



# CORE HEALING CENTER

157 S. Mill St., Plymouth, MI 48170 (734) 776-2284

Date \_\_\_\_\_

Name \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Calling Restrictions? \_\_\_\_\_ If "yes" explain:

\_\_\_\_\_  
Email Address \_\_\_\_\_

Date of Birth \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone Number \_\_\_\_\_

Referred By \_\_\_\_\_

Spouse/Partner \_\_\_\_\_ Age \_\_\_\_\_

## Previous Mental Health Treatment:

Have you seen a counselor before? \_\_\_\_\_ If "yes":

How long ago? \_\_\_\_\_

Name of Counselor \_\_\_\_\_

At the time sought treatment for \_\_\_\_\_

Any other family members in counseling? \_\_\_\_\_

**Medical History:** Physician \_\_\_\_\_

Last seen (approx. date) \_\_\_\_\_ For \_\_\_\_\_

Taking Any Medications? \_\_\_\_\_ If "yes":

Medication \_\_\_\_\_ For \_\_\_\_\_ Dosage \_\_\_\_\_

Medication \_\_\_\_\_ For \_\_\_\_\_ Dosage \_\_\_\_\_

Medication \_\_\_\_\_ For \_\_\_\_\_ Dosage \_\_\_\_\_

**Family History**

Father \_\_\_\_\_ Age \_\_\_\_\_ If deceased date \_\_\_\_\_

Mother \_\_\_\_\_ Age \_\_\_\_\_ If deceased date \_\_\_\_\_

Step Parent (s) names (s) \_\_\_\_\_

Brothers/Sisters Names	Age	Sex	Occupation	Where living	Deceased?
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Children's Names	Age	Sex	School & Grade	Lives at home?	Step?
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

**Personal History:** Have you ever been a victim of: sexual abuse \_\_\_\_\_ physical abuse \_\_\_\_\_  
verbal/emotional abuse \_\_\_\_\_

Who was the abuser(s) \_\_\_\_\_

**Social History:** How many friends do you have? \_\_\_\_\_

How well do you get along with co-workers? \_\_\_\_\_

What do you like to do socially? \_\_\_\_\_

**Education:** Highest grade achieved \_\_\_\_\_ Date of graduation \_\_\_\_\_

Degree \_\_\_\_\_

**Employment:** Current employer \_\_\_\_\_

Been there for \_\_\_\_\_ years. Duties \_\_\_\_\_

**Substance Use:** Have you used drugs/alcohol in the past week? \_\_\_\_\_ Past month? \_\_\_\_\_

Type \_\_\_\_\_ Amount \_\_\_\_\_

Has alcohol/drug use ever caused a problem? \_\_\_\_\_ If "yes" please explain: \_\_\_\_\_

Have you ever been treated (residential/out patient) for substance abuse? \_\_\_\_\_

Where and when \_\_\_\_\_

Have you ever attended a 12-step program? \_\_\_\_\_

Parents or grandparents with alcohol/addiction problems? \_\_\_\_\_

Siblings with alcohol/addiction problems? \_\_\_\_\_

**Daily Routine:** How well do you sleep? \_\_\_\_\_ Fall asleep OK? \_\_\_\_\_

Stay asleep? \_\_\_\_\_ Feel rested in the AM? \_\_\_\_\_

Any changes in the last six months? \_\_\_\_\_

How is your energy level during the day? \_\_\_\_\_

Does your life feel sufficiently organized? \_\_\_\_\_

Do you currently have any homicidal thoughts? \_\_\_\_\_

Do you currently have any suicidal thoughts? \_\_\_\_\_

**Check the items that relate to you**

- |   |  |
|---|--|
| <input type="checkbox"/> bereavement          | <input type="checkbox"/> guilt                         |
| <input type="checkbox"/> depression           | <input type="checkbox"/> suicidal feelings or thoughts |
| <input type="checkbox"/> anxiety              | <input type="checkbox"/> relationship with parents     |
| <input type="checkbox"/> nervousness          | <input type="checkbox"/> relationship with children    |
| <input type="checkbox"/> marriage problems    | <input type="checkbox"/> spiritual issues              |
| <input type="checkbox"/> sexual concerns      | <input type="checkbox"/> loss of hope                  |
| <input type="checkbox"/> infidelity of spouse | <input type="checkbox"/> loss of meaning               |
| <input type="checkbox"/> sexual identity      | <input type="checkbox"/> loss of self respect          |
| <input type="checkbox"/> sexual orientation   | <input type="checkbox"/> loss of love                  |
| <input type="checkbox"/> fear                 | <input type="checkbox"/> helplessness                  |
| <input type="checkbox"/> anger                | <input type="checkbox"/> hopelessness                  |
| <input type="checkbox"/> work/career          | <input type="checkbox"/> low self-esteem               |

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



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## **CONSENT FOR TREATMENT**

I am voluntarily seeking treatment from Alice Brown of the Core Healing Center. I understand that there is no guarantee concerning my treatment outcome. My therapist and I shall develop the treatment plan in accordance with my presenting problems. The fee for therapy sessions are \$110 for individual sessions and \$125 if sessions include others along with the individual. Sessions are 45-50 minutes in length. I understand that all fees are due in full at the beginning of each session, and that I may request a receipt to submit to my insurance company. If I need to cancel an appointment, I understand that a 24-hour notice is required. Should I cancel without notice, I will be charged the full fee for the session. I reserve the right to terminate treatment anytime I wish, but I will discuss termination of treatment with my therapist before discontinuing. I understand that all personal information will be considered confidential and can only be released with my written consent, unless there is a "Duty to Warn."

I have read this notice, understand and agree to it.

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**Client's Signature**

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**Date**

**CORE HEALING CENTER**

**NOTICE OF PRIVACY PRACTICES SIGNATURE SHEET**

I acknowledge that I have received for review a copy of the Core Healing Center Notice of Privacy form.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Patient Name