TREASURE WELLNESS COUNSELING CENTER
1655 W. FAIRVIEW AVE, SUITE 115
BOISE, IDAHO 83702
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.*

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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☐
☐ ☐	☐	☐	☐	☐
☐ ☐	☐	☐	☐	☐
☐ ☐	☐	☐	☐	☐
☐ ☐	☐	☐	☐	☐
☐ ☐	☐	☐	☐	☐

☐

HEALTH HISTORY

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

What	When☐	Treatment☐
☐ ☐	☐	☐
☐ ☐	☐	☐
☐ ☐	☐	☐
☐ ☐	☐	☐
☐ ☐	☐	☐

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: _____

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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? _____

_____

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TREAMENT EXPERIENCES

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

	☐ ☐	☐ ☐
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☐

CURRENT CONCERNS

What brought you into treatment?:

_____
_____

What are your expectations for treatment?:

_____
_____

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)

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

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)

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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: _____

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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