Exodus Synergy

245 N Broadway SUITE 207 • Sleepy Hollow, NY 10591 • (914) 586 – 2520

Welcome!! To speed up the initial process, please fill out this form as completely as you can. All information you provide will be kept confidential within the guidelines expresses in the Coaching agreement. Thank you.

Please Print

Name:______________________________________ Date:_____________

Address:____

(City)______________________________________ State:______________ Zip:____________

	OK to Contact	OK to send/leave message
Email Address:___________________	Y N	Y N
Home Telephone:_________________	Y N	Y N
Work Telephone:_________________	Y N	Y N
Cell Phone:______________________	Y N	Y N

Age: _______ Date of Birth:____/____/____ Male__ Female__

Place of Birth:_____________________

How long have you lived at your current residence?___________

Military Service: Branch:_______________ From______________To__________________
Education:____
Current Occupation:____
Employed By:____
Address;____
(City):____State:_____________Zip:__________

Describe your primary reason for coming to Coaching:______________________________

____

Whom may I thank for referring you?
Name:____________________________Address:______________________________________
City:_____________________________State:______Zip:___________Phone:_____________
I give my permission to send a letter of acknowledgment to my referral source:

____
(Your Signature & Date)

Emergency Contact Name & Number: ____

Please Sign & Date____

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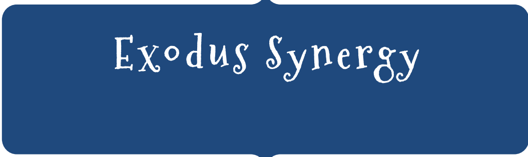

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Family Information

Current Marital Status:

Married: _ Divorced: _ Separated:_ Widowed: _ Co-Habitating:_
Single: _ Engaged: _ Other____________

List all of your household members:

Name	Age	Relationship	Occupation/(School/Grade)
1.________________	_________	_________________	__________________________
2.________________	_________	_________________	__________________________
3.________________	_________	_________________	__________________________
4.________________	_________	_________________	__________________________
5.________________	_________	_________________	__________________________
6.________________	_________	_________________	__________________________

Please list all of your marriages or significant relationships.

Name of Spouse	Date Married	Children from this Relationship	Terminated (Death/Date, Divorced/Date)
1.______________	_______________	_________________	___________________
2.______________	_______________	_________________	___________________
3.______________	_______________	_________________	___________________

Please list all of your Spouse's marriages or significant relationships.

Name of Spouse	Date Married	Children from this Relationship	Terminated (Death/Date, Divorced/Date)
1.______________	_______________	_________________	___________________
2.______________	_______________	_________________	___________________
3.______________	_______________	_________________	___________________

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Medical and Psychotherapy History

Any Surgeries? Yes □ No □

Procedure Date Comments/Outcome

______________________ ___________ ____

______________________ ___________ ____

Any current medical diagnosis or diseases? Yes □ No □

Diagnosis Date Comments/Status

______________________ ___________ ____

______________________ ___________ ____

Any current treatments or therapies for these conditions? Yes □ No □

____

Family Impact of Diagnosis:

____

Any previous psychotherapy? Yes □ No □

Date Started:	Date Completed:	Purpose of Therapy:	Therapist Name:

How helpful was it? Much improved □ Somewhat improved □ Improved □

Worse □ Somewhat worse □ Much worse □

No change □

Any hospitalizations? Yes □ No □

Date Hospital Reason

_________________ _______________________ ________________________________

_________________ _______________________ ________________________________

Current Medications:

Medication Dose Prescribing Physician

______________________ ___________ ________________________________

______________________ ___________ ________________________________

______________________ ___________ ________________________________

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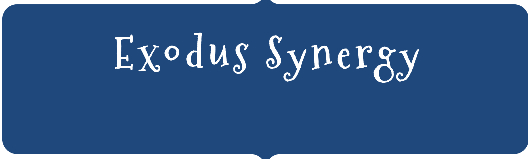

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CONSENT TO RELEASE MEDICAL AND PSYCHOLOGICAL INFORMATION

I, ___________________________________(print name), am a patient of D. Natalie Diaz Ludewig, LCSW (the "Medical Provider"), from whom I receive psychological or counseling services (the "Services"). The Medical Provider has explained to me that his ability to treat me and to provide the Services to me will be benefited and enhanced by his discussing from time to time confidential information about my diagnosis, prognosis, progress and/or treatment plan (which I collectively refer to as the "information") with members of my selection and disclosure listed below. This may also include other medical professionals that are providing, or have provided, treatment for me in ways that may be salient to my recovery and health.

Therefore, I hereby consent to the Medical Provider discussing and sharing any information as may be indicated and in my best interest with the following individuals during the entire course of my treatment:

Name/Nature of Relationship	Contact Information	Initials/Date

In the event that I wish to revoke this Consent in full, or with respect to specific individuals, I will notify the Medical Provider who will provide me with the necessary written materials. I maintain the right to limit the nature of the information that may be shared and accept that it is my responsibility to clearly communicate any limits that I wish to have adhered to with respect to my protected information.

