

## Client Information Form

Date: \_\_\_\_\_ Full Name: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Who referred you? \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Contact Number: (\_\_\_\_) \_\_\_\_\_ Secondary Contact Number: (\_\_\_\_) \_\_\_\_\_

Email address: \_\_\_\_\_

Please indicate where you prefer to be contacted:  home phone  work phone  cell phone  email

Please indicate where we have permission to leave a message:  home phone  work phone  cell phone  email

Please choose one (1) option for your appointment reminder:

voicemail (\_\_\_\_) \_\_\_\_\_  text (\_\_\_\_) \_\_\_\_\_

email \_\_\_\_\_  No reminder needed

Please indicate you have read:

I understand that email and texting, while confidential, may not be secure to third-party intrusion.

**Emergency Contact** Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_

### Employment History/Education History

Highest level of education:  high school  associate's degree  bachelor's degree  graduate degree

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ How long? \_\_\_\_\_

Current job satisfaction:  Strongly Dissatisfied  Dissatisfied  Satisfied  Strongly Satisfied

Current Household Income:  Under \$30,000  \$30,000 to \$45,000  \$45,000 to \$60,000  Over 60,000

### Military Service History

Branch: \_\_\_\_\_ Dates of Service: \_\_\_\_\_ Deployments: \_\_\_\_\_

### Relationship Information

Current relationship status:  Single  Partnered/Dating  Married  Separated  Divorced  Widowed

Spouse/Partner Name: \_\_\_\_\_ Age: \_\_\_\_\_ Length of relationship: \_\_\_\_\_

Spouse/Partner Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Please list information about your previous significant relationships/ marriages:

Name: \_\_\_\_\_ Approx. start date: \_\_\_\_\_ Approx. end date: \_\_\_\_\_

Name: \_\_\_\_\_ Approx. start date: \_\_\_\_\_ Approx. end date: \_\_\_\_\_

Name: \_\_\_\_\_ Approx. start date: \_\_\_\_\_ Approx. end date: \_\_\_\_\_

Who currently lives in your household?

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Please list information about your children, if any:

Child's Name	Age	Deceased (yes/no)	Current City, State	Relationship (excellent, good, fair, poor)	Physical/ Mental Illnesses

**Family History**

Where were you born? \_\_\_\_\_ Where you were raised? \_\_\_\_\_

Family spiritual/religious practices, if any: \_\_\_\_\_

Current religious/spiritual preference, if any: \_\_\_\_\_

Are your parents married?  Yes  No If not, mother remarried?  Yes  No Father remarried?  Yes  No

Please list information about your family:

Relative (mother, father, siblings)	Name	Age	Deceased (yes/no)	Current City, State	Relationship (excellent, good, fair, poor)	Physical/ Mental Illness

**Personal Health History**

In general, my health is:  excellent  very good  good  fair  poor

Please indicate if you have a serious medical condition:  Asthma  Diabetes  Heart Disease  Chronic Pain

Other \_\_\_\_\_

If employed, how many days in the past 6 months were you unable to work due to your physical or mental health? \_\_\_\_\_

If employed, how many days in the past 6 months were you able to work but had to cut back on how much you got done due to your physical or mental health? \_\_\_\_\_

Have any of your medical conditions required hospitalization?  No  Yes Please describe: \_\_\_\_\_

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Have you been hospitalized for psychiatric or substance abuse issues?  No  Yes

Hospital/treatment center: \_\_\_\_\_ Location: \_\_\_\_\_

Dates of Treatment: \_\_\_\_\_

Please list your current medications:

Medication	Dose	Frequency	Reason for Medication	Prescribing Physician

Please describe your previous counseling history:

Dates of Service	Counselors Name	Reason for Services/Outcome

**Current Health Information**

Briefly describe your reason for seeking counseling services at this time: \_\_\_\_\_

\_\_\_\_\_

Briefly describe your expectations/anticipated outcome of counseling: \_\_\_\_\_

\_\_\_\_\_

Symptom Checklist	Never	Somewhat	Moderately	A Lot
1. Feeling hopeless				
2. Feeling anxious or worried				
3. Loss of interest				
4. Racing or pounding heart				
5. Feeling nervous or shaky				
6. Feeling fearful				
7. Feeling angry or irritable				
8. Feeling sad				
9. Eating difficulties				
10. Overeating/ binge eating				
11. Restricted eating/laxative abuse				
12. Restlessness				
13. Repeated unwanted thoughts				

Symptom Checklist	Never	Somewhat	Moderately	A Lot
14. Difficulty with concentration				
15. Stomach or intestinal distress				
16. Sexual difficulties				
17. Trouble falling asleep				
18. Trouble staying asleep				
19. Difficulty at home				
20. Difficulty at school or work				
21. Financial stress				
22. Non-suicidal self-injury				
23. Suicidal or homicidal thoughts				
24. Have you ever felt bad or guilty about your alcohol or drug use?				
25. Have you felt like you should cut down on your alcohol or drug use?				
26. Have others criticized your alcohol or drug use?				

27. How many alcoholic drinks have you had in the past week? \_\_\_\_\_

28. Have you ever attempted suicide?  No  Yes Please describe: \_\_\_\_\_

29. Do you have a history of abuse or trauma?  No  Yes Please describe: \_\_\_\_\_

30. I feel good about myself.  Strongly Agree  Agree  Disagree  Strongly Disagree

31. I can deal with my problems.  Strongly Agree  Agree  Disagree  Strongly Disagree

32. I am able to accomplish the things I want.  Strongly Agree  Agree  Disagree  Strongly Disagree

33. I have friends or family that I can count on.  Strongly Agree  Agree  Disagree  Strongly Disagree

**Please initial the following statements regarding payment, release of information, and confidentiality:**

\_\_\_\_\_ I understand that all fees from professional services rendered are my responsibility, including services not covered by insurance. I am aware that this office files my insurance as a courtesy, and services must be paid when rendered.

