**Heal and Hope Counseling Services**

Client and Assessment Information

**DEMOGRAPHICS:**

1. Client Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Child □ Adult

Married? □ Yes □ No

If Child:

Parent / Custodian Names \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who has Legal Guardianship? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the State involved (DCS, CPS)? □ Yes □ No

Case Worker \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Custody \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Custody \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Client Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(street, city, state, and zip)

3. Client Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent / Custodian Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Client email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent / Custodian email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Client Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: □ Male □ Female □ Other

6. Client’s Employer or School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. How did you hear of Heal and Hope Counseling Services?

□ Website: healhopecounseling.com, □ Psychology Today, □ Referral from Doctor

□ Referral from insurance, □ other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. Referral Date to Counselor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was Appointment Kept? □ Yes □ No

Main Reason for Requesting Therapy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE:**

1. Insurance of Client:

□ BCBS □ BlueCare □ Cigna □ Humana □ UHC □ UHC TNTNCare □ EAP

□ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Is the Name on the Insurance Card Different from the Client? □ Yes □ No

If Yes:

Member’s Name on Card \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member’s Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member’s Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance ID Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Co-Pay for Office Visit \_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Phone Number (back of card) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Customer Service Number (back of card) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Client’s Relationship to Insured Member:

□ Self □ Spouse □ Child □ Custodian □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Is the Client covered by a Secondary Insurance policy? □ Yes □ No

If Yes:

Member’s Name on Card \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member’s Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member’s Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance ID Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Co-Pay for Office Visit \_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Phone Number (back of card) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Customer Service Number (back of card) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LEGAL:**

1. Does Client have an Arrest Record?

□ Yes □ No

If Yes, What was the Offence? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Was the Client Detained in Custody?

□ Yes □ No If Yes, How Long was the incarceration? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. How many times was the Client involved with Legal Issues for the Same Offence? \_\_\_\_\_\_\_\_

Why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Was the Client involved in Illegal behaviors at School? □ Yes □ No

If Yes, what were the behaviors? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did the behaviors result in □ Suspension or □ Expulsion?

Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was Substance Abuse involved? □ Yes □ No

What Substances? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How Often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much was usually used? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. At what age did the □ Aggressive Behavior and / or □ Substance Abuse begin? \_\_\_\_\_\_\_\_\_

What seemed to be the trigger / reason for these issues? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did parents, grandparents, other family members also do these behaviors? □ Yes □ No

Were these behaviors done in front of or with the Client? □ Yes □ No

Does Client have a parole officer? □ Yes □ No

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long is Client’s Probation? \_\_\_\_\_\_\_\_\_

Is Therapy Court Ordered? □ Yes □ No

Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(HHCS needs a copy of the court order to note what the court seeks from HHC)

6. HHCS offers □ Classes and □ Individual sessions for certification to use in court.

Please choose: □ Parenting □ Alcohol & Drug □ Anger Management

**MEDICAL HISTORY:**

1. Has Client been diagnosed before with any medical issues? □ Yes □ No

If Yes, please describe and provide medication per each diagnosed issue \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Who diagnosed the Client? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Client’s Primary Care Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(insurance requires this information and a release so HHCS can advise the physician of the Client's care and coordinate services)

Client / Custodian agrees to Release of Information □ Yes □ No

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Does Client's biological family also have the same diagnostic issues? □ Yes □ No

Which Relatives and which side of family? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Has Client been diagnosed with mental or behavioral illness / conditions? □ Yes □ No

6. What were the diagnoses' \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. How long has the Client suffered with the above issues? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. Who diagnosed Client with the above issues: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. Client / Custodian agrees to Release of Information □ Yes □ No

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10. How often does the Client suffer with this issue? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

11. Describe Client’s Symptoms \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

12. How severe are the symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

13. What has Client done to attempt to not suffer? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

14. Has Client lost interest in things they once enjoyed? □ Yes □ No

15. Can Client Focus / Concentrate easily? □ Yes □ No

16. Does Client experience Sleep Disturbances? □ Yes □ No

17. Does Client experience Eating Disturbances? □ Yes □ No

18. Is this affecting Client at school / work, home, and other areas? □ Yes □ No

If it is only affecting one area, which one is the worst and what is thought to be the cause?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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19. Has Client received Psychiatric Care? □ Yes □ No

Diagnosis? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

20. Who is Client’s Psychiatrist? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

21. Psychiatrist contact information \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

22. Most see Psychiatrist due to the need for medication. What medications are prescribed for the

diagnosis? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

23. Is medication effective? □ Yes □ No

What side effects are experienced? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

24. Is Client open for Alternative Medicine? □ Yes □ No

25. How is Client’s nutrition? Does Client eat / drink: □ Grains, □ Vegetables, □ Fruit, □ Meat,

□ Fowl, □ Fish, □ Sweets, □ Sodas, □ Alcohol, □ Water, in a □ 3 meal per day average intake?