I have fully discussed this Consent with the Medical Provider and all of my questions have been satisfactorily answered. I have signed the consent voluntarily.

_______________________________________ ________________

Signature Date

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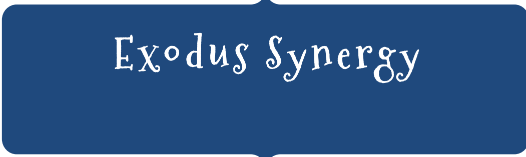

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Clinical Information

Name (Printed): ______________________

Please check all items that you have experienced in the last 6 months:

Physical Symptoms
- ☐ Headaches
- ☐ Fainting Spells/ Dizziness
- ☐ No appetite/Overeating
- ☐ Stomach/ Bowel disturbances
- ☐ Palpitations
- ☐ Tremors – shaking
- ☐ Poor sleep
- ☐ Nightmares/ Night Tremors
- ☐ Unusual bodily sensations
- ☐ Sexual Problems
- ☐ Tired/No Energy

Emotional Symptoms
- ☐ Anxious
- ☐ Depressed
- ☐ Self-Esteem Issues
- ☐ Fears/Worries
- ☐ Inferiority feelings
- ☐ Panic Attacks
- ☐ Anger Issues
- ☐ Feeling Tense/Stressed
- ☐ Shy
- ☐ Poor Decision Making
- ☐ Lack Ambition or Interests
- ☐ Unable to relax
- ☐ Other____

Social/Family Issues
- ☐ Marital/Partner problems
- ☐ Parent/Child problems
- ☐ Unemployed/Work Issues
- ☐ Financial Problems
- ☐ Court/Legal problems
- ☐ Problems making/keeping friends

Addictions
- ☐ Drinking problem
- ☐ Drug Abuse
- ☐ Gambling
- ☐ Sexual Addiction
- ☐ Food Addiction
- ☐ Excessive Shopping

Mental Health
- ☐ Previous Suicide Attempts
- ☐ Suicidal Ideas
- ☐ Visual Hallucinations
- ☐ Hearing Voices
- ☐ Disturbing thoughts or fears
- ☐ Manic

Please describe in detail those items checked above and for how long you have been experiencing each:

____

____

____

____

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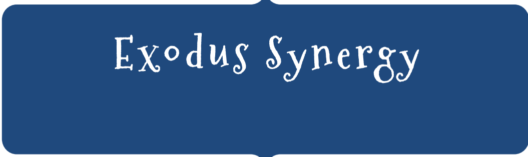

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Other Information

Please reflect upon and add any data that you believe is best to communicate in advance:

Signature:____________________________

Date: _______________________________

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Payment Agreement

I agree to pay for my medical visits out of pocket as detailed below. I understand that the typical range of completed treatment is between 8 hours and 12 hours, depending on varied factors beyond the Coach's control. These factors include the client's ability to answer the guided questions efficiently. Also the extent to which there is deviance or centeredness on the matters needed for the treatment. Other factors such as transparency versus withholding data also interplay with the duration and efficacy of the treatment. Moreover, factors such as frequency and intensity of significant events also interplay with the hours needed for this treatment and are beyond the coach's ability to estimate. The above is not an exhaustive list.

I agree that it is my responsibility to request a Superbill if I determine I may benefit from one. I agree to a minimum of 8 hours for my course of treatment.

Payment Schedule

50% of 8 hours fee	Due before the first session
At completion of 4 hours	The remaining 50% of 8 hours
At completion of 8 hours, if more sets of hours are needed	50% of the estimated hours that may still be needed
At completion of that estimated set	The remaining 50% of those additional hours

____
Client's Printed Name

____
Signature & Date

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Consent To Receive Psychological Medical Cyber Services

I, ________________________________(Print Name), am a client of D. Natalie Ludewig, LCSW (the "Medical Provider"), from whom I receive psychological or counseling services (the "Services"). The Medical Provider has explained to me that cyber based face time services is an option and I am choosing to exercise this option of my own accord and for my specific circumstance. I understand and assume any risk or impact on service or confidentiality that may be involved in choosing to receive psychological services in this manner. I further understand that it is my responsibility to ensure a secure internet access in order to be available in real time for this service.

Therefore, I hereby consent to receive cyber based face time psychological and counseling services of my own accord.

____

Signature & Date

Acknowledgement of Attendance Policy

I, ____, am a patient of D. Natalie Ludewig, LCSW (the "Medical Provider"), from whom I receive psychological or counseling services (the "Services"). The attendance policy is that notice must be provided a minimum of **48 hours** in advance of the scheduled appointment time, excluding life altering emergencies. Any cancellation or not presenting self for treatment beyond that time frame will result in my being responsible for the **payment amount in full** for that scheduled session. We have mutual respect for one another's time, so if the Medical Provider cancels without a minimum of 48 hours advanced notification (excluding life altering emergencies), then one full treatment hour as scheduled to follow will be offered at **Zero Cost**.

____

Signature & Date

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