

### Client Information Questionnaire

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 \_\_\_\_\_

Address \_\_\_\_\_

Phone numbers (List all that apply.): \_\_\_\_\_

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

Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Male \_\_\_\_\_ Female Marital status: \_\_\_\_\_

Occupation(s): \_\_\_\_\_

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

Religious preference: \_\_\_\_\_ Where do you attend? \_\_\_\_\_

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

\_\_\_\_\_ Single parent \_\_\_\_\_ Both birth parents \_\_\_\_\_ Birth parent & Step-parent \_\_\_\_\_ Adoptive parents

\_\_\_\_\_ Foster parents \_\_\_\_\_ Grandparents \_\_\_\_\_ Other relatives

Other (Please explain): \_\_\_\_\_

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?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

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Please list any medications that you are taking at present:

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Have you ever considered suicide? \_\_\_\_\_YES \_\_\_\_\_NO If so, when? \_\_\_\_\_

Have you ever attempted suicide? \_\_\_\_\_YES \_\_\_\_\_NO If so, when? \_\_\_\_\_

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Have you ever had struggles with an addiction of any type? If so, please describe:

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

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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   | Suicidal thoughts |
| Children        | Headaches       | Nightmares    | Temper            |
| Concentration   | Health problems | Parenting     | Tiredness         |
| Confusion       | Inferiority     | Parents       | Ulcers            |
| Dating          | Infidelity      | Premarital    | Unhappiness       |
| Decision-making | In-laws         | Relaxation    | Work              |

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

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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? \_\_\_\_\_

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

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## **Informed Consent**

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 Kristen Warren. I am a graduate student counselor at Tarleton State University practicing under the supervision of Beverly Ross, MA, LPC-S. I am a member of the Texas Counseling Association and I hold a Bachelor of Business Administration degree from Abilene Christian University.

All information pertaining to your counseling experience, including the knowledge that you are being seen for counseling is strictly confidential. By law, information cannot be released without your consent, with the following exceptions:

- I have reason to believe that you are a danger to yourself or others
- I have reason to believe you intend to physically harm someone else
- I have reason to believe you are abusing or have abused a child or elderly person
- I am ordered by a court to disclose information

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. 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 Hotline at 1-800-942-5540.

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 a year, please consider paying \$10 a session, up to \$120. (Example: if your family brings home \$50,000 a year, please pay \$50 a session.) Checks or cash will be accepted. Checks will be made payable to Wise County Christian Counseling. Because there is a waiting list for our services, we ask that you notify us at least 24 hours in advance if you are unable to come at your scheduled time. **If you do not notify us before the appropriate time, you will be charged your full session fee for the missed appointment.**

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.

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 Kristen Warren 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:** \_\_\_\_\_

**Client:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Counselor:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**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 that 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 Individual

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

\_\_\_\_\_  
Relationship to Patient

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