WISHING YOU WELL COUNSELING CENTER
21731 Timberlake Road, Lynchburg, VA 24502 434-455-5033

Client Information Sheet

Today's Date: _____ Referral Source: _____

Please fill in the blanks completely:
Client Name: _____ Client's SSN: _____
Client's Age: _____ Client's Date of Birth: _____
Street Address: _____
City: _____ Zip: _____
Mailing Address: (if different from above): _____
_____
Home Phone: _____ Emergency Phone: _____
Cell Number: _____ Work Phone: _____
Email: _____
Place of Employment/School: _____
Address of Employment/School: _____

Marital Status: ___ Never Married ___Married ___Separated ___Divorced
___Widowed ___Unmarried Couple Length of Current Status:_____
Spouse's Name & Address: _____
_____
Spouse's Phone: _____ Work Number: _____
Spouse's Employer: _____

Please Complete this Section Only if Client is a Minor:
Mother's Name: _____ Mother's Address: _____
Mother's Home Phone: _____ Mother's Work Phone: _____
Mother's Employer: _____ Address of Employer: _____
Father's Name: _____ Father's Address: _____
Father's Home Phone: _____ Father's Work Phone: _____
Father's Employer: _____ Address of Employer: _____

Responsible Party:_____ Phone:_____
Address of Responsible Party:_____

For Therapist Use Only: DSMIV DIAGNOSIS: AXIS 1:_____
AXIS II: _____AXIS III: _____
AXIS IV: _____ AXISV: _____
INITIAL TREATMENT INTERVENTION & RATIONAL:
_____
_____
Discharge Plan: _____
_____

Insurance Information:

Insurance Company: _____
Policy Number: _____ Group Number: _____
Insured's Name (if other than client): _____
Insured's SSN:_____ Insured's Date of Birth:_____
Relationship to Insured:_____

Medical Treatment/History of Client:

Primary Care Physician: _____ Phone: _____
Has the client had any treatment by a physician during the past 5 years? ____ Yes ____ No
If yes, please explain: _____
Has the client had any major operations or hospitalizations? _____ Yes _____ No
If yes, please explain: _____

Is the client currently taking any medication? If so, please list with dosage and purpose:

_____
_____
_____
Does the client have any allergies? If so, please list: _____
_____

Has the client ever attempted suicide? _____ No _____ Yes, When: _____
Has the client ever been physically abused? ____No ____Yes, When: _____
Has the client ever been sexually abused? ____No ____Yes, When: _____
If you answered yes to any of the above questions, please give a brief explanation:

_____
_____
_____

Substance Use/Abuse History:

Does the client currently or ever had an alcohol problem? ___ No ___Yes, When: _____
Does the client currently or ever had a drug problem? ___ No ___ Yes, When:_____
If you answered yes to any of the above questions, please give a brief explanation:

_____
_____
_____

Does anyone in the client's family have or have ever had a problem with alcohol?
____ No____ Yes, Who: _____
Does anyone in the client's family have or have ever had a problem with drugs?
____ No ____ Yes, Who: _____
Does anyone in the client's family have or have ever had a mental health concern?
____ No ____ Yes, Who: _____

If you answered yes to any of the 3 previous questions, please give a brief explanation:

_____
_____
_____

Family History of Client:

Birth order of client: _____ of _____ siblings.

Relationship	*Name*	*Age if Living*	*Date & Age of Death*	*Occupation*	*City of Residence*
Father					
Mother					
Stepfather					
Stepmother					
Foster Mother					
Foster Father					
Brothers					
Sisters					
Children					
Previous Spouses					

Education and/or Employment History:

Current School Attending: _____
Highest grade completed? _____ Any grades repeated? _____
Any academic or school behavioral concerns? _____No ____Yes please explain: _____
_____
_____

Present Employer: _____
Job Title: _____ Length on job: _____
If unemployed please explain length of time and why: _____
_____

Legal History of Client:

Pending/Past Charges	Court Date Pending or Date of Charge	Disposition (guilty, not guilty, time served, fines, etc.)

Presenting Problem of Client (Check All That Apply):

_____ Abuse (Physical, Sexual, Emotional)
_____ Anger Management
_____ Anxiety
_____ Chemical Dependency
_____ Compulsive Behavior
_____ Depression
_____ Divorce/Separation
_____ Family Problems
_____ Gambling
_____ Gender Role Identity
_____ Grief & Loss
_____ Legal Issues
_____ Marital Conflict
_____ Medical Issues
_____ Obsessive Thinking
_____ Parenting Issues
_____ Self-Esteem Issues
_____ Stress
_____ Violent Behaviors
_____ Other

Please briefly explain all that are checked above:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

SYMPTOMS CHECKLIST

Check the symptoms you've noticed lately in yourself/dependent.

