



CENTER FOR HEALTH AND HEALING

6700 WEST 44TH AVENUE, WHEAT RIDGE, CO 80033

PHONE: 303-420-8080 FAX: 303-420-9299

Demographic Information

CLIENT NAME: _____ ENTRY DATE: _____
ADDRESS: _____ HOME PHONE: _____
APT #: _____ SSN: _____
CITY: _____ STATE: _____ ZIP: _____
DOB: _____ RACE: _____ GENDER: MALE FEMALE
CELL PHONE: _____ WORK PHONE: _____
EMAIL ADDRESS: _____

Responsible Parties

SPOUSE: _____ GUARDIAN: _____
ADDRESS: _____ ADDRESS: _____
PHONE: _____ PHONE: _____
FATHER: _____ MOTHER: _____
ADDRESS: _____ ADDRESS: _____
APT #: _____ APT#: _____
CITY: _____ CITY: _____
STATE: _____ ZIP: _____ STATE: _____ ZIP: _____
HOME PHONE: _____ HOME PHONE: _____
EMERGENCY CONTACT (PLEASE LIST AT LEAST ONE NAME AND PHONE NUMBER):

RELIGIOUS PREFERENCE: _____ ASSIGNED COUNSELOR: _____



Policies and Acknowledgements

(All lines/questions must be filled out. If it does not apply indicate by writing: N/A)

Fee Related Policies

Initial on the line provided for each statement. If client is a minor both Client and Guardian initial and sign.

1. _____ I understand that all individual, family, and group sessions are scheduled for a 50 minute hour.
2. _____ I am aware that 24-hour notice is required for cancellation of appointments.
 - a. _____ appointments not cancelled with a 24-hour notice will be billed in full.
 - b. _____ additionally, I agree to provide at least 24-hour notice of intent to terminate therapy to avoid being subject to the no show/cancellation fee.
3. _____ I understand that payment is expected at the time of service, that Lost and Found, Inc., will seek payment for my therapy session(s) from 3rd party payors (Insurance, Victim's Comp, etc.) at my request. Ultimately:
 - a. _____ I am responsible for resolving any problems with 3rd party payers. This includes being fully responsible for any and all incurred insurance non-payments such as deductibles, overage of maximum benefits, errors in billing procedure codes made by the insurance company, delay of payments by the insurance company or any other reasonable cause for non-payment of the insurance company involved.
 - b. _____ I am responsible for maintaining clear communication with Lost and Found, Inc, re: solutions to missed/late payments.
 - c. _____ I am solely responsible for all indebtedness incurred at Lost and Found, Inc.
4. _____ I understand that my treatment may be interrupted/terminated for lack of commitment to the therapeutic process for the following:
 - a. _____ after 3 unpaid NO SHOWS.
 - b. _____ due to 3 consecutive cancellations
 - c. _____ unresolved debt of 3 sessions or more.
5. _____ Phone calls in excess of 5 minutes will be billed to the client's account in 15 minute increments at a rate of \$30.00.
6. _____ Calls to the emergency/after-hours pager will be billed at the rate of \$30.00 for each 15-minute increment.
7. _____ Clients are not to be in possession of alcohol, drugs, paraphernalia or weapons at any time while on Lost and Found property. Individuals who come to their session under the influence of alcohol or drugs will be:
 - a. _____ asked to leave the premises
 - b. _____ cancelled for session time and held responsible for re-scheduling.
 - c. _____ billed for cancelled time at full session rate.

Client Signature

Date

Therapist Signature

Date



Facility Related Policies

Initial on the line provided for each statement. If client is a minor both Client and Guardian initial and sign.

