CLIENT QUESTIONNAIRE

Please fill in the following information as thoroughly as possible.

Name: ____________________________________ Social Security # ______ - ____ - ______

Address: ____

City: ____ State: ________ Zip: __________

Home Phone: (_____) __________________ Work Phone: (_____) ____________________

Cell or Pager: (_____) __________________ e-mail: ________________________________

Occupation: ____
Male (___) Female (____) Date of Birth: ______/______/_______ Age: ______
Birth City & State: ___________________________________ Adopted? (__) Yes (__) No

Who referred you to Counseling Associates? (Friend? Physician? Yellow Pages? Internet? Insurance Network? Other?): ____

Briefly describe the reason or problem for which you are seeking assistance:
____
____

Education History: (Please circle highest grade completed.)

Grade School	4 5 6 7 8
High School	9 10 11 12
College	1 2 3 4
Business/Trade	1 2 Specify Area of Concentration ________________________
Graduate School	Number of Years ______ or Specify Degree Earned ____________

Family History: (Please list all members of your birth/adoptive family, including yourself. Please use the back of this sheet if you need additional room for siblings.)

	Name	Age	Occupation	Education Level	Marital Status
Father	__________________	____	____________	______________	____________
Mother	__________________	____	____________	______________	____________
Sibling	__________________	____	____________	______________	____________
Sibling	__________________	____	____________	______________	____________
Sibling	__________________	____	____________	______________	____________

Relationship History & Current Relationship Status?

(____) Single (_____) Engaged (_____) Married # of Years ________
(____) Separated (_____) Divorced (_____) Widowed # of Years ________
(_____) Remarried – How many times? _______ and # of Years? _________

Spouse / Partner's Name: __________________ Date of Birth _______________ Age _______
Spouse / Partner's Occupation: ____________________________ Education Level ___________

Children	Name	Age	Sex	Live with you? (Y or N or part-time?)	Adopted or Step?
1st born	__________________	____	____	_______________	_______________
2nd born	__________________	____	____	_______________	_______________
3rd born	__________________	____	____	_______________	_______________
4th born	__________________	____	____	_______________	_______________
5th born	__________________	____	____	_______________	_______________
6th born	__________________	____	____	_______________	_______________
7th born	__________________	____	____	_______________	_______________
8th born	__________________	____	____	_______________	_______________

Faith / Religious Affiliation (if any)**: ____**
Frequency of attendance to church / temple / other (if applicable): ___________________

Sexual Orientation: (__) Heterosexual (__) Homosexual
(__) Bisexual (__) Struggling/Uncertain

Have you ever been a victim of abuse (physical, sexual, verbal, or emotional)? (__) Yes
(__) No
(__) Uncertain

Legal History:
Have you ever been arrested? (__) No (__) Yes Date of arrest _____ / _____ / _____
If you answered yes, for what? (___) Assault (___) Shoplifting (___) Battery
(___) Possession of an illegal substance (___) DUI
(___) Drunk & disorderly conduct
(___) Other ____

Do you have any court dates pending? (___) No (___) Yes Date(s) __________________

Medical History:
My general health is (___) good, (___) average, (___) poor.
My current weight is ________________ and height is _______________.
Primary care physician: ______________________ Phone number: _______________
Estimated date of recent exam: ______ / _______ / _______

List dates and reasons for all hospitalizations or surgeries:

Date	Reason	Length of Stay
___________	____	_________________________
___________	____	_________________________
___________	____	_________________________

List medications that you take or have taken on a regular basis:

Name	Frequency	Dosage	Reason
___________	___________	___________	____
___________	___________	___________	____
___________	___________	___________	____
___________	___________	___________	____

List medications that you take on an as-needed basis:

Name	Frequency	Dosage	Reason
___________	___________	___________	____
___________	___________	___________	____
___________	___________	___________	____
___________	___________	___________	____

For women only: Age at first period _________ / Number of days in cycle ________
Menopause (___) Yes (___) No

For men or women, list any current physical complaints or problems: ________________________
____

Have you ever been to see a mental health professional? (___) Yes (___) No

If "Yes," please list:	Name	Year(s)	Reason
Psychiatrist (MD)	___________________	__________	_______________________________
Psychologist (PhD)	___________________	__________	_______________________________
Social Worker	___________________	__________	_______________________________
Counselor	___________________	__________	_______________________________
Therapist	___________________	__________	_______________________________
Clergy (pastor/priest)	___________________	__________	_______________________________

