

## Information, Policies, and Informed Consent

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<b>Name</b>		<b>Today's Date</b>	
<b>Address</b>			<b>Email:</b>
<b>Telephone:</b>	<b>Cell Phone:</b>		<b>Other Phone:</b>
<b>Occupation:</b>			
<b>How did you hear about me?</b>			<b>If referred by someone else, may I send a thank-you note?</b>

### Emergency Contact Information

*(Please let these people know they are being listed.)*

<b>1<sup>st</sup> Emergency Contact</b>	<b>Name:</b>		<b>Phone Number:</b>		<b>Relationship:</b>	
<b>2<sup>nd</sup> Emergency Contact</b>	<b>Name:</b>		<b>Phone Number:</b>		<b>Relationship:</b>	

IF WE ARE WORKING LONG DISTANCE - BY PHONE OR INTERNET - AND YOU SUDDENLY HANG UP, I WILL CALL YOUR EMERGENCY CONTACT IN ORDER TO ASSURE YOUR SAFETY. I WILL DO THE SAME IF YOU SUDDENLY LEAVE AN IN-PERSON SESSION.

### PERSONAL AND FAMILY INFORMATION

<b>Sex/Gender Identity:</b>		<b>Preferred personal pronouns:</b>		<b>Marital Status:</b> (Single/Spouse/Significant Other)	
<b>Spouse/ Partner's Name:</b>		<b>Children (Names/Ages):</b>			
<b>Please describe any concerns you have about your current family situation:</b> <i>(Please type in the box below.)</i>					

## **FAMILY OF ORIGIN INFORMATION**

*(Please type responses in the box below each question. If you need more space, reduce font size in that section.)*

<b>Names of siblings and age difference from you when they were born:</b>
<b>If they are still alive, please describe your relationship with them now. If not, how old were you when they died?</b>
<b>Please describe your childhood and current relationship with your mother, father, and anyone else living with you when you were a child:</b>
<b>Please describe your parents' relationship with each other while you were growing up:</b>
<b>Are they still living? If deceased, how old were you? If divorced, how old were you?</b>
<b>Please briefly describe any major childhood traumas.</b>

## MEDICAL INFORMATION

*(Please type responses in the box below or beside each question. If you need more space, reduce font size in that section.)*

<b>Date of Birth:</b>				
<b>If you are you currently under the care of any medical practitioners, when was your last visit? Anything notable? If so, please explain:</b>				
<b>Was there anything unusual about your birth, or your mother's experience of her pregnancy with you? Please explain below:</b>				
<b>Have you ever suffered a closed head injury (Concussion)?</b>		<b>Have you ever had brain surgery?</b>		<b>Do/did you have any learning disabilities, or ADD or ADHD?</b>
<b><u>Current Health Concerns</u></b>				
<b>In the box below, please list any current medical problems, symptoms, or illnesses.</b>				
<b>Previous medical and/or psychiatric hospitalizations, approximate dates, and reasons:</b>				
<b>In the space below, please list any prescription medications you are currently taking and what they are for.</b>			<b>In the space below, please list any over-the-counter medications or supplements you are taking. What kind and how often?</b>	
<b>Do you consume caffeine? If yes, how much per day?</b>			<b>Do you exercise regularly? How often and what do you do?</b>	
<b>What do you do for self-care?</b>			<b>What do you do for pleasure?</b>	

## PSYCHOLOGICAL INFORMATION

<b>Life Stressors</b>			
<i>Please place an "X" in the box to the left of any that apply to you. If experienced in the last year, place an "X" in the box to the right.</i>			
Applies	Stressor	In last year	Comment/Explanation
	Addition to the household		
	Alcohol/drug use or abuse (indicate self or family member)		
	Care of elderly or sick family member		
	Child or children in daycare		
	Death of family member		
	Financial difficulties		
	Incarceration (Indicate either self or family member)		
	Interpersonal problems		
	Issues with weight		
	Loss/change of home		
	Loss/change of job		
	Marital or relationship problems		
	Newly married, or engaged to be married		
	Problems at work		
	Separated/divorced (If so, how long ago?)		
	Serious illness (indicate self or family member)		
	Sexual abuse		
	Physical abuse		
	Emotional abuse		
	Sexual difficulty		
	Smoking		
	Work more than 40 hours per week		
	Thoughts of harming yourself or others. Past or present suicidal ideation.		
	Issues of sexual identity		

