



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: _____

Email: _____

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):

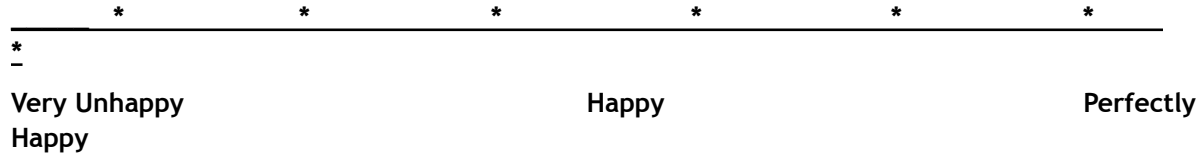
- | | | | | |
|---------------|-------------------|-----------------|-----------------|-------------|
| Abuse | Depression | Insomnia | Religion | Alcohol use |
| Divorce | Legal Matters | Sadness | Allergies | Drug use |
| Loneliness | Self-Concept | Anxiety | Education | Marriage |
| Self-control | 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: _____

Print Name _____ Date _____

Circle the dot on the scale line which best describes the degree of happiness, everything considered, of your present relationship. The middle point "happy" represents the degree of happiness which most people get from marriage, and the scale gradually ranges on one side to those few who are very unhappy in relationship, and on the other, to those few who experience extreme joy or felicity in relationship.



State the approximate extent of agreement or disagreement between you and your mate on the following items. Please check each column.

	Always Agree	Almost Always Agree	Occasionally Disagree	Frequently Disagree	Almost Always Disagree	Always Disagree
Handling Family Finances						
Matters of Recreation						
Demonstrations of Affection						
Friends						
Sex relations						
Conventionality (right, good, or proper conduct)						
Philosophy of Life						
Ways of dealing with in-laws						

Circle one letter in each statement:

When disagreements arise, they usually result in: (a) me giving in, (b) my partner giving in, (c) agreement by mutual give and take.

Do you and your mate engage in outside interests together? (a) All of them, (b) some of them, (c) very few of them, (d) none of them.

In leisure time do you generally prefer: (a) to be "on the go", (b) to stay at home?

Does your mate generally prefer: (a) to be "on the go", (b) to stay at home?

Do you ever wish you had not married? (a) Frequently, (b) occasionally, (c) rarely, (d) never

If you had your life to live over again, do you think you would: (a) commit to the same person, (b) commit to a different person, (c) not commit at all?

Do you ever confide in your mate: (a) almost never, (b) rarely, (c) in most things, (d) in everything?

Name: _____

Date: _____

Weiss-Cerreto Relationship Status Inventory

We would like to get an idea of how your marriage stands right now. Please answer all the questions below by circling TRUE or FALSE for each item with regard to how things stand right now. For items that are true, please indicate what year the item began to be true.

1. I have made specific plans to discuss separation or divorce with my spouse. I have considered what I would say, etc.	False	True	Year _____
2. I have set up an independent bank account in my name in order to protect my own interests.	False	True	Year _____
3. Thoughts of divorce occur to me very frequently, as often as once a week or more.	False	True	Year _____
4. I have suggested to my spouse that I wished to be separated, divorced, or rid of him/her.	False	True	Year _____
5. I have thought specifically about divorce or separation. I have thought about who would get the kids, how things would be divided, pros and cons, etc.	False	True	Year _____
6. My spouse and I have separated. This is a (check one) _____ trial separation or _____ legal separation.	False	True	Year _____
7. I have discussed the question of my divorce or separation with someone other than my spouse (trusted friend, psychologist, minister, etc.).	False	True	Year _____
8. I have occasionally thought of divorce or wished that we were separated, usually after an argument or other incident.	False	True	Year _____
9. I have discussed the issue of divorce seriously or at length with my spouse.	False	True	Year _____
10. I have filed for divorce, or we are divorced.	False	True	Year _____
11. I have made inquiries of nonprofessionals as to how long it takes to get a divorce, grounds for divorce, costs involved, etc.	False	True	Year _____

12. I have contacted a lawyer to make preliminary plans for a divorce.	False	True	Year ____
13. I have consulted with a lawyer or other legal aid about the matter.	False	True	Year ____
14. I have considered divorce or separation a few times, other than during or after an argument, although only in vague terms.	False	True	Year ____

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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. I hold a Bachelor degree 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 or University Behavioral Health at (940) 320-8100.

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

Staffing 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.

Mrs. Bearden charges \$125 per 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 re-book 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 (\$500.00) 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.).

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: _____

HIPAA 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

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



Phone: 940-627-1618

www.wiseccc.org

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