A. Dawn Stula

Welcome to my practice!

Please fill out the following as completely and legibly as possible. This information is confidential.

Your name: _____

Address: _____

City: _____State:_____ Zip/Postal Code: _____

Home phone: _____ Cell phone number: _____

Personal E-mail Address: _____

Referred by: _____

Age: _____ Birth date: ____/____/_____ Birthplace: _____

Highest level of education completed: _____

Current Occupation: _____ Number of hours worked per week: _____

Do you practice a religion: ___ Yes ___ No

If yes, what is your faith? _____

If no, do you consider yourself to be spiritual? ___ Yes ___ No

Emergency Contact: _____ Phone: _____

Relationship to you: _____

Primary Care Physician: _____ Phone: _____

Relationship status (circle one): Single Married Partnered Separated Divorced Widowed Other

Spouse/partner's name (if applicable): _____Age: _____

Length of relationship: _____

Children (gender, age):

_____

Please describe your current living situation. Do you live alone, with others, with family, etc.

_____

_____

Please describe any significant current or past medical problems:

_____

_____

Do you have suicidal thoughts? ___ Yes ___ No

Have you ever attempted suicide? ___Yes ___ No

Has anyone in your family attempted suicide? ___Yes ___ No

Have you had previous counseling or psychotherapy? ___Yes ___ No

Have you ever been hospitalized for a psychological difficulty? ___ Yes ___ No

_____

Please indicate any of the following you have experienced in the past six months:

_____ Increased appetite
_____ Decreased appetite
_____ Trouble Concentrating
_____ Difficulty Sleeping
_____ Excessive Sleep
_____ Low Motivation
_____ Isolation from others
_____ Fatigue/ low energy
_____ Low self-esteem
_____ Depressed Mood
_____ Tearful or crying spells
_____ Hopelessness
_____ Loss of interest in activities
_____ Anxiety
_____ Fear
_____ Panic
_____ Other: _____

Please describe any additional symptoms you have experienced in the past six months:
_____
_____

Please describe any physical challenges, disabilities, or illnesses you have experienced or are currently experiencing.
_____
_____
_____
_____

In your own words, what is the nature of the concern you wish to address in counseling? What has brought you to counseling? Is there something specific, such as a particular event?
_____
_____
_____
_____

What are your goals for our work together?
_____

_____
_____
_____
_____
_____

Please indicate how you plan to pay for your counseling sessions: Cash Check Card

Payment is due at time services are rendered.

Client Signature: _____ Date: _____

Acknowledgment of Receipt of Privacy Practices Notice:

I hereby acknowledge that I have received or have been given an opportunity to read a copy of Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact

A. Dawn Stula, MSW, LCSW, CDPC at 706-621-2548.

Client Signature: _____ Date: _____

Patient/Client Refuses to Acknowledge Receipt:

Therapist Signature: _____ Date: _____

Late Appointment Cancellations or Missed Appointment Agreement

By signing below, I am acknowledging that I have read, understand, and agree to abide by A. Dawn Stula, MSW, LCSW, CDPC around late appointment cancellations and missed appointments. I accept I am responsible for paying the full session fee of $110 for any missed appointments or appointments that are cancelled or rescheduled in less than 24 hours of the scheduled appointment time. Legally, insurance cannot be filed for any scheduled appointments that are missed. The fee will be collected at the next scheduled appointment or a statement mailed if no further appointments are scheduled.

Client Signature: _____ Date: _____

Practice Policies Agreement and Informed Consent for Counseling: Practice Polices Agreement:

By signing below, I am acknowledging that I have read, understand, and agree to abide by the Practice Policies outlined in the attached document, having had any questions answered to my satisfaction.

Informed Consent: By signing below I am acknowledging that I have read the Information about the Therapeutic Process and understand the risks and benefits of counseling, the nature and limits of confidentiality.

I agree to abide by the contents and terms of the document and I consent to participate in counseling/psychotherapy with A. Dawn Stula, MSW, LCSW, CDPC.

I understand I may withdraw from counseling/psychotherapy at any time.

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____