Instructions: Please fill out information completely and sign before returning.

ADULT BACKGROUND INFORMATION

Name: _____Date of Birth: _____

Address: _____
Street City State Zip

Telephone: _____
Home Work Cell/Pager

Name of Employer: _____Occupation:_____

Address of Employer:

_____
Street City State Zip

Social Security #_____N/A_____

Married ___ Single ___Divorce____ Widowed ___ Separated ____Other___

Spouse's Name: _____Date of Birth:_____
Address only if different from above

Address: _____
Street City State Zip

Telephone: _____
Home Work Cell/Pager

Name of Employer: _____Occupation: _____

Address of Employer:

_____
Street City State Zip

Social Security #_____N/A_____

Children's Name(s): Age: Date of Birth: SS#: **

_____ ___ _____ ____N/A_____

_____ ___ _____ _____N/A_____

_____ ___ _____ _____N/A_____

How did you hear about our office? _____

Are you interested in faith-based counseling? _____

What religious group/affiliation do you identify yourself with? _____

What is your primary issue that has led you to seek counseling at this time?

_____

_____

_____

_____

Person who will be financially responsible for therapy treatment? _____

_____

Billing Address of Responsible Party if other than self :

_____

Street City State Zip

INSURANCE INFORMATION

Do you have insurance that covers psychological services? _____
If yes, what insurance do you have? _____
Policy # or Medicaid # : _____
Group # : _____
Phone Number of Insurance Company: _____
Will you like to take care of your own insurance claims? _____
Individual Counseling Sessions: $85.00
Marriage/Family Counseling Sessions: $100.00
Do you plan on paying cash or check for services provided? _____
If not:
1. You can provide credit card information below:
Credit Card : VISA MASTERCARD DISCOVER
Credit Card #: _____ Expiration Date: _____
Security Code: CCV or CVC on back of card: _____(usually 3-4 numbers)
-OR-
2. Provide PayPal Account Email to send Invoices to:_____

I agree to pay for my spouse's Individual Counseling Sessions? Y/N
If YES, I give consent to charge my credit card on file? Y/N

For Married Couples Only
I will notify my spouse and therapist when I no longer want my credit or debit card charged for my spouse's individual counseling sessions. I agree to notifying the therapist at least 24 hours prior to their next session. If not, I agree to my credit or debit card being charged.

Cancellation Policy: If you need to reschedule or cancel an appointment, please call at least 24 hours in advance. If you are a "No Show" or "No Call" for an appointment regular fees will be charged to you for that time. Sudden emergencies or illnesses can be discussed.

Financial Responsibility: I understand that I am responsible for all charges incurred for services provided to me and/or my family. I agree to pay my account as services are provided unless other arrangements are made. If there is an outstanding balance on my account or an issue with insurance, I agree to pay remaining or unpaid balance as soon as I receive notice.

Signature of Responsible Person _____Date_____

Monica M. Munoz, M.A., L.P.C.
305 E Ramsey Dr
San Antonio, Texas 78216
210-459-1957

Informed Consent

1. The client is entitled to information regarding the credentials, degrees and licenses of the therapist.
2. The client is entitled to information concerning methods of therapy, techniques used, duration of the therapy, if known, and fees.
3. The client may seek a second opinion from another therapist or may terminate therapy at any time.
4. Privileged communication information provided by the client during therapy session is legally confidential in the case of a licensed therapist, except as provided by sections of the law (e.g., concerning criminal activity and delinquency proceedings) and for certain other legal exceptions, that is, disclosures indicating child or elderly abuse, or bodily harm to self or others.
5. In a professional relationship, sexual intimacy is never appropriate and should be reported to the grievance board at the address listed below.
6. Any questions of ethics or complaint may be addressed to:

The Texas State Board of Examiners of Professional Counselors
1100 West 49th Street
Austin, Texas 78756-3183
(512)-834-6658

7. I understand my therapist has up to 24 hrs. to return calls. Calls are not intended to provide therapy. If I feel I am in crisis such as suicidal or homicidal ideations, I agree to call 911 or report to the closest emergency room.
8. I understand my therapist does not provide therapy via text messaging or email. Text messaging and emails are not intended for therapy and will not be used for emergencies or crisis. I agree to call 911 or go to closest emergency room.

