Jewish Family SERVICES

Adult Therapy - New Client Form

Please complete all paperwork prior to your appointment. Insurance card must be presented at each appointment.

Client Legal Name or as listed on insurance : _____

Name you prefer to be called, if different than above: _____

Client DOB: _____/____/_____

Client Address: _____

City: _____, **County**: _____ **, Zip Code:** _____

Preferred Phone: _____ ☐ Check (if JFS is authorized to leave message)

Other Phone: _____ ☐ Check (if JFS is authorized to leave message)

Email: _____ ☐ Check (if JFS is authorized to send message/information)

Gender : _____ what pronouns do you use? _____ (ex., He/Him; She/Her; They/Them)

Race: _____ **Religion** :_____

Marital Status : _____**; Sexual Orientation :** _____

Employment Status : *Full-time Part-time Temporary Unemployed Retired Student Other*

Yearly Household income : $_____**, Number of people living in home : Adults:** _____**, children**_____

Reason for Contacting JFS : _____

_____

How did you hear about JFS : ☐Friend / Family , ☐JFS Marketing, ☐Jewish Agency, ☐Non-Jewish Agency, ☐Physician, ☐Self,

☐Clergy, ☐Synagogue: which one _____, ☐Volunteer, ☐Website, ☐Psychology Today , ☐Other _____

Primary Care Physician : _____ **Phone** : _____

Preferred Hospital / Clinic : _____

Primary Insurance Carrier : _____**Name of Policy Holder** : _____

Policy # : _____ **Group #** _____ **DOB of Policy Holder** : ___/___/_____

Secondary Insurance Carrier : _____**Name of Policy Holder**: _____

Policy # _____ **Group #** _____ **DOB of Policy Holder** ____/____/_____

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In Case of Emergency, Please Contact the Following Individual :

Name : _____

Relationship:_____

Preferred Phone Number : _____

I hereby give permission for JFS to provide, seek, and consent to emergency treatment for the client names above, as may necessary.

_____

Signature of JFS Client or Guardian

Date : _____

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Client Legal Name: _____ Client DOB: ____/____/_____

PLEASE INITIAL THE FOLLOWING :

____ I have read and agree to the Office Policies and guidelines, Clients Rights & Privacy Practices (you may view a copy of these on the JFS website or request a copy from the JFS office) and do so annually.

____ I understand that I must complete the following forms prior to consultation and update them annually:

1. Emergency Information
2. Clinical Surveys
3. Policies and Guidelines

____ I grant permission for JFS and their representatives, to communicate with me via email as indicated below. I confirm that the email address that I have given is a private email and I release JFS from any responsibility for access to my private email by any other person not authorized by me. See JFS Email Informed Consent Policy.

I authorize my therapist/case worker to communicate with me via email. ☐Yes ☐ No

I would like to receive email communication regarding JFS services and programs ☐Yes ☐ No

____ All fees or costs have been explained to us/me.

CLIENT CONSENT FOR SERVICES : PLEASE INITIAL EACH LINE :

____ We / I agree to allow Jewish Family Services of Greater Charlotte (JFS) to provide services to me/my ward.

____ We/I will participate in developing a service plan, which will identify goals to work toward, time frames and methods to achieve these goals

____ JFS services have been described to me/us.

____ We/I have been informed about the alleged benefits, potential risks and possible alternative methods of treatment and the ways that JFS can support the achievements of the desired outcomes.

By signing below, I certify that I have answered the questions above honestly and accurately.

_____ Date ____/_____/_____

Signature of JFS Client or Guardian

_____Date _____/____/_____

Print Name of JFS Client or Guardian

_____ Date _____/_____/_____

Signature of JFS Staff Member

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Please list any major changes or ongoing stressors that you feel may be impacting you?

_____

_____

_____

Please describe how your symptom(s) is affecting your daily functioning, either at home, work, or school, or with interactions with other people.

_____

_____

_____

How long have you been experiencing these current symptom(s)?

_____

_____

MEDICATION HISTORY

List current medications including prescribed, over the counter, herbs, vitamins, non-prescribed medications (e.g., taking something suggested by a friend, taking family member's medication, etc.) Use back of page if necessary.

Medications	Currently Using? Y/N	Reason for Medication	Outcome

MENTAL HEALTH HISTORY

Please complete the table below with your mental health history, including current and past psychiatrists, psychologists, hospitalizations, etc. Use back of page if necessary.

Facility/Name of Provider	Treatment Dates	Symptoms/Reasons for Treatment	Outcome

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