CLIENT QUESTIONNAIRE

Please fill in the following information as thoroughly as possible.

Legal Name: _________________________________ Preferred Name: _________________

Address: ____

City: ____ State: ________ Zip: __________

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

Cell Phone: (_____) ____________________ e-mail: ________________________________

Occupation: ____

Male (___) Female (___) Other (___) Date of Birth: ______/______/_______ Age: _____

Birth City & State: ____________________________________ Adopted? (__) Yes (__) No

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

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

____

____

Education History: (Please circle level of education completed.)

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.)

	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 (__) Other:_________________

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 (printed on the previous 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 attorneys, probation officers, other clinicians, 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 will be charged full session fee ($125 for 1.0 scheduled session / $185 for 1.5 scheduled session) if I fail to give such notice;
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

______________________________ ______________________________

Name (PRINTED)   Name (PRINTED)

____
(Date)

Please provide name, date of birth, and address for main INSURANCE MEMBER (if different from person listed on page 1):

Name _________________________________ Date of Birth ___________ Phone ___________

Address ____

Fee Schedule & Payment Policy

Schedule of Fees & Session Rates

Indiv. / Family / Couple (1.0 session)	45-50 minutes	$125.00
Indiv. / Family / Couple (1.5 sessions)	70-75 minutes	$185.00
Report / Letter Writing	per 30-min. increments	$50.00

Legal Participation of Any Kind = $350/hour w/ 4-hour minimum, $135/hour travel, $2000 deposit due min. 10 days prior to court date (Ask your clinician for detailed document to sign if needed.)

Account Payment

Full payment is expected at the time of service. Cash, personal checks, money orders, as well as MasterCard, Visa, Discover, AmEx, and HSA cards (in office or through Square) are accepted. We cannot accept post-dated checks. If full payment is not possible, financial arrangements must be made <u>prior</u> to appointment. Insurance will be filed for the primary carrier, if requested, whether in-network or out-of-network. Any co-payments for in-network benefits are due at time of service. For all out-of-network insurances, full payment is expected at time of service, and insurance will be filed, noting that payment was made in full. Any balances that are filed with insurance are due within 90 days of service, at which time the balance becomes the client's.

Cancellations

Client agrees to give notice of cancellation **at least 24 hours** before the scheduled appointment time and reschedules within a week (7 days) of the cancelled appointment if availability allows. Failure to show up or contact the Counseling Associates office will result in a full-fee session charge ($125 for 1.0 session / $185 for 1.5 sessions if so scheduled). 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 date of service. Once an account is defaulted, client agrees to assume responsibility for all court costs, attorney fees, or collection agency fees that may be incurred to rectify the account. Pre-judgment 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), parent(s) or legal guardian(s) is responsible for payment of account. In cases where parents are divorced, payment of 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 to coordinate and present full payment.

Returned Checks
A charge of $40 will be assessed for all returned checks.

For Emergency Crisis Intervention, call 317-251-7575

(Mental Health America of Greater Indianapolis) or 911