Wise County Christian Counseling
1650 S FM 51, Ste 400
Decatur, Texas 76234
(940) 627-1618

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.):

_____

_____

_____

Please list any medications that 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 ever had struggles with an addiction of any type? If so, please describe:

_____

_____

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

_____

_____

_____

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.

_____
_____
_____

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.)

_____
_____
_____
_____

Jody Adams
Wise County Christian Counseling

Informed Consent to Counseling

Welcome to Wise County Christian Counseling. Thank you for choosing us 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.

Qualifications: I am a Practicum Student working towards a Master's Degree in Professional Counseling from Amberton University in Frisco, Texas. I am under the supervision of Beverly Ross, LPC-S. I also hold a Bachelor of Business Administration degree in Real Estate from The University of North Texas.

Counseling Relationship: During our counseling relationship, we will direct our mutual efforts toward agreed upon goals determined on an individual basis. Sessions will usually last approximately 45-50 minutes, unless otherwise scheduled. Although sessions may be very personal, the relationship between you and I 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 the full fee.

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 prior to 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.

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 able 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.

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) If 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 the 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. 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.

Your signature below indicated your understanding of and agreement to the terms and conditions stated on this form.

Please provide and 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 Jody Adams at Wise County Christian Counseling. We do this of our own free will. We recognize that 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: _____

Client: _____ Date: _____

Counselor: _____Date: _____

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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 phone and leaving a message on my answering machine, voicemail, 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.
___Yes ____No —-Texting or telephoning my cell phone number with a message.

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 Relationship to Patient
(e.g., Attorney-In-Fact, Guardian, Parent if a minor)
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