List dates and reason for past psychiatric hospitalizations:

Hospital	Date	Reason
_________________________	____________	______________________________________
_________________________	____________	______________________________________
_________________________	____________	______________________________________

Have any of your relatives ever seen, even once (or in your opinion, should have seen), a psychiatrist, psychologist, counselor, or therapist? (Please include maternal and paternal grandparents, aunts, uncles, cousins, children, and grandchildren.) If yes, explain:

____
____
____

Financial Responsibility & Confidentiality

I hereby certify that this information is accurate to the best of my knowledge. In addition, I understand and agree to all of the following:

A. I agree to take responsibility to insure that my account is paid in full at each visit and that the balance is kept current;

B. I have read and understand the fee schedule and payment policy of Counseling Associates (which is printed on the following page);

C. I agree to the information contained in the fee schedule and payment policy of Counseling Associates;

D. I understand that I may request a copy of the fee schedule and payment policy of Counseling Associates;

E. I agree to be responsible for any fees of non-therapeutic services relevant and necessary to my treatment, to be billed at the same hourly rate as therapeutic sessions (including but not limited to the following: paperwork other than regular post-session note-keeping; phone consultations with lawyers, probation officer, etc.; and court time);

F. I agree to give notice of cancellation at least 24 hours prior to a scheduled appointment, and I understand that I may be charged for full-session fee ($100 individual / $110 couple or family) if I fail to do so;

G. I understand that disclosure of information contained herein and contained within session will not be released to others without my signed consent, except in cases of emergency or when required by law (in instances of talk of harm to self, others, or child abuse [physical or sexual] or neglect).

I give my consent to be treated by Counseling Associates.

______________________________	______________________________
Client Signature	Parent / Legal Guardian Signature
______________________________	______________________________
Client Name (PRINTED)	Parent / Legal Guardian Name (PRINTED)
____________________	____________________
Date	Date

If client is 26 years old or younger, please put name, date of birth, and address for MAIN INSURANCE MEMBER:

Name ______________________________ Date of Birth __________ Phone __________

Address ____

Fees Schedule & Payment Policy

Schedule of Fees and Session Rates

Individual	45 to 55 minutes	$100.00
Family / Couple	50 to 55 minutes	$110.00
Report or Letter-Writing	up to 60 minutes	$50.00
Legal Participation of Any Kind	$100.00 / hour, door to door	

Account Payment

Full payment is expected at the time of service. Cash, personal checks, money orders, as well as MasterCard, Visa, and Discover are accepted. It is not office policy to accept post-dated checks. If full payment is not possible, financial arrangements must be made prior to the appointment. Insurance will be filed for the primary carrier, if requested. Any co-payments for participating providers in a healthcare network are due at the time of service. For all other insurance, full payment is expected at the time of service, and insurance will be filed, noting that payment was made in full. Any balances that are filed with the insurance are due within 90 days of service, at which time the responsibility of the balance becomes that of the client.

Cancellations

The client agrees to give notice of cancellation at least 24 hours before the scheduled appointment time and agrees to reschedule within three (3) days of the cancelled appointment. Failure to show up or contact the office of Counseling Associates will result in being charged for the full session ($100 individual / $110 couple or family). Exceptions will be made for emergencies at the discretion of the Director of Counseling Associates.

Defaulted Accounts

An account will be considered in default if delinquent more than 60 days past the date of service. Once an account is defaulted, the client agrees to assume responsibility for all court costs, attorney fees, or collection agency fees that may be incurred to rectify the account. Prejudgment or post judgment interest at the current legal rate also may be added to the account.

Payment for Minors

In situations involving children under the age of eighteen (18), the parent(s) or legal guardian(s) is responsible for payment of his/her child(ren)'s account. In cases where the parents are divorced, payment for services is the responsibility of the parent who schedules the appointment for the child. When legal agreements specify percentages to be paid by each parent, it is the responsibility of the custodial parent to coordinate and provide full payment.

Returned Checks

A charge of $25 will be assessed for all returned checks.

For Emergency Crisis Intervention, call 317-251-7575

(Mental Health America of Greater Indianapolis) or 911