Millcreek Counseling Associates Individual Client Information Questionnaire

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

Full Name: _____ Date:_____
Address: _____
_____
Telephone: _____
_____ (Home) (Work)
Email: Client Birth Date: _____ Marital Status: _____
Social Security Number: _____
Occupation: _____
Employer: _____
Education:
_____
Who suggested you contact us?
_____
Please briefly describe your reason for seeking Counseling/Therapy:
_____

Insurance Information: Primary Insurance:

Insurance Company
Name:_____
ID Number:_____
Group Number:_____
Policy Holder Information (if different from the patient):
Policy Holder
Name:_____
DOB:_____SSN:_____
Relationship to patient:_____
CurrentAddress:_____
City:_____State:_____
Zip Code:_____
Secondary Insurance: Insurance Company
Name:_____
ID Number:_____
Group Number:_____
Policy Holder
Name:_____
DOB:_____SSN:_____
Relationship to patient:_____
Current
Address:_____
City:_____
State:_____
Zip Code:_____

Emotional Status

Are you currently experiencing strong emotions? If yes, describe
Do you make decisions based on your emotions?
How well does that work for you?
Did you have what you would consider to be childhood or other traumas?
If yes, describe
Have you been treated for emotional disturbances? If yes, when?
Have you had any thoughts of suicide? If so, when?
Do you have any thoughts now?

Present Situation

Please state why you decided to come for counseling/therapy:_____
_____
What is the nature of your situation?
_____
_____
_____
What would you like to experience that is different from what you are experiencing now?
_____
_____

How long has this been a problem for you?_____

Please state what you would like to work on in therapy:_____
_____
_____

Please circle any of the following problems which pertain to you:

Nervousness Depression Fears Shyness Sexual Problems Suicidal thoughts Separation Divorce Finances Drug use Alcohol use Friends Anger Self-control Unhappiness Sleep Stress Work Relaxation Headaches Tiredness Legal matters Memory Ambition Inferiority feelings Concentration Education Career choices Health problems Temper Nightmares Marriage Being a parent My thoughts Physical problems Losses

Spiritual History/Religious Affiliations

Present Affiliations _____

Is this an important part of your life? _____

Why/why not? _____
_____

Work History Occupation:

How long have you been in your current position? If presently unemployed, describe the situation:
_____
_____

Hobbies/
Avocations:_____
_____

Family Information:

Please list the members of your family and all others in your
home:_____
_____
_____
_____

Name(s) Age/ Birth Date Relationship Occupation
_____
_____
_____

Family Systems Information

Where born? _____
How long there?_____
Ethnic ID _____
Parents: Father alive? _____
Where residing? _____Relationship _____

Mother alive? _____Where residing? _____ Relationship
_____

Parents divorced? _____
If yes, what year? _____ Your age at time _____

If deceased, what year? _____

Your age at the time _____

Cause of death _____

Any step parents? _____

If yes, describe when and your relationship with them
_____
_____

If reared by someone other than your birth parents, describe the situation in some detail
_____
_____
_____

Marital Status _____ # of marriages _____

Spouse's name _____

Living with partner? _____

How long? _____

Partner's name _____

Children:

1. Age _____ M or F 2. Age _____ M or F 3. Age _____ M or F 4. Age _____ M or F 5. Age _____ M or F 6. Age _____ M or F Siblings: Circle your place in the family. If a sibling is deceased, put an X through the placement number. 1. Age _____ M or F 2. Age _____ M or F 3. Age _____ M or F 4. Age _____ M or F 5. Age _____ M or F 6. Age _____ M or F

Family Alcoholism or Domestic Violence? _____

Sexual Addictions or Abuse? _____

Please add any further information that you feel would be helpful:_____
_____
_____
_____
_____
_____
_____

Medical Information Form

In the event you would need medical attention during your counseling session the following information is necessary to best care for you. General Health: Are you now under a doctor's care? Reason for doctor's care:

