Client Information Questionnaire

Wise County Christian Counseling
2200 S FM 51 Suite 500
Decatur, Tx. 76234

Your cooperation in completing this questionnaire will be helpful in planning our services for you. Please answer each item carefully. Ask your therapist for clarification if you do not understand an item.

Name: _____Date: _____
Completed by: _____ Relationship: _____
Address_____

_____
Phone numbers (List all that apply.):

_____
Email address:

_____
Please indicate if a message can be left at any of these numbers: yes ____ no ____

Sex: _____Male _____Female_____

Date of Birth:_____

Occupation(s):_____

Household family income (including child support, unemployment, disability, etc.):

_____

Religious preference: _____Where do you attend? _____

Brief description of living arrangement:

_____
_____
_____

List the members of your family and all others that are currently living in your home.
Name(s) Age/Grade Relationship Occupation

_____
_____
_____
_____

Briefly describe your reason(s) for seeking help:

_____
_____
_____

What do you hope to accomplish through counseling?

_____
_____
_____

How did you find out about us?

_____

Have you ever consulted a professional counselor? _____YES _____NO
If yes, name of agency:_____

How was counseling helpful then?

_____
_____
_____

Please list any medications you are taking at present:

_____

Have you ever considered suicide? _____YES _____NO
If so, when?_____
Have you ever attempted suicide?_____YES _____NO
If so, when?_____

Have you experienced any trauma that has impacted your life (ex. Parents' divorce, abuse, death of a close relative/friend)? If so, please describe:

_____
_____
_____
_____
_____

Was there any trauma surrounding your birth you are aware of? If so, please describe:

_____
_____
_____
_____

Mark any of the following which are presently causing difficulty (Put a * by the two most important items):

Problems Related to Abuse _____
Current or past physical abuse _____
Current or past sexual abuse _____
Current or past emotional abuse _____
Current or past neglect_____

History of abandonment_____
Suspected sexual abuse_____
History of family domestic violence_____

Mood-related Concerns_____
Disturbing memories_____
Difficulty going to sleep/staying asleep _____
Nightmares/night terrors _____
Suicidal ideation _____
Sadness _____
Feelings of guilt and shame _____
Excessive worrying _____
Anger/Irritable _____

Rule-Breaking/Behavior Problems _____
Aggression toward others _____
Drug/Alcohol use _____
Truancy _____

Running away _____
Stealing _____
Intentionally hurting animals _____
Fire-setting _____

Academic/School Problems _____
Learning difficulties _____
Problems with peers _____
Problems with teachers _____
Speech problem _____

Family-Relationship Concerns _____
Difficulty adjusting to family changes _____
Discipline concerns_____
Parent-child relationship problems _____

Sibling concerns_____
Divorce/Separation_____

Other Behavioral Concerns _____
Sexual identity concerns _____
Inappropriate sexual behavior _____
Overeating/Refusal to eat _____
Hyperactive/Inattentive_____

Other Unusual Behaviors
(Please specify)
_____
_____
_____

Please provide any additional information which you feel may be useful to your therapy.
_____
_____
_____

Is there any history of mental illness in the family, including yourself? (anxiety, depression, OCD, schizophrenia, bipolar, addictions, etc.)
_____
_____
_____
_____

*HISTORY OF TRAUMA/STRESSORS

(For each of the following items that apply, write in your approximate age at the time it occurred):

Chronic illness of family member____ Death of significant person____ Domestic violence____
Family member absent (explain)
_____
Family member's disability/major accident/illness____
Family member emotional problems (explain)
_____
Family member suicide (explain)
_____
Parent's divorced_____
Child separated from parent (how long and

when)_____
Death of a pet____ Difficult medical treatments____ Natural disaster____
Sexual assault____ Victim of trauma (unusual, terrifying experience)____
Other_____

History of learning, emotional, or behavioral problems:
Yes _____ No _____
(If yes, please explain)
_____

History of your alcohol/drug/substance abuse:
Yes _____ No _____
(If yes, please explain)
_____

History of family violence:
Yes _____ No _____
(If yes, please explain)
_____

History of criminal activity in the family:
Yes _____ No _____
(If yes, please explain)
_____

Have you been abused (check all that apply):
Physically____ Emotionally____ Sexually____
Has your child been neglected (check all that apply):
Physically____ Emotionally____ Sexually____

School problems (check all that apply):
Academic problems____ Discipline problems____ Social problems____ Other____

Early language/Speech problems (explain):
_____
History of health/physical problems includes (check all that apply):

Asthma____ Bedwetting____ Bone/joint/muscle____ Chest pain____
Chronic illness____ Developmental delay(s)____ Chronic Diarrhea____
Disability____ Dizziness____ Severe headaches____ Heart Palpitations____
Hospitalization____ Major accident____ Major illness____Nervous Stomach____
Neurological problems/exam____Severe PMS____Serious overeating/undereating____
Shortness of breath without exercise____ Sleep problems____ Surgeries____ Other___

Angela D. Conway, MA, LPC
Wise County Christian Counseling
2200 S. FM 51 Ste. 500
Decatur, Texas 76234
940-627-1618

Consent to Counseling

Welcome to Wise County Christian Counseling! Thank you for choosing me for your counseling needs. This document is designed to inform you about my background and to ensure that you understand agency policies, procedures, and services.
I am a Texas State Licensed Professional Counselor specializing adolescents and adults. I hold a Bachelor of Science degree in Human Development and Family Studies from Abilene Christian University and a Master of Arts degree in Counseling from Amberton University.

