LIFEPULSE CENTER™
for Development & Growth
Faith Nouri, PhD, LPC

NEW CLIENT INFORMATION SHEET

Today's Date: _____

Name (print): _____ **Gender:** _____ _____
(Last) (First) (Middle) (male) (female)

Soc. Sec. No.:___ ___ ___ - ___ ___ -___ ___ ___ ___

Date of Birth: ___-___-___ **Age:** ____

E-mail Address: _____

Referral Source: _____

Home Address: _____ **Home Phone:** _____

_____ **Cell Phone:** _____

_____

Business Name & Address:

_____ **Work Phone:** _____

_____

_____

Occupation: _____

Highest Academic Degree: _____ **Major:** _____

Emergency Contact: _____

Phone Number: _____

Would you like to receive our Newsletter through:

_____ **Regular Mail**
_____ **E-mail**

Please help me know you better by responding to the following questions:

Please describe the reason/s for seeking services now.

_____

_____

_____

_____

_____

_____

Family members living with you:

Name	Relationship	Age	Sex
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Children (if not in the above list):

Name	Age	Sex	Name of child's other parent
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Other currently significant individuals in your life:

Name	Relationship	Age	Sex
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Marriages or significant relationships:

Name	Dates
_____	_____
_____	_____

List the members of your family of origin. List your siblings in their correct birth order including yourself.

Name	Age	Sex	If deceased, give age date/ cause of death
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Did your parents divorce? _____ If yes, when? _____ How old were you then? _____
Who did you reside with? _____

Do you exercise? _____ If yes, what type? _____How often? _____

Do you smoke cigarettes? _____ if yes, how many per day? _____

Do you drink alcohol? _____ if yes, how much per week? _____

Do you use other drugs, prescription or otherwise? _____

If yes, please name: _____ How often? _____
_____ How often? _____
_____ How often? _____

Are you aware of a history of medical/metal health issues in your family? If yes, please describe.

_____

_____

_____

Have you previously used any type of mental health services? _____
If yes, approximate date: _____ Therapist: _____

Reason for seeking help: _____

Is there anything else you want me to know about you?

_____

_____

_____

_____

Please Note:

Services at LifePulse Center include, but are not limited to psychotherapy, hypnotherapy, life coaching, individual or business/corporate/parenting consultations, as well as play and activity therapy for children and adolescents.

You are responsible for payment of $120 for 45-50 minutes session, $180 for 90 minute session at the time of service.

Signature: _____

Date: _____

Dr. Faith Nouri

SYMPTOMS CHECKSLIST

NAME: _____ *DATE:* _____

Please complete this checklist to better inform me about yourself. Check each of the items of concern to you. Check twice those items which are of most concern to you.

	1	*Not being the kind of person I want to be*		26	*Being talked about or made fun of*
	2	*Too tired to do anything*		27	*Feeling that nobody understands me*
	3	*Unhappy with my physical appearance/weight*		28	*Nervousness*
	4	*Discouraged about future*		29	*Unhappy too much of the time*
	5	*Financial problems*		30	*Worrying about unimportant things*
	6	*Dissatisfied or bored with everything*		31	*Unsure of career choice*
	7	*Concerned about physical health*		32	*Afraid of making mistakes*
	8	*Feel guilty all the time*		33	*Not mixing well with the opposite sex*
	9	*Concerned over living situation*		34	*Concern about sexual matters*
	10	*Lost my interest in other people*		35	*Relationship problems*
	11	*Being ill at ease at social gatherings*		36	*Headaches*
	12	*Can't make decisions anymore*		37	*Lacking love and affection*
	13	*Too little or too much social life*		38	*Parental pressure or conflict*
	14	*Eating problems*		39	*Family problems*
	15	*Feelings too easily hurt*		40	*Belonging to a minority group*
	16	*Sleep problems*		41	*Confused in my religious beliefs*
	17	*Feel that others do not like me*		42	*Fearing failure or rejection*
	18	*Thoughts of suicide*		43	*Have difficulty trusting other people*
	19	*Intentions of suicide*		44	*Feel I'm a complete blank; don't know what to do*
	20	*Can't seem to work effectively*		45	*Feeling inferior*
	21	*Absent from work too often*		46	*Getting into arguments*
	22	*Worrying about job*		47	*Too easily influenced by other people*
	23	*Unable to concentrate well*		48	*Concerned about my use of drugs or alcohol*
	24	*Conflict with boss*		49	*Feel a great sense of loss or grief*
	25	*Indecision about job*		50	*Wonder whether to get /stay married*

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PROFESSIONAL DISCLOSURE STATEMENT

Effects of Counseling: At any time, you may initiate a discussion of possible positive or negative effects of entering, not entering, continuing, or discontinuing counseling. While benefits are expected from counseling, specific results are not guaranteed. Counseling is a personal exploration and may lead to major changes in your life perspectives and decisions. These changes may affect significant relationships, your job, and/or your understanding of yourself. Some of these life changes could be temporarily distressing. The exact nature of these changes cannot be predicated. Together we will work to achieve the best possible results for you.

