Name ____

Street Address ____

City ________________________ State __________ Zip ____________________

PLEASE CHECK

Private Insurance ( ). Cash ( ). Other ( ).

CONFIDENTIALITY

Communication between patient and therapist is privileged except child, elder or dependent abuse and/or a threat to the life of another person. If you have managed health care, their utilization review panel will be involved. Confidentiality law binds them.

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RELEASE OF INFORMATION

This form must be signed and approved by you if you wish that records or information be released to any others except to your insurance/managed care provider.

I authorize this office to release any information necessary to expedite insurance claims. I understand that I am responsible for all charges, regardless of insurance coverage and for missed appointments or cancellations with less than 24 hours notice. A copy of this signature is valid as the original.

The fee for a 45-50 minute session is $110.00 and is due at the time service is rendered unless special arrangements are made.

I consent to assessment and treatment under the care of Leslie A. Campbell, LCSW, Five Tribes Therapy. I have read and understand the above stipulations.

Signed ____________________________________ Date ___________________

Signed ____________________________________ Date ___________________