C. Christopher Pawson, PCC
5210 Cherrington Rd
Toledo, OH 43623
419-318-4627 f 419-754-4117

Registration Form

Client Name _____ SS# _____ Date of Birth _____ Age ___

Address _____City_____State_____Zip_____

Phone Home _____ Cell/Text _____ Work _____

Where is it acceptable to leave you a message? Home Cell Text Work

Gender: M F / Marital Status: Single, Married, Committed (Spouse/Partner Name and how long_____)

Emergency Contact Person & Phone Number _____

Who referred you to this office? _____

PERSON RESPONSIBLE FOR PAYMENT AND INSURANCE INFORMATION

Employer _____ EAP: Y N (EAP Name_____ # sessions____)

Primary Insurance Co _____ Insured Name _____ SS#_____ DOB_____

Secondary Insurance Co _____ Insured Name _____ SS#_____ DOB_____

Did you contact your insurance company to review your benefits and let them know that you were coming to this office? Y N

If so, what is your deductible _____how much has been met _____What is your co-payment/co-insurance per session _____

If authorization was needed, how many sessions were approved ___ (auth # _____)

Please provide Insurance Card (s) and Photo ID for copying.

I consent to medical treatment and agree to the terms outlined in the Counseling Service Agreement.

Please initial the following:

_____ I was given a copy of the Counseling Service Agreement which includes the Ohio Notice Form and HIPPA Notice

_____ I understand the risks associated with internet and wireless device communications between the counselor and myself.

_____ I authorize the release of any medical/information necessary to process claims paid to C Christopher Pawson PCC or supervisor.

_____ I am informed of my financial responsibility which includes the following

- Regardless of insurance, I am financially responsible.
- Fees are due at the time of service
- Appointments not cancelled within 24 hours of the appointment will be charged
- I will pay any outstanding balance within 30 days of receiving an invoice (or call to make payment arrangements).

Signature _____ Date _____

C. Christopher Pawson, PCC
5210 Cherrington Rd
Toledo, OH 43623
419-318-4627 f 419-754-4117

Information Form

Client Name _____ Date of last physical exam _____

Children (list gender & ages) _____

Do you have concerns about your health now N Y - are you being treated for it N Y _____

Psychiatric Medications you are currently taking _____

Major medical or traumatic events in your lifetime (including accidents, major surgeries) _____

Are you now or have you ever been involved in abuse including domestic violence N Y explain _____

Past Mental Health Treatment (Outpatient and Inpatient) _____

Past Substance Abuse Treatment (Outpatient and Inpatient) _____

Do you have any physical or mental limitations (disabilities) N Y explain _____

Do you get regular exercise N Y explain _____

Do you have concerns about your sexual: function / identity / orientation / activity N Y explain _____

Do you consider your eating habits to be healthy N Y explain_____

Have you had any changes in your appetite or had significant weight gains or losses in the past 3 months N Y explain _____

How many hours of sleep have you had in the last 24 hours?_____

Do you use tobacco (Smoke/Chew) N Y use per day_____

Do you drink alcohol N Y use per week_____

Do you use drugs not prescribed to you N Y what & how often _____

Do you have concerns about obsessive, addictive or habitual behaviors (gambling, spending, internet, other)_____

Are you currently employed N Y What is your job title and what are your job responsibilities _____

Do you enjoy your work N Y Is there anything stressful about your work _____

Have you ever served in the Military N Y explain _____

Do you consider yourself to be spiritual or religious N Y explain _____

What do you consider to be your strengths _____

What do you consider to be your weaknesses _____

What is your passion, what excites you, hobby / interest _____

Who is your best support _____

What would you like to accomplish in counseling _____

C. Christopher Pawson, PCC
5210 Cherrington Rd
Toledo, OH 43623
419-318-4627 f 419-754-4117

Coordination of Care between Health Care Providers

Patient Name:_____ Date of Birth:_____ Today's Date: _____

Check one:

_____ Please DO NOT communicate with my Primary Care Physician _____
Signature

STOP HERE, UNLESS YOU WANT COMMUNICATION WITH PCP

_____ Please communicate with my Primary Care Physician. (sign below)

Behavioral Health Provider:	***Primary Care Physician:***
C. Christopher Pawson, PCC *Professional Clinical Counselor* *5210 Cherrington Rd* *Toledo, OH 43623* *p:419-318-4627 f:419-754-4117*	**PCP Name**_____ *Address* _____ *Phone*_____ *Fax* _____

Presenting Problem:_____

_____

Clinical Finding:_____

_____

Clinical Impression:_____

_____

Treatment and follow-up recommendations:_____

_____

Patient Consent to Disclose Medical Information

I, _____ , hereby expressly authorize the release and disclosure of all medical and counseling records, including but not limited to the types of information referenced above, to Dr. _____, for the purpose of coordinating my healthcare. I understand that my records are confidential and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations.

_____ _____
Patient Signature Date

*This consent is valid for one year from the date of signature unless revoked in writing by the patient or legal guardian.

C. Christopher Pawson, PCC
5210 Cherrington Rd
Toledo, OH 43623
419-318-4627 f 419-754-4117

On Track Outcomes Form

Name **Date** **Time**

1	Over the last 2 weeks, how often have you been bothered by l**ittle interest or pleasure in doing things?**	Not at all	Several days	More than half the days	Nearly every day	
2	Over the last 2 weeks, how often have you been bothered by **feeling down, depressed or helpless?**	Not at all	Several days	More than half the days	Nearly every day	
3	Over the last 2 weeks, how often have you been bothered by **trouble falling or staying asleep or sleeping too much?**	Not at all	Several days	More than half the days	Nearly every day	
4	Over the last 2 weeks, how often have you been bothered by **thoughts that you would be better off dead, or of hurting yourself?**	Not at all	Several days	More than half the days	Nearly every day	
5	**How often do you have a drink containing alcohol?**	Never	Monthly or Less	2-4 times a month	2-3 times a week	4 or more times a week
6	**How many drinks containing alcohol do you have on a typical day when you are drinking?**	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
7	**How often do you have five or more drinks on one occasion? (A drink is defined as: 12 ounces of beer, 5 ounces of wine, or 1.5 ounces of spirits)**	Never	Less than monthly	Monthly	Weekly	Daily o almost daily
8	**How many times since we last talked have you used an illegal drug or used a prescription medication for a non-medical reason?**	#_____	Explain:			
9	**The Counselor and I work well together**	Agree	Somewhat Agree	Not Sure	Somewhat Disagree	Disagre
10	**The counselor understands me**	Agree	Somewhat Agree	Not Sure	Somewhat Disagree	Disagre
11	**We talk about things that are important to me**	Agree	Somewhat Agree	Not Sure	Somewhat Disagree	Disagre

12 What is your goal for today's session: