



Wel come! There is Hope!

WELCOME...

Thank you for choosing me to help you on your journey. You are well on your way to having a significant change in your life. There is Hope!

As you come to your first appointment, you can share more of the details of your situation. For now, it will be a great help to move us forward, if you will take a few minutes to fill out the attached handouts.

Also, please bring this with you as you come to your appointment. It will save your valuable session time.

Again, I look forward to seeing you at my office. Maps are provided below.

If you have any questions, please feel free to call me.

Priscilla Kelly

Licensed Mental Health Counselor



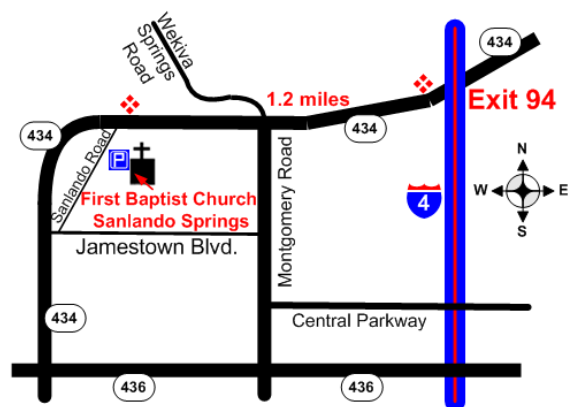
Winter Park Office

1850 Lee Road, Suite 215
Winter Park, FL 32789



Altamonte Springs Office

(FBC Sanlando Springs)
742 Sanlando Road
Altamonte Springs, FL 32714



There is Hope!

Call Priscilla Kelly

Licensed Mental Health Counselor

321.356.5115 PriscillaKelly@earthlink.net www.MakingThePiecesFit.com

CLIENT REGISTRATION

Patient Name: _____
(Last) (First) (Middle) (Nickname)

Address: _____ City: _____ Zip: _____

Home Phone: () _____ Work Phone: () _____ Ext #: _____

Cell Phone () _____

Birth date: _____ Age: _____ Sex: _____

E-Mail address (will not be given to anyone else) _____

Marital Status: Single Separated Married Divorced Widowed

Employer/ Student/School: _____

Referred by: _____

If dependent child, are custodial parents: ___Married ___Separated ___Divorced ___Other

IN CASE OF EMERGENCY NOTIFY:

Name: _____ Relationship _____ Phone: () _____

Financially Responsible Party (Guarantor) Information

Guarantor Name: _____ Birth date: _____
(Last) (First) (Middle)

Guarantor Address: _____ City: _____ Zip: _____

Guarantor Relationship to Client (Circle one): Spouse Mother Father Sibling
Other relative Friend Other

Home Phone: () _____ Work Phone: () _____ Ext #: _____

Guarantor's Employer: _____

Occupation: _____

SPECIAL ARRANGEMENTS:

GUARANTOR AGREEMENT: I certify that the above information is true and correct. I agree to take full responsibility for the entire amount due for any and all services rendered by Priscilla Kelly, LMHC.

Guarantor Signature (client signature if patient is guarantor)

Date

Client Signature

Date

Client Information and Consent to Treatment

Thank you for choosing Priscilla Kelly for your counseling needs. I am committed to giving you the best care possible. To acquaint you further with the procedures and policies of this clinic, I am providing the following information.

Appointments: If you need to cancel an appointment, **a minimum of 24 hours notice is required**, otherwise, you are subject to full charge for the appointment. In the evenings and on weekends, you may leave a message on the answering machine, which will accurately record the date and time you placed the call. I ask that you be punctual as well. If you are late, for any reason, you will receive the remainder of your scheduled time. This is necessary so I can see following patients at their scheduled times.

Emergencies: In case of true emergencies, first dial 911. For prayer and encouragement you may call our friends at the Central Florida Helpline (407) 740-7477. To leave a message for me, please call (321) 356-5115 and I will return your call as soon as possible.

Financial Responsibility: You are fully responsible for all services rendered. Full payment is expected at the time of service, unless other contractual arrangements apply. **Please make all checks payable to Priscilla Kelly.** As another payment option, I accept Visa, MasterCard, and American Express. There will be a **\$25 fee for payments returned as non-sufficient or non-payable.** Please feel free to discuss financial concerns with me during the session.

Confidentiality: To comply with state and federal laws regarding patient confidentiality, your records will not be released without the properly executed written consent. Everything about your care will be held in strictest confidence (with the exception of those situations which we are required by law to report; such as suspected or reported child abuse, homicidal or suicidal plans, etc.) If you choose to have a third party informed of your progress in counseling, it will be necessary to complete a "Release of Information" form that will be kept on file.

