Kristy Dillon, MS, LPCC-S
8801 N. Main St, Dayton OH 45415
PH: (937) 776-0052

CLIENT INFORMATION FORM

Date of First Appointment: _____

Name: _____**DOB**_____**Age**_____

Address: _____

City/State/Zip Code: _____

Home Phone: _____ **May I call you here? ___Yes ___No**

Cell Phone (*optional*): _____ **May I call you here? ___Yes ___No**

E-mail (*optional*): _____

Other (*provide special contact instructions*): _____

School or Employer:_____

Address: _____

City/State/Zip Code:_____

Grade Level or Occupation:

_____

Work Phone (*if applicable*):_____ **May I call you here? ___Yes ___No**

PLEASE NOTE ANY MENTAL HEALTH SERVICES.
If you have been in counseling, please describe why you were in treatment and if you found it to be helpful.

Place You Received Counseling	Date	Description
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please describe in your own words why you are seeking services at this time:

_____

_____

_____

Personal Data:

Race: • Caucasian • Asian • African-American • Hispanic • Native American • Other

Education: • Grades 1-8 • Grades 9-11 • High School/GED • Some College • 2-Yr College Degree
• 4-Year College Degree • Graduate Degree • Business/Tech beyond High School

What is your primary relationship status?

_____

Please list the persons with whom you live, their ages and relationship to you:

_____

_____

_____

Please list any brothers and sisters and their ages:

_____

_____

Are your parents living or deceased? (*Please mark "L" for living - or - "D" for deceased.*)

_____ Mother _____ Father _____ Step-Mother _____ Step-Father

How would you describe your current physical health? • Good • Fair • Poor

MEDICATIONS: ***List any medications you are currently taking for any reason:***

Medication Name	Strength & how you take it	Purpose of Medication	Prescribing Doctor
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you use caffeine, tobacco, marijuana, alcohol or other recreational substances? If so, note approximate amounts weekly.

_____

_____

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY TO YOUR CURRENT EXPERIENCE/SITUATION:

_____ **Job stress/work difficulties**
_____ **Financial problems (bills, etc.)**
_____ **Family problems/parenting**
_____ **Change in appetite**
_____ **Major weight change**
_____ **Sleep problems**
_____ **Irritability/moodiness**
_____ **Thoughts of hurting self and/or others**
_____ **Drug or alcohol use by self/others**
_____ **Abusive relationship**
_____ **Eating disorder**
_____ **Feeling out of control**
_____ **Nightmares / bad dreams**
_____ **Easily startled**
_____ **Difficulty concentrating**
_____ **Crying spells**
_____ **Low self-esteem**
_____ **Lack of assertiveness**
_____ **Memory difficulties**
_____ **Depression or Sadness**
_____ **Disturbing thoughts**
_____ **Excessive worry, feelings of panic**
_____ **Loss of relationship**
_____ **School problems**
_____ **Sexual concerns**
_____ **Relationship problems**
_____ **Sexual abuse issues**
_____ **Other:** _____

WHAT ARE THE GOALS YOU WOULD LIKE TO ACHIEVE IN COUNSELING:

PLEASE LIST A PERSON TO CONTACT IN CASE OF AN EMERGENCY:

Name: _____ **Telephone:** _____

Address: _____

City/State/Zip Code: _____

Relationship of contact person to client: _____

Kristy Dillon M.S., LPCC-S

PROFESSIONAL CLINICAL COUNSELOR
8801 N. MAIN STREET
DAYTON, OH 45415
(937) 776-0052

CONSENT FOR TREATMENT

Your record is confidential and no information about you or the services that you receive will be released without your written permission. Kristy Dillon M.S., PCC-S may release certain information without your authorization under the following circumstances:

1. **Upon receipt of court order (this will be discussed with you);**
2. **In the event of a valid emergency or threat of bodily harm to self and/or others;**
3. **If there is evidence to suggest that abuse/neglect of a child or an elderly person has occurred.**

Payment and Missed Session Fee

I agree to pay the fee of $100 at the time of my session (cash, checks, credit cards, Health Savings Accounts). I understand that if I do not cancel my appointment within 24 hours I will be expected to pay a missed session fee of $50 at my next session.

.

- **I have indicated my consent to treatment by my signature below.**

Signature of Client: _____ **Date:** _____

Signature of Clinician: _____ **Date:** _____

Kristy Dillon

For additional information about counselor responsibilities and client rights, or to file a grievance contact:

THE STATE OF OHIO COUNSELOR, SOCIAL WORKER, MARRIAGE AND FAMILY THERAPIST BOARD
77South High Street, 24th Floor
Columbus, OH 43215-6171
(614) 466-0912
www.cswmft.ohio.gov

Kristy Dillon M.S., LPCC-S

PROFESSIONAL CLINICAL COUNSELOR
8801 N. MAIN STREET
DAYTON, OH 45415
(937) 776-0052

CONSENT FOR TREATMENT

Your record is confidential and no information about you or the services that you receive will be released without your written permission. Kristy Dillon M.S., PCC-S may release certain information without your authorization under the following circumstances:

4. **Upon receipt of court order (this will be discussed with you);**
5. **In the event of a valid emergency or threat of bodily harm to self and/or others;**
6. **If there is evidence to suggest that abuse/neglect of a child or an elderly person has occurred.**

Payment and Missed Session Fee

I agree to pay the fee of $100 at the time of my session (cash, checks, credit cards, Health Savings Accounts). I understand that if I do not cancel my appointment within 24 hours I will be expected to pay a missed session fee of $50 at my next session.

.

- **I have indicated my consent to treatment by my signature below.**

Signature of Client: _____ **Date:** _____

Signature of Clinician: _____ **Date:** _____

Kristy Dillon

For additional information about counselor responsibilities and client rights, or to file a grievance contact:

THE STATE OF OHIO COUNSELOR, SOCIAL WORKER, MARRIAGE AND FAMILY THERAPIST BOARD
77South High Street, 24th Floor
Columbus, OH 43215-6171
(614) 466-0912
www.cswmft.ohio.gov