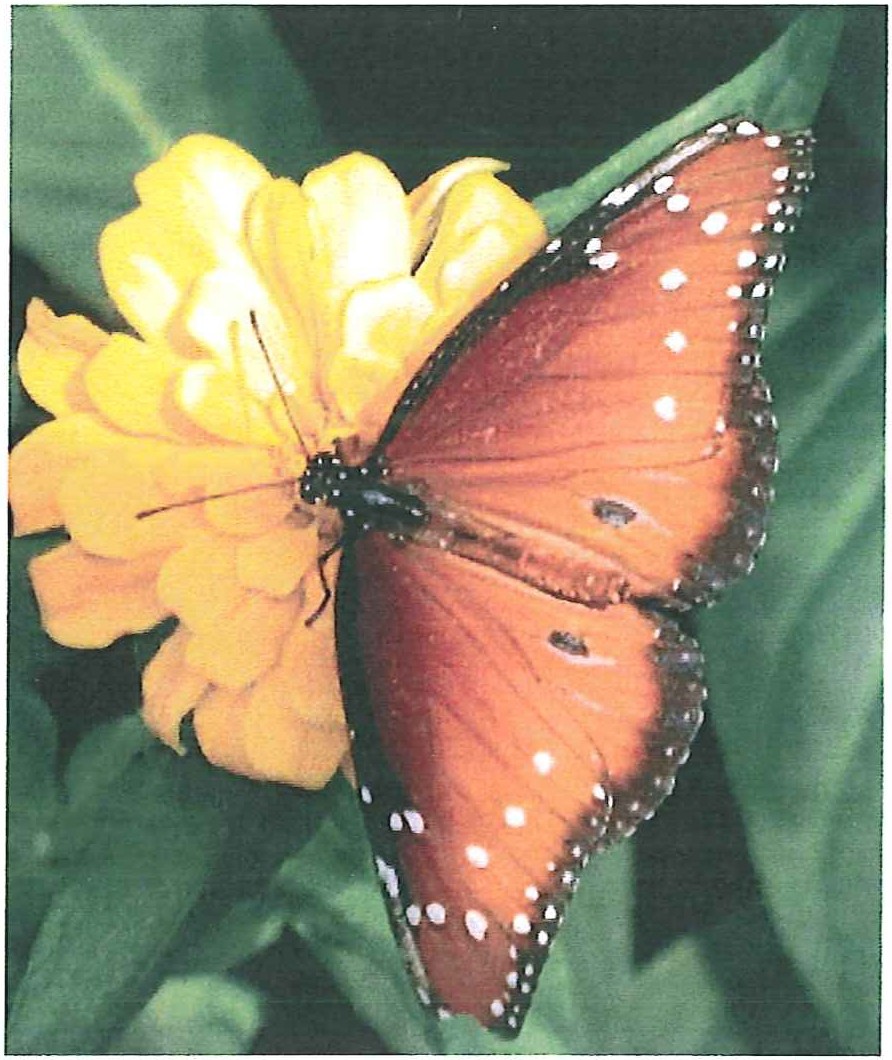
wi



WELCOME TO THE OFFICE OF SUSANNE SLAY-WESTBROOK, L.P.C., L.M.F.T

PLEASE FILL OUT TIDS FORM AS COMPLETELY AS YOU CAN. BY DOING SO, YOU WILL ENABLE YOUR THERAPY TO BECOME FOCUSED AND PRODUCTIVE AS QUICKLY AS POSSIBLE.

THANK YOU FOR YOUR HELP.

#### PATIENT INFORMATION

ALL INFORMATION PROVIDED WILL BE KEPT IN THE STRICTEST CONFIDENCE.

Today's Date: \_ Referred By: \_ PERSONAL INFORMATION:

Patient's Full Name:------------------- Date of Birth: ---

Home Address:----------------------------

#### Street Address or P.O. Box City State Zip Code

Home Phone: ( ) \_ Work. Phone: ( ) \_

Cell Phone:( ) \_ E-Mail:--------------

#### Sex: Male Female Marital Status: \_Single \_Married \_Separated \_Widowed \_Divorced Employment Status: \_Full Time \_Part Time \_Unemployed \_Student .

