Alliance Counseling Group

1 W. Camino Real, STE. 201
Boca Raton, FL, 33432
www.alliancecounseling.net

Please indicate the clinician with whom you will be working; email addresses are provided so that you may send these forms to her/him if you choose:

- ☐ Dr. Andrew Baker - andrewbakerlmhc@protonmail.com
- ☐ Dr. Patricia Diaz - pdiaz@alliancecounseling.net
- ☐ Dr. Robert Freund - rfreund@alliancecounseling.net
- ☐ Dr. Paul Peluso - drpaulrpeluso@gmail.com

<table>
<tr><td colspan="2">Name:</td><td>Birth Date:
/ /
mm dd yy</td></tr>
<tr><td colspan="3">Address:</td></tr>
<tr><td>Gender:</td><td>Preferred Phone #:</td><td rowspan="2">Emergency Contact:
Name: _____
Relationship: _____
Phone #: _____
Address: _____
_____</td></tr>
<tr><td>Highest Leve of Education:</td><td>Number of moves in past 5 years:</td></tr>
</table>

Relationship status: _____ Length of time in current relationship: _____

Partner's name _____ Age _____ Quality of Rel. (1 low – 10 high) _____

Hometown: _____

How long have you been in South Florida? _____

Do you consider yourself to be a spiritual person? (Yes / No)

Religious identification: _____ Level of importance (1 low – 10 high): _____

What is your current occupation? _____

Place of employment: _____

How long at current position? _____ Do you enjoy what you do for a living? _____

What is the career you've always dreamed of? _____

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Family Information:

Mother's Name: _____ Age: _____ Quality of Rel. (1-10) _____

Father's Name: _____ Age: _____ Quality of Rel. (1-10) _____

Paternal (dad's side) grandparents (names and ages): _____

Maternal (mom's side) grandparents (names and ages): _____

Siblings – please list all brothers and sisters:

Name: _____ Age: _____ Quality of Rel. (1-10) _____

Name: _____ Age: _____ Quality of Rel. (1-10) _____

Name: _____ Age: _____ Quality of Rel. (1-10) _____

Name: _____ Age: _____ Quality of Rel. (1-10) _____

Children:

Number of living children: _____ Number of pregnancies: _____ Sexually active? Y / N

Name: _____ Age: _____ Quality of Rel. (1-10) _____

Name: _____ Age: _____ Quality of Rel. (1-10) _____

Name: _____ Age: _____ Quality of Rel. (1-10) _____

Name: _____ Age: _____ Quality of Rel. (1-10) _____

History of mental health issues for you or your family: _____

History of substance abuse for you or your family: _____

History of sexual, physical or emotional abuse: _____

Did you have a best friend when you were growing up? _____

Have you ever attempted suicide? _____ Any current thoughts of suicide? _____

Have you ever engaged in non-suicidal self-injury? : _____

Have you ever been violent towards others? _____ Any current thoughts of harm to others? _____

Do you have any medical concerns/conditions? _____

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Are you currently taking any medications? Yes / No

Please list all medications: _____

Are you now or have you ever seen a psychiatrist? _____

Name and telephone of your primary physician: _____

May we contact your physician? _____

Number of emergency room visits in the past five years: _____

Experience with previous counseling (inpatient/outpatient?): _____

_____

What are your primary goals for treatment? _____

_____

_____

If you won the lottery, what are the first three things you would do with the money?

_____

_____

I hereby consent to be treated and have been informed of the limitations and risks:

_____ _____
Signature *Date*

Please note that a minimum of 24 hours notice is required for cancellations

or rescheduling to avoid the full fee of $125 (unless otherwise specified) being due.

_____ *(Initial)*

THANK YOU!

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AUTHORIZATION TO OBTAIN AND RELEASE INFORMATION

Client Name: _____ Date of Birth: _____
This will authorize Alliance Counseling Group to disclose and/or obtain from:

_____

The following information: (Client must check and initial each item to be included)
[ ] Assessments _____
[ ] Psychosocial evaluation _____
[ ] Treatment plan or summary _____
[ ] Progress in treatment _____
[ ] Discharge / Transfer summary _____
[ ] Other (please specify) _____

Purpose: The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If there is another purpose, please specify:

_____.

Right to Revocation: I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Everyday Wellness Counseling, LLC at the address listed above. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration:
[ ] This information release is for a specific instance, valid for 90 days, and will expire on the following date: _____.
[ ] Unless sooner revoked, this consent is valid for 1 year due to the need for ongoing communication for the coordination of treatment and will expire on the following date: _____.

Conditions: I understand that Everyday Wellness Counseling, LLC, will not condition my treatment on whether or not I give authorization for the requested disclosure.

Form of Disclosure: Unless you have requested in writing that disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner deemed to be appropriate and consistent with applicable law, including but not limited to verbally, on paper or electronically.

Re-disclosure: Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2.

_____ _____

Client Date

_____ _____

Parent/Guardian (if applicable) Date

_____ _____

Parent/Guardian/Witness Date