TREASURE WELLNESS COUNSELING AND TRAINING CENTER
ADMINISTRATIVE OFFICE
3006 E. GOLDSTONE DR., MERIDIAN, ID 83642
208-515-7661
WWW.TREASUREWELLNESS.COM

CLIENT INFORMATION

Please answer all information as completely as possible. Information will be managed as protected health information. If you need assistance, please ask. Your Counselor will review this information with you.

Client: _____ Date: _____
Last First

Address: _____
Street City State Zip

Home Phone:_____ Cell Phone:_____ Work Phone: _____

May we leave message: YES ☐ NO ☐ **May we leave message: YES ☐ NO ☐** **May we leave message: YES ☐ NO ☐**

Appointment Reminders: YES ☐ NO ☐ **Appointment Reminders: YES ☐ NO ☐** **Appointment Reminders: YES ☐ NO ☐**

Best Phone to Contact you at ☐ Home ☐ Cell ☐ Work Best Time: _____

Email Contact:_____May we contact you by email: ☐YES ☐NO

Gender: _____ DOB: _____ Age: _____ Race/Culture: _____ Occupation: _____

EMERGENCY CONTACT: _____
Name Relationship Phone

MARITAL INFORMATION

☐Single ☐Living with Partner ☐Married ☐Separated ☐Divorced ☐Widowed Length of Time: _____

PRESENT FAMILY

Please identify the family you currently live with and nature of your relationship with each member.
Including yourself, list the members of your current family from oldest to youngest. Use back if needed.

Name	Relationship	Age	Currently this relationship is ... *i.e. good, neutral, conflictual etc.*

How did you find me? ☐ Referral If so, Who? _____

☐ **Web Search** ☐ **Psychology Today** ☐ **Website** ☐ **Other:** _____

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HEALTH INFORMATION

Primary Care Physician: ☐ Y ☐ N Name: _____ Phone: _____

Date of Last Visit: _____

Primary Care Psychiatrist: ☐ Y ☐ N Name:_____ Phone: _____

Date of Last Visit: _____

Are you currently taking any medication or homeopathic? Y ☐ N ☐

Name of Current Medication	Dosage	Frequency	Purpose	Prescribing Doctor

HEALTH HISTORY

Please list past and current medical conditions (major illness/injuries/surgeries/etc.)

What	When	Treatment

Are you in physical pain? Y ☐ N ☐ If yes, where? _____

What type of Pain do you experience? Dull ☐ Sharp ☐ Nagging ☐ Burning ☐ Other: _____

How long have you experienced this type of Pain? _____

Please rate your Pain today: 1 2 3 4 5 6 7 8 9 10 On a good day:_____ On a bad day: _____

SEXUALITY

What sexual issues would you like to discuss during treatment?_____

_____

Have you ever been sexually and or physically abused? YES ☐ NO ☐

Have you witnessed or experienced any other trauma? YES ☐ NO ☐

If yes, please explain briefly: _____

_____

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ALCOHOL / SUBSTANCE USAGE

Preferred Substance: ☐Alcohol ☐Tobacco ☐Narcotics ☐Prescription ☐Other: _____

Date of last use: _____

Type and amount of usage: _____

Age usage began? _____ How often do you use/consume? _____

Have you ever had any legal problems related to your use/consumption? ☐Yes ☐No

Have you ever had any relationship problems related to your use/consumption? ☐Yes ☐No

Has your use/consumption ever become a problem? ☐Yes ☐No

INTERESTS/HOBBIES

Do you participate in any cultural activities related to your social or ethnical background? ☐Yes ☐No

Please list your hobbies or interests: _____

_____

SPIRITUALITY

Do you practice a faith or religion? ☐Yes ☐No If so, please identify: _____

Would you like faith to be a part of treatment? ☐Yes ☐No

If Yes, please describe what this might look like? _____

_____

TREAMENT EXPERIENCES

	YES	NO	INPATIENT/ OUTPATIENT	WHEN	WAS IT HELPFUL?		
Individual Counseling					YES	SOME	NO
Couples Counseling					YES	SOME	NO
Developmental Therapy/PSR					YES	SOME	NO
Psychiatric Services					YES	SOME	NO
Drug/Alcohol/Sexual Addiction Treatment					YES	SOME	NO
Self-Help Group					YES	SOME	NO
Hospitalization					YES	SOME	NO

Have you or are you currently contemplating harming yourself? ☐ YES ☐ NO ☐ Past ☐ Present