PLEASE SIGN BELOW TO INDICATE YOU HAVE READ AND UNDERSTAND THE ABOVE NOTIFICATIONS AND THAT YOU ARE CONSENTING TO RECEIVE TREATMENT:

Client/Guardian Signature

Date

MARRIAGE and FAMILY:

Marital Status: Single _____ Engaged _____ Married _____ Separated _____ Divorced _____

How long divorced _____ Number of divorces _____ Length of current marriage _____

Spouse Name _____ Age _____ Occupation _____

Please list children by age: (Place a check by name if from previous marriage or adoption)					
NAME	AGE	SEX	EDUCATION	LIVING AT HOME	SPECIAL CONCERNS

Please list any other person (s) living in your home:

NAME	AGE	SEX	RELATIONSHIP	SPECIAL CONCERNS

HEALTH RATING: Excellent _____ Good _____ Average _____ Poor _____ Very Poor _____

Are you currently under a doctor's care? _____ If yes, please explain. _____

Physician's Name: _____ Phone () _____

Are you currently taking medication? _____ What? _____

Have you ever used drugs recreationally? _____ What and when? _____

Alcohol use: Never _____ Occasionally _____ Often _____ Habitually _____

Have you, your spouse or children ever had any major medical or emotional problems? If yes, please explain. _____

Have you seen a counselor before today? _____ Who?: _____

RELIGION/FAITH:

Do you attend church? _____ How frequently?: _____ Occasionally _____ Weekly _____ More than once a week

Are there any recent changes in your faith or church attendance? _____ Please explain _____

SPECIFIC PROBLEM AREAS: Please check any of the following that are currently troubling you:

<input type="checkbox"/> Abortion/Adoption	<input type="checkbox"/> Depression	<input type="checkbox"/> Legal issues	<input type="checkbox"/> Religion/Faith Issues
<input type="checkbox"/> Addictions	<input type="checkbox"/> Divorce	<input type="checkbox"/> Loneliness	<input type="checkbox"/> Separation
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Eating disorder	<input type="checkbox"/> Loss of appetite	<input type="checkbox"/> Sexual Abuse/Rape
<input type="checkbox"/> Anger	<input type="checkbox"/> Envy /Jealousy	<input type="checkbox"/> Loss of control	<input type="checkbox"/> Sexual Addiction
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Family issues	<input type="checkbox"/> Loss of concentration	<input type="checkbox"/> Sexual issues
<input type="checkbox"/> Apathy	<input type="checkbox"/> Father issues	<input type="checkbox"/> Loss of energy	<input type="checkbox"/> Single parent
<input type="checkbox"/> Bitterness/Resentment	<input type="checkbox"/> Fear	<input type="checkbox"/> Loss of memory	<input type="checkbox"/> Singleness
<input type="checkbox"/> Burnout/Stress	<input type="checkbox"/> Finances/Debt	<input type="checkbox"/> Loss of sleep	<input type="checkbox"/> Spouse abuse
<input type="checkbox"/> Change of lifestyle	<input type="checkbox"/> Forgiveness	<input type="checkbox"/> Loss of temper	<input type="checkbox"/> Substance abuse
<input type="checkbox"/> Child abuse	<input type="checkbox"/> Frustration	<input type="checkbox"/> Loss of trust	<input type="checkbox"/> Suicidal thoughts
<input type="checkbox"/> Children/discipline	<input type="checkbox"/> Guilt	<input type="checkbox"/> Marriage	<input type="checkbox"/> Self-esteem
<input type="checkbox"/> Children/school	<input type="checkbox"/> Health/Medical	<input type="checkbox"/> Medication/Drug Issues	<input type="checkbox"/> Rejection
<input type="checkbox"/> Children/rebellion	<input type="checkbox"/> Homosexuality	<input type="checkbox"/> Mid-life	<input type="checkbox"/> Unemployment
<input type="checkbox"/> Communication	<input type="checkbox"/> Honesty	<input type="checkbox"/> Mother issues	<input type="checkbox"/> Violence/Rage
<input type="checkbox"/> Confusion	<input type="checkbox"/> Infidelity	<input type="checkbox"/> Panic attacks	<input type="checkbox"/> Withdrawal
<input type="checkbox"/> Crisis/Conflict	<input type="checkbox"/> In-Laws	<input type="checkbox"/> Physical abuse	<input type="checkbox"/> Worry
<input type="checkbox"/> Death of loved one	<input type="checkbox"/> Job problems	<input type="checkbox"/> PMS/Hormones	

How long have these problems existed? _____