Karen Tantillo, MSW, LCSW
5755 North Point Parkway, Suite 249 Alpharetta, Ga 30022 (770) 296-4842

CLIENT INFORMATION FORM

This Form is Confidential

Today's date: _____

Your name: _____
Last First Middle Initial

Date of birth: _____ Age:_____

Home street address: _____

City: _____ **State:** _____ **Zip:**_____

Name of Employer:_____

Address of Employer: _____

City: _____ **State:** _____ **Zip:**_____

Home Phone: _____ **Work Phone:** _____

Cell Phone: _____ **Email:** _____

Calls will be discreet, but please indicate any restrictions:_____

_____

Referred by: _____

- May I have your permission to thank this person for the referral?
  ☐ **Yes** ☐ **No**
- If referred by another clinician, would you like for us to communicate with one another?
  ☐ **Yes** ☐ **No**

Person(s) to notify in case of any emergency: _____
Name Phone

I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so: (Your Signature): _____

Please briefly describe your presenting concern(s): _____

_____

_____

_____

_____

_____

What are your goals for therapy? _____

_____

_____

_____

_____

How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)? _____

The following information on this form will help guide your treatment. Please try to fill out as much as you are comfortable disclosing.

MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses: _____

_____

_____

Current Medications:

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Do you smoke or use tobacco? YES NO If YES, how much per day?_____

Do you consume caffeine? YES NO If YES, how much per day? _____

Do you drink alcohol? YES NO If YES, how much per day/week/month/year? ____

Do you use any non-prescription drugs? YES NO

If YES, what kinds and how often? _____

Have any of your friends or family members voiced concern about your substance use? YES NO

Have you ever been in trouble or in risky situations because of your substance use? YES NO

Previous medical hospitalizations (Approximate dates and reasons):_____

_____

_____

Previous psychiatric hospitalizations (Approximate dates and reasons):_____

_____

_____

Have you ever talked with a psychiatrist, psychologist, or other mental health professional? YES NO
(Please list approximate dates and reasons): _____

_____

_____

Height _____ Weight (if applicable) _____ Age_____ Gender _____

Sexual & Gender Identity: __ Heterosexual __Lesbian __Gay __Bisexual __Transgender
__ Asexual __ In Question __Other

Racial/Ethnic Identity:
__African/African-American/Black __ Latino/Latino-American __Bi-Racial/Multi-Racial
__American Indian/Alaska Native __ Middle Eastern/Middle Eastern-American
__Asian/Asian-American/Asian Pacific Islander __White/European-American __Not listed

FAMILY:

How would you describe your relationship with your mother?_____

_____

How would you describe your relationship with your father?_____

Are your parents still married?_____ If they divorced, how old were you when they separated or divorced, and how did this impact you? _____

_____

Were there any other primary care givers who you had a significant relationship with? If so, please describe how this person may have impacted your life: _____

_____

How many sisters do you have? _____ Ages? _____
How many brothers do you have? _____ Ages? _____
How would you describe your relationships with your siblings? _____

_____

RELATIONSHIPS & SOCIAL SUPPORT & SELF-CARE:

Currently in Relationship? ____ How Long? ____ Relationship Satisfaction: POOR 1 2 3 4 5 6 7 EXCELLENT

Married/Life Partnered? _____ How Long? ____ Previously Married/Life Partnered? YES NO
If so, length of previous marriages/committed partnerships_____

Do you have Children?____ If YES, how many and what are their ages:_____

Describe any problems any of your children are having: _____

_____

List the names and ages of those living in your household: _____

_____

Please briefly describe any history of abuse, neglect and/or trauma: _____

_____

_____

Current level of satisfaction with your friends and social support: POOR 1 2 3 4 5 6 7 EXCELLENT

Please briefly describe your coping mechanisms and self-care:_____

_____

_____

Is spirituality important in your life and if so please explain:_____

_____

Briefly describe your diet and exercise patterns:_____

_____

EDUCATION & CAREER

High School/GED___ College Degree___ Graduate Degree(or Higher)___ Vocational Degree___

What is your current employment?_____

Employment Satisfaction: POOR 1 2 3 4 5 6 7 EXCELLENT

Any past career positions that you feel are relevant?_____

_____

What do you think are your strengths?_____

PLEASE CHECK ALL THAT APPLY & ***CIRCLE*** THE MAIN PROBLEM:

DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST
Anxiety →			People in General →			Nausea →		
Depression			Parents			Abdominal Distress		
Mood Changes			Children			Fainting		
Anger or Temper			Marriage/Partnership			Dizziness		
Panic			Friend(s)			Diarrhea		
Fears			Co-Worker(s)			Shortness of Breath		
Irritability			Employer			Chest Pain		
Concentration			Finances			Lump in the Throat		
Headaches			Legal Problems			Sweating		
Loss of Memory			Sexual Concerns			Heart Palpitations		
Excessive Worry			History of Child Abuse			Muscle Tension		
Feeling Manic			History of Sexual Abuse			Pain in joints		
Trusting Others			Domestic Violence			Allergies		
Communicating with Others			Thoughts of Hurting Someone Else			Often Make Careless Mistakes		
Drugs			Hurting Self			Fidget Frequently		
Alcohol			Thoughts of Suicide			Speak Without Thinking		
Caffeine			Sleeping Too Much			Waiting Your Turn		
Frequent Vomiting			Sleeping Too Little			Completing Tasks		
Eating Problems			Getting to Sleep			Paying Attention		
Severe Weight Gain			Waking Too Early			Easily Distracted by Noises		
Severe Weight Loss			Nightmares			Hyperactivity		
Blackouts			Head Injury			Chills or Hot Flashes		

FAMILY HISTORY OF (Check all that apply):

Drug/Alcohol Problems		Physical Abuse		Depression	
Legal Trouble		Sexual Abuse		Anxiety	
Domestic Violence		Hyperactivity		Psychiatric Hospitalization	
Suicide		Learning Disabilities		"Nervous Breakdown"	

Any additional information you would like to include:

_____

_____

This is your copy.

