Kelley Connell, LCSW

5400 West Plano Parkway
Suite 210
Plano, TX 75093

Confidential Background Questionnaire

Today's Date:_____ Referred by:_____

Client's Name:_____ Age:_____

Address/Zip Code:_____

Home Phone:_____ Work Phone:_____ Cell Phone: _____

Please indicate with an * which number/s at which you prefer to be reached, and may a message be left.

Email address:_____Can I contact you by email? ____Yes ____No

Sex: M___ F___ Date of Birth:_____ Occupation:_____

Signature of Legally Responsible Adult:_____

Person to Notify in Case of Emergency: (Name)_____(Ph.)_____

Presenting Problems:

Problem Areas: Please check items applicable to you.

_____Self Esteem	_____Relationships	_____Financial
_____Marital	_____Spiritual	_____Parent/Child
_____Sexual Dysfunction or Abuse	_____Drug?Alcohol Abuse	_____Health
_____Depression	_____Eating Disorder	_____Other
_____Suicidal Ideation	_____Suicide Attempts	

In your own words describe why you are seeking counseling:

_____

_____

_____

Has anyone in your immediate or extended family ever received treatment for a mental, emotional or stress-related disorder, or for alcohol or chemical addiction?_____
If yes, please indicate type of treatment and approximate dates. (Please indicate the relationship of the family member.)

_____
Do you smoke? Yes/No How often?_____
Do you drink alcohol? Yes/No How often?_____
Do you take any drugs other than over the counter or prescription? Yes/No How often?_____

Insurance:

Primary Policy

Policy Holder: _____ *SS#: _____*

Insurance Company: _____ *Policy #: _____*

Birth date of Policy Holder: _____

Social History:

Single_____ Dating_____ Married_____ Separated_____
Divorced_____Widowed_____

If married, how long?_____Your age when married?_____

If divorced, date:_____ Who filed for the divorce?_____

Dates of previous marriages & divorces:_____

Children: Your own (present & previous marriages) total #_____
Your mate's (present & previous marriages) total #_____

What are the terms of child custody? _____

Please list the names, ages and relationship of all individuals currently residing in your household:_____

_____

Health History:

Please check and date any of the following the apply:

____ Serious accident	_____ Hearing problems	_____ Blood Sugar
_____ Vision problems	_____ Menstrual pain	_____ Cancer
_____ Insomnia	_____ Major surgery	_____ Nervous Tics
_____ Hormone Imbalance	_____ Asthma	_____ Panic Attacks
_____ Impotence	_____ Arthritis	_____Obsessive/Compulsive
_____ Thyroid trouble	_____ Headaches	_____Addictions
_____ Heart trouble	_____ Alcohol abuse	_____Abortion
_____ Sterility	_____ Aids/HIV +	_____Anemia
_____ Sinus infection	_____ Fainting	_____Tension/stress
_____ Epilepsy	_____ Depression	_____Diabetes
_____ Paralysis	_____ Eating disorder	_____Suicidial Ideation
_____ Miscarriage	_____ Drug Abuse	_____Other

Previous psychotherapy or counseling:

Date:_____ Counselor or Center:_____
Presenting Problem:_____

Name of your Psychiatrist_____ date when started_____
Medical Diagnosis: _____
Results of Therapy: _____
Reason for Termination: _____

When was the last time you saw a doctor?_____ Reason for the visit:_____

What prescription or non-prescription medications are you taking currently, in what dosages, and for what reason?_____
_____
_____

Describe any recent or ongoing sleep or appetite changes or difficulties:
_____
_____

Other helpful information (if any):_____
_____

Family History:

Parent's marital status: (if married to each other)

____very happy____ happy____average____unhappy____separated____divorced

*If divorced, your age then explain:*_____
_____

Father remarried? _____ Your age when remarried _____
Mother remarried? _____ Your age when remarried _____

Siblings:

Name	*Age*	*Occupation*	*Marital Status*

*Overall, how would you describe your family life growing up?*_____
_____

_____

_____.

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972/532-9535

Credit Card Authorization Form

I authoritze Kelley Connell, LCSW to keep my signature on file and to charge my Visa or MasterCard account for the intial intake psychotherapy session of $150.00 and for the recurring charges of $125.00 per each additional session, or if insurance is utilized for the copay in the amount of $_____per session.

I understand this form is valid for two years unless I cancel the authorization in writing. I promise not to dispute charges ("charge back") for any appointments I have scheduled. I understand this includes appointment times reserve for me which I have not cancelled 24 hours prior to the appointment. I further authorize Kelley Connell, LCSW to disclose information about my attendance/cancellation to my credit card issuer if I dispute a charge.

Credit Card Authorization

_____ _____
Client Name Date of Birth

_____
Cardholder Name

_____
Cardholder Billing Address City State Zip Code

_____Visa _____MasterCard

Card Number: _____ Expiration Date:_____

Last 3 or 4 numbers from back of card:_____

My signature below signifies that I have read, understand, and agree to abide by the above policies.

_____ _____
Signature Date