Have you or are you currently contemplating ending your life? ☐ YES ☐ NO ☐ Past ☐ Present

Has anyone in your immediate family attempted or completed suicide? ☐ YES ☐ NO ☐ Past ☐ Present

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CURRENT CONCERNS

A. What brought you into treatment: _____

_____

B. What are your expectations for treatment: _____

_____

C. What is the one thing that you want me to know about you today: _____

_____

PRESENTING PROBLEMS/FEELINGS/EXPERIENCES (Check all that apply)

- ☐ Aggressive Behavior
- ☐ Alcohol Abuse/Dependency
- ☐ Anger
- ☐ Anxiety
- ☐ Change in Appetite
- ☐ Compulsions
- ☐ Cutting/Injuring
- ☐ Delusions/Hallucinations
- ☐ Depression
- ☐ Easily Annoyed
- ☐ Easily Distracted
- ☐ Eating Disorder
- ☐ Emotional Abuse
- ☐ Excessive Worry
- ☐ Family Issues
- ☐ Fatigue
- ☐ Fearful
- ☐ Financial
- ☐ Friendship
- ☐ Grief/Loss
- ☐ Guilt/Worthlessness
- ☐ Headaches
- ☐ Hearing Things
- ☐ Hopeless
- ☐ Impulsivity
- ☐ Insomnia
- ☐ Intimacy
- ☐ Irritable
- ☐ Life Decision
- ☐ Loss of Pleasure
- ☐ Mania
- ☐ Medical/Organic Condition
- ☐ Mood Instability
- ☐ Muscle Tension
- ☐ Pain
- ☐ Panic
- ☐ Paranoia
- ☐ Parenting
- ☐ Physical Abuse
- ☐ Poor Concentration
- ☐ Racing Thoughts
- ☐ Relationships
- ☐ Restless
- ☐ Sadness
- ☐ School
- ☐ Seeing Things
- ☐ Self-Destructive Behavior
- ☐ Sex Compulsion/Dependency
- ☐ Sexual Abuse
- ☐ Sexuality
- ☐ Sleeping Too Little
- ☐ Sleeping too much
- ☐ Spirituality
- ☐ Stomachaches
- ☐ Stress
- ☐ Substance Abuse/Dependency
- ☐ Suicidal Ideation
- ☐ Tearful
- ☐ Trauma
- ☐ Uncertain
- ☐ Work
- ☐ Other: _____

Please identify and rate the six feelings or experiences that are most troubling for you currently from most severe to least severe:

#1: _____ #2: _____ #3: _____

#4: _____ #5: _____ #6: _____

Approximately how long have these been bothering you? _____

Approximately how much distress do you believe these problems are causing in your life?

Mild (less than once a week) Moderate (1-2 times per week) Severe (4-5 times per week) Impairing (Daily)

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AGREEMENT TO PAY FOR PROFESSIONAL SERVICES

I request that _____ provide professional service to,
(Counselor Name)

☐ myself _____ ☐ and/or _____,

who is my _____.

- I agree to pay the counselors stated fees as listed in Informed Consent document and posted in the Treasure Wellness Counseling and Training Center Lobby.
- I agree that this financial relationship with this counselor will continue as long as the counselor provides services or until I inform him/her, in person or by certified mail that I wish to end this professional relationship.
- I agree to meet with my counselor at least once before stopping therapy.
- I agree to pay for service provided to me or stated client up until the time that I have fulfilled my financial responsibility.
- I agree that I am responsible for the charges of service provided by this counselor, although other persons or insurance companies may make payment on my or clients behalf.

Client/Guardian Signature	Relationship	Date
Client/Guardian Signature	Relationship	Date

I, the counselor, have discussed the issues above with the client and/or the person representing the client. My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Counselor	Counselor Signature	Date

PAYMENT INFORMATION

Acceptable forms of payment: Cash, Check, Credit, and Debit
Please make checks payable to: Above listed counselor or as directed

For ongoing credit and debit payments:

Name as it appears on Card:_____ Amount of Payment: _____

Billing Zip Code: _____ Frequency of Payment: _____

Card#:_____ Expiration Date:_____ Security Code: _____

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INSURANCE RESPONSIBILITY and ASSIGNMENT OF BENEFITS

FINANCIAL RESPONSIBILITY

I understand that insurance billing is a service provided as a courtesy and that I am financially responsible to my providing counselor for any charges not covered by my health care benefits. It is my responsibility to notify my counselor of any change in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives a claim. I understand that I am responsible for the entire balance of the bill.