1. _____ I understand that Lost and Found, Inc. is a faith-based counseling center, that faith principles may be used and referred to appropriately in the context of the therapy session. I understand that I have the freedom and right to ask for prayer with my counselor. I have the right to refuse prayer/spiritual guidance.
2. _____ I understand that I am responsible for my children's behavior. I agree not to leave children unattended at this facility for any reason. I understand that supervision for children is not provided before, after, or during my therapy session. I agree to pick up my children immediately after their session.
3. _____ I understand that Lost and Found, Inc. is a smoke-free environment and that smoking is prohibited on facility grounds.
4. _____ I understand that all pets are prohibited. The exception is for service animals which must have papers with them at all times and be clearly designated.
5. _____ I am aware that while on Lost and Found property I will not be allowed to harm myself, others, or any property. If I become a threat of harm to any of these, the authorities will be notified immediately and I will be held responsible for any damages incurred.
6. _____ I am aware that Lost and Found, Inc. is not responsible for items left in the facility during or after sessions. An unclaimed item box is provided in the reception area.
7. _____ I understand that Lost and Found, Inc. is not responsible for damage to vehicles in or around the facility.
8. _____ I understand that Lost and Found, Inc. is a training clinic, and as such:
 - a. _____ therapy sessions may include co-facilitation or sole-facilitation by a qualified Masters level intern from an accredited university, requiring supervision by a licensed psychotherapist.
 - b. _____ supervision may include:
 - 15 minutes or more of direct supervision by the supervisor during the therapy session;
 - audio/videotaping of the session as a standard tool for supervision or for other therapeutic reasons. Prior disclosure of the intent to tape a session will be made by the therapist and all rules governing client confidentiality will be strictly enforced.
9. _____ I agree to give Lost and Found, Inc. and/or The Family Counseling Center permission to correspond with me by letter, telephone, or by other means necessary to check on my progress after discharge.
10. _____ I understand that my records are protected by HIPPA regulation. I have read and understood the Lost and Found, Inc. privacy protection notice.
11. _____ I understand that I must fill out a specific Authorization for Release of Information form indicating to whom and for what reason(s) records are being requested per HIPPA standard.
12. _____ I understand that recommendations for nutrition, supplements, exercise, and other healthcare suggestions, are not intended to replace medical advice and treatment from your primary care physician.



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- 13. _____ I understand that occasionally Lost and Found, Inc. sends newsletters and other information to clients and other interested parties unless otherwise personally directed/requested in writing.
- 14. _____ I/We have willingly placed my/ourselves in the program of Lost and Found, Inc. and do authorize Lost and Found, Inc. to act in my best interests and to perform any treatment that is deemed proper and fit by the agency.
- 15. _____ By means of my/our signature, I/we hereby release Lost and Found, Inc., it's staff and directors from all suit, libel, damages or legal litigation of any kind that could be brought against them for any reason by us on our behalf.
- 16. _____ I/we do also hereby state that this agreement and contract is to be in effect for the life of my/ourselves and that even after death this contract shall stay in effect.

I attest that I have read, reviewed, understood and agreed to abide by all the above-initialed policies, disclosures, and acknowledgments:

Client Name (**Please PRINT**)

Guardian Name (**Please PRINT**)

Signature of Client

Date

Signature of Guardian

Date

Signature of Interviewer

Date



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Health/Mental Health History

Height: _____ Weight: _____ 1 year ago: _____ 5 years ago: _____

Occupation: _____ Full Time Part Time

Living situation: Alone Friends Partner/Spouse Parents Children Pets

What are your major health/mental health concerns and intentions for your visit today? _____

Please list any other health care providers or consultants you are currently working with:

Please list any current health conditions diagnosed by a medical doctor:

When was your last physical exam? _____

Please list all herbs, vitamins, and dietary supplements you are currently taking, including dosage and frequency:

List all medications you are currently taking (including aspirin, antacids, etc.) indicating whether they are over the counter (OTC) or prescription, including dosage and frequency:

List all medications, herbs, foods, environmental factors, to which you have a known allergy:

DIETARY INFORMATION

Describe below your typical meals. Please be as specific as possible. For example, instead of "oil" note the type of oil, such as olive, corn, etc. Instead of "bread" list whether it is white or whole grain, etc. Instead of "vegetables," list the type of vegetable, how it was prepared, whether canned, frozen, or fresh, etc. Please include the type and quantity of all beverages (two cups of orange juice, one cup of coffee, etc.).

Breakfast:

Morning snack(s):

Lunch:

Afternoon snack(s):

Dinner:

Daily water consumption (number of glasses/day): _____ Any recurring food cravings (such as salt, starch, sugar, chocolate, etc.)? Please list as many as applicable including time of day or month:

Client Name: _____



MEDICAL HISTORY

List all major health problems including any operations:

PROBLEM

YEAR

GENERAL HEALTH

Cardiovascular

- High blood pressure
- Low blood pressure
- Pain in heart
- Poor circulation
- Swelling
- Stroke/murmur