I have been informed of my therapist's degrees, credentials, and licenses. I have also read the preceding information and understand my rights as a client.

Client/Guardian's
Signature_____ Date_____

Therapist Signature_____ Date_____

Name _____ Age____ Sex____

USE THE FOLLOWING GUIDELINES TO ANSWER EACH QUESTION ABOUT HOW BOTHERED YOU HAVE FELT FOR EACH OF THESE SYMPTOMS DURING THE PAST WEEK.

0- Not Bothered
1- Occasionally Bothered
2- Slightly Bothered
3- Moderately Bothered
4- Frequently Bothered
5- Constantly Bothered
6- Severely Bothered

Pain in my shoulders……	0	1	2	3	4	5	6
Headaches……	0	1	2	3	4	5	6
Neck or chest pains……	0	1	2	3	4	5	6
Not knowing where I am……..	0	1	2	3	4	5	6
Troubling thoughts that repeat themselves……..	0	1	2	3	4	5	6
Feeling dizzy……	0	1	2	3	4	5	6
Dry mouth…….	0	1	2	3	4	5	6
Feeling restless…….	0	1	2	3	4	5	6
Less interest in things I use to enjoy…….	0	1	2	3	4	5	6
Feeling nervous……	0	1	2	3	4	5	6
Problems with alcohol or taking drugs……..	0	1	2	3	4	5	6
A need to count unimportant items……	0	1	2	3	4	5	6
Feeling sick to my stomach…….	0	1	2	3	4	5	6
My mind going blank……	0	1	2	3	4	5	6
Feeling guilty about alcohol or drug use……...	0	1	2	3	4	5	6
Increase in sleep walking……	0	1	2	3	4	5	6
Trying too hard to help others……...	0	1	2	3	4	5	6
Back pain……	0	1	2	3	4	5	6
Needing to block out impulsive thoughts……..	0	1	2	3	4	5	6
Sudden fears of dying……..	0	1	2	3	4	5	6
Drinking or using drugs too often……...	0	1	2	3	4	5	6
Problems reading my own handwriting…….	0	1	2	3	4	5	6
Feeling helpless……	0	1	2	3	4	5	6
Nightmares about something bad that happened to me……	0	1	2	3	4	5	6
Talking in my sleep more than usual……..	0	1	2	3	4	5	6
Fears of going outside alone……..	0	1	2	3	4	5	6
Feeling like I'm having a heart attack……...	0	1	2	3	4	5	6
Having to repeat certain things I do to avoid getting nervous…….	0	1	2	3	4	5	6
Feeling sensitive about my thoughts…….	0	1	2	3	4	5	6
Crying a lot……	0	1	2	3	4	5	6
Trouble thinking of the names of family members/ close friends…	0	1	2	3	4	5	6
Shortness of breath……..	0	1	2	3	4	5	6
Feeling anxious…….	0	1	2	3	4	5	6
Flashbacks of something bad that happened to me……...	0	1	2	3	4	5	6
Needing to use alcohol or drugs to get high…….	0	1	2	3	4	5	6
Being too unselfish for my own good……	0	1	2	3	4	5	6
Feeling hopelessness……	0	1	2	3	4	5	6

