

Kidder Counseling Services

150-B Staring Lane
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 are causing problems for you. You can add notes at the bottom of the page.

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

Any other concerns not listed?

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

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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