Center for Cancer Counseling
1000 Quail Street #187
Newport Beach CA. 92660
949-474-4337; 855-474-4337

NEW PATIENT INFORMATION

Today's Date _____

Patient's Name _____

Date of Birth _____ Age _____SSN_____

Address_____
Street City State Zip Code

Telephone _____
Home Cell Work

Employer/School_____Occupation_____

Legal Status ☐Single ☐ Married ☐ Separated ☐Divorced ☐ Widowed ☐Living Together

Primary Care Physician _____Telephone_____

Referred By_____

Person To Be Contacted In Case Of Emergency

Name _____ Telephone Home_____

Relationship _____ Telephone Cell_____

Medical History:

Prescription Drugs /Over The Counter Medications.

_____

Medical Conditions Present and Past.

_____

Psychiatric History:

Outpatient Therapy Dates and Professional Names:

_____

Inpatient Therapy Dates and Hospital Names

_____

Medications Prescribed and Psychiatrist's Name.

_____

Family History:

Describe Medical or Psychiatric Conditions of any Relatives.

_____

Habits:	Amounts Currently Using	Most Ever Used
Coffee (cups/day)		
Cigarettes (Packs/day)		
Alcohol		

Substance Abuse History: ☐Yes ☐No

If Yes please describe:

Substance	Amount	Frequency	When (First use/Last use)

_____

Do you have a history of Blackouts? ☐Yes ☐No

Please Check all Symptoms and Concerns.

☐Depressed Mood	☐Hyperactivity	☐Sleeping Patterns
☐Decreased Energy	☐Disruption of Thoughts	☐Eating Patterns
☐Hopelessness ☐Delusions		☐Sexual Functioning
☐Guilt	☐Hallucinations	☐Difficulty Paying Attention
☐Anxiety	☐Paranoia	☐Difficulty Concentrating
☐Panic Attacks	☐Periods of Dissociation	☐Impulse Control
☐Irritability	☐Physical Abuse	☐Anger Management
☐Worthlessness	☐Sexual Abuse	☐Suicide Ideation/Attempts
☐Grief ☐Assaults		☐Homicide Ideation
☐Worry/Fears	☐Physical Complaints	☐Other_____

Recent Changes in Lifestyle.

☐Friendships	☐Finances	☐Living Arrangements	☐Hobbies
☐Family	☐Health	☐Job/School	☐Legal

PLEASE READ CAREFULLY AND INITIAL EACH SECTION AS ACCEPTANCE OF THESE CONDITIONS.

PATIENT SIGNATURE_____

1) LIMITATIONS OF PATIENT CONFIDENTIALITY.

We greatly respect your right to privacy regarding all of the information shared in therapy and want you to fully understand the limitations of confidentiality in order for you to make an informed decision regarding what you disclose in therapy.

All therapists are required by law to disclose the following information if:

1) You are a danger to yourself or others, or unable to care for yourself.
2) You are under 16 years old and you are the victim of a crime.
3) Child or elder emotional/physical/sexual abuse.
4) You have filed a suit against anyone and have claimed mental/emotional damages as part of the suit.
5) You seek treatment to and or enable anyone to commit a crime or avoid detection or apprehension.
6) The communication is important to an issue between parties claiming through you after you have died.
7) You waive your rights to privilege or give consent to limited disclosure.

☐ INITIAL

2) FINANCIAL TERMS

Payment is due at time of service unless other arrangements have been made prior to this session. Sessions are 45- 50 minutes in length unless otherwise planned.

☐ INITIAL

3) CANCELED/MISSED APPOINTMENTS

A scheduled appointment means that a time is reserved only for you. If an appointment is missed or canceled with less than 24-hour notice, you will be billed for the hour.

Please be respectful of our time and if need be cancel as soon as possible so that we can offer that time slot to another patient.

☐ INITIAL

4) CONSENT FOR TREATMENT

We understand how stressful having cancer is (or having a family member who has/had cancer) and the many emotional, psychological, relationship and life style challenges that accompany the diagnosis, treatments and recovery, as well as terminal and grief stages. We are here to help you develop strong coping skills that will enable you to process these challenges, deal with the emotional struggles, minimize the emotional pain and
maximize strengths so that you can maintain as productive a life as possible.

☐ INITIAL

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CONSENT TO RELEASE AND RECEIVE INFORMATION:

This consent is for your therapist, _____, and the Center for Cancer Counseling to contact by telephone, or/and to send copies of these records to one or all of the following health care providers:

☐ Nurse Navigator ☐ Primary Care Physician ☐ Psychiatrist ☐ Oncologist

Name:_____

Phone: _____

Address:_____.

For developing, implementing and providing a comprehensive treatment plan.

Patient's Name: _____
(Please Print)

Patient's Signature:

_____**Date:**_____

Guardian or Parent's Signature if patient is under 18.

_____**Date:**_____

This consent is valid for as long as the patient is in treatment with Center for Cancer Counseling, unless a hard written copy of notification is provided. Please feel free to contact us in writing if you wish to change these consents. We cannot guarantee that a message left by phone, text or email will be received. Therefore, these messages will not be sufficient consent to change this permission form,

☐ **I do not give my permission to release any information to any health care providers.**

☐ **I understand that if I send a bill to my insurance carrier they may request records.**

CONSENT TO CONTACT

I GIVE PERMISSION FOR CENTER FOR CANCER COUNSELING TO CONTACT ME IN THE FOLLOWING MANNER.

TELEPHONE:

Home_____ Consent to leave a message Yes No

Cell_____ Consent to leave a message Yes No

Work_____ Consent to leave a message Yes No

EMAIL_____

Consent to email educational/general and center fundraising activity updates information (circle) Yes No

MAIL:

Address that we can send information i.e.: bills, statements, letters and center activity updates.

Please feel free to contact us in writing if you wish to change these consents. We cannot guarantee that a message left by phone, text or email will be received. Therefore, these messages will not be sufficient consent to change this permission form.

Patient Signature_____Date_____

Center for Cancer Counseling: Demographic Information Form

Instructions: **Please provide a response for each of the following questions:** **Today's Date: _____**

Name:_____

1. What is your age? _____

2. In what city do you reside? _____

3. What is your sex?

Female ○ Male ○

4. What is your marital status?

Single ○ Married ○ Partnered ○ Separated ○ Divorced ○ Widowed ○

5a. How were you referred to the Center?

_____

_____

5b. What prompted you to seek counseling at this time?

_____

_____

6. With which racial or ethnic category do you identify?

African American ○ Asian/Pacific Islander ○ Caucasian ○ Latino ○ Other O

7. List the type(s) of cancer for which you are currently seeking support?

_____

8. What is the date of your original cancer diagnosis? _____

9. Please indicate the types of treatment you have received or are currently receiving?

Surgery ○ Chemotherapy ○ Radiation Therapy ○ Hormone Therapy ○ Immunotherapy ○

_____

_____

9. Please indicate the status of your cancer treatment?

In Active Treatment ○
Receiving Maintenance Treatment ○
Not currently receiving treatment ○ _____(month/year treatment completed)

10. Please indicate if you would like the Center for Cancer Counseling to send you information regarding events, volunteering, and fundraising opportunities.

Yes, I give consent for the Center to contact me ○ _____
(please provide email address)

No, I do not want the Center to contact me ○