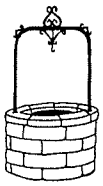


Wishing You Well Counseling Center
21731 Timberlake Road
Lynchburg, VA 24502
(434) 455-5033/ (434) 455-5034 fax

Client Information Sheet

Today's Date: _____ Referral Source: _____

Client's Name: _____ Client's SSN: _____
Client's Age: _____ Client's Date of Birth: _____
Street Address: _____
City: _____ Zip Code: _____

Mailing Address: (if different from above): _____
_____
Home Phone: _____ Emergency Phone: _____
Cell Number: _____ Work Phone: _____

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: _____

Please Complete this Section Only if Client is a Minor:

Mother's Name: _____ Father's Name: _____
Mother's Address: _____ Father's Address: _____
Mother's Home Phone: _____ Father's Home Phone: _____
Mother's Cell Phone: _____ Father's Cell Phone: _____
Mother's Work Phone: _____ Father's Work Phone: _____
Mother's Employer: _____ Father's Employer: _____

Responsible Party Information:

Name: _____ SSN: _____
Address: _____
Email: _____ Phone: _____

CONTINUE TO THE NEXT PAGE

For Therapist Use Only: DSM V DIAGNOSIS: _____
_____
INITIAL TREATMENT INTERVENTION & RATIONAL: _____
_____
Discharge Plan: _____
_____

Marital Information:

Never Married (Single): _____ Married: _____ Separated: _____ Divorced: _____
Widowed: ____ Unmarried Couple (Living Together): _____ Length of Current Status: _____
Spouse or Partner's Name & Address: _____
_____
Spouse or Partner's Home Phone: _____ Cell Phone: _____
Spouse or Partner's Employer: _____

Previous Spouses (Name & Length of Marriage): _____
_____
_____

Family History of Client:

Birth order of client: _____ of _____ siblings.

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

Medical Treatment/History of Client:

Primary Care Physician: _____ Phone: _____
Has the client been treated 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: _____
_____
List all current medical conditions: _____
_____
_____

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

Medication	Dosage and Purpose

Does the client have 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:

Is there currently or has there ever been an alcohol problem? No ____ Yes___, when: _____
Is there currently or has there ever been a drug problem? No ____ Yes_____, when: _____
Please give a brief explanation for 'yes' answers above:_____
_____
_____

Is there anyone in the client's family who currently has or has had a problem with alcohol?
No____ Yes____, who: _____
Is there anyone in the client's family who currently has or has had a problem with drugs?
No ____ Yes____, who: _____
Is there anyone in the client's family who currently has or has had a mental health concern?
No ____ Yes____, who: _____
Please give a brief explanation for 'yes' answers above: _____
_____
_____

Education and/or Employment History:

Schools Attended	Highest Grade Completed	Diploma or Degree Received

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 and/or Matters Before the Court:

Pending/Past Charges or Matters before the court (custody, protective orders, etc.)	Dates of Incident	Court Dates	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
_____School Attendance
_____Self-Esteem Issues
_____Stress
_____Violent Behaviors
_____Work Issues
_____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

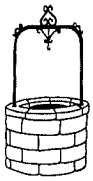
___Less Humor
___Intensified fatigue
___Angry outbursts
___Change in activity level
___Social withdrawal
___Manipulation of others
___Unlawful acts
___Risk-taking behaviors
___Self injury
___Suicidal attempts
___Attempts to harm others
___Self induced vomiting
___Eating binges
___Excessive exercising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

Use this space for additional information.

Please read and sign the Client Services Agreement on the following page.



Wishing You Well Counseling Center
21731 Timberlake Road
Lynchburg, VA 24502
(434) 455-5033 (434) 455-5034 fax

CLIENT SERVICES AGREEMENT

CONFIDENTIALITY: 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) unable 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, or their ward's, records subpoenaed by the court or a spouse's attorney. For best practice standards, your therapist reserves the right to consult with other Wishing You Well mental health professionals regarding your case.

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

Parent/Divorce Coaching	$135.00
Initial Intake or Consultation	$150.00
Individual, Family, or Marital Therapy per 45 minutes	$125.00
Individual, Family, or Marital Therapy per 55 minutes	$135.00
Consultation for client with other professionals per hour	$135.00 (pro-rated)
Telephone Consults, Email correspondence (including crisis intervention) per hour	$135.00 (pro-rated)
Report/Letter Preparation and Transmittal per hour	$135.00 (pro-rated)
Court Appearance (including review of record, preparation, consultation, traveling time, availability), per hour	$135.00

***minimum $625.00 to be paid at least 72 hours in advance**

MISSED APPOINTMENTS: Responsible parties will be charged at the rate above for any missed appointment that is not cancelled 24 hours in advance. A court appearance by a Wishing You Well Counseling Center Professional must be cancelled 72 hours in advance or the responsible party will be charged in full.

INSURANCE: Billing your insurance will be completed as a convenience to you. 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.

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.

EMAIL/TEXT: We are able to send you appointment reminders by email/text. The appointment reminders will include only the dates and times of your appointments and your service provider's name. We will not encrypt the messages. Health care information sent by regular e-mail could be lost, delayed, intercepted, delivered to the wrong address, or arrive incomplete or corrupted. If you understand these risks and would like to receive appointment reminders by email/text, please confirm you accept responsibility for these risks, and will not hold us responsible for any event that occurs after we send the message.

Email: _____ Mobile #_____

I give consent to receive reminder emails/texts for appointments. Initial here to indicate consent. _____

TERMINATION OF SERVICES: In order to provide optimal therapeutic services, session attendance is expected. Any client that has not attended a session after 8 weeks, will automatically be discharged from services. Multiple cancelled/missed appointments may result in referral to other servicing agencies. Failure to keep your account current may result in termination of services.

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. Any and all fees incurred as a result of the involvement of a collection agency to include court costs, attorney fees and collection agency fees will be the responsibility of the responsible party of the account. Collection agencies are not bound to any confidentiality agreement. 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 as well as collection agency fees.

ASSIGNMENT OF BENEFITS: By signing below you authorize Wishing You Well Counseling Center to bill and collect from your insurance company.

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)