Christy McNamara, LCSW
Psychotherapy

2150 Park Avenue North, Winter Park, FL 32789 (407) 928-2046 Fax (407) 539-2447

Name:_____ Today's Date: _____

Address: _____

_____

Home Phone: _____ OK to call? _____

Work Phone: _____ OK to call? _____

Cell Phone: _____ OK to call? _____

Date of Birth: _____

Who referred you? _____ May I thank this person? _____

Please list any previous counseling (names and dates): _____

_____

_____

Why are you seeking therapy at this time? _____

_____

_____

Marital status: _____ Partner's name: _____ Years together: _____

Name and ages of all individuals in your home: _____

_____

Current Physician and/or Psychiatrist: _____

What medical problems or conditions do you currently have? _____

_____

Medications: _____

Please check yes, no, or suspected for each of the following:

| Description: | Yes | No | Suspected |
|---|---|---|---|
| Cancer (specify type) | | | |
| Diabetes | | | |
| Thyroid Disease (specify) | | | |
| Body aches/pains (specify) | | | |
| Nervous or Mental Disorder (specify) | | | |
| Drug Allergies (specify) | | | |
| Have you attempted suicide? When? | | | |
| Are you currently suicidal? | | | |
| Have you been psychiatrically hospitalized? When? | | | |
| Have you been in trouble for threatening or harming others? | | | |
| Sleeping less | | | |
| Sleeping more | | | |
| Difficulty sleeping | | | |
| Eating less/loss of appetite | | | |
| Eating more/increased appetite | | | |
| Difficulty functioning at work/school | | | |
| Difficulty functioning socially | | | |
| Low energy, fatigue | | | |
| Nausea/vomiting | | | |
| Excessive crying | | | |
| Difficulty concentrating | | | |
| Hopelessness | | | |
| Irritability | | | |
| Chronic sadness | | | |
| Feelings of worthlessness and/or guilt | | | |
| Reduced interest in pleasurable activities | | | |
| Fear of dying | | | |
| Panic attacks | | | |
| Chest pain | | | |
| Shortness of breath | | | |
| Restlessness | | | |
| Excessive worry | | | |
| Racing thoughts | | | |
| Impulsivity | | | |
| Forgetfulness | | | |
| Substance use (specify) | | | |
| Alcohol use (specify amount weekly) | | | |
| Grief/loss | | | |
| Gambling | | | |
| Financial concerns | | | |
| Nightmares | | | |

**Consent for Treatment**
I, the undersigned, have voluntarily applied for and agree to participate in counseling and/or psychotherapy services. Please indicate your understanding and acknowledgement of the foregoing information by signing below.

Patient/Parent Name: _____

Patient/Parent Signature: _____ Date: _____

**Office of Christy McNamara, LCSW**
Please read carefully and initial where indicated.

**Rights**
As a patient, you have the right to receive available services individualized to your specific needs and provided in the least restrictive manner. You have the right to seek information about and to approve of therapeutic practices. With limited exceptions, information discussed and recorded is confidential. You will be asked to provide written consent if information is to be released to third parties. The exceptions this written consent and strict maintenance of confidentiality include: 1) information that is shared on a need to know basis during clinical supervision of the therapist's work; 2) imminent physical danger to self or others; 3) child abuse; 4) information legitimately ordered by court of law; and 5) information required by your insurance company in order to process a claim made by you. We are committed to providing you with the best possible care. Please ask if you have any questions about our fees, policies, and your responsibility.
Please initial: _____

**Appointments and Cancellations**
YOU MUST GIVE AT LEAST 24 HOURS NOTICE IF YOU NEED TO CANCEL AN APPOINTMENT. YOU WILL BE CHARGED IN FULL FOR THE APPOINTMENT –EVEN IF YOU DO NOT ATTEND– IF LESS THAN 24-HOUR NOTICE IS GIVEN.
Appointments can be scheduled as my hours become available. Traditionally, an "hour" is considered to be approximately 45-50 minutes. The length and frequency of therapy sessions depend on many factors and you may discuss this during your initial session.
Please initial: _____

**Professional Fees, Insurance, and Payments**
Payment is due in full at time of service. No insurance is accepted for your first visit, unless we have a contract with your insurance company. There is a $30 charge for checks returned. You are responsible for the fees that incur with Christy McNamara and NOT your insurance company or other third party. You will be given receipts, if requested, to submit to your insurance company for reimbursement (if applicable). You are responsible for co-payments and deductibles. Parents/guardians are responsible for payment of a minor. If you fail to pay on your account, we have a right to turn your account over to a collection agency or attorney for collection. If this account is assigned to an outside collection agency, an additional fee of 40% of the total amount owed will be added.
Please initial: _____