

# CLIENT INFORMATION PACKET

**Dee Desnoyers, M.Ed., LPC, RPT-S**

*At the Florence McDonnell Center*

2215 Cheshire Bridge Road, NE

Atlanta, GA 30324

\*\*Sign and return the entire 4 pg. personal info. Packet\*\*

Today's Date \_\_\_\_\_

Client's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Parent/Guardian's Name (if applicable) \_\_\_\_\_ Relationship \_\_\_\_\_

Parent/Guardian's Occupation: \_\_\_\_\_ Education Level: \_\_\_\_\_

Parent/Guardian's Name (if applicable) \_\_\_\_\_ Relationship \_\_\_\_\_

Parent/Guardian's Occupation: \_\_\_\_\_ Education Level: \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

May I send information to this address?  Yes  No

If No, please provide an address where information can be mailed: \_\_\_\_\_

Home Phone Number \_\_\_\_\_ May I contact you at this number?

Yes  No  Disguised

Cell Phone Number \_\_\_\_\_ May I contact you at this number?

Yes  No  Disguised

Work Phone Number \_\_\_\_\_ May I contact you at this number?

Yes  No  Disguised

If there are any further restrictions when calling you, please list them here \_\_\_\_\_

Education Level Completed \_\_\_\_\_ Occupation \_\_\_\_\_

Person to notify in case of emergency \_\_\_\_\_ Phone \_\_\_\_\_

***I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so:*** \_\_\_\_\_

Referred by \_\_\_\_\_

Please briefly describe your presenting concern(s): \_\_\_\_\_

How many sessions do you anticipate to address these concerns?

1-5

6-10

11-20

20+

I don't know

**MEDICAL HISTORY**

Please explain any significant medical problems, symptoms, or illnesses:

---

---

Current Medications	Indication	Dosage	Frequency
Side Effects			

*Please include over-the-counter medications and vitamins*

---

---

Past Medications	Date(s)	Indication	Dosage
Side Effects			

---

---

**MENTAL HEALTH TREATMENT HISTORY**

Have you ever talked with a mental healthy professional before today?  Yes  No

If yes: Date(s)	Type of Treatment	Reason
Professional Seen		

---

---

Would you like me to contact any of your previous providers?  Yes  No

If yes, please provide their contact information \_\_\_\_\_

---

---

**FAMILY HISTORY**

Please list all the people in your household and your relationship to them:

Name _____	Relationship _____	Age _____
Occupation _____	Education Completed _____	

Name _____	Relationship _____	Age _____
------------	--------------------	-----------

Occupation \_\_\_\_\_ Education Completed \_\_\_\_\_  
Name \_\_\_\_\_ Relationship \_\_\_\_\_ Age \_\_\_\_\_  
Occupation \_\_\_\_\_ Education Completed \_\_\_\_\_  
Name \_\_\_\_\_ Relationship \_\_\_\_\_ Age \_\_\_\_\_  
Occupation \_\_\_\_\_ Education Completed \_\_\_\_\_  
Name \_\_\_\_\_ Relationship \_\_\_\_\_ Age \_\_\_\_\_  
Occupation \_\_\_\_\_ Education Completed \_\_\_\_\_

Please list any family members who do not live in your house, but are important to you:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Age \_\_\_\_\_ Location \_\_\_\_\_  
Occupation \_\_\_\_\_ Education Completed \_\_\_\_\_  
Name \_\_\_\_\_ Relationship \_\_\_\_\_ Age \_\_\_\_\_ Location \_\_\_\_\_  
Occupation \_\_\_\_\_ Education Completed \_\_\_\_\_  
Name \_\_\_\_\_ Relationship \_\_\_\_\_ Age \_\_\_\_\_ Location \_\_\_\_\_  
Occupation \_\_\_\_\_ Education Completed \_\_\_\_\_  
Name \_\_\_\_\_ Relationship \_\_\_\_\_ Age \_\_\_\_\_ Location \_\_\_\_\_  
Occupation \_\_\_\_\_ Education Completed \_\_\_\_\_

### LEGAL ISSUES

Have the concerns you have today resulted in any legal issues?  Yes  No

If yes, please describe briefly: \_\_\_\_\_

Are you currently involved in any lawsuits, custody battles, or other legal battles?  Yes  
 No

Is therapy part of any court mandated requirement that you are required to complete?  Yes  
 No

### ADMINISTRATIVE INFORMATION

**Payment of Fees:** Please refer to the Florence McDonnell Center Fee sheet for 50 minute therapy sessions. Payment is due at the time of service. Out of office time that includes court or depositions will be charged at **\$290 per hour plus travel time**. If you are in need of a forensic therapist for child custody issues, I would be happy to provide you with referrals. Please initial here indicating that you have read and agree to this statement: \_\_\_\_\_

**Cancellation Policy:** Please be advised that I have a 24-hour reciprocal cancellation policy. You will be charged for my time if you do not give 24 hours notice to cancel an appointment. I will provide your next session at no charge if for any reason I cancel your appointment with less than 24 hours notice.

**Consent and Confidentiality:** You are consenting to treatment under the guiding principles determined by the code of ethics established by the American Counseling Association. In addition, I seek bi-monthly supervision with a licensed professional counselor supervisor and weekly peer supervision for my case load. The confidentiality of your psychotherapy will be kept unless it is my professional opinion that you present a danger to either yourself or others. No medical information will be disclosed without your notification and consent. Please discuss with me any concerns you may have about this. For more detailed information, please refer to the Professional Disclosure Statement which you signed for further information.

I have read and understood the above administrative policies:

Date: \_\_\_\_\_ Signature: \_\_\_\_\_  
\_\_\_\_\_