



TREASURE WELLNESS COUNSELING CENTER  
 2176 East Franklin Road, Ste. 100  
 Meridian, Idaho 83642  
 208-515-7661  
 WWW.TREASUREWELLNESS.NET

### 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: \_\_\_\_\_

**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
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**HEALTH HISTORY**

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

What	When	Treatment
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

**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? \_\_\_\_\_  
\_\_\_\_\_



**TREATMENT EXPERIENCES**

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

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  NO

**CURRENT CONCERNS**

What brought you into treatment?:

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What are your expectations for treatment?:

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What is the one thing that you want me to know about you today?:

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

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

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)



AGREEMENT TO PAY FOR PROFESSIONAL SERVICES

I request that \_\_\_\_\_ provide professional service to,
☐ 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 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

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: \_\_\_\_\_



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