Employer: \_

Address:--------------------------

#### Street Address or P.O. Box City State Zip Code

Occupation: \_ Length of Employment: \_

IF YOU ARE USING YOUR COMPANY'S EAP:

NAME OF EAP-------CASE NO.

----NO. OF VISITS----

#### INSURANCE INFORMATION:

Name of Insurance Company: .Phone ...,(\_\_..,\_) \_ \_ Name of Insured: \_ Insured SSN: -------

Group No: -----------Group Name: \_ Policy No: \_ Annual Deductible: Co-Pay Amount: \_

RESPONSIBLE PARTY: (If Different From Above) Name of Responsible Party: .Relationship:

Home/Cell Phone":-.,( .), \_ Address:

Work Phone":-.(, .)... \_

Street Address or P.O. Box

City

State Zip Code

Sex: Male Female Date of Birth: *I I*-

EMERGENCY CONTACT INFORMATION (If Different From Above)

Name: Home/Cell Phone:.,\_< ) Work Phone-'-'

Relationship \_

**BACKGROUND INFORMATION**

Spouse's Name \_ Date of Birth \_\_\_\_

Children 's name(s) and Age(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Primary Care Physician: Phone : ( ) \_ Are you currently on any medications? If so, please list: \_

Do you consume alcohol? Yes *I* No (circle one) If so, where/when/with whom: \_

Do you currently use any drugs other than those prescribed by a physician? Yes *I* No (circle one) If so, please list the name and the frequency of use.

Have you ever received counseling before? Yes *I* No (circle one) If so where/when/with whom:

Check any member(s) of your family who experience or have experienced problems with the following topics:

Alcoholism : D Self D Spouse D Mother D Father D Sibling D Other Sexual Abuse: D Self D Spouse D Mother D Father D Sibling D Other Eating Disorder: D Self D Spouse D Mother D Father D Sibling D Other Violence: D Self D Spouse D Mother D Father D Sibling D Other Emotional Abuse: D Self D Spouse D Mother D Father D Sibling D Other Low Self Esteem: D Self D Spouse D Mother D Father D Sibling D Other Learning Disabilities: D Self D Spouse D Mother D Father D Sibling D Other Chemical Dependency: D Self D Spouse D Mother D Father D Sibling D Other Suicide: D Self D Spouse D Mother D Father D Sibling D Other Depression : D Self D Spouse D Mother D Father D Sibling D Other Anxiety: D Self D Spouse D Mother D Father D Sibling D Other Anger: D Self D Spouse D Mother D Father D Sibling D Other Divorce: D Self D Spouse D Mother D Father D Sibling D Other Schizophrenia: D Self D Spouse D Mother D Father D Sibling D Other Bi-Polar *I* Mania: D Self D Spouse D Mother D Father D Sibling D Other Depressive Disorder: D Self D Spouse D Mother D Father D Sibling D Other

Please state your primary reason for seeking counseling at this time.

### CANCELATION POLICY

Unless canceled at least twenty-four (24) hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments .

*I have read the cm1celation policy and I understand and agree to the terms of this policy .*

Signature: \_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### AUTHORIZATION FOR THE TREATMENT OF A MINOR

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize Susanne Slay, L.P.C., L.M.F.T., and whomever she may designate as assistants, to administer care/treatment of my \_\_\_ (please indicate relationship), \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(child's full name).

Signature: \_ Date: \_

# Susanne Slay-Westbrook LPC, LMFT 6633 E. Hwy 290 Ste. 212

**Austin, TX 78723**

**512.470-0104**

**CONSENT OF RELEASE**

Sometimes in the counseling process it is important to exchange further information about you with other professionals or interested parties to maximize the progress of the counseling. This can only be done with your explicit written permission given to this office. Any information given to this office is strictly confidential and will be used only for your benefit in counseling.

If you are using insurance, PPO, HMO, EAP, or any other form of third party reimbursement, it is herein understood that I will be interacting with them, giving pertinent treatment information.

j **Signature: Date:**

If there are any other parties, such as doctors, lawyers, school counselors, or other therapists that you think are important for me to exchange relevant information with, please name them and give me a way to contact them. If you want to limit the content shared please specifically do so under "notes."

NAME, **TITLE: CONTACT** INFO:

**(PHONE, EMAIL, ETC.)**

**NOTES:**

I **Signature: Date:**