Kidder Counseling Services

9035 Bluebonnet Blvd., Suite 1
Baton Rouge, LA 70810
225-769-5990 ● KidderCounseling@gmail.com

All information is kept strictly confidential.

Full Name _____ **Date of Birth** _____

Home Address _____
Street City State Zip

Phone _____ **Email** _____
Home Cell

If Employed _____
Employer Street Address

Job Title _____
City State Zip

Person responsible for payment, if different from above:

Name _____ **Contact No.** _____

Address _____
Street City State Zip

If using insurance, please provide **a copy of your insurance card** and the following:

Ins. co. name _____ **Policy holder date of birth (if not client)** _____

Policy holder name _____ **Relationship** _____

Religious/ Church affiliation _____ **Last year of school completed:** ☐**High school/GED** **College** ☐**1** ☐**2** ☐**3** ☐**4** ☐**Graduate**

☐ **Single** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widowed** ☐ **Remarried** ☐ **Life Partner**

If married, # of years _____ **Spouse's name** _____

Age _____ **Employment** _____

Please list all your children:

Name	Age	Gender	Biological, Step, Adopted	Living with You?

Do we have permission to confirm office visits? ☐**Yes** ☐**No** **Preferred Contact** _____

Emergency contact name: _____ **Phone** _____

Please describe your family of origin:

Member	Name	Age (If deceased, place/year of death)	Has This Individual Ever Had Counseling?	If so, for what reason?
Mother				
Father				
Brother				
Brother				
Sister				
Sister				
Other				

For you or any in your family of origin, is there any history of physical or sexual abuse? _____

If so, please explain: _____

Do you use alcohol and/or drugs? ☐ **Yes** ☐ **No** **If yes, please describe frequency and choice:**

_____

Any history of sexual difficulty? ☐ **Yes** ☐ **No** **If yes, please describe:**

_____

Have you worked with a therapist/counselor before? ☐ **Yes** ☐ **No** **If yes, please describe:**

_____

Name of previous counselor: _____

Describe any major changes in the recent past (moves, births, deaths, marital status, finances, etc.)

_____

Describe any major health changes or conditions for which you have been treated in the last months/years:

_____

Primary care physician: _____ **Phone:** _____

Prescribed Medication	Amount	How Long Taken?	Treatment For	Doctor Who Prescribed

If you need more space, please indicate that you are listing additional medications on the back of this sheet. ☐

Please indicate which areas <u>are causing problems</u> for you. You can add notes at the bottom of the page.

- ☐ Alcohol use
- ☐ Ambition
- ☐ Anger
- ☐ Anxiety
- ☐ Appetite Change
- ☐ Asthma
- ☐ Back pain
- ☐ Blood pressure
- ☐ Body odor
- ☐ Breathing difficulties
- ☐ Career choices
- ☐ Chest Pains
- ☐ Children
- ☐ Concentration
- ☐ Depression
- ☐ Disability
- ☐ Divorce
- ☐ Dizziness
- ☐ Drug use
- ☐ Education
- ☐ Energy too high
- ☐ Energy too low
- ☐ Engaged
- ☐ Exercise too little
- ☐ Exercise too much
- ☐ Fatigue
- ☐ Fear(s)
- ☐ Finances
- ☐ Friends
- ☐ Grades
- ☐ Grief issues
- ☐ Headaches
- ☐ Health problems
- ☐ HIV positive
- ☐ Inferiority
- ☐ Insomnia
- ☐ Jaw pain
- ☐ Legal matters
- ☐ Making Decisions
- ☐ Marriage
- ☐ Memory
- ☐ Moodiness
- ☐ Nightmares
- ☐ Organization
- ☐ Other (please specify)
- ☐ Panic
- ☐ Ringing in ears
- ☐ Self control
- ☐ Separation
- ☐ Shyness
- ☐ Sleep too little
- ☐ Sleep too much
- ☐ Smoker
- ☐ Stomach aches
- ☐ Stress
- ☐ Suicidal thoughts
- ☐ Swelling
- ☐ Temper
- ☐ Terminal illness
- ☐ Unhappiness
- ☐ Weight too little
- ☐ Weight too much
- ☐ Work

Any other concerns not listed?

_____

Other comments or information you would like to share with the therapist?

_____

_____

_____

Kidder Counseling Services
9035 Bluebonnet Blvd. ● Suite 1
Baton Rouge, LA 70810
225-769-5900 ● KidderCounseling@gmail.com

Late Cancellation/Missed Appointment Policy

We are pleased that you have scheduled an appointment with our office.

Unless you experience a true emergency, the office requires 24-hour notice for a cancelled session.

If you do not provide proper notice or miss your appointment altogether, you will be charged for the session and be responsible for any accompanying co-pays or deductibles.

We will not be able to schedule any further appointments until this balance has been satisfied.

We also reserve the right to remove any additional future appointments from the schedule.

Because we usually have a waiting list and try to schedule each client fairly, we appreciate your understanding and cooperation.

I understand and agree to the cancellation policy.

Signature of client or signature of parent or guardian if client is minor	Date