

**Application for Services**

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Last Name First Middle Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number Age Date of Birth Married/Single/Divorced

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Local Address City State Zip

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Local Phone Number Cell Phone Number

* May I call your **local** number: Yes – No?

* May I call your **cell** phone: Yes – No?

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Print Email Address

* May I contact you by email with appointment information if necessary or in the event of an emergency Yes – No?
* May I contact you by text message with appointment information if necessary or in the event of an emergency?

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Name of emergency contact person. Local or cell phone of emergency contact person

**FAMILY HISTORY**: List name and ages of mother, father, siblings, spouse, and children.

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Mother’s Name Age

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Father’s Name Age

**FAMILY HISTORY**: List name and ages of mother, father, siblings, spouse, and children.

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Brother (s) Name (s) Age

Sister (s) Name (s) Age

Spouse/Significant Other Age

Children -\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Children Ages

**Brief Psychosocial History**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Have you ever received psychological counseling? If so where and when?

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Are you currently taking any mental health medications?

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If yes, please list medications.

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Have you ever received addiction treatment? If so where and when?

Do you have any family history of mental health or addiction issues or concerns?

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Are you currently having any suicidal thoughts and/or do you have a plan to kill yourself? If yes, please describe.

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Have you ever attempted suicide? If so where and when?

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Are you currently having any thoughts of harming others or yourself?

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Describe any serious medical problems?

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Describe any current employment issues or concerns?

Describe any current legal problems?

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Describe your current living situation?

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Have you ever been physically, sexually or emotionally abused?

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Ever been arrested or charged with domestic violence?

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Are you currently separated, going through a divorce or experiencing significant problems in an intimate relationship? If yes describe?

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**Please Check All That Apply in the Past Year**

|  |  |  |
| --- | --- | --- |
| * **Apathetic** | * **Anxious** | * **Exhausted** |
| * **Annoyed** | * Lonely | * Confused |
| * **Withdrawn** | * Suicidal | * Optimistic |
| * **Angry** | * Calm | * Depressed |
| * **Hyper** | * Discouraged | * Bored |
| * **Unloved** | * Stressed | * Intense Pressure |
| * **Resentful** | * Physical Pain | * Violent |
| * **Like a Failure** | * Miserable | * Alcohol |
| * **Agitated** | * Guilty | * Drugs |
| * **Hopeless** | * Frustrated | * Fearful |

Please describe why you are here today? List any personal or professional issues or problems you are concerned about in your life?

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How Can I Help You?

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Please list the name of the person or agency that may have referred you?

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Welcome to Testa Counseling. I will do my best to address the issues that caused you to seek my services. It is important that you understand some information about the treatment process and my policies.

**Qualifications:** All treatment is done by Marlisse Testa, who holds a valid Florida License Status. I have over 11 years of experience with children, adults, couples, families and groups.

**Treatment and Outcome** : I provide only outpatient services on a weekly basis. When needed, I provide referrals to medical doctors, psychiatrists, psychologists and other mental health providers.

You play a major part in the outcome of treatment. Treatment is not a passive process and what you put into treatment will in part determine the results. I will make all attempts to render useful and effective services, but I cannot guarantee results.

**Treatment Risks and Alternatives**: Treatment of mental health disorders may involve discussion of sensitive difficult personal areas. My intent always is to focus on a solution to a client problem, but sometimes it may be necessary to explore sensitive areas to achieve that result. When it is believed medication might be helpful, I may suggest referral to a psychiatrist or medical doctor.

**Mutual Obligations**: I have the highest ethical responsibility to treat you in a respectful, professional and caring manner. I ask that you also act in a responsible way with regard to appointments that you make with me. Please call as much in advance as possible if you must cancel or reschedule an appointment. I request that you respect these appointment times.

**Questions and Communications**: You have the right to ask about issues that concern you. I encourage full communication between clients and therapist regarding all questions.

I have read and understood the above and state that it is my desire to receive services from Marlisse Testa LMHC at Testa Counseling. No other party has unduly influenced my decision to receive services.

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Client Signature Date

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Marlisse Testa LMHC Date