New Client Information

Client Name: _____ Today's Date: _____

Home Address: _____

Date of Birth: _____ Age: _____

Contact Number: _____

Referred By: _____

Emergency Contact: _____

Household Members: _____

Name/Relationship to child: _____

Are you the Legal Guardian? Y/N

Education: Grade/School Attended: _____

Medical History:
Are there any current medical conditions? Y/N (if yes, please explain further)

_____

_____

_____

Is your child currently taking any medications? Y/N

Please list medications and dosages:

_____

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celia@positivesolutionstherapy.com

What concern(s) brought your child to counseling?

_____

_____

_____

_____

_____

Has your child had counseling in the past? Y/N

Therapist's name: _____

Was it helpful? Y/N (please explain):

_____

_____

_____

_____

_____

_____

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Consent for Treatment:

I, the undersigned, hereby voluntarily request to receive services from Positive Solutions Therapy/Celia Marchese a Licensed Mental Health Counselor, Licensed Marriage and Family Therapist. I understand that these services may include individual, family and/or marital therapy. I acknowledge that no guarantees have been made to me as to the effect of therapeutic assessments, therapy, treatment or care of my condition of that of my child. I further understand that before beginning any treatment procedure, I will be given an explanation of the nature and purpose of such treatment and any probable risks involved. I may refuse any and all treatment at any time. I understand that the information I share with the therapist will be held in the strictest confidence with the exception of the following reason as outlines by Florida Statues: 1) You consent in writing 2) Someone's life or safety is seriously threated 3) Disclosure is required by law 4) You file a benefit claim and the claims payor requires information. I understand that I am responsible for the full payment of all services.

Signature: _____

Date: _____

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