Client Rights: Some clients need only a few counseling sessions to achieve their goals; others may require months or even years of counseling. As a client, you are in complete control and may end our counseling relationship at any time though I do ask you participate in termination session. You also have the right to refuse or discuss modification of any of my counseling techniques or suggestions that you believe might be harmful.

I assure you that my services will be rendered in a professional manner consistent with accepted legal and ethical standards. If at any time for any reason you are dissatisfied with my services, please let me know and I will address your concerns. If I am not able to resolve your concerns, you may report your complaints to the Texas LPC Board at 1-800-942-5540.

Postponement and Termination: I reserve the right to postpone and/or terminate counseling of clients who come to their session under the influence of alcohol or drugs. I also reserve the right to discontinue counseling of clients who do not comply with the medication recommendations of their psychiatrist or physician.

Cancellation: In the event that you will not be able to keep an appointment, please notify me at least **24 hours in advance**. I reserve your scheduled appointment only for you; therefore, your failure to cancel appointments 24 hours in advance does not allow me to offer your time slot to other clients requesting time. As a result, **YOU ARE RESPONSIBLE FOR $60 PAYMENT FOR THE MISSED SESSION.** In the case that fee for the sessions is covered by an Employee Assistance Program, please note **you – NOT THE INSURANCE PROVIDER – are responsible for the $60 payment of the missed session.**

Fees: In return for a fee of $120 per session, I agree to provide counseling services for you. The fee for each session will be due and must be paid at the conclusion of each session. Credit card, cash or personal checks made out to "Dr. Nouri" are acceptable for payment. I only file for reimbursement from a few health insurance companies. However, I will provide you with a receipt for services that you can file with your insurance company for out-of-network benefits. Let me know if you have questions about the insurance companies I work with.

Counseling Relationship: During the time we work together, we will meet weekly for approximately **45 minute** sessions. Although our sessions may be very intimate psychologically, ours is a professional relationship rather than a social one. Our contact will be limited to counseling sessions you arrange with me. Please do not invite me to social gatherings, offer me gifts, ask me to write references for you, or ask me to relate to you in any way other than the professional context of our counseling sessions. You will be best served if our sessions concentrate exclusively on your concerns.

Records and Confidentiality: All of our communication becomes part of the clinical record. Adult client records are disposed of seven years after the file is closed. Minor client records are disposed of seven years after the client's 18th birthday. Most of our communication is confidential, but the following limitations and exceptions do exist: 1) I determine that you are a danger to yourself or someone else; 2) you disclosed abuse, neglect, or exploitation of a child, elderly, or disabled person; 3) you disclose sexual contact with another mental health professional; 4) I am ordered by a court to disclose information; 5) you direct me to release your records; or 6) I am otherwise required by law to disclose information. If I see you in public, I will protect your confidentiality by acknowledging you only if you approach me first.

In the case of marriage or family counseling, I will keep confidential (within limits cited above) anything you disclose to me without your family member's knowledge. However, I encourage open communication between family members and I reserve the right to terminate our counseling relationship if I judge any secret to be detrimental to the therapeutic progress.

By your signature below, you are indicating that you read and understood this statement, or that any questions you had about this statement were answered to your satisfaction, and that you were furnished a copy of this statement By my signature, I verify the accuracy of this statement and acknowledge my commitment to conform to its specifications.

_____
Client's Name

_____ _____
Client's Signature (Parent or Guardian) Counselor's Signature

_____ _____
Date Date

HIPPA, Emails, Texts, Audio/Video (Skype or other forms of communication):
I have been informed and am aware of HIPPA regulations.
I recognize that online and mobile communication is not confidential. I give permission to LifePulse Center™ and/or Dr. Nouri to communicate with me through the above means of communication as needed.

_____
Client's Signature (or Parent or Guardian)

CONSENT FOR RELEASE OF RECORDS
(Optional)

(PLEASE CHECK ALL THAT APPLY)

__ I hereby authorize Dr. Nouri to release ____ assessment and/or ____ counseling records for client named below to agent or individual named below.

__ I hereby authorize Dr.Nouri to request ___educational, ___psychological and/or _____medical records for client named below from agent named below. Date of services_____

__ I hereby authorize Dr. Nouri to consult with appropriate school personnel, medical professional and/or mental health professional named below for client named below.

_____
Client (Print name)

_____
Agency/School

_____
Name of Service Provider & Title

_____
Address

_____
City, State & Zip

_____ _____
Client or Managing Conservator's Signature Therapist

_____ _____
Date Date