<b>Do you currently have friends and social support?</b>	
<b>Are you currently, or have you ever been in traditional psychotherapy? If so, when, and for how long? What was your experience?</b>	
<b>If you have participated in traditional psychotherapy, were you given a DSM diagnosis code? If so (and you know it), please provide the DSM code number:</b>	
<b>Do you feel that your daily demands exceed your coping resources and/or support system?</b>	

<b>What are your goals for our work together? Please describe your current therapeutic concerns. (i.e., Symptoms: what you want <i>healed</i> in your life)</b>

**Which issue is your highest priority at this time?**

Please describe your response in one of the boxes below:

If your issue is *emotional or spiritual*, please describe to the best of your ability (in the box to your right) addressing these questions:

- a. When was the first time you noticed this problem?
- b. How does it manifest in your body and/or in your life?
- c. What was going on in your life during the 6 months before it started? If it started in childhood, how old were you?
- d. When do you notice it the most often, or what triggers it?
- e. What have you already tried to resolve this issue?
- f. What makes it better?
- g. What makes it worse?

If your issue is *physical*, please describe to the best of your ability (in the box to your right) addressing these questions:

- a. What is the doctor's diagnosis of your condition?
- b. If there is pain involved exactly where is the pain located and what is it like? Be as specific as you can.
- c. **If there were an emotional cause or contributor to this problem, what do you think it might be? (Best guess)**
- d. When was the first time you noticed this problem, (pain or illness)?
- e. What was going on in your life during the 6 months before it started?
- f. When do you notice it the most often, or what triggers it?
- g. What have you already tried to resolve this issue, relieve the pain, or manage the illness?
- h. What makes it better?
- i. What makes it worse?

**In addition to your primary issue, is there another that you would like to work on?**

**Please type your response in one of the boxes below**

If your issue is *emotional or spiritual*, please describe to the best of your ability (in the box to your right) addressing these questions:

- h. When was the first time you noticed this problem?
- i. How does it manifest in your body and/or in your life?
- j. What was going on in your life during the 6 months before it started? If it started in childhood, how old were you?
- k. When do you notice it the most often, or what triggers it?
- l. What have you already tried to resolve this issue?
- m. What makes it better?
- n. What makes it worse?

If your issue is *physical*, please describe to the best of your ability (in the box to your right) addressing these questions:

- j. What is the doctor's diagnosis of your condition?
- k. If there is pain involved exactly where is the pain located and what is it like? Be as specific as you can.
- l. If there were an emotional cause or contributor to this problem, what do you think it might be? (Best guess)
- m. When was the first time you noticed this problem, (pain or illness)?
- n. What was going on in your life during the 6 months before it started?
- o. When do you notice it the most often, or what triggers it?
- p. What have you already tried to resolve this issue, relieve the pain, or manage the illness?
- q. What makes it better?
- r. What makes it worse?

### SPIRITUAL INFORMATION

*(Please type responses in the box below each question. If you need more space, reduce font size in that section.)*

<b>Do you believe in a Creator/Source/Higher Power...and by what name to do call it?</b>	
<b>Do you have a religious/faith affiliation in which you are an active participant?</b>	
<b>Do you believe that you have a soul?</b>	
<b>Do you believe that your soul has a specific purpose?</b>	
<b>Do you believe in reincarnation?</b>	
<b>Do you believe the soul lives on after death?</b>	
<b>Do you believe in Hell?</b>	

<b>If there is anyone you would like to grant permission for me to share or exchange information, please list them and the phone numbers below.</b>
<b>Is there anything else that you would like me to know?</b>

***Please begin thinking now about your goal for our time together. The Law of Attraction states that what we focus on we get more of, so I invite you to start envisioning the successful changes you wish to manifest at this time your life.***