\_\_\_\_\_ I hereby authorize Triad Counseling and Clinical Services, PLLC to release any information necessary to process insurance claims concerning my diagnosis and treatment, and I authorize payment of medical/psychological benefits to Triad Counseling and Clinical Services, PLLC.

\_\_\_\_\_ I understand that Triad Counseling and Clinical Services, PLLC, is ethically and legal required to report to legal authorities information I give about ongoing abuse of children, disabled, and elderly persons and imminent physical danger I present to myself or others because of psychological factors.

\_\_\_\_\_  
Client's Signature (Parent/Guardian)

\_\_\_\_\_  
Date

## Release of Information Scheduling or Billing

You can authorize the release of your private health information to others for scheduling or billing purposes. Keep in mind that we cannot discuss your records without your written consent. Please complete the section below if you would like to allow access to your records.

Please initial the following:

\_\_\_\_\_ I **do not authorize** access to my private health information (PHI) at this time,

OR

\_\_\_\_\_ I **authorize** access to my private health information (PHI) to the following individual other than myself:

Name: \_\_\_\_\_, Relationship: \_\_\_\_\_, in

the following forms and purposes only:

\_\_\_\_\_ Scheduling (making, changing, or verifying appointments)

\_\_\_\_\_ Billing (accessing verbal and written detailing in regards to payments, session dates, and general billing inquiries, including allowing others to make payments on my behalf)

\_\_\_\_\_  
Client's Signature (Parent/Guardian)

\_\_\_\_\_  
Date

Triad Counseling & Clinical Services, PLLC  
5587 D Garden Village Way, Greensboro, NC 27410  
1623 York Avenue, Suite 104, High Point NC, 27265

## **CONSENT TO DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS & ACKNOWLEDGEMENT OF PRIVACY PRACTICES**

I hereby consent to the use or disclosure of my individually identifiable health information ("protected health information" or PHI), excluding psychotherapy notes, by Triad Counseling and Clinical Services, PLLC (Provider) in order to carry out treatment, payment, or health care operations (TPO). My specific authorization must be obtained for disclosure of my PHI, including summary of psychotherapy notes, for purposes other than TPO, except in special situations. I have reviewed the Notice of Privacy Practices for a more complete description of the potential disclosures of such information.

I have the right to inspect and obtain a copy of my medical/mental health records, although I understand the Provider has the right to deny such request under certain circumstances. I have the right to have a denial to inspect reviewed by a "reviewing official." A reasonable fee may be charged for providing a copy of my records. I have the right to request amendments to the information in my medical/mental health records, although I understand the Provider has the right to deny such request. I have the right to request an accounting of disclosures of my PHI for purposes other than TOP and those for which I provided authorization. I may submit a written privacy complaint to 5587 D Garden Village Way, Greensboro, NC 27410 or to the U.S. Secretary of the Department of Health and Human Services, without any action being taken by the Provider against me without any change in my treatment.

Provider reserves the right to change the terms of its Notice of Privacy Practices at any time. If the terms of the Notice of Privacy Practices are changed, I may obtain a copy of the revised Notice by requesting a copy.

I retain the right to request that the Provider further restrict how my protected health information is used or disclosed to carry out treatment, payment, or health care operations. The Provider is not required to agree to such requested restrictions; however, if the Provider does agree to the requested restriction(s), such restrictions are then binding on the Provider.

At all times, I retain the right to revoke this Consent. Such revocation must be submitted to the Provider in writing. The revocation shall be effective *except* to the extent that the Provider has already taken action in reliance on the Consent.

The Provider may refuse to treat me if I (or authorized representative) do not sign the Consent portion of this form (except to the extent that the Provider is required by law to treat individuals). If I (or authorized representative) sign the Consent portion and then revoke Consent, the Provider has the right to refuse to provide further treatment to me as of the time of revocation (except to the extent that the Provider is required by law to treat individuals).

Please initial the following:

I \_\_\_\_\_ HAVE HAD AN OPPORTUNITY TO REVIEW THE PROVIDER'S NOTICE OF PRIVACY PRACTICES.

I \_\_\_\_\_ **CONSENT** TO THE RELEASE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

**OR**

I \_\_\_\_\_ **DO NOT CONSENT** TO THE RELEASE FOR PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

_____ Please Print Name	_____ Client's Signature (or authorized representative)	_____ Date
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Representative's Authority to act on behalf of the Patient: \_\_\_\_\_

For office staff use only:

Acknowledgement of Privacy Practices was not obtained because: \_\_\_\_\_

HIPAA

11/2019

## Consent for the Release of Mental Health Information

This form is used to be able to discuss or release information to you (or your child's) primary care doctor only, in order to coordinate treatment.

If you wish for information to be released to the primary care doctor only, please fill in the name of that doctor, check by the authorization line and **sign and date the form**.

If you **DO NOT** wish for information to be released to the primary care doctor, check by the decline line and **sign and date the form**.

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Mental Health Provider Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Primary Care Physician Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

\_\_\_\_\_ I authorize the release of relevant treatment information to the provider(s) named above. I understand that these records are confidential and cannot be disclosed without my written authorization, except as otherwise provided by law. My consent may be revoked at any time, and expires one year from the date signed.

\_\_\_\_\_ I decline the release of treatment information to my Mental Health Provider or Primary Care Physician.

\_\_\_\_\_  
Client's Signature (Parent/Guardian)

\_\_\_\_\_  
Date

Relationship to Client: \_\_\_\_\_