Sankofa Sex Therapy, LLC
De-Andrea Blaylock-Solar, LCSW-S, CST
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314-877-8510 SankofaSexTherapy@gmail.com SankofaSexTherapy.com

*Please provide the following information and answer the questions below. Please note: Information you provide here is protected as confidential information. Please fill out this form and bring it to your first session.*

Name (Legal/Chosen): _____
Birth Date: ____ /____ /____ Age: _____ Gender: _____ Pronouns: _____
Marital Status: □ Never Married □ Partnership □ Married □ Separated □ Divorced □ Widowed
Please list any children/ages:

_____

_____

_____
Address: Street and Number

_____
City/State/Zip Code
Primary Phone: _____ May we leave a message? □Yes □No
E-mail: _____ May we email you? □Yes □No
*Please note: Email correspondence is not considered to be a confidential medium of communication.
Referred by (if any): _____
Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? □ No □ Yes, previous therapist/practitioner:

_____
Are you currently taking any prescription medication? □ Yes □ No
Please list:
_____
_____
Have you ever been prescribed psychiatric medication? □ Yes □ No
Please list and provide dates:
_____
_____
GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (Please Circle)
   Poor Unsatisfactory Satisfactory Good Very Good
   Please list any specific health problems you are currently experiencing:
   _____
   How would you rate your current sleeping habits? (Please circle)
   Poor Unsatisfactory Satisfactory Good Very Good
2. Please list any specific sleep problems you are currently experiencing:
   _____

3. How many times per week do you generally exercise? _____ What types of exercise to you participate in: _____
4. Please list any difficulties you experience with your appetite or eating patterns.
   _____
   _____
5. Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes
   If yes, for approximately how long? _____
6. Are you currently experiencing anxiety, panic attacks or have any phobias? □ No □ Yes
   If yes, when did you begin experiencing this? _____
7. Are you currently experiencing any chronic pain? □ No □ Yes
   If yes, please describe: _____
8. Do you drink alcohol more than once a week? □ No □ Yes
   If yes, please describe: _____
9. How often do you engage recreational drug use? □ Daily □ Weekly □ Monthly □ Infrequently □ Never
10. Are you currently in a romantic relationship? □ No □ Yes
    If yes, for how long? _____
    On a scale of 1-10, how would you rate your relationship satisfaction? _____
11. What significant life changes or stressful events have you experienced recently:
    _____
    _____

**FAMILY MENTAL HEALTH HISTORY**: In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.). Please Circle and list family member

| | |
|---|---|
| Alcohol/Substance Abuse | yes/no _____ |
| Anxiety | yes/no _____ |
| Depression | yes/no _____ |
| Domestic Violence | yes/no _____ |
| Eating Disorders | yes/no _____ |
| Obsessive Compulsive Behavior | yes/no _____ |
| Schizophrenia | yes/no _____ |
| Suicide Attempts or Thoughts | yes/no _____ |
| Self-injurious Behaviors | yes/no _____ |

ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes If yes, name of your employer:
   _____
   _____
   Do you enjoy your work? Is there anything stressful about your current work?
   _____
   _____
2. Do you consider yourself to be spiritual or religious? □ No □ Yes
   If yes, describe your faith or belief:
   _____

3. What do you consider to be some of your strengths?
   _____
   _____
   _____

4. What do you consider to be some areas for growth?
   _____
   _____
   _____

5. What would you like to accomplish during your time in therapy?
   _____
   _____
   _____

**CREDIT CARD AUTHORIZATION FORM**

Please note that this form will be securely stored in your clinical file and you are willing to assume the risk for keeping this information on file. I authorize De-Andrea Blaylock-Solar, Licensed Clinical Social Worker #2010006307 at Sankofa Sex Therapy, LLC to keep my signature and card information on file and to charge for unpaid therapy session fees (individual, couple, family, group, consultation or other), to charge for insurance co-pays and/or payments not covered by insurance, or for any appointments with De-Andrea Blaylock-Solar, LCSW-S, CST that are not cancelled within 24 hours of the scheduled appointment time. I understand that this form is valid until cancelled in writing or within 90 days of termination of services. I understand that I will be charged for missed appointments within 72 hours of the missed session. Additionally, I agree that the card listed will be charged within one week upon termination of services for any outstanding balances accrued by the client. I agree that if I have any concerns or questions regarding charges to my account, or if the charge fails to post to my account, I will contact De-Andrea Blaylock-Solar, LCSW-S, CST for assistance and/or disclosure. I agree that I will not dispute any charges with my credit card company unless I have already attempted to rectify the situation directly with De-Andrea Blaylock-Solar, LCSW-S, CST and those attempts have failed. I understand and agree to these terms. I understand the conditions of this payment policy and agree to the conditions stated above:

Cardholder Name (Print): _____
Zip Code: _____
Card Type (Visa, MasterCard): _____
Credit Card Number: **SAVED IN IVY PAY; DO NOT FILL OUT HERE**
Expiration Date: **SAVED IN IVY PAY** Security Code: **SAVED IN IVY PAY**

Signature: _____ Date: _____

**PHYSICIAN NOTICE AND RELEASE OF INFORMATION**

Most insurance plans request that the therapist notify the physician that their patient is being seen in counseling. Please complete and sign. If you do not wish for your physician to have this notice in your medical files, please indicate below.

_____
Name of MD

_____
Address of MD

_____
City, State and zip of MD

_____
Email address/Website

The client named below is receiving psychotherapy at this office with De-Andrea Blaylock-Solar, LCSW-S, CST. The client has indicated that you are the primary physician _____ or psychiatrist_____. The client's insurance has requested that you be notified, and the client has authorized this notice. I look forward to working with you in a team effort for the benefit of the client. If you wish to contact me, please call (314) 877-8510.

Thank you.
De-Andrea Blaylock-Solar, LCSW-S, CST

I_____ authorize _____ (do not authorize _____) that this notice be sent to the above-named doctor and further authorize consultations between the patient's doctor and therapist relative to my medical and psychological care.

_____ Date: _____
Signature of client

**MEDICAL HISTORY**

Please complete this form as this information is very important. Please feel free to add any additional information that you feel is needed.

Name: _____
Current Physician and/or Primary Care Physician: _____
Address: _____City/State: _____ Zip: _____
Phone: _____
Medications prescribed by this M.D. (Name and dosage)_____
_____
_____
Are you are under the care of a psychiatrist? Yes_____ No_____
Name of Psychiatrist or Psychiatric Nurse
_____
Address: _____City/State: _____
Zip: _____
Medication and dosage prescribed by Psychiatrist: _____
_____

Have you been hospitalized for emotional problems? Yes_____ No_____
If so: When_____Where_____

Have you had previous individual therapy? Yes____No_____ Dates:_____

Name of Therapist:_____Address:_____
City:_____Zip_____Telephone_____

Name of Therapist:_____Address:_____
City:_____Zip_____Telephone_____

Have you been treated for substance abuse? No: _____ Yes: _____ Date: _____
Are you being treated now for substance abuse? No: _____ Yes: _____

Please list any and all physical illnesses that are now being treated by a physician:
_____
_____
_____
_____

What would you want your therapist to know about your physical or emotional health:
_____
_____
_____

I authorize De-Andrea Blaylock-Solar, LCSW-S, CST to contact by telephone or mail the following medical professionals for the purpose of consulting and coordinating care for my therapy and treatment.

Name_____Address:_____ City: _____ State: _____ Zip: _____
Phone: (  )_____ Email: _____

Name_____Address:_____ City: _____ State: _____ Zip: _____
Phone: (  )_____ Email: _____

_____ Date: _____
Signature