Stacey L. Maples, PhD
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417-440-0826
Fax: 888-602-7956

Client Information Sheet

Date: __________

Name: ____________________ Date of Birth: ________Gender: F M Age: ____

Home Address: ____________________________________City/Zip:________________

Preferred Telephone number: ________________________ ok to leave message? Y N

Emergency Contact Name, Relation and Phone:

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How did you hear about us? ____

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May I have your permission to thank this person? Y N

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Primary Care Physician Name and Phone: _______________________________________

Would you like me to coordinate care with your physician? (recommended) Y N

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Other Household Members and their relation to you:

NAME and AGE	Relationship

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List ALL medications you are currently taking including vitamins or over the counter medications:

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What medical conditions do you have? ____

Do you use tobacco? Y N if so about how many per day? ______

Do you use alcohol? Y N if so about how much? ______

Have you been feeling like harming yourself or anyone else? Y N

Are you currently involved in an abusive relationship? Y N

Are you currently experiencing any legal difficulties? Y N

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ψmindbody wellness

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Mark the concerns that brought you here today:

❑ Abuse—physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals	❑ Abuse—physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals	❑ Aggression, violence	❑ Alcohol use	❑ Anger, hostility, arguing, irritability
❑ Anxiety, nervousness	❑ Attention, concentration, distractibility	❑ Career concerns, goals, and choices	❑ Childhood issues (your own childhood)	❑ Codependence
❑ Confusion	❑ Compulsions	❑ Custody of children	❑ Decision making, indecision, mixed feelings, putting off decisions	❑ Delusions (false ideas)
❑ Dependence	❑ Depression, low mood, sadness, crying	❑ Divorce, separation	❑ Drug use—prescription medications, over-the-counter medications, street drugs	❑ Eating problems—overeating, undereating, appetite, vomiting (see also “Weight and diet issues”)
❑ Emptiness	❑ Failure	❑ Fatigue, tiredness, low energy	❑ Fears, phobias	❑ Financial or money troubles, debt, impulsive spending, low income
❑ Friendships	❑ Gambling	❑ Grieving, mourning, deaths, losses, divorce	❑ Guilt	❑ Headaches, other kinds of pains
❑ Health, illness, medical concerns, physical problems	❑ Housework/chores—quality, schedules, sharing duties	❑ Inferiority feelings	❑ Interpersonal conflicts	❑ Impulsiveness, loss of control, outbursts
❑ Irresponsibility	❑ Judgment problems, risk taking	❑ Legal matters, charges, suits	❑ Loneliness	❑ Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments
❑ Memory problems	❑ Menstrual problems, PMS, menopause	❑ Mood swings	❑ Motivation, laziness	❑ Nervousness, tension
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❑ Obsessions, compulsions (thoughts or actions that repeat themselves)	❑ Oversensitivity to rejection	❑ Pain, chronic	❑ Panic or anxiety attacks	❑ Parenting, child management, single parenthood
❑ Perfectionism	❑ Pessimism	❑ Procrastination, work inhibitions, laziness	❑ Relationship problems (with friends, with relatives, or at work)	❑ School problems (see also "Career concerns ...")
❑ Self-centeredness	❑ Self-esteem	❑ Self-neglect, poor self-care	❑ Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")	❑ Shyness, oversensitivity to criticism
❑ Sleep problems–too much, too little, insomnia, nightmares	❑ Smoking and tobacco use	❑ Spiritual, religious, moral, ethical issues	❑ Stress, relaxation, stress management, stress disorders, tension	❑ Suspiciousness, distrust
❑ Suicidal thoughts	❑ Temper problems, self-control, low frustration tolerance	❑ Thought disorganization and confusion	❑ Threats, violence	❑ Weight and diet issues
❑ Withdrawal, isolating	❑ Work problems, employment, workaholism/overworking, can't keep a job, dissatisfaction, ambition	❑ Other concerns or issues:		

Is there anything else about you that you think it important for me to know?

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Consent to Participate in Psychotherapy—Our Agreement

I, _________________________, understand I have the right not to sign this form. My signature below indicates that I have read and discussed the information brochure covering policies of this practice, the risks and benefits of therapy, the limits of confidentiality, what the goals of therapy are, how long therapy might take as well as how much services cost. This information was provided in a separate handout to me and I was given the opportunity to ask questions to my satisfaction. I understand that any of the points mentioned above can be discussed and may be open to change. If at any time during the treatment I have questions about any of the subjects discussed in the brochure, I can talk with you about them and you will do your best to answer them.

I understand that after therapy begins I have the right to withdraw my consent to therapy at any time, for any reason. However I will make every effort to discuss my concerns about my progress with you before ending therapy.

I understand that no specific promises have been made to me by this therapist about the results of treatment, the effectiveness of the procedures used by this therapist, or the number of sessions necessary for therapy to be effective.

I agree to act according to the points covered in the brochure. Further, I authorize MindBody Wellness, LLC and Dr. Stacey Maples and their associates to consult with and discuss the results of my confidential evaluation and treatment with the medical, nursing, and therapeutic staff at my treatment facility and/or with my private physician in order to facilitate the highest level of medical restoration and quality of life. I also authorize MindBody Wellness to furnish information to my insurance carrier concerning my diagnosis, treatment, and related matters. I assign MindBody Wellness, LLC all payments for professional services rendered, and I understand that I am responsible for paying my therapist the amount not covered by my insurance.

ASSIGNMENT OF BENEFITS & MEDICAL RELEASE OF INFORMATION: My right to payment for all procedures and psychologist services including major medical benefits are hereby assigned to MindBody Wellness, LLC and their associates. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. In the event my insurance carrier does not accept assignment of benefits, or if payment is made directly to my representative or myself, I will endorse such payments to above providers. I understand that I am responsible for any charge not reimbursed by Medicare or other insurance coverage that is in effect. I authorize Medicare or any other insurance carrier to release my personal data and any facility or previous psychologists to

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furnish MindBody Wellness, LLC and/or their associates copies of any records of my medical history, services, or treatments. I also authorize the release of any medical information and/or reports related to my treatment to any federal, state, or accreditation agency, or any physician or insurance carrier as needed. I also agree to a review of my records for purposes of audits, outcome research, and quality assurance reviews within the scope of the above clinician's practices where no personal information is disclosed or published.

I hereby agree to enter into therapy with this therapist and to cooperate fully and to the best of my ability as shown by my signature here.

_______________________________________ _______________________________
Signed Date Printed Name

I, the therapist, have met with this client (and/or his parent or guardian) for a suitable period of time, and have informed him or her of the issues and points raised in the brochure. I have responded to all of his or her questions. I believe this person fully understands the issues, and I find no reason to believe this person is not fully competent to give informed consent to treatment. I agree to enter into therapy with the client, as shown by my signature here.

_______________________________________ ______________
Stacey L. Maples, PhD Date

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Certification that verbal consent was obtained (if applicable). I, as a representative of a care facility, have discussed the option of psychological services with the resident's POA. The POA was not available to sign the consent at this time, but I hereby acknowledge receiving verbal consent to treat.

_______________________________________ ______________
Verbal Consent Received from______________ Date
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