Karen Lucas L.M.H.C. ,L.M.P.

Consulting and Counseling - Individuals, Couples, Families and Groups

Date_____

Name_____ Telephone (HM)_____ Message OK? Y☐N☐

Address_____ Telephone (WK)_____ Message OK? Y ☐N☐

_____ Date of Birth_____ Age _____

Ethnic Background _____ Occupation _____

Person to contact in case of emergency _____Telephone _____

Who referred you? _____Relationship__

May I contact the person who referred you to thank them? Y_ / N _____

Are you in counseling now? Y☐N☐(If yes, with who?) _____

Have you been in counseling before? Y☐N☐(If yes, with who?) _____
(Please list names and approximate dates)

Are you currently taking any medication? Y☐N☐
(If yes, please list medication and symptoms for which it was prescribed):

_____

_____

Prescribing Physician_____

Previous Diagnosis _____

Date of your last physical: _____ Physician_____ Telephone _____

Permission to contact your Physician, please initial _____

Name/ Relationship/ Age / Gender of other persons living in household:

_____ _____

_____ _____

1605 12th Ave. Suite 30, Seattle, WA 98122 (206) 324-5744

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What are some specific goals that you would like to accomplish in your Mind/Body counseling session?

_____

_____

_____

Please check or add any concerns you may have:

☐ Alcoholism	☐ Depression	☐ Physical Abuse	☐ Sexual Abuse
☐ Addiction	☐ Eating Problems	☐ Emotional Abuse	☐ Fear
☐ Anger	☐ Anxiety	☐ Sexual Concerns	☐ Low Self Esteem
☐ Physical Health	☐ Shame	☐ Compulsive Behaviors	☐ Chronic Pain

What areas in your body to hold stress and or emotion (which emotions) or trauma?

_____

_____

Is there any additional information that you think would be helpful in our counseling? _____

_____

_____

Contract for Care

I promise to participate fully as a member of my health care team. I will make sound choices regarding my treatment plan based on the information provided by my Manual Therapist and other members of my health care team, and my experience of those suggestions. I agree to participate in the self-care program we select. I promise to inform my practitioner any time I feel my well-being is threatened or compromised. I expect my acupuncturist to provide safe and effective treatment.

Consent for Care

It is my choice to receive manual Therapy, and I give my consent to receive treatment. I have reported all health conditions that I am aware of and will inform my practitioner of any changes in my health.

Signature _____ Date_____

Signature of parent or guardian (If patient is a minor) _____ Date_____