If not, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Does Client fear becoming Overweight or Underweight? □ Yes □ No

26. If so, does Client binge, use laxatives, force their self to vomit? □ Yes □ No

Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

27. Please describe the issues that have brought the Client to HHC:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**EUDCATIONAL HISTORY:**

1. Has the Client ever had a learning disability? □ Yes □ No

If Yes, what was it? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who diagnosed it? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Did this effect the Client’s grades and / or conduct in school? □ Yes □ No

Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. What are the Client’s strengths, skills, talents? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. What are the Client’s weaker areas? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**A&D ASSESSMENT:**

1. Is the Client using, abusing, or addicted to alcohol or drugs? □ Yes □ No

2. When did the Client first use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Did Client use more than one substance? □ Yes □ No

4. What were the substances? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. How much at each occurrence?

7. Has there be legal issues due to use? □ Yes □ No

How many times? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Incarceration? □ Yes □ No

8. Has the Client lost family, jobs, friends, or other relationships due to use / abuse?

□ Yes □ No

9. Has Client ever had therapy due to use? □ Yes □ No

Inpatient care? □ Yes □ No

10. Would Client agree that he / she has a problem with substances? □ Yes □ No

**Heal and Hope Counseling Services**

*Check all that apply:*

**□ Abuse**

Victim of Type: □ Physical □ Emotional □ Sexual □ Neglect

Perpetrator of Type: **□** Physical □ Sexual

**□ Anxiety**

□ Excessive Worry □ Restlessness □ Autonomic □ Hyperactivity

□ Hypervigilance □ Specific Fear □ Sleep Disturbance □ Phobia

□ Obsessive / Compulsive

**□ Self Harmful**

□ Cutting □ Burning

**□ Psychotic**

□ Hallucinations □ Visual □ Auditory □ Paranoid Thinking Delusion

□ Suicidal Attempt □ Suicidal Ideation □ Suicidal Gestures

**□ Attention Deficit / Hyperactivity**

□ Short Attention Span □ Inattentive □ Impulsive □ Easily Distracted

□ Failure to Follow through □ Negative Attention Seeking Behaviors

□ Excessive Talking □ Risk Taker □ Projecting Blame □ Low Self Esteem

□ Poor Social Skills □ Low Frustration Tolerance □ Enuresis □ Encopresis

□ History of Failure to Thrive □ Fire Setting □ Fire Play □ Gang Association

□ Manipulative / Lying □ Learning Disability

**□ Post Traumatic Stress**

□ Decreased concentration □ "Flashbacks" □ Avoidance of Issue □ Vigilance

□ Sleep Disturbances □ Recurrent nightmares

**□ Eating Disorder**

□ Self-Induced Vomiting □ Use of Laxatives □ Refusal to Maintain Healthy Weight

□ Preoccupation with Body Image □ Irrational Fear of Becoming Overweight

**□ Sexually Inappropriate Behavior**

□ Touching □ Exposing

**□ Poor Verbal Skills**

□ Expressive □ Receptive

**□ Pregnancy**

**□ Physical / Medical issues**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□ Depression**

□ Sad / Flat Affect □ Irritability □ Isolative / Withdrawn □ Reduced Appetite

□ Sleep Disturbances □ Unresolved Grief □ Feeling Hopeless □ Hygiene Problems

□ Inactive / Low Motivation

**□ Mood Disruption**

**□ Oppositional Defiant**

□ Hostile Towards Adults □ Temper Tantrums □ Constant Arguing with Adults

□ Refusing to Comply □ Blaming Others □ Demanding

□ Verbal Aggression / Swearing

**□ Conduct Disorder**

□ Failure to Comply □ Fighting / Assaultive □ Homicidal □ Intimidation

□ Harmful to Animals □ Stealing □ School Maladjustment □ Truancy

□ Conflict with Authority □ Risk Taking □ Blaming Others □ Little / No Remorse

□ Destruction of Property

**Heal and Hope Counseling Services**

**Disclaimers:**

Facetime, online, texts; have added confidentiality issues to consider; out of each, Facetime provides less issue and the most benefits of any of the other convenient forums for therapy. Facetime allows the Clinician and the patient to see each other which is a benefit since each can see the other's facial and body expression which aids in the communication occurring between both. However confidential issues still exists.

