Tiffany Smith Counseling, Inc.
2901 Corporate Circle
Flower Mound, TX 7502
(214) 405-4030
tiffanysmithcounseling@yahoo.com

Adult Form

Date of First Appointment: _____ Email _____

Name: _____
Last *First* *Middle*

_____
Address

_____
City *State* *Zip Code*

Phone numbers: _____ _____ _____
Home *Cell* *Work*

May I leave a message for you at home? Y / N
May I leave a message for you at work? Y/ N
May I leave a message for you on your cell? Y/ N

May I contact you via email? Y/ N
Please list the email address that you wish to be contacted at (we do not release email addresses):

_____

If you would like to be able to sent text messages to schedule/cancel appointments, please provide us the phone number and authorization to respond to these text messages:

Phone number for texting:_____

Signature:_____ Date:_____

Race/Ethnicity: African American_____ Asian_____ Caucasion_____ Latin____

Native American____ Other_____

Relationship Status: Married____ Single___ Divorced____ Widowed____

Cohabitating____ Other_____

Sexual Orientation: _____

Education Level: Elementary School_____ High School_____ Some college_____

Bachelor's Degree_____ Graduate Degree_____ Other _____

Occupation: _____ Employer: _____

Employer address:_____

Please list all current members of your household:

Name	Age	Relationship	Occupation

Briefly describe your reason for seeking counseling: _____

_____

_____

What goals do you hope to achieve by attending counseling?_____

_____

_____

Medical Doctor: _____Phone #_____

When were you last examined by a physician? _____

List any major health problem for which you currently receive treatment:

_____

Please list any medications you are currently taking:

Medication	Dosage	Treatment of Symptoms	Length of Use of Medication

Current height_____ Current weight_____

Are you currently involved in an exercise regimen?

Yes____ No_____ If yes please list the type of exercise and amount per week

_____

Current hobbies/ personal interests:_____

_____

Current religious/spiritual beliefs:_____

_____

Please answer the following as it applies to you:

Do you currently drink alcohol and if so please state the amount consumed per

day/week? _____

Do you currently smoke and if so please state the amount consumed per

day/week?_____

Do you currently use any controlled substances and if so please state the amount consumed per day/week?_____

Have you ever previously attended therapy or received counseling services of any kind? Yes____ No_____ If yes please list the type of therapy you received_____

Did you find treatment helpful?_____

Previous therapist: _____

Reason treatment terminated?_____

Previous Psychiatric Hospitalizations?_____

Treatment and Diagnosis Rendered?_____

Tell me briefly if you or anyone in your family has ever been affected by the following:

	Self	Spouse/ Partner	Sibling(s)	Child(ren)	Parent(s)	Other
Alcoholism/Drugs						
Obeseity						
Anorexia						
Mental Illness						
Terminal Illness						
Dementia						
Abuse/Domestic Violence						
Chronic Health Problems						
Criminal Activity						
CPS Involvement						
Child Abuse						
Depression/Anxiety						

Do you anticipate being involved in a lawsuit in the near future? Y/ N

If yes, please explain_____

_____

Have you ever been a party to a lawsuit? Y/ N

If yes, please provide a description of the suite, the date, and the outcome:

_____

_____

Have you ever filed a complaint with a licensing or regulatory authority? Y/ N

If yes, please provide a description of the suite, the date, and the outcome:

_____

_____

How did you hear about us?_____

_____

Customer Satisfaction Survey: Upon discharge we will ask you to complete a client satisfaction survey. The survey is anonomous and confidential and is used so that we can improve the quality of our services. Please provide us with your email address. We do not release email addresses to third parties.

I would like the survey sent to my email address at:

_____

Would you like to receive our e-newsletter? Yes/ No
(We do not release email addresses to third parties)

I authorize payment of medical benefits to the provider of services, and the release of any treatment information necessary to process claims or obtain authorizations for treatment:

Signature _____ Date _____