Karen Tantillo, LCSW
5755 North Point Parkway
Suite 249
Alpharetta, Ga 30022

STATEMENT OF SERVICES/NOTICE OF PRIVACY PRACTICES

I provide counseling services that include assessment, evaluation, diagnosis, and direct psychotherapy treatment in accordance with professional standards of practice. These standards of practice include providing each client with information concerning several aspects of the counseling process and the counseling relationship.

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and client, and the particular problems you are experiencing. There are many different methods that I may use to deal with the problems you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Risks and Benefits of Therapy

Psychotherapy has been shown to be effective for the improvement and resolution of personal problems. The process of psychotherapy, however, does involve risks on the part of the client. Change, and the processes involved in creating positive change, can at times be difficult and unsettling.

Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. While every attempt will be made to prepare each client for this, each client must make the decision to enter into this process with a clear understanding of these risks.

On the other hand, while there are no guarantees, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress.

Provision of Services

Our first few sessions will involve an assessment of your needs (usually 1-4 sessions). By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be careful about the therapist you select. If you have questions about my procedures we should discuss them whenever they arise. If your doubts persist, you may want to set up a meeting with another mental health professional for a second opinion.

During the evaluation period, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 60-minute session per week at a time we that we agree. We may decide to change the frequency of sessions according to your needs.

The length of the course of psychotherapy can vary depending upon the severity of the problems presented, and the ability of each client to utilize therapeutic approaches.

There are boundaries in the nature of our relationship. This means that I am your therapist and we have a professional relationship. I will not crossover to a relationship of any other kind with you, nor can I accept gifts from you.

Confidentiality

The confidentiality of your records is covered under state and federal law under the health Insurance Portability Act (HIPPA).

I will not release information about your treatment unless you give me written permission to do so or unless I am required to do so by law. The law requires that I take action if you are of danger to yourself or another person. This generally means that others may be involved when necessary to protect you and others if you are suicidal, intend to harm another person, or are unable to provide self-care at a level necessary for basic survival. Georgia law also requires that recent or current child abuse or neglect be reported when there is a reasonable suspicion of its existence.

If I am seeing you for couples therapy, I do not keep secrets between you.

Your insurance company has access to your records. For other sources, I will only release this information if you sign a Release of Information form giving me specific instructions about how you want it to be released.

I use a cell phone to make contact with you. This and other electronic forms of communications have security risks.

Professional Fees

My hourly fee is $140 per 60-minute session. I sometimes charge for other services you may need such as report writing, telephone conversations lasting more that 10 minutes, consulting other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other services you request of me. If you become involved in legal proceedings that require my participation, I will refer you to an appropriate provider since I am unable to be appear in court proceedings or provide legal consultation as a clinical social worker.

You will be expected to pay me at the time of the session by cash, check or PayPal unless we agree otherwise or unless you have insurance coverage that requires another arrangement. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan.

Insurance

Where a professional relationship exists between me and your insurance carrier, you will be expected to pay the co-insurance amount designated under the policies of the insurance carrier unless your deductible has not been met. In the case of the latter, you will be required to pay the appropriate amount as required by your insurance company. Claims will be filed by me. Where a professional relationship does not exist with the client's insurance company, you will be expected to pay the full amount for each psychotherapy session.

Contacting Me

Due to my work schedule, I am often not immediately available by telephone. When I am unavailable, my telephone is answered by voice mail. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays unless your call is of an urgent nature. If you are difficult to reach, please inform me of times when you will be available.

When I am out of town, I still check my voice mail and will make contact with you as stated above. I will have another therapist available it you have to meet in person.

If you are unable to reach me and feel that you can't wait for me to return your call, there are some resources available to you. The Georgia Crises and Access Line at 800-715-4225 is available is available 24/7 for your support. If your treatment needs might require hospitalization, I please call 911 or go to the nearest emergency room for immediate help. With your permission, I will communicate with the treatment source to provide information about you that will assist them in providing appropriate treatment services.

Appointment Cancellation

Your appointment times are reserved for you. If you cancel last minute, you may prevent someone else from being able to use your time slot.

Missed appointments will be billed at my session rate of $140 unless canceled at least *24 hours* in advance of your appointment time regardless of whether or not you use insurance (insurance companies will not pay for missed sessions). I understand that there may be an occasional emergency that interferes with your notifying me within the 24 hour window of time and I will take these circumstances into account.

Your Rights

You have the right to expect competent psychotherapy in accordance with accepted professional standards. You have the right to request information about any aspect of treatment, including but not limited to assessment results, treatment techniques utilized, course and direction of treatment. You also have the right to provide feedback to me about where treatment is being successful and unsuccessful, and to terminate treatment at any time.

Your Responsibilities

You are responsible for engaging in the therapeutic process in ways that further treatment progress, making available to the provider such information as is needed to provide effective treatment, and participating in directing the course and direction of treatment.

Karen Tantillo, LCSW
Licensed Clinical Social Worker

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CONSENT TO TREATMENT

I have received and read the Statement of Services/Notice of Privacy Practices attached (this is a copy for your records). If I use insurance, I am aware that required communications with your insurance company as they request.

I agree to these conditions and I consent to treatment.

_____ _____
Signature Date

_____ _____
Signature of Guardian for those under 18 years of age Date