All of our communication becomes part of the clinical record. Adult records are disposed of six years after the file is closed. Minor client records are disposed of six years after the client's 18th birthday. In the case of my incapacitation or death, you will be contacted by one of my colleagues who will handle your records and care as needed.
I will keep confidential anything you say to me with the following exceptions: (a) you direct me to tell someone else; (b) I have reason to believe you are a danger to yourself or others; (c) I have reason to believe you intend to physically harm someone else; (d) you are abusing or have abused a child or an elderly person; or (e) I am ordered by a court to disclose information (f) If you disclose sexual contact with another health professional.

Supervision is a process within the counseling profession whereby cases are reviewed with objective, professional colleagues to ensure quality counseling. It is understood that this process may be utilized to provide the highest quality services.

I assure you that my services will be rendered in a professional manner consistent with accepted ethical standards. Please note that it is impossible to guarantee any specific results regarding your counseling goals. Together we will work to achieve the best possible results for you. If you have any complaints, please discuss them with me. If you are not satisfied with the resolution of the problem, you have the right to call the Consumer Complaint Hotline at 1-800-942-5540.

We may utilize email or text as a means of communication, but it is important to understand the parameters of this medium. I will not engage in therapy over the Internet or through text. There may also be times where I receive, but do not respond to your email or text. I will respond if I believe it is appropriate/or necessary. My lack of response does not indicate a lack of interest.

Any type of audio/visual recording is prohibited in counseling sessions.

I am dedicated to providing counseling services to my clients knowing certain financial limitations exist. Being a non-profit organization, I can set my fees at a lower rate. No family will be turned away because of lack of funds. This agency asks our clients to determine their fees by using a sliding scale. For every $10,000 your household brings home per year, please consider paying $10 per session, up to $120. (Example: if your family brings home $50,000 per year, please pay $50 per session.) Checks or cash will be accepted. Checks will be made payable to Wise County Christian Counseling.

Due to our high demand of calls, there is a $50 charge for all no shows and cancellations made within the same day. A 24 hour notice of all cancellations is requested.

Mrs. Conway charges $125/hour for court appearances, depositions, and arbitrations, including related travel and preparation. If I am subpoenaed to court because of your case, then I will block out a 4 hour portion (unless I am notified that I will be required to stay longer) of my work day. If your hearing is rescheduled, it is your responsibility to notify me at least 48 business hours in advance, so that I may rebook those appointments. If you fail to notify me within the appropriate time frame, you will be billed for that block of time and your minimum court fee will not be refunded. I require the minimum court fee ($500) 48 business hours in advance of the hearing, and any additional fees will be billed, and are expected to be paid, within 48 hours of the court appearance. You are responsible for any legal fees I incur as related to your case (litigation issues, lack of payment, etc).

Your signature below indicates your understanding of and agreement to the terms and conditions stated on this form. If you have any questions, please feel free to ask for an explanation.

Please provide an emergency contact with whom you give permission for me to contact in case of intended harm or threat to self or others:

Name_____ Phone Number _____
Relationship_____

By signing this consent form, we give our permission for any or all of our family members including minors to enter into a counseling relationship with Angela Conway at Wise County Christian Counseling. We do this of our own free will. We recognize there is no guarantee expressed or implied that our problems will be alleviated in coming to counseling, and that in some cases our situation/problems may initially worsen before they improve. We recognize that we can terminate counseling at any time that we choose.

Signature of parent(s)/couple/individual:
Client: _____Date: _____
Counselor: _____ Date: _____

Wise County Christian Counseling
Patient Consent for Use and/or Disclosure of HIPAA Defined Protected Health Information to Carry Out Treatment, Payment, and Healthcare Operations

I, _____, hereby state that by signing this consent, I acknowledge and agree as follows:

The Provider's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Provider to provide treatment to me, and also necessary for the Provider to obtain payment for that treatment and to carry out its health care operations. The Provider explained to me that the Privacy Notice will be available to me in the future at my request. The Provider has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

The Provider reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

I understand that, and consent to, the following appointment reminders that may be used by the Provider: ____Yes ____No – A postcard mailed to me at the address provided by me.
____Yes ____No – Telephoning my home and leaving a message on my answering machine or with the individual answering the phone.
____Yes ____No – Telephoning my office and leaving a message on my phone mail or with the individual answering the phone.

The Provider may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Provider to treat me and obtain payment for the treatment, and as necessary for the Provider to conduct its specific health care operations.

I understand that I have a right to request that the Provider restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Provider is not required to agree to any restrictions that I have requested. If the Provider agrees to a requested restriction, then the restriction is binding on the Provider.

I understand that this Consent is valid for seven years and that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Provider has already taken action in reliance on this consent.

I understand that if I revoke this consent at any time, the Provider has the right to refuse to treat me.

I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Provider will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Name of Individual (Printed): _____

Signature of Legal Representative
(e.g., Attorney-In-Fact, Guardian, Parent if a minor)

_____

Signature of Individual _____

Relationship to Client _____

Date signed _____ Witness: _____

Wise County

CHRISTIAN COUNSELING

Due to the length of our waiting list and our deep desire to help people, beginning January 1, 2017, there will be a $50 charge for all appointments not kept or broken without 24 hour notice.

Signature(s) of couple/individual

X_____ _____
Client signature Date

X_____ _____
Client signature Date

X_____ _____
Counselor signature Date