



**TREASURE WELLNESS COUNSELING AND TRAINING CENTER**

ADMINISTRATIVE OFFICE  
 3006 E GOLDSTONE DRIVE, MERIDIAN, ID 83642  
 208-515-7661  
 WWW.TREASUREWELLNESS.COM

**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: \_\_\_\_\_



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**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: \_\_\_\_\_

**SEXUALITY**

What sexual issues would you like to discuss during treatment? \_\_\_\_\_  
 \_\_\_\_\_

Have you ever been sexually and or physically abused? YES  NO

Have you witnessed or experienced any other trauma? YES  NO

If yes, please explain briefly: \_\_\_\_\_  
 \_\_\_\_\_



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**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?		
					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



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**CURRENT CONCERNS**

A. What brought you into treatment: \_\_\_\_\_

B. What are your expectations for treatment: \_\_\_\_\_

C. What is the one thing that you want me to know about you today: \_\_\_\_\_

**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)



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**AGREEMENT TO PAY FOR PROFESSIONAL SERVICES**

I request that \_\_\_\_\_ provide professional service to,  
(Counselor Name)

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 Counseling and Training Center 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

\_\_\_\_\_  
Client/Guardian Signature Relationship Date

I, the counselor, have discussed the issues above with the client and/or the person representing the client. My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

\_\_\_\_\_  
Counselor Counselor Signature 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

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Counselor

\_\_\_\_\_  
Counselor Signature

\_\_\_\_\_  
Date



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**CONSENT FOR TREATMENT AND ACKNOWLEDGMENT**

I, hereby acknowledge that I have received, read and been given an opportunity to ask questions regarding the following Treasure Wellness Counseling and Training Center business documents. I understand that if I have any questions or concerns regarding these business documents, I may contact my clinician or the TWCTC office.

- Your Counselor’s Informed Consent and Procedures
- Treasure Wellness Counseling and Training Center Informed Consent and Procedures
- Client Bill of Rights
- Agreement to Pay
- Cancellation/No Show Policy – May Be Subject to ½ Billable Rate
- Insurance Assignment of Benefits
- Emergency Procedures
- HIPAA-Notice of Privacy
- Authorization for Live Observation
- Authorization for Audio-Video Recording

I, voluntarily consent to the live observation of session by TWCTC Interns, Affiliates, Supervisors or Intern University Representative.

- YES
- NO

I, voluntarily consent to audio-video recording of sessions by TWCTC Interns, Affiliates, or Supervisors for educational training use.

- YES
- NO

I, voluntarily consent to participate in the intake, assessment and treatment process. I also acknowledge the following:

1. I have been given the opportunity for discussion of any concerns that I have regarding treatment.
2. I will be informed and take part in my treatment and goal planning.
3. I have been given no guarantee of treatment outcomes.
4. I have been informed of any and all fees associated with my treatment.
5. TWCTC will use and disclose personal health information for treatment and to receive payment for services provided.

\_\_\_\_\_  
Printed Name of Client

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Parent/Guardian

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Parent/Guardian

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Counselor

\_\_\_\_\_  
Signature of Counselor

\_\_\_\_\_  
Date



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**AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

Date initiated: \_\_\_\_\_

Client's Name: \_\_\_\_\_  
First Name Middle Name Last Name

Client's Date of Birth: \_\_\_\_\_

I, \_\_\_\_\_ authorize the release of my confidential protected health information, as described in my directions below. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

\_\_\_\_\_ Release To: \_\_\_\_\_ Obtain From: \_\_\_\_\_ Exchange With:

\_\_\_\_\_  
Name of Clinician, Office, Individual

\_\_\_\_\_  
Address Phone Fax

**Information to be released:**

- Authorization for Psychotherapy Notes
- Authorization for History/Intake
- Authorization for Diagnosis
- Authorization for Dates of Treatment/Attendance
- Other (describe information in detail): \_\_\_\_\_

**The reason I am authorizing release is:**

- Evaluation/Assessment and/or Coordinating Treatment Efforts
- Other (describe): \_\_\_\_\_

**\*\*This Authorization will expire 180 Days after initiated\*\***

I understand, that I have the right to refuse the release of any protected health information. I may revoke my consent to release at any time except to the extent that the information has already been released.

Signature of Client: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Counselor: \_\_\_\_\_ Date: \_\_\_\_\_