

Welcome to The Center For Family Wellness

Date _____

Name _____

Referred by _____

Type of Counseling: Family _____ Self _____ Couple _____

General Information

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

E-Mail Address _____

Date of Birth _____ Male/Female

*Date I understand that I am responsible for the fees stated below.
This office does not accept assignment from insurance companies.*

Signature _____

Fees

\$75.00 per hour for Individual Consultation

\$125.00 per hour for Couple/Family Consultation

After the first hour, fees will be prorated by the quarter-hour. For example,
the fee for 1½ hours for a Couple/Family consultation will be \$187.50
(\$125.00 + \$62.50 = \$187.50).

CONFIDENTIAL PERSONAL DATA INVENTORY

Please complete this inventory carefully

PERSONAL IDENTIFICATION

Name _____ Birth Date _____

Age _____ Sex _____ Referred by _____

Marital Status: Single _____ Engaged _____ Married _____ Separated _____

Divorced _____ Widowed _____

Education: (last year completed) _____

Employer _____ Position _____ Yrs. _____

MARRIAGE AND FAMILY

Spouse _____ Birth Date _____

Age _____ Occupation _____ How Long Employed _____

Date of marriage _____ Length of dating _____

Give a brief statement of circumstances of meeting and dating: _____

Have either of you been previously married _____ who _____

Information about children:

Name	Age	Sex	Living	Yr. Ed.	Stepchild
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Describe relationship to your father _____

Describe relationship to your mother _____

Number of siblings _____ your sibling order _____

Did you live with anyone other than parents _____

Are your parents living _____ Do they live locally _____

PHYSICAL HEALTH

Describe your health _____

Do you have any chronic conditions _____ What _____

List important illnesses and injuries or handicaps _____

Date last medical exam _____ Report _____

Physician's name and address _____

Current medications and dosage _____

Have you ever-used drugs for other than medical purposes _____

If yes, please explain _____

Do you drink alcoholic beverages _____ If so, how frequently and how much _____

Do you drink coffee _____ how much _____

Other caffeine drinks _____ how much _____

Do you smoke _____ What _____ Frequency _____

Have you ever had interpersonal problems on the job _____

Have you ever had a severe emotional upset _____ If yes, explain _____

Have you ever seen a psychiatrist or counselor _____

If yes, explain _____

Are you willing to sign a release of information form so that your counselor may request social, psychiatric, or other medical records

SPIRITUAL HEALTH

Denominational/ Religious preference _____

Church home _____ are you a Member _____

Church attendance per month (circle) 0 1 2 3 4 5 6 7 8+

Do you believe in God _____ Do you pray _____ would you say you Are a Christian, _____ or still in the process of becoming a Christian _____

How often do you read the Bible: Never Occasionally Often Daily

Explain any recent changes in your religious life: _____

********THIS SECTION FOR WOMEN ONLY********

Have you had any menstrual difficulty _____ Do you experience tension, tendency to cry, other symptoms prior to your cycle; please explain: _____

Is your husband willing to come for counseling: _____

Is he in favor of your coming _____ if no explain: _____

EMOTIONAL HEALTH

CIRCLE any of the following words which best describe you *now*: active ambitious self-confident persistent nervous hardworking impatient impulsive moody kindly often-blue excitable imaginative calm serious easy-going shy good-natured introvert extrovert likeable leader quiet hard-boiled submissive spiritual self-conscious lonely sensitive other.

Have you ever felt people were watching you?	Yes	No
Do people's faces ever seem distorted?	Yes	No
Do you ever have difficulty distinguishing faces?	Yes	No
Do colors ever seem too bright?	Yes	No
Are you sometimes unable to judge distance?	Yes	No
Have you ever had hallucination?	Yes	No
Are you afraid of being in a car?	Yes	No
Is your hearing exceptionally good?	Yes	No
Do you have problems sleeping?	Yes	No

PROBLEM CHECK LIST (Circle those which apply to you.)

Anger	Envy	Appetite
Anxiety	Fear	Memory
Apathy	Gluttony	Moodiness
Bitterness	Guilt	Rebellion
Change in lifestyle	Health	Sex
Children	Homosexuality	Sleep
Depression	Impotence	Wife Abuse
Deception	In-laws	A Vice

BRIEFLY ANSWER THE FOLLOWING QUESTIONS: (use reverse side, if necessary)

1. Have you or any member of your family ever been involved in or experienced any type of spiritual phenomenon?
_____ (. I.e. angels, ghosts, magic, Ouija board, hypnotism, voodoo, Transcendental meditation, out-of-body experience, speaking to or hearing from the dead, spells, visions, etc.)
2. What is your problem (what brings you here)?
3. What have you done about this problem?
4. What are your expectations from counseling?
5. Is there any other information we should know?

NOTICE OF HEALTH INFORMATION PRACTICES

The Center for Family Wellness

Effective April 14th, 2003

The records we create in providing you with care are by law, kept confidential. We are also required to inform you of our policies concerning the use and storage of your personal health information. If you have any comments or questions about our Privacy Notice you may call 256-880-6199.

Privacy Policy

The following describes the manner in which we use and disclose your personal health information:

1. We may collect and share appropriate information about you to document the medical necessity of the services we are providing. Examples include diagnosis, prescription, referral and physician or health care provider information.
2. We may share appropriate information about you to bill and collect payment for the health care we provide, including insurance companies and third parties, which includes family members or other financially responsible parties you have informed us of. Examples include insurance coverage and eligibility verification.
3. We may use and disclose information to monitor and operate our business. Examples include satisfaction surveys, health care outcomes and utilization reporting, reports provided to any federal, state or local authority (as required by law), or to remind you of equipment, supplies or service needs.
4. We may release appropriate information about you to family or friends that are helping you with the financial responsibilities incurred while receiving services from us.
5. We may use and disclose information about you to respond to a court or legal authoritative body that legally requests information about you. Examples include providing documents for legal subpoenas or discovery proceedings and our staff testifying about the care we have provided.

The following describes **your** rights to the information we maintain about **you**:

1. You have the right to direct the use of your personal health information.
2. You have the right to terminate or revise your authorizations or consents that pertain to our use of your personal health information, and have those terminations or revisions affect any new service. We are not required to accept your terms. If we do not accept your restrictions, we will honor your specifications, except where prohibited by law. All requests must be in written form.
3. You have the right to request a copy of your personal health information as long as any federal, state or local law does not prohibit it. This request must be in writing. There is a charge for copying, producing and delivering your information.
4. You have the right to request, in writing, a revision to your personal health information. Revision requests will be evaluated on an individual basis and amended, if appropriate. At no time will a revision be made that may erroneously record the personal health information stored by us. Your written request must detail the requested revision and the reasons for the modification. If no explanation is provided, no revision will be made. If we deny your request for amendment, you have the right to file a statement of disagreement.
5. You have the right to request an accounting of non-routine disclosures we have made with your personal health information. You can receive one free accounting service in a twelve-month period. We will charge for any accounting services that exceed one per twelve months. You must agree to this charge before we will provide any accounting services. These requests cover dates of services on or after April 14, 2003.
6. You have the right to file a complaint about our use of your personal health information with the Secretary of the Department of Health and Human Services.

By signing below, I acknowledge receipt of this Notice of Health Information Practices and that I have been provided a copy of the notice.

_____ Date _____
Patient Signature or Representative for Patient