Teletherapy Group LLC

CLIENT INFORMATION

Client Name		Date of Birth and Gender	
Additional Client Name		Date of Birth and Gender	
Address		Today's Date	
City, State, Zip Code		Home Phone	
Work Phone		Cell Phone	
E-mail Address		Emergency Contact and Phone Number	
Responsible Party		Responsible Party's SSN	
Address (If Different From Client)		Phone Number	
City, State, Zip Code			

INSURANCE INFORMATION

Primary Insurance Company		Secondary Insurance Company	
Policy Holder's Name		Policy Holder's Name	
Policy Holders Date of Birth		Policy Holders Date of Birth	
Relationship to Client		Relationship to Client	
Home Address (If Different)		Home Address (If Different)	
City, State, Zip Code		City, State, Zip Code	
Policy Holder's Insurance ID#		Policy Holder's Insurance ID#	
Insurance Group Number		Insurance Group Number	
Employer Name		Employer Name	

REFERRAL INFORMATION

How Did You Hear About Teletherapy Group?			
Family Member		Internet	
School		Lawyer	
Therapist		Doctor	
Other		Friend	

FAMILY INFORMATION

Client Name	Client Age	Relationship to Client	Education and Occupation

MEDICAL INFORMATION

Client Name		Second Client (If Necessary)	
Have you been to counseling or any mental health services before? If so, where and with whom?		Have you been to counseling or any mental health services before? If so, where and with whom?	
Have you been hospitalized for psychiatric reasons? (List)		Have you been hospitalized for psychiatric reasons? (List)	
Primary care physician: Name and Practice		Primary care physician: Name and Practice	
Address of Practice and Phone Number		Address of Practice and Phone Number	
Do you have any health concerns you would like to discuss?		Do you have any health concerns you would like to discuss?	
List any current Medications		List any current Medications	

PLEASE CIRCLE OR HIGHLIGHT ALL THAT APPLY: (If **more than one client, please separately initial)**

Excessive crying

Decreased energy

Feelings of being worthless

Thoughts of suicide

Feeling overwhelmed. trouble making decisions

Experiencing panic attacks

Excessive worrying

Avoiding going places

Isolating from others

Checking things repeatedly

Afraid of being judged or rejected

Sensitive to criticism

Needs things to be perfect

Excessive anxiety about separation from caregivers

Impulsive, acts without thinking

Can't sit still, antsy

Always on the go, hyper

Problems following rules

Difficulty with authority

Unmotivated, Procrastinating

Problems with work or school

Apathetic, doesn't seem to care

Angry, easily irritated

Abruptly changing moods

Difficulty controlling temper

Reckless behaviors, taking excessive risks

Abusive toward others

Lying, stealing

Problems in relationships with partner or children

History of traumatic experiences

Full of energy, little need for sleep

Feeling overly important

Talking fast and excessively

Hoarding food or objects

Poor body image

Problems with eating or food

Stomachaches, digestion issues

Trouble managing pain or disabling condition

Lots of aches and pains

Legal problems

Financial concerns

Sexual concerns

Feds bullied or picked on

Has few or no friends

Considered weird by others

Socially awkward or inappropriate

Lacks physical boundaries with peers

Skin picking, hair pulling, nail biting

Inf1exible, trouble handling change

Self-injury or cutting

Problems in relationships with parents

Problems in relationships with parents, siblings, roommates

Trouble sleeping. nightmares

Suspicious, paranoid

Threatens or bullies others

Thoughts of hurting others

AUTHORIZATION TO SHARE MEDICAL INFORMATION

Client Name		Date of Birth	
I Authorize Teletherapy Group to Share My (Circle All that Apply)	Scheduling Information Medical Information Billing/Financial Insurance Information		

With the following

Name	Phone Number	Relationship to me

OR

[ ] I do not authorize Teletherapy Group to release any of my medical information to anyone, with the exception of coordination of benefits (i.e. insurance) or continuation of care (i.e. referrals).

This authorization will remain in effect until revoked in writing by the above listed client.

_____ _____

Client Signature Date

Signature Required

I acknowledge that I have read and understand all of the foregoing statement and that my signature below indicates that I agree to abide by all of the above conditions. If more that one adult client, each person should check and initial boxes.

[ ] Yes [ ] No I have received a copy of the HIPPA Privacy Noticed.

[ ] Yes [ ] No I authorize the release of any medical information necessary to process my insurance claims and I authorize benefits to be paid directly to Teletherapy Group.

[ ] Yes [ ] No I consent to the exchange of treatment information between Teletherapy Group and my primary care physician.

Client(s) Physician's Name/Office and Phone Number _____

_____

Client/Responsible Party Signature and Printed Name

_____

Client/Responsible Party Signature and Printed Name