## FAMILY COUNSELING SERVICE

## CLIENT INFORMATION

Last Name _____ First _____ DOB _____

SS# _____ Age _____ Race _____ Gender _____ Religion _____

Phone: Home_____ Work_____ Cell_____

Would you like to have access to our online patient portal? ☐ Yes ☐ No Email_____

Address _____ City, State, zip _____ County_____

Spouse's Last Name _____ First _____ Date of Marriage _____

DOB_____ Age _____ Race _____ Gender _____ Religion _____

E-mail_____ Phone: (Spouse) Home _____ Cell _____

**Name of Legal Guardian(s) (if under age 19):** _____

How did you hear about us? (Circle best answer) Website/Internet – Brochure – Friend – Insurance Company – Doctor
Pastor – Attorney – Another Counselor – EAP – School – Court

**Children**: Name _____ Age _____; Name _____ Age _____;

Name _____ Age _____; Name _____ Age _____;

**Education**: Self_____ Spouse _____

**Employer**: Self_____ Spouse _____

**Physician**: Self _____ Spouse _____ Children _____

***Session cost will be covered by** (please circle): **EAP** **Insurance** **Self Pay** **Positive Directions** **Other**

If cost is covered by an EAP, please list employer: _____ If other, please identify: _____

## INSURANCE INFORMATION

Person Responsible for Bill: _____ Date of Birth: _____

Method of Payment: ☐ Insurance ☐ Credit Card ☐ Cash or Check ☐ Co – Pay $_____ due today

Is this patient covered by insurance? ☐ Yes ☐ No Insured's Date of Birth: _____

Insurance Name: _____ Contract #: _____

Policy Holder: _____ Group #: _____

Secondary Insurance: _____ Contract #: _____

Policy Holder:_____ Group #: _____

Client's relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Policy Holder Address: _____ Phone Number: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance. I also authorize Family Counseling Service or insurance company to release any information required to process my claims.

_____

**Client Signature** **Date**

**Office Use Only:** **Fee Per Session:** _____

Case #: _____ Counselor: _____ Date: _____

# FAMILY COUNSELING SERVICE
# CONSENT FOR THE PURPOSES OF SERVICE, PAYMENT AND HEALTHCARE OPERATIONS

**FAMILY COUNSELING SERVICE (FCS) IS DEDICATED TO MAINTAINING THE PRIVACY OF YOUR PERSONAL HEALTH INFORMATION. FCS IS ALSO REQUIRED BY LAW TO DO THIS.**

**SHARING OF SOME INFORMATION, HOWEVER, IS NECESSARY UNDER SOME LIMITED CIRCUMSTANCES DESCRIBED BELOW. THIS CONSENT FORM MUST BE COMPLETED BY CLIENTS BEFORE THEY ARE SEEN BY A FCS MENTAL HEALTH PROFESSIONAL.**

**IF YOU HAVE ADDITIONAL QUESTIONS OR CONCERNS ABOUT OUR AGENCY'S PRACTICES IN THIS REGARD, PLEASE FEEL FREE TO CONTACT OUR PRIVACY OFFICER, LARRY DEAVERS, AT (205) 752-2504.**

I consent to the use or disclosure of my protected health information, including mental health information, by Family Counseling Service (FCS) and its staff for the purpose of (1) providing services to me, (2) obtaining payment for my health care bills or (3) as necessary to conduct health care operations of Family Counseling Service. I understand that services provided to me by FCS may be conditioned upon my consent as evidenced by my signature on this document.

I authorize Family Counseling Service to release any health, mental health, medical or other information necessary to process any claim filed with my health insurance provider for services rendered by Family Counseling Service. I authorize payment of health/ mental health/ medical benefits to Family Counseling Service for services provided.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out services, payment or healthcare operations of the practice. If Family Counseling Service agrees to the restriction that I request, the restriction is binding on Family Counseling Service and its staff. Any request for restrictions on the use or disclosure of my protected health information must be submitted in writing.

I have the right to revoke this consent, in writing, at any time, except to the extent that Family Counseling Service has taken action in reliance on this consent. I understand that such revocation may mean cessation of healthcare services by Family Counseling Service, except as may be required by law.

My "protected health information" means health information, including mental health information, collected from me and created or received by my mental health provider, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I hereby confirm that I have read and understand FAMILY COUNSELING SERVICE'S NOTICE OF PRIVACY PRACTICES and understand that I may have a copy, upon request, to take with me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my mental health care, payment of my bills, or in the performance of health care operations of Family Counseling Service. The Notice of Privacy Practices for Family Counseling Service is also posted in the office waiting area and on the Family Counseling Service web site at www.counselingservice.org /notice.htm. This Notice of Privacy Practices also describes my rights and Family Counseling Service's duties with respect to my protected health information.

FCS reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by accessing the Family counseling Service web site, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____
Name of Client, Parent or Guardian (Print)

