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 Number_____ (is it ok to leave messages at this number? Y/N)
Alternate Phone Number _____(is it ok to leave messages at this number? Y/N)

Email address _____ (would you like appointment reminders sent to this email address Y/ N)

Referred by _____
Is it ok to send a thank you note to this referral? Y/N

Occupation _____ Employer _____

Gender _____ Age _____ Date of Birth _____

Ethnic Background _____ Relationship Status _____

Name(s) of previous counselor(s) and dates seen:

_____

_____

Describe any health concerns: _____

_____

List general medications/psychotropic medications you presently use (please list purpose of medication): _____

_____

List psychotropic medications you have used in the past (please list purpose of medication): _____

_____

Please describe briefly the concern(s) that bring you here: _____

Please check any of the following items that concern you:

_____ Self-esteem, self-confidence	_____ Family conflicts or pressures
_____ 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 use
_____ Parent–child problems	_____ Health 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? _____

Any previous attempts of suicide? _____

Have you had thoughts about harming other people, animals, or property 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 you:

Name	Relationship	Age	Occupation	City/State

Ciepcielinski Counseling, PLLC
President, Emily Ciepcielinski, Ph.D., LPCS, CEDS
6845 Fairview Rd
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REQUEST AND AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, request and authorize:

_____ _____
(Name) (Phone)

_____
(Address)

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

the following information:

_____

This disclosure is made for the following purpose:

_____

Furthermore, I authorize Ciepcielinski Counseling, PLLC to discuss information that is relevant to my treatment with the individuals or agencies named above. I authorize Ciepcielinski Counseling, PLLC to release any medical, psychological, or other information necessary to my insurance company (_____) in order to process any insurance or managed care claims or to request pre-authorization for treatment. I authorize payment of medical benefits to Dr. Ciepcielinski for all mental health services provided. I specifically authorize the release of information pertaining to drug and alcohol abuse and/or HIV testing if such information is a part of the record.

I make this request and authorization of my own free will. I understand that my mental health records constitute privileged information that is protected by the laws of the State of North Carolina. I understand that I have no obligation whatsoever to disclose the requested information and that I may revoke this consent at any time by providing written notice to the above named individuals. I understand that this consent remains in effect until specifically revoked by me in writing. I understand that any revocation will not be effective to the extent that Ciepcielinski Counseling, PLLC has taken action in reliance on the authorization, or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule.

Signed: _____ Date Signed: _____

Printed Name: _____