

# DEARDRE MCGUIRE, L.I.C.S.W., PLLC

*~Psychotherapist~*

## Client Information Form

Today's Date: \_\_\_\_\_

### A. DEMOGRAPHIC INFORMATION

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Nicknames/Aliases: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Cultural/Ethnic Background/Religion: \_\_\_\_\_

Local Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zipcode: \_\_\_\_\_

Preferred phone: \_\_\_\_\_ Cell Home Work OK to leave msg? Y N

Secondary phone: \_\_\_\_\_ Cell Home Work OK to leave msg? Y N

Email: \_\_\_\_\_

Health Insurance Carrier: \_\_\_\_\_ Member ID#: \_\_\_\_\_

### B. EMERGENCY CONTACT INFORMATION

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

### C. Health/MEDICAL CARE

Significant Medical History (including major illnesses, chronic conditions, accidents):

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

Doctor's/Clinic's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Current Psychiatrist: \_\_\_\_\_ Phone: \_\_\_\_\_

Current Psychiatric Medication: \_\_\_\_\_

Past Psychiatric Medication: \_\_\_\_\_

Other Current Medication: \_\_\_\_\_

If you enter treatment with me, may I tell your doctor(s) so that he or she can be fully informed and so that we can coordinate your treatment?    Yes    No

Previous Psychological Treatment (including any past hospitalizations): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**D. PRIMARY CONCERN**

Please describe your primary difficulties and concerns at this time.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please check all the items which are concerns at this time and circle those which are most important.

- |                                                                       |                                                    |                                                        |                                                          |
|-----------------------------------------------------------------------|----------------------------------------------------|--------------------------------------------------------|----------------------------------------------------------|
| <input type="checkbox"/> Abortion Issues                              | <input type="checkbox"/> Drug use                  | <input type="checkbox"/> Loneliness                    | <input type="checkbox"/> Self-injury, mutilation         |
| <input type="checkbox"/> Abuse: emotional<br>physical, verbal, sexual | <input type="checkbox"/> Eating problems           | <input type="checkbox"/> Memory problems               | <input type="checkbox"/> Self-neglect,<br>poor self-care |
| <input type="checkbox"/> Academic issues                              | <input type="checkbox"/> Emptiness                 | <input type="checkbox"/> Mood swings                   | <input type="checkbox"/> Sexual assault                  |
| <input type="checkbox"/> Aggression/violent behavior                  | <input type="checkbox"/> Family relationships      | <input type="checkbox"/> Motivation                    | <input type="checkbox"/> Sexual concerns                 |
| <input type="checkbox"/> Alcohol use                                  | <input type="checkbox"/> Fearing failure           | <input type="checkbox"/> Overly responsible to others  | <input type="checkbox"/> Sexual harassment               |
| <input type="checkbox"/> Anger, arguing                               | <input type="checkbox"/> Fears, phobias            | <input type="checkbox"/> Overly sensitive to rejection | <input type="checkbox"/> Sexual identity,<br>Orientation |
| <input type="checkbox"/> Anxiety, nervousness                         | <input type="checkbox"/> Financial problems        | <input type="checkbox"/> Panic attacks                 | <input type="checkbox"/> STDs                            |
| <input type="checkbox"/> Body image                                   | <input type="checkbox"/> Gambling                  | <input type="checkbox"/> Perfectionism                 | <input type="checkbox"/> Shame                           |
| <input type="checkbox"/> Career concerns, choices                     | <input type="checkbox"/> Guilt                     | <input type="checkbox"/> Peer relationship concerns    | <input type="checkbox"/> Shyness                         |
| <input type="checkbox"/> Childhood issues                             | <input type="checkbox"/> Harassment/stalking       | <input type="checkbox"/> Pregnancy                     | <input type="checkbox"/> Smoking                         |
| <input type="checkbox"/> Child/parent issues                          | <input type="checkbox"/> Health, medical concerns  | <input type="checkbox"/> Prejudice/bias concerns       | <input type="checkbox"/> Sleep problems                  |
| <input type="checkbox"/> Compulsive behaviors                         | <input type="checkbox"/> Hallucinations            | <input type="checkbox"/> Procrastination/time mngt.    | <input type="checkbox"/> Stress                          |
| <input type="checkbox"/> Computer excessiveness                       | <input type="checkbox"/> Identity issues           | <input type="checkbox"/> Racial, ethnic concerns       | <input type="checkbox"/> Suicidal thoughts               |
| <input type="checkbox"/> Concentration                                | <input type="checkbox"/> Impulsive, out of control | <input type="checkbox"/> Repeated troubling thoughts   | <input type="checkbox"/> Tiredness, fatigue              |
| <input type="checkbox"/> Decision making, indecision                  | <input type="checkbox"/> Independence from parents | <input type="checkbox"/> Relationship concerns         | <input type="checkbox"/> Violent thoughts                |
| <input type="checkbox"/> Grief issues                                 | <input type="checkbox"/> Irresponsibility          | <input type="checkbox"/> Relationship violence         | <input type="checkbox"/> Withdrawal, isolation           |
| <input type="checkbox"/> Depression, sadness, crying                  | <input type="checkbox"/> Learning disability       | <input type="checkbox"/> Religious/spiritual concerns  | <input type="checkbox"/> Worthless feeling               |
| <input type="checkbox"/> Divorce, separation                          | <input type="checkbox"/> Legal problems            | <input type="checkbox"/> Romantic relationship issues  | <input type="checkbox"/> Other                           |

**E. REFERRAL INFORMATION: Who gave you my name to call?**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

May I have permission to thank this person for the referral?    Yes    No

**F. EMPLOYMENT/EDUCATION**

Employer/University: \_\_\_\_\_

Your job description/Degree: \_\_\_\_\_

**Agreement to Pay for Professional Services**

I request that Deardre McGuire, L.I.C.S.W. provide professional services to me (or to my dependent named below) and I agree to pay Ms. McGuire’s fee at the beginning of each session instead of being billed monthly.

If I have the Georgetown University Student Health Insurance (GUSHI) and if I have met my deductible this academic year, I understand that I am responsible for the 30% co-pay each session, and Ms. McGuire will seek reimbursement for the additional 70% directly from GUSHI. However if I have not yet met my deductible, I understand that I am responsible for the \$250 deductible and then my 30% co-pay thereafter as my benefits will then be in effect.

I agree that this financial relationship will continue as long as Ms. McGuire provides services or until I inform her, in person or by certified mail, of my wish to terminate it. I agree to pay for services provided up until the time I terminate the relationship. Once I have decided to terminate psychotherapy, I agree to meet with Ms. McGuire at least one more time before ending therapy to discuss treatment and continuity of care.

\_\_\_\_\_  
Signature of client (or person acting for client)

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Name of Dependent if applicable

I, Deardre McGuire, have discussed the issues above with the client (and/or the person acting on the client’s behalf). My observations of the person’s behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date