# -------- Alternative Health Consultants -------

A California Corporation

## Counseling / Therapy / Registration Form

| | |
|---|---|
| --- For Office Use Only --- | Referred from: Court / Probation / or: _____ |
| Date received: ___/___/___ | Case #: _____ |
| Next Court date: ___/___/___ | Contact Person's Name: _____ |
| | Phone: _____ |

Name: _____ Date of birth: _____

Address: _____ Place of birth: _____
(Street)

_____ Male / Female
City State Zip (Circle One)

Home Phone: _____ Work Phone: _____

Message or Cell Phone: _____ Social Security #: _____ - _____ - _____
(Circle one) (Optional)

Name & Address of Employer: _____
_____ How long employed there: _____

***Identity &*** Primary Language Spoken: _____
Caucasian Asian-Pacific Islander (specify - _____)
African American Native American
Hispanic (Specify - _____) Other: _____

***Types of services requested***: Individual Therapy Couples Therapy CC-DAR™
Collaborative Parenting™ Anger Management – 12Weeks 12 Week Parenting Class
Batterer's Intervention – 52 weeks Batterer's Intervention – Repeat Offender Program
Child Abuse Intervention Program – 52 Weeks Sex Offender Treatment Program
Other: _____

What individual or agency referred you: _____
Best time to reach you by phone: _____ Best Day / Time to schedule appointments: _____

**Please give a brief statement of your problem (or why referred)**

_____
_____

***Is this court ordered***: Yes No If yes, we ask that you provide the therapist with a copy of the court order before we schedule your 1st session. Also, please understand that we will require you to sign a release for that 3rd party if you want participation to count.

Relationship status: Single (not married) Divorced Widowed

Never Married Married Married, but currently separated Living together



I understand that counseling does not work for everyone, and no program can "make" a person change.
AHC reserves the right to modify / update program curriculum, Program schedules, & fee schedules

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Have you ever received Counseling / Therapy services before? Yes No If "Yes" when, where, what for, and with whom: _____

_____

Focus of the counseling was: _____

Did you find it helpful, and if so, what made it helpful: _____

_____

Medical Doctor's name: _____ Medications you are currently taking:_____

_____

***Adult Member's of Client's Household***

| Name | Birthdate | Relationship to client | Ethnic Origin | Highest Grade Completed |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

***Children Living in Client's Household***

Name: _____Social Security #: _____ / _____ / _____ Age: _____
Date of Birth: _____ Ethnicity: _____ Language Spoken: _____

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Date of Birth: _____ Ethnicity: _____ Language Spoken: _____

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Name: _____Social Security #: _____ / _____ / _____ Age: _____
Date of Birth: _____ Ethnicity: _____ Language Spoken: _____

I understand that Alternative Health Consultants does not accept insurance. AHC does accept Credit Cards, cash, personal checks, and money orders. We will provide receipts documenting your payment for service, and you may take these to your provider if you seek reimbursement.

I understand that what I share with Alternative Health Consultants staff will be considered confidential, and will not be shared with any 3rd party unless I sign a release of information. Further, I understand that employees of Alternative Health Consultants are mandated reporters. Under certain situations confidentiality may be breached, and the appropriate agencies contacted if staff suspects Child Abuse, Elder or D.D. adult abuse, I am a danger to myself, or a danger to others – including serious risk of committing property damage. If I am referred for Co-Parenting, I understand that staff may inform my ex that I have enrolled and / or failed to follow through. Further, re Co-Parenting - I understand that Alternative Health Consultantshas a "No Secrets Policy". When important issues come up (phone conversation with staff, or in a 1:1 session), and I am here for couples, family, or Co-Parenting counseling, therapists will expect that I will bring up the difficult issues in session with the other party. If I am unable, my therapist may refer me out for individual therapy until such a time that I am ready.

Signed: _____ Date: _____
(Client)

Staff Witness: _____ Date: _____



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