OPTIMAL LIFE, LLC
Confidential – Client History Form

PERSONAL INFORMATION:

My name is_____

Address:

_____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ May we call? Y / N Leave messages? Y / N

Work Phone: _____ May we call? Y / N Leave messages? Y / N

Cell Phone: _____ May we call? Y / N Leave messages? Y / N

Email: _____ May we email? Y / N

Date of birth: _____ Age: _____

Gender: ☐ male ☐ female ☐ mtf ☐ ftm ☐ queer

☐ other (please describe):

_____

My sexual orientation is: ☐ Heterosexual ☐ Bisexual ☐ Gay ☐ Lesbian ☐ Queer ☐ Other

Emergency Contact: _____ Phone: _____

Relationship to Emergency Contact Person: _____

PHYSICAL HEALTH HISTORY:

Current physical health problems:

_____

_____

_____

Medications/vitamins currently used (name, dosage, how long taking it, side effects experienced): _____

_____

Date of last physical: _____

FAMILY INFORMATION:

I am: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered

My partner's name is: _____ Age: _____ Years together: _____

Do you have any children? ☐ Yes ☐ N If Yes, please list (with age): _____

_____

There are significant concerns from my childhood that are currently impacting me: ☐ Yes ☐ No

If Yes, please explain:

_____

_____

DRUG AND ALCOHOL USE:

Any personal history of drug/alcohol usage?

_____

_____

What is your current consumption of:

Alcohol _____ per _____; Caffeine _____ per _____; Cigarettes _____ per _____;

Cocaine _____ per _____; Sugar _____ per _____; Marijuana _____ per _____;

Other substances:

_____

Do you want to change the use of any of these substances? ☐ Yes ☐ No

If Yes, please explain:

_____

MENTAL HEALTH HISTORY:

Previous therapy/counseling (when/with whom) _____

_____

Have you ever been hospitalized for mental health concerns: ☐ Yes ☐ No
If yes, how many times: _____

Have you ever seriously considered attempting suicide: ☐ Yes ☐ No If yes, when: _____

Have you ever made a suicide attempt: ☐ Yes ☐ No
If yes, how many times: _____

Do you <u>currently</u> have any thoughts of suicide: ☐ Yes ☐ No If yes, do you feel safe: ☐ Yes ☐ No

Do you <u>currently</u> have any thoughts of injuring another person: ☐ Yes ☐ No

VOCATION:

I am employed: ☐ Yes ☐ No I am employed with: _____

My title is: _____ I have worked there for: _____

My job has been impacted by my presenting concerns: ☐ Yes ☐ No

If Yes, please explain:

_____

ABUSE HISTORY:

I have been physically abused: ☐ Yes ☐ No If Yes, please explain: _____

_____

I have been emotionally abused: ☐ Yes ☐ No If Yes, please explain: _____

_____

I have been sexually abused: ☐ Yes ☐ No If Yes, please explain: _____

_____

Currently impacted by the above abuse: ☐ Yes ☐ No If Yes, please explain: _____

_____

PRESENTING CONCERN:

Briefly state why you are seeking psychotherapy at this time:

_____
_____
_____
_____
_____

How long have you been troubled by these issues?_____

How long do you expect therapy to last_____

Do you consider the severity of your problem(s) to be:

____ Mild ____ Moderate ____ Severe ____ Extreme ____ Incapacitating

OTHER RELEVANT INFORMATION:

_____
_____
_____
_____
_____

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**

	During the past TWO (2) WEEKS, how much (or how often) have you been bothered by the following problems?	**None** Not at All	**Slight Rare** Less than a day or two	**Mild** Several Days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score (clinician only)**
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

DISCLOSURE OF INFORMATION, POLICIES,
CLIENT AGREEMENT AND PRIVACY NOTICE
SIGNATURE PAGE

YOUR AGREEMENT

I have read or have had a satisfactory explanation of Kan Guvensel's **FORM 1**, Disclosure of Information, and I understand it. I have asked any questions that I had about this form, and about statements regarding fees and payment policies. (For clients under the age of 18, consent must be given and this form signed by a parent or legal guardian). I understand and agree to the description of confidentiality and its exceptions as stated in the document. I consent to counseling under the terms described by Kan Guvensel and understand that I have the right to terminate counseling at any time I desire. I also understand that Kan Guvensel requests notice of termination at the beginning of a regularly scheduled session so that the reasons for termination may be discussed in terms of my therapeutic issues. My signature below indicates that I have received or have access to a copy of these documents.

Date Signed ____/____/____

_____ _____

Print Name Client Signature

Additional Signature Block For Minors (If applicable)

_____ _____

Parent or Guardian Name (If applicable) Parent or Guardian Signature & Date (If applicable)

OPTIMAL LIFE, LLC
KAN GUVENSEL, PH.D.

PRIVACY NOTICE (HIPPA) ACKNOWLEDGEMENT FORM

By signing below, I acknowledge that I have received and reviewed the accompanying Privacy Notice (HIPPA), FORM 2, and that my questions have been answered to my satisfaction.

Date Signed ____/____/____

_____ _____
Print Name Client Signature

Additional Signature Block For Minors (If applicable)

_____ _____
Name of Legal Representative (e.g., Attorney-In-Fact, Guardian, Parent or Guardian if client is a minor): Signature of Legal Representative

_____
Relationship to Client

Optimal Life, LLC
Kan Guvensel, Ph.D., LPC, CPCS
809 Church Street
Decatur, GA 30030
(404) 860-2180

Credit/Debit Card Payment Consent Form *

I authorize **Optimal Life, LLC** to charge my card for professional services as follows (please initial):

_____ All fees incurred from late cancellation/no show fees.

**** I understand that I have a right to revoke this authorization at any time. I understand that if I want to revoke this authorization, I must do so by writing or emailing Kan Guvensel (kan@guvensel.com). I understand that any revocation will not apply to any charges run prior to this cancellation date.***

Client Name_____
Print Last First Middle Initial

Name on Card if different_____

Type of Card: ☐ VISA ☐ MasterCard ☐ Discover ☐ AmEx **Exp. Date**_____

Card Number _____ - _____ - _____ - _____ **CVV Number** _____

Card Holder's Billing Address for Monthly Card Statements:

_____
Street City State Zip

_____ _____
Email address (only if you want copies of receipts) Phone Number

Card Holder Signature _____ Date ____ /____ /____