KATHERINE FABRIZIO

Licensed Clinical Mental Health Counselor

NEW CLIENT INFORMATION

Name _____ Today's Date _____
First Middle Last

Address _____

City _____ State ____ Zip _____

Home (____) _____ Work (____) _____ Cellular (____) _____

Email _____

Please be advised that I can't guarantee that your email or text communication is private.
Please limit your email and text to scheduling concerns.

I am authorized to leave you messages:

☐ Home ☐ Work ☐ Cell ☐ Email ☐ Other_____

Date of Birth ____/____/____ Sex ☐M ☐F

Credit Card Number*: _____ Expiration Date* /__ __ Verification Code* _____

*Sessions will be charged to your credit card unless other arrangements are made.

Marital Status ☐Married ☐Single ☐Widowed ☐Divorced ☐Separated ☐Domestic Partner

Who referred you to my practice or did you find me on line?_____

Student Status:☐ Full Time ☐ Part Time ☐ Institution

Whom should be contacted in the event of an emergency?

Name_____ Relationship to you_____

Address_____ City_____ State_____ Zip_____

Best Phone Number (____)_____

Do I have your permission to contact the above person regarding your therapy? ☐ Yes ☐ No

Please list psychiatric medications you have taken in the past and describe your response: _____

_____

List all medications you are currently taking. Include supplements and over the counter medications:
Please include dose and frequency of each medication. _____

_____

List any drug or other allergies you have: _____

Have you been in therapy before? ☐ Yes ☐ No If yes, with whom? _____

Alcohol use? ☐ Yes ☐ No #____ drinks per week. Caffeine use? ☐ Yes ☐ No #____ Beverages a day

Illicit drug use? ☐ Yes ☐ No Tobacco use? ☐ Yes ☐ No #____ packs per day

Do you exercise? ☐ Yes ☐ No Type and frequency _____

Average sleep hours per night. Trouble falling asleep? ☐ Yes ☐ No Trouble staying asleep? ☐ Yes ☐ No

List names, ages and relations of those you live with and names and ages of any children you may have.

_____

_____

Who raised you? _____ List siblings and their ages. _____

Were your parents divorced? ☐ Yes ☐ No If yes, how old were you? ____

Did one of your parents or siblings die during your childhood? ☐ Yes ☐ No If yes, how old were you? ____

How far did you go in school? ☐ High School ☐ Some College/Technical degree ☐ College

☐ Graduate school or Professional school ☐ Specialized Training

Any strong religious affiliation or spiritual practices? ☐ Yes ☐ No If yes, please describe. _____

_____

_____

Have any of your blood relatives experienced any of the following illnesses listed below? Please check the diseases and beside them, write which relative had the illness (i.e. mother, father, brother, sister, uncle, etc.).

☐ Depression _____ ☐ Bipolar disorder/manic-depression _____ ☐ Alcoholism/drug abuse _____

☐ Severe trauma _____ ☐ ADHD/learning disorders _____ ☐ Attempted or completed suicide

☐ Anorexia/bulimia _____ ☐ Severe obesity _____ ☐ Anxiety/nerves _____ ☐ Epilepsy/seizures _____

☐ High blood pressure _____ ☐ Diabetes _____ ☐ Cancer_____ ☐ Schizophrenia _____

☐ Alzheimer's or Parkinsons Disease _____ ☐ Psychiatric hospitalization _____

CLIENT DISCLOSURE STATEMENT (INFORMATION AND CONSENT)

Please read carefully and sign• Licensed Professional Counselor
CLIENT DISCLOSURE STATEMENT (INFORMATION AND CONSENT)
I am pleased you have selected me as your counselor. This document is designed to inform you of my background and to ensure that you understand our professional relationship.

Degrees/Licenses/Certificates
hold a Bachelor of Arts in Clinical Psychology from UNC-Chapel Hill. I attended NCCU on a scholarship and graduated Summa Cum Laude with a Master of Arts in Clinical Psychology in 1988.1 have been in private practice since 1988.1am licensed as a Professional Counselor (license #2793, issued July 1, 1997), as well as having certification as a Health Services Provider (issued December 1, 1994). Both licenses involve successfully completing a body of required coursework, passing nationally standardized licensing exams in addition to clinical internships, and hundreds of hours of supervised clinical practice. Following licensure I have pursued ongoing training in the area of psychodynamic psychotherapy.

Counseling Services Offered/Theoretical Approaches
I offer individual psychodynamic psychotherapy for adults and older adolescents. I treat diagnoses that include: personality disorders, adjustment, anxiety, and depressive disorders. I see clients for weekly sessions from one to three times a week depending on the nature and intensity of the work. My approach could best be described as psychodynamic/psychoanalytic. This approach has its theoretical roots in the early discoveries of Dr. Sigmund Freud about unconscious conflicts. These theories have undergone changes and advancements that span over 100 years. Psychodynamic psychotherapy focuses on both the conscious and unconscious factors that act to keep a person stuck in painful ways of relating to others and to himself/herself. Current psychodynamic theories emphasize the importance of self-esteem, relationship trauma, and empathy. The process of psychodynamic therapy involves uncovering and working through this painful forgotten material. Through the client's expressed current concerns and difficulties there emerge patterns and links to this unconscious material. Insight and healing are set into motion through a collaborative, careful and empathic examination of the patient's thoughts and feelings. As awareness is gained, the client is freed psychologically to make choices in work and relationships that alleviate suffering and bring greater joy and satisfaction.

Business Policies
After an evaluation period you can expect me to hold a regularly scheduled time(s) for you each week that we agree upon. I ask that you give me 24 hours notice if you must cancel. I charge the full fee for missed sessions with the exception of illness or unavoidable emergencies.

Your monthly statement has the appropriate information for filing insurance. Be aware that there is great variability in insurance coverage. It will include a diagnosis which becomes part of your medical record. You are personally responsible for any fees incurred. My fee per 45-minute session is **$165.00**

Any information regarding your treatment is confidential and will not be released without your permission. Legal mandates give two exceptions to this policy; (1) if a client is believed to be harmful to himself/herself or others, or (2) situations where there is suspected child or elder abuse, or (3) by court order. I am legally bound to break confidentiality and report such instances.

If you believe you have been treated unethically or unfairly by me you may contact the North Carolina Board of Licensed Professional Counselors at PO. Box 7369, Garner, NC. 27529, (919) 667-0820 for clarification of client's rights as I've explained them or to lodge a complaint.

_____

Katherine Fabrizo Date

_____

Client's signature Date