Skin

- Boils
- Bruises
- Dryness
- Itching
- Varicose veins
- Skin eruptions

Muscles/Joints

- Backache
- Broken bones
- Limited mobility
- Arthritis
- Bursitis
- Weakness

Respiratory

- Chest pain
- Difficulty breathing
- Cough
- Tuberculosis
- Congestion
- Itchy ears/eyes
- Asthma
- Coughing up blood

Urinary/Kidney

- Excessive urination
- Water retention
- Burning urine
- Kidney stones
- Lower back pain
- Wheezing
- Circles under eyes
- Blood in urine

Gastro-Intestinal

- Belching
- Colitis
- Constipation
- Abdominal pain
- Liver disorders
- Gallstones
- Ulcers
- Digestive troubles

Eyes, Ears, Nose and Throat

- Ear aches
- Sinus infections
- Hearing loss
- Eye pains
- Sinus congestion
- Canker sores
- Failing vision
- Sore throat
- Nosebleeds
- Hay fever
- Tonsils
- Difficulty breathing

General

- Fatigue
- Loss of appetite
- Night sweats
- Always hungry
- Fever
- Difficulty sleeping
- Excessive thirst
- Irritability
- Cold hands and feet

Male Reproductive

- Burning/discharge
- Vasectomy
- Lumps/swelling of testicles
- Painful testicles

Female Reproductive

- Age of first period: ___
- Blood clots
 - Pains/cramps
 - Breast pain
 - Genital herpes
 - Irregular cycles
 - Menopause
 - Painful intercourse
 - Breast lumps
 - Hot flashes
 - Pre-menopausal
 - Vaginal discharge
 - Vaginal dryness
 - Anemia
 - Mood Swings
 - Heavy bleeding
 - Vaginal itching
 - Pelvic pain
 - Infertility
 - PMS
 - Not able to conceive

Contraceptive/Pregnancy History

- Birth Control Pills
- Mucous-method
- Rhythm-method
- Cervical Cap
- I.U.D.
- Spermicides
- Diaphragm
- Fertility lens
- Condoms



Please list each pregnancy you have had, including miscarriages:

CURRENT STATE OF EMOTIONS AND SPIRITUAL WELL-BEING

Please check all those that describe you:

- I am often stressed out and not able to cope properly.
- Even though I'm in a relationship, I often feel lonely.
- I often feel anxious and nervous for no good reason.
- I don't sleep well at night and have a hard time waking up in the morning.
- I often suffer from bad dreams and nightmares.
- There are many things I'd like to change in my life I just don't have the means.
- I have very low energy and often feel exhausted mentally and physically.
- I don't enjoy my work and would rather be doing something else.
- I find my children irritating and hard to relate to.
- I have very few hobbies.
- I often feel depressed for no reason.
- I often become angry with people and feel guilty about it later.
- I have a hard time letting go of the past.
- I don't look towards the future with much enthusiasm.
- I am not able to concentrate for extended periods of time.
- My outlook is more negative than positive.
- I spend a great deal of time worrying about what people think about me.
- I tend to see the good in people.
- I have a great sense of humor and love a good joke.
- I receive great joy from my family.
- My outlook on life is positive.
- My job uses all my greatest talent.
- I have plenty of energy to do all the things I want.
- I sleep well at night and feel rested in the morning.
- I can concentrate on the task at hand for as long as it takes.
- I have a strong spiritual faith.
- I am able to express anger constructively.
- I practice meditation or other relaxation techniques.
- I try to maintain peace of mind and tranquility.
- I have many close friends that I can always count on.
- I accept full responsibility for my actions.
- I trust my intuition and believe that things happen for a reason.
- I do not harbor any resentment from the past.
- I can feel completely fulfilled even if I'm alone.
- I have many hobbies and interests to keep me preoccupied.
- How I see myself is more important than how others see me.
- I often go out of my way to help others.



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Please list approximate dates and describe the nature of any traumatic experiences you have had in the past 7 years (divorce, surgery, end of a relationship, loss of job, change of residence, injury, death of a loved one, etc.):

YEAR

EVENT

LIFESTYLE HABITS

Do you engage in regular physical activity? Yes No
If yes, for how many minutes? _____ How often? _____

Do you smoke tobacco? Yes No
If yes, how much? _____/day

Do you drink alcohol? Yes No
If yes, how much? _____ How often? _____

Do you drink coffee and/or caffeinated beverages? Yes No
If yes, how much? _____ How often? _____

How many hours of television do you watch in a week? _____

Do you use artificial sweeteners? Yes No

Please use this space to add any other information about yourself that you think will be helpful:
