The Center for Counseling & Wellness
Client Information Sheet

Client Legal Name: _____
First Middle Last

Client Preferred Name: _____
First Middle Last

Address: _____
Street City State Zip

Social Sec #: _____ **Marital Status:__M __S __ D __ W __ Sep __ O**

Primary Phone: _____ **Type:_____** **Secondary Phone:** _____ **Type:_____**

Gender Assigned at Birth: _____ **Identified Gender:** _____

Preferred Pronouns: _____ **DOB:** _____ **Age:** _____

Email Address: _____

Parent/Guardian (If Minor/Disabled):_____
First Middle Last

Relationship to Client: _____ **Phone #:** _____**: Type:_____**

Emergency Contact Name: _____
First Middle Last

Relationship to Client: _____ **Phone #:** _____**: Type:_____**

Local Police Department (City/County): _____ **Phone #:** _____

Primary Care Physician: _____
Name Phone #

Employment Status: ( ) Employed ( ) Unemployed ( ) Disabled ( ) Retired

How did you learn about us? ( ) Family ( ) Friend ( ) Church ( ) School

( ) Insurance ( ) Internet ( ) Doctor ( ) Sign/brochure ( ) Other

Person Completing Form: _____
Relationship to Client

THE CENTER

For Counseling and Wellness

www.thecenter4counseling.com

The Center for Counseling & Wellness

Client Intake Signature Form

Client Legal Name_____

Client Preferred Name _____

My signature below confirms that I have received, reviewed, and/or completed a copy of*:*

- **The Center for Counseling & Wellness' Disclosure Statement with Informed Consent to Participate in Clinical Counseling, HIPAA Rules, and Virtual Care Disclosure**
- **Notice of Privacy Practices for The Center for Counseling & Wellness**
- **The Center For Counseling & Wellness Biopsychosocial History Intake Form**
- **My counselor's personal Professional Disclosure Statement**

and have had an opportunity to discuss any questions I have about this information. I acknowledge that a copy of these documents has been made available to me at no charge and that they are available on our website at thecenter4counseling.com.

_____

Client's Signature (Parent/Legal Guardian if client is a minor) Date

Updated 08/20/2023

110 Ye Old Kings Highway, North Myrtle Beach | 4466 Holmestown Road, Myrtle Beach
3505 Main Street, Loris | 602 Main Street, Conway
Phone (843) 663-0770 | Fax (843) 663-0772 l Email: admin@thecenter4counseling.com

CLIENT LEGAL NAME AS SHOWN ON INSURANCE CARD: _____

CLIENT PREFERRED NAME: _____CLIENT'S DATE OF BIRTH: _____

FINANCIAL COVENANT AGREEMENT

The Center for Counseling & Wellness

_____ INSURANCE (*Fill out this section if you are using insurance to pay for treatment*)

PRIMARY INSURANCE CARRIER:

Name of Insurance:	Policy #
Policy Holder:	Relationship to client:
Home Address:	City, State, Zip:
Policy Holder's Date of Birth:	Phone #

_____ SECONDARY INSURANCE CARRIER:

Name of Insurance:	Policy #
Policy Holder:	Relationship to client:
Home Address:	City, State, Zip:
Policy Holder's Date of Birth:	Phone #

_____ PRIVATE OR THIRD-PARTY PAYMENT (*Fill out this section if insurance is not applicable*)

Sliding Fee Scale: Agreed Amount: _____ Staff Initials: _____	**Third Party Payor:** Name: _____ Address: _____ Contact Number: _____

AUTHORIZATION AND RELEASE

I CERTIFY THAT THE ABOVE STATEMENTS ARE TRUE TO THE BEST OF MY KNOWLEDGE. I understand I am personally responsible for payment of all insurance co-pays and deductibles regardless of any insurance payments made to The Center for Counseling & Wellness (The Center). I authorize The Center to release all information necessary to process any insurance claims or third-party payment**. I authorize payment of insurance benefits directly to The Center**. I understand the **Late Cancellation fee of $50** is not covered by insurance and is accordingly my responsibility (*does not apply to Medicaid clients*). **There will be a $25 fee for all returned checks. I understand if I am a self-pay client, I have the right to a good faith estimate of the cost of each visit and the agreed amount above is such an estimate.** I further understand my account needs to remain current to continue in the counseling process.

_____ _____

Client Signature/Parent or Guardian Signature if Minor Date

THE CENTER

for Counseling & Wellness

www.thecenter4counseling.com

Credit Card Authorization Form

Credit Card Information Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX

Cardholder Name (as shown on card): _____

Card Number: _____

Expiration Date (mm/yy): _____

Cardholder Billing Address & Zip Code:

_____

_____

I, _____ (client legal name), authorize *The Center for Counseling & Wellness*, to charge my credit card listed above for counseling services. I understand that my information will be saved to file for future transactions on my account.
I agree to pay $_____for each individual session.

Signature of Client/Representative _____ Date _____

Client Printed Name _____ Date of Birth _____

Relationship to Client_____

*****ALL CREDIT CARDS WILL BE SUBJECT TO A 3.5% PROCESSING FEE EFFECTIVE 1/1/2023*****

110 Ye Old Kings Highway, North Myrtle Beach | 4466 Holmestown Road, Myrtle Beach
3505 Main Street, Loris | 602 Main Street, Conway
Phone (843) 663-0770 | Fax (843) 663-0772 I Email: admin@thecenter4counseling

THE CENTER

for Counseling & Wellness

AUTHORIZATION FOR RELEASE OF INFORMATION

I _____ DOB: _____ hereby authorize *The Center for Counseling & Wellness* to release this form letter to my primary care physician for continuity of care.

_____ _____
(Name of Primary Care Physician or Facility) (Telephone Number)

_____ _____
(Street Address, City, State, Zip Code) (Fax Number)

I understand that by signing this authorization:

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke the authorization at any time. The revocation must be in writing and will not affect information that has already been used or disclosed.
- I am signing this authorization voluntarily. I may refuse to do so and my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits.
- This authorization will remain in effect for one year from the date signed unless revoked in writing.
- If my records contain documentation of alcohol abuse, psychiatric condition, drug abuse, or communicable diseases, this information will be released as part of my record.
- I further understand that if a person or entity to whom records and information are disclosed pursuant to this authorization are not covered by federal privacy regulations, this information will no longer be protected and may be disclosed.

_____ _____ _____
(Signature of Client/Personal Representative) (Relationship to Client) (Date)

For office use only

The above client was seen in our office on _____ and was diagnosed with _____ _____. A follow up appointment is scheduled for _____. Please do not hesitate to contact us if you require anything further.

_____
(Counselor Signature and Date)

Notice: This fax message is {or the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure, or distribution is prohibited- If you are not the intended recipient, please contact the sender and destroy all copies of the original message.

110 Ye Old Kings Highway, North Myrtle Beach | 4466 Holmestown Road, Myrtle Beach
3505 Main Street, Loris | 602 Main Street, Conway
Phone (843) 663-0770 | Fax (843) 663-0772 l Email: admin@thecenter4counseling.com

The Center For Counseling & Wellness Biopsychosocial History Intake Form-Adult

Client Legal Name_____ Preferred Name _____DOB_____Date_____pg 1

Sources of information: ( ) Client self-report ( ) Other Sources (eg. parent, guardian, doctor, spouse, child)

_____

Presenting Problems (Identify duration of problem and any additional information that would be helpful.)

_____

_____

CURRENT CHECKLIST (Rate intensity of symptoms/experiences.)

