Wise County
CHRISTIAN COUNSELING

1650 S. FM 51, Ste 400
Decatur, TX 76234

Phone: 940-627-1618

Client Information Questionnaire

Each client must complete their own intake paperwork and sign all release forms before meeting with their therapist. 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.

Full name _____ Date_____

Spouse Full Name: _____

Address: _____

Phone numbers (List all that apply): _____

Please indicate if a message can be left at any of these numbers: _____

Age: _____ Sex: _____ Race / ethnicity: _____ Relationship status: _____

Occupation: _____ Employer: _____

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

_____

Religious preference: _____ Where do you attend? _____

Have you or a family member served in the military? _____

_____

_____

Please described any previous or ongoing medical issues that may impact your mental health (ex. chronic pain, cancer, hypothyroidism, etc.) _____

_____

_____

Please list all medications that you are taking at present: _____

_____

If applicable, briefly describe your marital history (divorce, # of marriages, etc): _____

_____

_____

Check all of the following which reflect the parent figures currently in your home:

_____Both birth parents _____Single parent _____Birth parent & Step-parent

_____Foster parents _____Adoptive parents _____Grandparents

_____ Other relatives Other (Please explain): _____

List the members of your family and all others that are currently living in your home.

Name(s) Age/Grade Relationship Occupation

_____

_____

_____

_____

_____

_____

_____

_____

Who has custody of minor children living in your home? _____

_____

_____

Has your current relationship ever included any type of abuse? _____

_____

_____

Briefly describe your reason(s) for seeking help: _____

_____

_____

_____

What do you hope to accomplish through counseling? _____

_____

_____

_____

How did you find out about us? _____

_____

Mental Health History

Have you ever consulted a professional counselor? _____YES _____NO

If yes, name of agency: _____

_____

How was counseling helpful then? _____

_____

Please list any psychiatric medications, including antidepressants or antianxiety medications, that you have been prescribed along with the date prescribed and place a star by any you are currently taking. _____

_____

_____

_____

Please list any mental health diagnosis you have received along with the date diagnosed and the person who diagnosed you. _____

_____

_____

_____

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

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

Have you ever struggled an addiction of any type? If so, please describe: _____

_____

_____

Have you ever received inpatient psychiatric treatment? If yes, please describe when and where. _____

_____

_____

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

_____

_____

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

_____

_____

What symptoms are you hoping to improve with therapy? _____

_____

_____

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

Abuse	Depression	Insomnia	Religion	Alcohol use
Divorce	Legal Matters	Sadness	Allergies	Drug use
Loneliness	Self-Concept	Anxiety	Education	Marriage
Self-control	Appetite	Energy	Memory	Separation
Assertiveness	Fears	Mood swings	Sexual problems	Asthma
Finances	Motivation	Shyness	Bed-wetting	Food
My past	Sleep	Bowels	Friends	My thoughts
Stress	Career	Choices	Guilt	Nervousness
Temper	Suicidal thoughts	Children	Headaches	Nightmares
Parenting	Health problems	Concentration	Tiredness	Confusion
Inferiority	Parents	Ulcers	Dating	Infidelity
Premarital	Unhappiness	Decision-making	In-laws	Relaxation
Work	Other: _____			

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

_____

_____

_____

_____

Please describe any concerns you have about your partner's mental health: _____

_____

_____

_____

_____

Informed Consent to Counseling

Welcome to Wise County Christian Counseling. Thank you for choosing me for your counseling needs. Starting counseling is a major decision and you may have many questions. This document is designed to inform you about agency policies and procedures as well as your rights, so that you can consent to treatment. If you have other questions or concerns, do not hesitate to ask me about them.

My name is Jana Bearden and I am a Texas State Licensed Professional Counselor Intern, under the supervision of Beverly Ross LPC-S. I hold a Bachelor of Science degree in marketing and merchandising from Baylor University and a Master of Science degree in Professional Counseling from Grand Canyon University.