INSURANCE INFORMATION (Client responsible for all charges not covered by insurance)

Client Name:_____ Date of Birth: _____

Primary Insurance: ☐ Y ☐ N CoPay: _____ Out of Pocket Payment: ☐ Y ☐ N

Primary Insurance Co: _____ Policy #:_____ Group #: _____

Primary Insurance Co. Phone #:_____

Policy Holder's Name:_____ Relationship to Client: _____

Policy Holder's Date of Birth:_____ Policy Holder's Phone#: _____

Policy Holder's Address: _____

Secondary Insurance: ☐ Y ☐ N CoPay: _____

Secondary Insurance Co:_____ Policy #:_____ Group #: _____

Secondary Insurance Co. Phone #:_____

Policy Holder's Name:_____ Relationship to Client: _____

Policy Holder's Date of Birth:_____ Policy Holder's Phone#: _____

Policy Holder's Address: _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) if choosing to use my insurance benefits, assign directly to my providing counselor listed below all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I also understand it is my responsibility to pay any deductible amount, co-insurance, or any other balances not paid by my insurance company or pay the full client fee if I have no insurance coverage. I authorize the release of necessary information to file said claim with my insurance or third party payer.

Client	Signature	Date
Parent/Guardian	Parent/Guardian Signature	Date
Counselor	Counselor Signature	Date

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CONSENT FOR TREATMENT AND ACKNOWLEDGMENT

I, hereby acknowledge that I have received, read and been given an opportunity to ask questions regarding the following Treasure Wellness Counseling and Training Center business documents. I understand that if I have any questions or concerns regarding these business documents, I may contact my clinician or the TWCTC office.

- ☐ Your Counselor's Informed Consent and Procedures
- ☐ Treasure Wellness Counseling and Training Center Informed Consent and Procedures
- ☐ Client Bill of Rights
- ☐ Agreement to Pay
- ☐ Cancellation/No Show Policy – May Be Subject to ½ Billable Rate
- ☐ Insurance Assignment of Benefits
- ☐ Emergency Procedures
- ☐ HIPAA-Notice of Privacy
- ☐ Authorization for Live Observation
- ☐ Authorization for Audio-Video Recording

I, voluntarily consent to the live observation of session by TWCTC Interns, Affiliates, Supervisors or Intern University Representative.

☐ YES ☐ NO

I, voluntarily consent to audio-video recording of sessions by TWCTC Interns, Affiliates, or Supervisors for educational training use.

☐ YES ☐ NO

I, voluntarily consent to participate in the intake, assessment and treatment process. I also acknowledge the following:

1. I have been given the opportunity for discussion of any concerns that I have regarding treatment.
2. I will be informed and take part in my treatment and goal planning.
3. I have been given no guarantee of treatment outcomes.
4. I have been informed of any and all fees associated with my treatment.
5. TWCTC will use and disclose personal health information for treatment and to receive payment for services provided.

_____	_____	
Printed Name of Client	Signature of Client	Date
_____	_____	
Printed Name of Parent/Guardian	Signature of Parent/Guardian	Date
_____	_____	
Printed Name of Parent/Guardian	Signature of Parent/Guardian	Date
_____	_____	
Printed Name of Counselor	Signature of Counselor	Date

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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Date initiated: _____

Client's Name: _____ _____ _____
First Name **Middle Name** **Last Name**

Client's Date of Birth: _____

I, _____ authorize the release of my confidential protected health information, as described in my directions below. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

_____ Release To: **_____ Obtain From:** **_____ Exchange With:**

_____
Name of Clinician, Office, Individual

_____ _____ _____
Address **Phone** **Fax**

Information to be released:
- ☐ **Authorization for Psychotherapy Notes**
- ☐ **Authorization for History/Intake**
- ☐ **Authorization for Diagnosis**
- ☐ **Authorization for Dates of Treatment/Attendance**
- ☐ **Other (describe information in detail)**: _____

_____

_____

The reason I am authorizing release is:
- ☐ **Evaluation/Assessment and/or Coordinating Treatment Efforts**
- ☐ **Other (describe):**

This Authorization will expire 180 Days after initiated

I understand, that I have the right to refuse the release of any protected health information. I may revoke my consent to release at any time except to the extent that the information has already been released.

Signature of Client: _____ **Date:** _____

Signature of Parent/Guardian: _____ **Date:** _____

Signature of Counselor: _____ **Date:** _____