Physician's Name:
_____
Address:
_____
Phone:
_____

Are you taking any medication? _____

If yes, what kind? _____

Reason for medication: _____

Last medical examination: _____

Have you ever been hospitalized for a physical illness? If yes, please describe:_____
_____

Have you been hospitalized for a mental illness? _____

Describe: Any recent major illnesses or surgeries? _____

Any recurrent or chronic conditions?_____

Do you smoke: Do you take drugs? If yes, what kind?
_____
_____

Do you drink? _____

How much? _____

Any previous Therapy/Counseling? If yes, describe, when, where, how long, and what for:

CLIENT'S PERSONAL HEALTH HISTORY (please check) _____ Alcoholism _____ Head Injuries _____ Birth Defects _____ Heart Problems _____ Blood Pressure Problems _____ Menstrual Irregularities _____ Cancers or Malignancies _____ Mental Retardation _____ Convulsions _____ Psychiatric Condition _____ Diabetes _____ Smoking _____ Epilepsy _____ Environmental Allergies _____ Medial Allergies

IN THE EVENT OF AN EMERGENCY, PLEASE NOTIFY:

Name:
_____

Address:_____
_____

Phone: _____

Relationship to Client: _____

Millcreek Counseling Associates Financial Agreement

Meetings I normally conduct an assessment that will last from 2 to 4 sessions. Typically, I will schedule one 45-50 minute session (one appointment hour of 45-50 minutes duration) per week at a time we agree on, although some sessions may be longer or more frequent. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 48 hours advance notice of cancellation (unless we both agree that you were unable to attend due to circumstances beyond your control). It is important to note that insurance companies do not provide reimbursement for cancelled sessions. A missed appointment charge will cost $100. If it is possible, I will try to find another time to reschedule your appointment. Insurance Reimbursement If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out the forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers. Billing and Payments You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. The Co-Pay is due at the session by cash or personal check. The Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment plan. The following credit card will be charged $100 for missed appointment:

Name on Credit Card_____

Street Address Associated with Credit Card:
_____
City:_____
State:_____
Zip Code:_____

Credit Card Number: _____

Security Code:_____
Expiration Month: _____
Expiration Year: _____

Signature: _____Date: _____

Consent for Treatment
and Limits of Liability

Limits of Services and Assumption of Risks:

Therapy sessions carry both benefits and risks. Therapy sessions can significantly reduce the amount of distress someone is feeling, improve relationships, and/or resolve other specific issues. However, those improvements and any "cures" cannot be guaranteed for any conditions due to the many variables that affect these therapy sessions. Experiencing uncomfortable feelings, discussing unpleasant situations and/or aspects of your life are considered risk of therapy sessions.

Limits of Confidentiality:

What you are discussing during your session is kept confidential. No contents of the therapy sessions, whether verbal or written may be shared with another party without your written consent or the written consent of your legal guardian. The following is a list of exceptions:

Duty to Warn and Protect
If you disclose a plan or threat to harm yourself, the therapist must attempt to notify your family and notify legal authorities. In addition, if you disclose a plan to threaten or harm another person, the therapist is required to warn the possible victim and notify legal authorities.

Abuse of Children and Vulnerable Adults
If you disclose, or it is suspected, that there is abuse or harmful neglect of children or vulnerable adults (i.e. the elderly, disabled/incompetent), the therapist must report this information to the appropriate state agency and/or legal authorities.

Prenatal Exposure to Controlled Substances
Therapists must report any admitted prenatal exposure to controlled substances that could be harmful to the mother or child.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access client's records.

Insurance Providers
Insurance companies and other third-party payers are given information that they request regarding services to clients.

The type of information that may be requested includes: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, summaries, etc.

By signing below, I agree to the above assumptions of risk and limits of confidentiality and understand their meanings and ramifications.

_____ _____

Client signature/Client's Parent/Guardian if under 18 Date