Sessions will last approximately 45-50 minutes. Although sessions may be very personal, the relationship between you and I, and your child, is a professional one, rather than a social one. If I see you in public, I will protect your confidentiality by acknowledging you only if you approach me first.

Services are by appointment only and you are responsible for keeping your appointments and arriving on time. In the event that you cannot keep an appointment, it is your responsibility to call the office at least 24 hours in advance to cancel or reschedule. Cancellations made within the 24 hours prior to the session or no- showed, will be billed $50.

You have the responsibility to notify me of any other ongoing mental health relationship. If you are seeing another mental health professional, then permission must first be granted by the first therapist to proceed with a secondary counseling relationship. During the course of this relationship, if you choose to seek counseling elsewhere, you have the responsibility to terminate this counseling relationship before being seen by another mental health professional.

Other options for counseling include talking with other professionals, your clergy person, or choosing to let the situation remain the same. 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 Hot Line 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 and/or necessary. My lack of response does not indicate a lack of interest.

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

Referrals: Should you or I believe that a referral is needed, I will provide some alternatives including programs and/or people who may be available to assist you. A verbal exploration of alternatives to counseling will also be made available upon request. You will be responsible for contacting and evaluating those referrals. In the event that you have a mental health emergency, you may wish to call 911.
Records and Confidentiality: 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 would be contacted by one of my colleagues at Wise CCC, who would handle your records and care, as needed.

I will keep confidential anything you say to me with the following exceptions:

(a) If you direct me to release your records
(b) I have reason to believe you are a danger to yourself or others
(c) In the case of billing or collection of fees
(d) In the cases of abuse, neglect, or exploitation of a child or elderly adult
(e) I am ordered/subpoenaed by a court to disclose information
(f) I am otherwise required by law to disclose information
(g) If you disclose sexual contact with another health professional

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

Fees: I am dedicated to providing counseling services to my clients knowing certain financial limitations exist. Because Wise CCC is 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, credit cards or cash will be accepted. Checks will be made payable to Wise County Christian Counseling.

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

Name: _____ Phone: _____ Relationship_____

Name: _____ Phone: _____ 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 Jana Bearden 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(s) of parents(s)/ couple/individual:

Client: _____ Date: _____

Counselor: _____ Date: _____

Notice of Privacy Practices
This notices describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and this is related to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your therapist and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the therapist’s practice as necessary, and any other use required by law.
Treatment: We will use and disclose your protected health information as necessary to provide, coordinate, or manage your health care and any related services. This includes the coordination of management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you; or your protected health information may be provided to a physician to whom you have referred to insure that the physician has the necessary information to diagnose or treat you.
Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay or a higher level of treatment may require that your relevant protected health information be disclosed to the health plan to obtain approval for admission.
Healthcare Operations: We may use or disclose, as needed, your protected health information to support the business activities of your therapist’s practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of therapists associated with this practice, licensing, marketing and fund raising activities, and conducting or arranging for other business activities. For example, we may call you by name in the waiting room when the therapist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization: communicable diseases, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, and if you present a threat to yourself and others.

I understand that, and consent to, the following appointment reminders that may be used by the Provider:
____Yes ____No – A text message sent to the cell phone number provided.
____Yes ____No – Telephoning my home or cell and leaving a message on my answering machine or with the individual answering the phone.
____Yes ____No – An email sent to the email address provided.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization and opportunity to object unless required by law. You may revoke this authorization at any time, in writing, except to the extent that your therapist or therapist’s

practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

I acknowledge that I have received and understand the HIPAA Notice of Privacy Practices for this office:

_____ _____

Client Signature (parent or guardian if minor client) Date

You have the right to request restrictions of uses and disclosures of your health information; however, this office is not required to agree to a requested restriction. You have the right to revoke this consent in writing, except to the extent that this office has previously taken action in reliance to this consent. Your treatment by this office is conditional on your signing this consent.

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