PHYSICAL

___Appetite change
___Headaches
___Tension
___Fatigue
___Insomnia
___Weight change
___Increased colds/viruses
___Muscle aches/pains
___Digestive upsets
___Pounding heart
___Accident prone
___Teeth grinding
___Rash, Hives
___Restlessness
___Increased alcohol, drug, tobacco use
___Bedwetting
___Shortness of breath
___Menstrual Difficulties

EMOTIONAL

___Anxiety
___Frustration
___The "blues"
___Mood swings
___Bad temper
___Nightmares
___Crying spells
___Irritability
___"No one cares"
___Depression
___Nervous laugh
___Worrying
___Easily discouraged
___Little joy
___Short fuse
___Guilt
___Anger

SPIRITUAL

___Emptiness
___Loss of meaning
___Doubt
___Unforgiving
___Martyrdom
___Looking for magic
___Loss of direction
___Needing to "prove oneself"
___Cynicism
___Apathy

MENTAL

___Forgetfulness/memory problems
___Dull senses
___Poor concentration
___Low productivity
___Negative attitude
___Confusion
___Lethargy
___Whirling mind
___No new ideas
___Boredom
___Spacing out
___Negative self-talk
___Difficulty making decisions
___Thoughts of harming self
___Thoughts of harming others
___Hallucinations

RELATIONAL

___Isolation
___Intolerance
___Resentment
___Loneliness
___Lashing out
___Hiding
___Clamming up
___Lowered sex drive
___Nagging
___Distrust
___Fewer contact with friend's
___Lack of intimacy
___Using people

BEHAVIORAL

___Less Humor
___Intensified fatigue
___Angry outbursts
___Change in activity level
___Social withdrawal
___Manipulation of others
___Unlawful acts
___Risk-taking behaviors
___Self injury
___Suicidal attempts
___Attempts to harm others
___Self induced vomiting
___Eating binges
___Excessive exercising
___Less attention to appearance and/or hygiene

SCHOOL/WORKPLACE

___Increased absenteeism
___Decrease in quality of work
___Erratic/disruptive behavior
___Tardiness
___Irritability toward supervisors/coworkers/teachers
___Less attention to safety rules
___Poor concentration
___Procrastination
___Negative attitude toward school/company

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CLIENT SERVICES AGREEMENT

CONFIDENTILITY: You are assured that all counseling services are absolutely confidential and that no information will be disclosed to any person or agency unless you have signed a Release of Information specifying which information is to be released and to whom. However, law binds the counselor – as do professional standards – to take appropriate action on behalf of any client who represents him/herself as being (1) in imminent danger (suicidal), (2) a danger to someone else (homicidal), or (3) demonstrating inability to care for self. Furthermore, certain major violations of law (such as child abuse) must be disclosed to authorities. Clients who are in divorce or other court proceedings may have their records subpoenaed by the court or a spouse's attorney.

FEE SCHEDULE: PAYMENT FOR SERVICES IS REQUIRED BY THE END OF EACH SESSION.

Initial Intake or one-time consultation	$100.00
Individual, Family, or Marital Therapy per 50 minutes	$85.00
Individual, Family, or Marital Therapy per 25 minutes	$50.00
Consultation for client with other agencies per 50 minutes	$85.00
Group Therapy per session	$50.00
Court Appearance (total fee including traveling time)	$500.00 minimum for ½ day
Court Appearance (hourly rate for preparation time)	$85.00
Report Preparation and Transmittal	$100.00
Telephone Consults (including crises intervention)	Pro-rated based on hourly rates

MISSED APPOINTMENTS: Missed appointments will be charged at the rates above. A (24) hour notice of cancellation is required to avoid this charge. Insurance companies do not pay for missed appointments , so understand that you will be charged directly. Further understand that a court appearance by a Wishing You Well Counseling Center Professional must be cancelled (72) hours in advance or it will be charged in full.

INSURANCE: Billing you primary insurance will be completed as a convenience to you. You are responsible for filing claims with any secondary insurance company you may have a policy with. If, for any reason, your insurance company does not provide reimbursement, or requests that reimbursement be returned to them, you will be fully responsible. Each month you will receive a billing statement for services. Understand that deductibles need to be paid within 30 days, and insurance co-payments are due at the time of service. After (60) days, any amounts not paid for by your insurance company are your responsibility.

RELEASE OF INFORMATION TO INSURANCE COMPANIES: Information regarding your diagnosis, reason for treatment, course of treatment, and treatment methodology are part of your records and may be released to insurance companies for authorization of payment, and/or client audits which they may perform. This condition is a requirement of most insurance policies.

TELEPHONE MESSAGES: The clerical staff may monitor information left on voice mail.

COLLECTION OF ACCOUNT: If it becomes necessary for your account to be collected through legal channels, you give permission to release your name, social security number, address, and the amount of your unpaid balance to a collection agency.

ASSIGNMENTS OF BENEFITS: By signing below you authorize Wishing You Well Counseling Center to bill and collect from your insurance company. Also by signing below you understand that you are responsible for all fees generated by your treatment, including those not paid or covered by insurance, and any legal fees incurred in the collection of your account.

I have read the above terms and agree to them on _____.
(Date)

_____ _____
(Signature of Client) (Signature of Responsible Party – if other than client)

_____
(Signature of Therapist)