Feeling of terror…….	0	1	2	3	4	5	6
Fears of going crazy……	0	1	2	3	4	5	6
Feeling detached from others…….	0	1	2	3	4	5	6
Problems falling asleep or staying asleep……	0	1	2	3	4	5	6
Stomach problems……	0	1	2	3	4	5	6
A pounding or racing heart…….	0	1	2	3	4	5	6
Thoughts of hurting or killing myself…….	0	1	2	3	4	5	6
Thoughts of something bad that happened to me……..	0	1	2	3	4	5	6
The need to keep things extra tidy……	0	1	2	3	4	5	6
Not remembering when or where I was born……..	0	1	2	3	4	5	6
Problems remembering bad things in my life……..	0	1	2	3	4	5	6
Feelings that things aren't real……	0	1	2	3	4	5	6
Needing to repeatedly wash hands……	0	1	2	3	4	5	6
Stress at work, home, or school…….	0	1	2	3	4	5	6
Arguments with family or friends about my alcohol or drug use...	0	1	2	3	4	5	6
Feeling keyed up or edgy……	0	1	2	3	4	5	6
Trying too hard……..	0	1	2	3	4	5	6
Feeling worthless…….	0	1	2	3	4	5	6
Sudden fear for no good reason…….	0	1	2	3	4	5	6
Fear of being in crowded place…….	0	1	2	3	4	5	6
Sadness……..	0	1	2	3	4	5	6
Muscle or body soreness……	0	1	2	3	4	5	6
Needing to retrace my steps……..	0	1	2	3	4	5	6
Being too honest for my own good……	0	1	2	3	4	5	6
Hearing things others don't……..	0	1	2	3	4	5	6
Feeling down or blue……	0	1	2	3	4	5	6
Seeing things I know aren't real…….	0	1	2	3	4	5	6
Problems concentrating……	0	1	2	3	4	5	6
Hot or cold feelings in my body……	0	1	2	3	4	5	6
Worry about the future……..	0	1	2	3	4	5	6
Struggles with personal hygiene…….	0	1	2	3	4	5	6
Feeling ashamed……	0	1	2	3	4	5	6
Feeling unusual sensations…….	0	1	2	3	4	5	6
Being too polite for other people……	0	1	2	3	4	5	6
More problems than usual seeing things in color……	0	1	2	3	4	5	6
Repeated checks of doors and windows……..	0	1	2	3	4	5	6
Startling easily or being jumpy……..	0	1	2	3	4	5	6
Feelings of having special gifts others don't…….	0	1	2	3	4	5	6
Being reminded of something bad that happened to me……...	0	1	2	3	4	5	6
Having to do something many times to keep from getting nervous.	0	1	2	3	4	5	6
Spending too much time reading or studying……	0	1	2	3	4	5	6
Being careless or reckless……	0	1	2	3	4	5	6
Splurging money on things……..	0	1	2	3	4	5	6
Binge eating……..	0	1	2	3	4	5	6
Feelings of anger……..	0	1	2	3	4	5	6
Thoughts or fears of hurting others……	0	1	2	3	4	5	6
Hearing voices others don't…….	0	1	2	3	4	5	6
Inflicting self-injury……	0	1	2	3	4	5	6
Having tingling sensations……..	0	1	2	3	4	5	6
Eating for comfort…….	0	1	2	3	4	5	6
Feelings of being overwhelmed…….	0	1	2	3	4	5	6
Loss of appetite…….	0	1	2	3	4	5	6
Trouble sleeping……	0	1	2	3	4	5	6
Accident-prone…….	0	1	2	3	4	5	6
Spontaneous acts…….	0	1	2	3	4	5	6
Feelings of being watched……..	0	1	2	3	4	5	6
Fears of being alone…….	0	1	2	3	4	5	6

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INFORMED CONSENT FOR CHRISTIAN BIBLICAL COUNSELING

1. I understand my therapist utilizes Christian biblical truths in the counseling sessions and scriptural references as part of the counseling treatment.

2. I understand my therapist will utilize prayer before and/or after session, while providing individual, family or marriage counseling.

Please circle one:

I GIVE CONSENT or DO NOT GIVE CONSENT to allow my therapist to use Scripture References within the counseling sessions (individual, family, marriage)

Client/Guardian Name: _____ Date: _____

Client/Guardian Signature: _____

Therapist Name: _____ Date: _____

Please circle one:

I GIVE CONSENT or DO NOT GIVE CONSENT to allow my therapist to Pray before and/or after session, while providing individual, family or marriage counseling.

Client/Guardian Name: _____ Date: _____

Client/Guardian Signature:_____

Therapist Name: _____ Date: _____