Online emails are at risk of confidentiality breeches due to the data going over the cloud, and therefore is at risk of interception or hacking to occur. With such issues then include no confidential, HIPAA protected information through emails, such as demographics, diagnoses, insurance information, and like information.

Another forum is Skype which is like Facetime, offers face to face therapy, yet still includes many of the confidential issues which exists as one is not in the office with protected surroundings to aid in other's not hearing the sessions and protected from interruptions and distractions.

Texts and emails have the most draw backs in efficacy since much of communication can be misunderstood. There are no inflections of tone or voice; no eye to eye contact; and often one risks hacking.

Either of these modes will need to have a charge card kept on hand so as to charge the session, ($50.00) on the card for a 45 minute session allowing for notes and for card receipts. Also the email of the Clients will ensure that they receive the receipts online as soon as the card is run.

The card information is kept securely in HHC’s online card processor with protected servers; and HHCS can write and send a receipt via email to Clients per each service as requested.

HHCS has a clearinghouse and personnel who will view Client Information and therefore although they are restricted to follow HIPAA's regulations, this adds to a possibility of Client’s information being shared to someone unbeknownst to Client or HHCS.

Social media also serves as a possible issue to guard Client Information and Privacy. Many know the Clinician. If Client befriends the Clinician, then they should expect a professional relationship. If Client speaks of their issue of which they need help with when online; please understand that the Clinician will not speak about their issue on that forum. In public, the Clinician will not approach the Client or act as if the Clinician knows the Client. This is to protect Client’s privacy. If Client opens the door for communication in public, regarding Client’s personal information, then Client is agreeing to release the Clinician of liability regarding Client’s privacy.

**Heal and Hope Counseling Services**

**Consent Form:**

Patient / Client agrees to release the Clinician as well as HHCS from liability of HIPAA violations due to the above issues.

Patient / Client agrees to release their information to all PCP, collaterals (probation officer, EAP, referral sources, insurance, or colleagues) for consultation or for referral; holding the Clinician and HHCS blameless of any liability of HIPAA violations regarding their protected information, should this need to share be used to increase efficacy of their treatment, payment of their claims, or well-being. Client-patient does hereby understand the risks of such practices listed in this forum.

Patient hereby agrees to allow HHCS to file insurance claims on their behalf to the insurance company represented, authorizes that insurance company to make payments direct to HHC, and will pay HHCS the portion of the insurance *allowed amount* that insurance does not pay. The *allowed amount* is a discounted rate that HHCS has agreed to accept as part of their contract with the patient’s insurance company. Patients who have not met their Deductible are liable to pay the full *allowed amount*. Those who have met their deductible may be responsible to pay a portion of the *allowed amount* as determined by their policy. Payment is due at the time of service. The patient is responsible to keep up with their deductible balances.

No payment is due from patients who have met their Out-of –Pocket Maximum , those with a BCBS Medicaid program, and those with authorizations that cover the entire cost of service.

Client understands that if they should not show for an appointment without cancelling the day before, then they will owe $35.00 for a missed appointment fee. After the third (3rd) no-show, we will see the client only on a walk-in basis.

Also: HHCS may require a charge card to be kept on file in case of no-shows, sessions, or online or phone sessions. The Clinician may charge to this card due to any of these issues without risk of charge-back issues.

On holidays please check to see if the office is open prior to coming; also inclement weather.

HHCS has appointment reminders available.

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witnessed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Heal and Hope Counseling Services**

**Client Safety Plan:**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, as of date \_\_\_\_\_\_\_\_\_\_\_\_ will hereby Abide / promise to take the following actions should I intend to harm or kill myself or intend to harm another person:

• I will distract myself with the following behaviors: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• I will call: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• I will contact my Counselor to advise of my thoughts and intent in order to gain help, support, guidance and possible assessment as to the level of risk that I am in. I do understand that by this call, the Counselor is legally liable to contact the needed authorities to keep me and others safe.

• I will call 911 or the Sheriff's Department for assistance should I not be able to reach the Counselor due to her being in session with another Client.

• I will not hurt myself or others.

• I understand that although life seems impossible and hurtful at this time, that I have a bright future ahead and that tomorrow will offer me opportunities and hope.

• Those who may miss me or who may be hurt should I hurt myself or others are:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Counselor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_