



## Profile Information

Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ (age) \_\_\_\_\_ S.S.# \_\_\_\_\_

Address \_\_\_\_\_ Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_

City/State/Zip \_\_\_\_\_ E-mail \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

What brings you to counseling: \_\_\_\_\_

Current Medical Concerns: \_\_\_\_\_

### Please Check All that Apply

APPETITE:  no changes  recent increase  recent decrease  weight gain/loss (circle which)  
 MOOD:  happy most days  often tearful  blah most days  feel hopeless  
 ANXIETY:  excessive worries  nightmares  fearful often  panic attacks  
 ANGER:  quick to anger  lose temper easily  often frustrated  often irritable  
 SLEEP:  trouble getting to sleep  interrupted sleep  sleeping a lot **I average [ ] hrs/night**

### Current Med's

### Dose/Frequency Date Started

### Used for

Current Med's	Dose/Frequency	Date Started	Used for
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(Medicine Prescribed By: \_\_\_\_\_, M.D.)

### Alcohol/Drug Amount/Frequency of Use Started Using at Age

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

### FAMILY of ORIGIN

I am adopted  I am a child of divorce  I had a single Parent Childhood

Primary Parents (names)

\_\_\_\_\_  Living  Deceased  Age \_\_\_\_\_ # of Children \_\_\_\_\_ Lived with from age \_\_\_\_\_ - \_\_\_\_\_

\_\_\_\_\_  Living  Deceased  Age \_\_\_\_\_ # of Children \_\_\_\_\_ Lived with from age \_\_\_\_\_ - \_\_\_\_\_

Step-Parents/Guardians (names)

\_\_\_\_\_  Living  Deceased  Age \_\_\_\_\_ # of Children \_\_\_\_\_ Lived with from age \_\_\_\_\_ - \_\_\_\_\_

\_\_\_\_\_  Living  Deceased  Age \_\_\_\_\_ # of Children \_\_\_\_\_ Lived with from age \_\_\_\_\_ - \_\_\_\_\_

### KEY SUPPORT SYSTEM

(Identify the significant people in your life to whom you turn for support)

Name

Relationship

Known How Long?

Name	Relationship	Known How Long?
_____	_____	_____
_____	_____	_____
_____	_____	_____



**CHILDREN**

Name	Age	Co-Parent(s)
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____

**RELATIONSHIP HISTORY (Please identify ALL SIGNIFICANT Relationships)**

Name	Length of Relationship	Reason Ended
_____	Your Age ____ to Age ____	_____
_____	Your Age ____ to Age ____	_____
_____	Your Age ____ to Age ____	_____
_____	Your Age ____ to Age ____	_____
_____	Your Age ____ to Age ____	_____

**LOSS HISTORY (Identify all significant deaths you have had in your life)**

Name /Relationship to you	Your Age	Cause of Death
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____

**GENERAL LIFE EXPERIENCES (please check all that apply, if more than once, place number in blank)**

____ Fire/Natural Disaster	____ Childhood Physical Abuse	____ Childhood Sexual Abuse	____ Miscarriage
____ Job Loss	____ Rejection by Family	____ Chronic Health Condition	____ Rape
____ Abortion	____ Victim of Discrimination	____ Child of Alcoholic(s)	____ Divorce
____ Victim of Crime	____ Suicide Attempt	____ Domestic Violence	____ Legal Problems
____ Financial Problems	____ Previous Inpatient Care	____ Previous counseling	____ Bankruptcy

**CURRENT HEALTH CONCERNS**

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**EMPLOYMENT**

Current Employer: \_\_\_\_\_ Length of Employment there: \_\_\_\_\_  
 Employment Concerns? \_\_\_\_\_

**GOALS**

What do you hope to accomplish through your participation in therapy?

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**How did you learn about me?** [ ] Advertisement [ ] Friend [ ] Internet [ ] Other \_\_\_\_\_





## Notice of Privacy Practices and Summary of Key Issues

This summary provides a summary of privacy practices followed by Michele O'Mara, LCSW, and any contracted or hired office personnel. For more information on our privacy practices, please review the complete Notice of Privacy Practices available at [www.micheleomara.com/forms.htm](http://www.micheleomara.com/forms.htm), and posted in the waiting room. The complete list of privacy practices is available upon request.

**Uses and Disclosures:** All health information used by us is to maximize your treatment benefit, to obtain payment for treatment – or insure that you receive your reimbursement from insurance if applicable, and to evaluate the quality of care you receive. We may use or disclose identifiable health information about you without your consent in specific situations described in the Notice of Privacy Practices. Beyond these situations, however, we will ask for your written authorization before using or disclosing any identifiable health information about you. Neither this summary nor the full Notice of Privacy Practices covers every possible use or disclosure.

**Your Rights:** In most cases, you have the right to look at or get a copy of health information about you. If you request copies, there is a usual and customary fee for copying, mailing and other services required to fulfill the request. You will also have the right to receive a list of certain types of disclosures of your information that we may have made other than for the purpose of treatment, payment, and health care operations. If you believe that information in your record is incorrect, you have the right to request an amendment.

**Our Legal Duty:** We are required by law to protect the privacy of your information, provide the Notice of Privacy Practices, follow the practices described in the notice, and seek your acknowledgement of receipt of the notice. Before we make a significant change in our policies, we will change our Notice of Privacy Practices and post the new notice. You can also request a copy of these at any time.

**Complaints:** If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact us or you may send a written complaint to the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

I HEREBY ACKNOWLEDGE: I have reviewed the information above and have received (if requested) a copy of the Notice of Privacy Practices.

Please sign and print your name, along with today's date.

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_



## Consent for Mental Health Care

I, the undersigned, agree and consent to participate in the mental health care offered and provided by Michele O'Mara, LCSW, a mental health professional as defined by Indiana law.

I understand that I am consenting and agreeing only to those mental health services that Michele O'Mara is qualified to provide within the scope of her professional license, certifications, and training.

Client's Printed Name: \_\_\_\_\_ | \_\_\_\_\_  
Date

Client/Guardian's Signature: \_\_\_\_\_ | \_\_\_\_\_  
Date

Witness Signature: \_\_\_\_\_ | \_\_\_\_\_  
Date