THE ROSS CENTER

Acknowledgement of Therapist–Client Agreement and HIPAA Notice

With my signature below, I acknowledge that I have read the "Therapist–Client Services Agreement" available on The Ross Center's website at www.NashvilleCounseling.org, understand its content, and agree to abide by the terms therein:

I. Counseling Services

II. Appointments

III. Limits on Confidentiality

IV. Clinical Records

V. Minors and Parents

VI. Professional Fees

VII. Billing and Payments

VIII. Insurance Reimbursement

IX. Emergencies

I also acknowledge that I have received a copy of the "Notice of Privacy Practices and Patient Rights" as required by the Health Insurance Portability and Accountability Act (HIPAA), and I understand the circumstances under which my Protected Health Information (PHI) can be disclosed.

_____ _____

Client Signature Date

Initial Client Questionnaire
(Please print clearly)

_____/_____/_____
Today's Date

_____ _____/_____/_____ _____
Identified Client's Name Date of Birth Age

_____ _____/_____/_____ _____
Spouse/Partner's Name (if applicable) Date of Birth Age

_____ _____ _____
Emergency Contact Name Relationship Phone

Highest level of education completed (circle one):

Jr. High GED High School 2 year college 4 year college Graduate degree

Pending legal issues? No _____ Yes _____ If yes, what? _____

Marital Status: o Single o Engaged o Married (number of times: _____)
o Separated o Widowed o Divorced (number of times: _____)

Client Contact Information:

To best ensure privacy and confidentiality, please list acceptable methods of contact, if messages are permitted, and the best days/times to reach you.

Home phone: _____ Message: Y/ N Days/Times: _____

Work phone: _____ Message: Y/ N Days/Times: _____

Cell phone: _____ Message: Y/N Days/Times: _____

Email: _____

Mailing address: _____

City: _____ State: _____ Zip: _____

TREATMENT INFORMATION:

Referred by:_____

Have you participated in previous counseling or psychological services with a psychiatrist, psychologist, therapist, pastor, or lay counselor? No _____ Yes _____ If yes, please circle the type above.

Reason(s) for previous counseling? _____

Counselor's name and location:_____

Dates seen: _____

What were the results? _____

_____

Briefly describe what brings you to initiate counseling now? _____

_____

Please check all topics that currently apply to your reason(s) for seeking therapy:

___ Anger
___ Loss/Grief
___ Self-esteem
___ Guilt/Shame
___ Mood shifts
___ Communication
___Spiritual/Religious
___ Medical/Pain
___ Obsessive thoughts
___ Depression
___ Worry
___ Marital Problems
___ Apathy
___ Health Concerns
___ Sleep Difficulties
___ Abuse History
___ Legal Problems
___ Body Image
___ Anxiety
___ Finances
___ Family Problems
___ Pornography
___ Job Stress
___ Relationship(s)
___ Substance Abuse
___ Adjustment
___ Withdrawn
___ Suicidal Thoughts
___ Self-Injury
___ School/Education
___ Sexual Problems
___ Fear/Phobia
___Crying Spells
___ Divorce/Separation
___ Disordered Eating
___Lying/Deceitfulness
___ Other (specify): _____

What are your goals for therapy? _____

_____

_____

FAMILY (household):

Name	Relationship	Age	Gender

Has there been a history of the following within you family (if yes, check “previously” or “currently”)

	Previously	Currently	Briefly Describe
Alcoholism			
Drug Abuse			
Mental Illness			
Domestic Violence			
Verbal/Emotional Abuse			
Sexual Abuse			
Sexual Addiction			
Divorce			
Infidelity/Affairs			
Financial Problems			

HEALTH HISTORY: List your current healthcare provider(s), using the back of this form if necessary.

Name	Specialty	Location	Phone	Last Visit

List any and all diseases, illnesses, important accidents or injuries that involved surgery, hospitalization, loss of consciousness, convulsions/seizures, or diagnosis (not including pregnancies). Some examples are: heart disease or surgery, cancer, diabetes, high blood pressure, respiratory illness, bone or joint problems, high cholesterol, arthritis, emphysema, hepatitis, HIV, stroke, seizures, **or a mental illness diagnosis**.

Illness/Injury/Surgery	Age	Treatment Received	Treated by	Result

Medications/Drugs:
List all medications or drugs you regularly take, or have taken, within the past year: prescribed, over-the- counter, etc. This would also include tobacco, alcohol, and marijuana products.

Medication	Amount	Taken for:	Prescribed and supervised

For women only:
Please describe any important and applicable medical information regarding: menstruation (associated pain or unusual frequency, duration, or heaviness); hysterectomy; or menopause: _____
_____

Health habits (lifestyle):
Rate your physical activity level (1 = "little-to-none" and 5 = "very active"): _____
In what kind of physical exercise or activities do you participate? _____
_____
How often do you exercise or are physically active (average per week)? _____
How much coffee, cola, tea, or other caffeine products do you consume each day/week? _____
Do you have any problems getting enough sleep? No _____ Yes _____
How many hours do you sleep per night on average? _____
Please check any of the following sleep problems that you have experienced *within the past six months*:
____ Sleep rhythm ____ Insomnia (unable to sleep) ____ Hypersomnia (over sleeping)
____ Nightmares ____ Sleep walking ___ Narcolepsy (unexpectedly falling asleep)
Are you involved with art such as dance, painting, music, etc.? No _____ Yes _____
What type of music do you listen to most often? _____
How often do you watch T.V.? _____
Which shows do you watch most often? _____
Do you enjoy reading? No _____ Yes _____ if yes, what types of material do you read?
_____
Please describe any current or chronic pain issues: _____
_____
_____

RELIGIOUS/SPIRITUAL:

Circle all phrases that describe your current religious experience:

Atheist	*Closed toward God*	*Communal worship*	*Seeking God*
Agnostic	*God is cruel*	*God is distant*	*Skeptical*
Charismatic	*Spiritual...not religious*	*God is good*	*Pray Often*
Open towards God	*Stagnant*	*God Loves Me*	*Curious*

With what religion/denomination, if any, are you affiliated? _____

"I hereby affirm that the information provided on this Questionnaire is complete and accurate to the best of my knowledge, and I will notify my therapist if any of the information should change."

_____

Client Signature

Notes: Clinician use Only