Location : Louisiana _____Florida : _____Other:_____

Cindy D. Ashkins, Ph.D., LCSW
504.606.6011
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www.doc4relationships.com

CLIENT INFORMATION FORM

Name:_____DOB:_____Age:_____

Social Security #: _____-_____-_____

Address:_____

City:_____Zip: _____

Telephone : Cell_____Email_____

Years of Education: _____ Gender: _____

Occupation: _____ Employer: _____

Referred By:_____

Emergency Contact:_____Relationship_____Phone:_____

Current Relationship Status:

Married_____ Single _____ Separated/Divorced _____

Life Partner _____ Other _____

Names and ages of children if applicable:

_____

_____

Please briefly indicate the reason for seeking treatment at this time:

_____

_____

Reasons for treatment (continued:)

_____

_____

_____

Please list current individual stressors (please check all that apply):

_____ Health _____ Relationship

_____Finances _____ Career

_____ Parents _____ Children

_____Social _____ School

_____ Fitness/Weight _____ Fatigue

_____ Anxiety _____ Depression

_____Trauma/PTSD _____ Divorce

_____ Addictive or compulsive behavior _____ Self-Harm

Other (please specify) _____

_____

Please list current relationship stressors (please check all that apply): _____N/A_____

_____ Lack of communication _____Anger

_____Conflict _____Health

_____ Finances _____Intimacy

_____Children _____Living Situation

_____Substance Abuse _____Addiction

Relationship Concerns (continued)

_____Untreated Mental Health concern (please specify):

_____

_____ Concern of/ or tendency toward violence

_____ Threat/Possibility of divorce

_____ Affair(s)

_____ Other (please specify)

_____

Please list any current physical illnesses or injuries:

_____

_____

Please list all current medications and dosages:

_____

_____

Current prescribing psychiatrist, NP or medical psychologist :

_____

_____

Please list any previous mental health treatment/couples counseling or mental health hospitalizations :

_____

_____

Please initial each statement and fully sign at the bottom:

Cancellations: Cancellations must be made 24 hours in advance to avoid being charged for the appointment time, as Dr. Ashkins has limited hours and often a waiting list. I understand that I will be charged for the appt, unless it is an emergency, if 24-hours notice is not given. _____

Illness: I understand that Dr. Ashkins has a compromised immune system and I will convert my appt to a virtual session or cancel if I am ill, contagious or have been recently exposed to COVID. _____

Payment: The session fee (5O minutes) for individuals is $145.00, and for couples and families $160.00. Many couples choose to book longer sessions and these are prorated for the hourly rate. Payment is due at the end of each session. Credit card payments or Venmo payments are currently accepted. _____

Insurance: Payment is expected in full at the time of each session. Dr. Ashkins does not accept insurance as payment may will provide a Superbill for you to submit to your insurance for reimbursement. _____

Legal: I understand that due to confidentiality Dr. Cindy Ashkins, Ph.D., LCSW, does not routinely to go to court for marriage/couples counseling cases and I agree not to call her as an expert in any case relating to this current counseling. _____

Electronic Communication: I understand Dr. Ashkins may at times use HIPAA compliant electronic communication and if requested will conduct sessions on Zoom. _____

Signed: _____ Date _____

Thank you and welcome to our practice.

Dr. Cindy Ashkins