Ciepcielinski Counseling, PLLC Emily Ciepcielinski, Ph.D., LPCS, CEDS 6845 Fairview Rd Charlotte, NC 28210 980.500.9260

CONFIDENTIAL CLIENT INFORMATION

	Date:		
Name			
Address			
City / State / Zip			
Preferred Phone NumberAlternate Phone Number	(is it ok to leave messages at this number? Y/N) (is it ok to leave messages at this number? Y/N)		
Email address email address Y/N)	_ (would you like appointment reminders sent to this		
Referred by Is it ok to send a thank you note to this it	referral? Y/N		
Occupation	Employer		
Gender Age	Date of Birth		
Ethnic Background	Relationship Status		
Name(s) of previous counselor(s) and d	ates seen:		
Describe any health concerns:			
List general medications/psychotropic medication):	medications you presently use (please list purpose of		
List psychotropic medications you have	e used in the past (please list purpose of medication):		

Please check any of the following items that concern you: Self-esteem, self-confidence Friendship conflicts or pressures Friendship conflicts Anxiety, nervousness, fears Friendship conflicts Depression Relationship/marital concerns Sexual concerns Shyness, being assertive Angry, hostile feelings Loneliness Traumatic experience Procrastination or motivation Physical distress Gay/Lesbian issues Eating or appetite problems Suicidal feelings or behaviors Alcohol or drug problems Stress Sleep problems Excessive gaming or Internet under the parent—child problems Survivor of abuse or neglect Self-control Other: Work or career concerns Please put a second check next to those that are of particular concern to you right now. Have you had thoughts about suicide in the past month? Please list the members of your immediate family (include parents, siblings, spouse/partner children, and all others in your home) and others who are of a significant relationship to your lamber of the page					
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	,	Relationship	Age	Occupation	City/St

Ciepcielinski Counseling, PLLC President, Emily Ciepcielinski, Ph.D., LPCS, CEDS 6845 Fairview Rd Charlotte, NC 28210 980.500.9260

REQUEST AND AUTHORIZATION FOR RELEASE OF INFORMATION

I,	, request and authorize:	
	(Name)	(Phone)
	(Address)	
	ase to Ciepcielinski Counseling, PLLC Emily Ciepcielinski, Ph.D., LPCS, CEDS 6845 Fairview Rd Charlotte, NC 28210 980.500.9260	
the following information:		
This disclosure is made for the follow	wing purpose:	
to my treatment with the individuals PLLC to release any medical, psychology or to request pre-authorization for trefor all mental health services provided drug and alcohol abuse and/or HIV to I make this request and author records constitute privileged informate understand that I have no obligation revoke this consent at any time by provided that this consent remains in effect underevocation will not be effective to the reliance on the authorization, or if the coverage and the insurer has a legal respective.	pcielinski Counseling, PLLC to discuss information agencies named above. I authorize Ciepcological, or other information necessary to measure to process any insurance eatment. I authorize payment of medical bead. I specifically authorize the release of information is a part of the recording if such information is a part of the recording to the information of my own free will. I understand that is protected by the laws of the State whatsoever to disclose the requested information will specifically revoked by me in writing. It is extent that Ciepcielinski Counseling, PLL is authorization was obtained as a conditional right to contest a claim. I understand that into may be subject to redisclosure by the recording Revoked Revoke	cielinski Counseling, my insurance company or managed care claims nefits to Dr. Ciepcielinski formation pertaining to cord. that my mental health the of North Carolina. I mation and that I may individuals. I understand understand that any C has taken action in of obtaining insurance formation used or
Signed:	Date Signed:	
Printed Name:		