_____
Signature of Client, Parent or Guardian

_____
Date

## Family Counseling Service
## Client Questionnaire

**Client Name:** _____ **Date:** _____

| Over the past 6 months, how often have you been bothered by any of the following problems? | Not at all | 1-2 Times | Several Days | More Than Half the Days | Nearly Everyday |
|---|---|---|---|---|---|
| Depressed mood (feeling sad, empty) | | | | | |
| Feelings of hopelessness | | | | | |
| Diminished interest or pleasure in activities | | | | | |
| Weight loss of over 5% in the past month when not dieting | | | | | |
| Decrease or increase in appetite | | | | | |
| Problems getting enough sleep or sleeping too much | | | | | |
| Moving or speaking so slowly that other people have noticed | | | | | |
| Fidgety or restless/moving around more than usual | | | | | |
| Fatigue or loss of energy | | | | | |
| Diminished ability to think, concentrate or make decisions | | | | | |
| Recurrent thoughts of death | | | | | |
| Feelings of low self-worth | | | | | |
| Anxiety in social settings | | | | | |
| Feeling anxious overall | | | | | |
| Feelings of losing control | | | | | |
| Excessive worry | | | | | |
| Feeling restless, or on edge | | | | | |
| Irritability | | | | | |
| Tension | | | | | |
| Feelings of panic | | | | | |
| Socially withdrawn | | | | | |
| Making careless mistakes | | | | | |
| Do not complete tasks | | | | | |
| Difficulty staying organized or focused | | | | | |
| Forgetful | | | | | |
| Confused | | | | | |
| Disoriented | | | | | |
| Compulsive checking or counting | | | | | |
| Indecisiveness | | | | | |
| Feeling emotionally distant from others | | | | | |
| Racing thoughts | | | | | |
| Impulsiveness | | | | | |

## Family Counseling Service
## Client Questionnaire

| Over the past 6 months, how often have you been bothered by any of the following problems? | Not at all | 1-2 Times | Several Days | More Than Half the Days | Nearly Everyday |
|---|---|---|---|---|---|
| Recurrent or distressing dreams | | | | | |
| Sexual problems | | | | | |
| Gender concerns | | | | | |
| I don't like my body | | | | | |
| Intense fear of weight gain | | | | | |
| I do risky or dangerous things | | | | | |
| Binge eating | | | | | |
| Laxative abuse | | | | | |
| People talk about me | | | | | |
| Some people want to hurt me | | | | | |
| I hear voices or sounds others do not hear | | | | | |
| I see things others do not see | | | | | |
| I smell things others do not smell | | | | | |
| My symptoms significantly impact my social, work, or family life. | | | | | |
| Sometimes I think I would be better off dead | | | | | |
| I think of hurting myself in some way | | | | | |
| I have engaged in self-mutilation | | | | | |
| I have tried to hurt myself | | | | | |
| Thoughts of hurting someone else | | | | | |

**Have you ever been exposed to a significant traumatic event, such as a violent event, serious accident, life-endangering event or other life-changing incident?**

**Please Circle: YES or NO**

In your own words, please describe what has led you to seek counseling?

_____

_____

_____

_____

# Family Counseling Service
# Client Questionnaire

**Personal Medical History:**

| | |
|---|---|
| **Thyroid Disease** | _____ Yes _____ No |
| **Anemia** | _____ Yes _____ No |
| **Liver Disease** | _____ Yes _____ No |
| **Chronic Fatigue** | _____ Yes _____ No |
| **Kidney Disease** | _____ Yes _____ No |
| **Diabetes** | _____ Yes _____ No |
| **Asthma/respiratory problems** | _____ Yes _____ No |
| **Stomach or intestinal problems** | _____ Yes _____ No |
| **Cancer (type)** | _____ Yes _____ No |
| **Fibromyalgia** | _____ Yes _____ No |
| **Heart Disease** | _____ Yes _____ No |
| **Epilepsy or seizures** | _____ Yes _____ No |
| **Chronic pain** | _____ Yes _____ No |
| **High Cholesterol** | _____ Yes _____ No |
| **High blood pressure** | _____ Yes _____ No |
| **Head trauma** | _____ Yes _____ No |
| **Liver problems** | _____ Yes _____ No |
| **Other** | _____ Yes _____ No |

**Do you have any other current medical problems?** _____

_____

_____

**Do you have any past medical problems, hospitalization, or surgeries?** _____

_____

_____

**Current Weight:** _____ **Height:** _____

**Current Psychiatric Medications:**
Please list any psychiatric medications you are taking, even if prescribed by your family physician.

| Medication Name | Total Daily Dosage | Estimated Start Date |
|---|---|---|
| | | |
| | | |
| | | |

***List any other current prescription medications*** **and how often you take them: (if none, write none)**

| Medication Name | Total Daily Dosage | Estimated Start Date |
|---|---|---|
| | | |
| | | |
| | | |

# Family Counseling Service
# Client Questionnaire

**How many caffeinated beverages do you drink a day?** Coffee_____ Sodas_____ Tea_____

**Do you smoke cigarettes or used tobacco products (chewing tobacco, pipes, cigars)** Yes or No

If yes, what type _____ and how often _____

## Past Psychiatric History:

**Outpatient treatment** ___ **Yes** ___ **No** If yes, Please describe when, by whom, and nature of treatment.

Reason Dates Treated By whom

_____

_____

_____

**Psychiatric Hospitalization** ____ **Yes** ____ **No** If yes, describe for what reason, when and where.

Reason Date Hospitalized Where

_____

_____

_____

## Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for:

| | | | |
|---|---|---|---|
| Bipolar Disorder | ___ **Yes** ___ **No** | Schizophrenia | ___ **Yes** ___ **No** |
| Depression | ___ **Yes** ___ **No** | Post-traumatic stress | ___**Yes** ___ **No** |
| Anxiety | ___ **Yes** ___ **No** | Alcohol Abuse | ___ **Yes** ___ **No** |
| Anger | ___ **Yes** ___ **No** | Other substance abuse | ___ **Yes** ___ **No** |
| Suicide | ___ **Yes** ___ **No** | Violence | ___ **Yes** ___ **No** |

If yes, who had each problem? _____

_____

## Emergency Contact:

**Name:** _____ **Relationship:** _____

**Telephone #:** _____

_____ _____

**Name of Client (Print)** **Signature of Client or Parent/Guardian**

_____

**Date**