Debra Orbuch Grayson, LCMFT
7133 W. 95th Street, Suite #216
Overland Park, KS 66212
Office: (612) 419-5638
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New Client Registration Packet

Please complete the attached documents and bring with you to our first session.

Feel free to contact me directly if you have any questions or concerns.

Thank you.

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Registration Information

Please complete the following questions. We will discuss this information more thoroughly in our first session and use it to determine goals.

Part One: Personal Background Information

Name:__________________________ Date of Birth____________ Age________

Address:________________________City__________State_______Zip________

Telephone (h)_________________ (w)_____________ (c)___________________

Email:_____________________________

Please list the members of your family and their ages and **dates of birth:**

_________________________________ ________________________________

_________________________________ ________________________________

Were you referred by someone?_____________________________________

Part Two: Counseling History/Reasons for Seeking Help

Have you or anyone in your family ever been in therapy before? ___ yes ___ no

If yes, briefly describe the reason(s), when, with whom and for how long:

____

If yes, was it a positive experience? ___ yes ___ no

What did you like about it/not like about it?

____

____

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Registration Information

Have you or anyone in your family ever attempted suicide? ___yes ___ no

If yes, please describe the situation:

____

Do you have any chronic illnesses, or medical conditions? ___ yes ___ no

If yes, please describe:____

Are you presently taking any medication? ___ yes ___ no
If **yes,** please list your medications and what you are taking them for as well as the prescribing physician:

____

Briefly describe your reason(s) for seeking help at this time:

____

____

What do you wish to accomplish through the process of therapy?

____

____

Please rate your support system (family, friends, religious, community, or other on a scale of 1-5, 5 being the strongest)

____

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Payment Agreement/Consent for Treatment

Name____

Address____

City_________________________ State____________Zip________________

Preferred Phone Number_____________________Circle: Home Work Cell

Insurance Carrier and policy #____

Birth Dates:____

Fees are **$150.00 per hour**, and all fees are payable at the time of service.
24 hour cancellation notice is required to avoid payment for missed sessions.

I/we understand that if I/we are delinquent in meeting the terms of this agreement that my service may be terminated.

You have the right to expect complete confidentiality with the exception of mandatory reporting as follows: mental health professionals are required by law to report physical harm or sexual abuse of a minor or vulnerable adult. We are also required by law to report the threat of harm to self or to a third party.

Please sign below to indicated your informed consent to the above conditions of our therapeutic relationship.

__________________________________   ______________
Signature   Date

__________________________________   ______________
Signature   Date