	None	Mild	Mod	Severe		None	Mild	Mod	Severe
Depressed mood	( )	( )	( )	( )	Appetite disturbance	( )	( )	( )	( )
Fatigue/Low energy	( )	( )	( )	( )	Weight gain/loss	( )	( )	( )	( )
Sleep disturbance	( )	( )	( )	( )	Bingeing/Purging	( )	( )	( )	( )
Mood swings	( )	( )	( )	( )	Food restricting/Anorexia	( )	( )	( )	( )
Emotionality	( )	( )	( )	( )	Memory Problems	( )	( )	( )	( )
Irritability	( )	( )	( )	( )	Self-mutilation/injury	( )	( )	( )	( )
Agitation	( )	( )	( )	( )	Guilt	( )	( )	( )	( )
Elevated mood	( )	( )	( )	( )	Emotional trauma survivor	( )	( )	( )	( )
Generalized anxiety	( )	( )	( )	( )	Physical trauma survivor	( )	( )	( )	( )
Panic attacks	( )	( )	( )	( )	Sexual trauma survivor	( )	( )	( )	( )
Phobias	( )	( )	( )	( )	Emotional trauma perpetrator	( )	( )	( )	( )
Obsession/compulsions	( )	( )	( )	( )	Physical trauma perpetrator	( )	( )	( )	( )
Poor concentration	( )	( )	( )	( )	Sexual trauma perpetrator	( )	( )	( )	( )
Paranoid ideation	( )	( )	( )	( )	Chronic medical condition	( )	( )	( )	( )
Delusions	( )	( )	( )	( )	Grief	( )	( )	( )	( )
Hallucinations	( )	( )	( )	( )	Hopelessness	( )	( )	( )	( )
Aggressive behaviors	( )	( )	( )	( )	Social isolation	( )	( )	( )	( )
Oppositional behaviors	( )	( )	( )	( )	Worthlessness	( )	( )	( )	( )
Substance abuse	( )	( )	( )	( )	Sexual dysfunction	( )	( )	( )	( )
Suicidal thoughts	( )	( )	( )	( )	Physical complaints	( )	( )	( )	( )
Homicidal thoughts	( )	( )	( )	( )	Other_____	( )	( )	( )	( )

PSYCHIATRIC HISTORY

Prior out-patient therapy? ( ) Yes ( ) No If Yes, on how many occasions? _____

Prior Provider Name City State Diagnosis/Reason for treatment Beneficial?

_____

_____

Has any family member had out-patient therapy? ( ) Yes ( ) No If yes, who/why (list all):_____

_____

Prior in-patient treatment for a psychiatric, emotional, or substance use disorder? ( ) Yes ( ) No If Yes, on how many occasions? _____

In-patient Facility Name City State Diagnosis/Reason for treatment Beneficial?

_____

Has any family member had in-patient therapy? ( ) Yes ( ) No If yes, who/why (list all):_____

_____

Current Medication ( ) Yes ( ) No If yes, please list: (Please use back side of page for additional information)

Medication Dosage Frequency Start Date Physician Side Effects Beneficial?

_____

_____

FAMILY OF ORIGIN (Please use back side of page for additional information)

Name Age Occupation Nature of Current Relationship Deceased? If Yes, year died.

Parent _____

Parent _____

Step -parent _____

Step-parent _____

Sibling _____

Sibling _____

Sibling _____

Extended family_____

Extended family_____

Extended family_____

Age at which you left home _____Circumstances:_____

Special Circumstances in childhood:_____

Describe childhood family experience:

( ) outstanding home environment
( ) normal home environment
( ) chaotic home environment
( ) witnessed physical/verbal/sexual abuse toward others
( ) experienced physical/verbal/sexual abuse from others
( ) witnessed hate crimes toward others
( ) experience hate crimes directed at self

Describe any traumatic experiences:

Age_____ Event_____
Age_____ Event_____
Age _____Event_____
Age_____ Event_____
Age_____ Event_____
Age_____ Event_____
Age_____ Event_____

IMMEDIATE FAMILY:

Marital Status:

( ) single, never married
( ) engaged ____months
( ) married for ____years
( ) divorced for ____years
( ) partnered, not living together
( ) domestic partnership, living with partner
( ) civil union
( ) polyamourous/non-monogamous
( ) widowed/grieving loss of partner
( ) separated for ____ years
( ) live-in for ____years
( ) ____prior marriages (self)
( ) ____prior marriages (partner)

Intimate Relationship

( ) never been in a serious relationship
( ) not currently in a relationship
( ) currently in a serious relationship
( ) very dissatisfied with relationship

Relationship Satisfaction:

( ) very satisfied with relationship
( ) satisfied with relationship
( ) dissatisfied with relationship

List all persons currently living in client's household:

Name Age Identified Gender Relationship to client

_____
_____
_____
_____

List children not living in same household as client:

Name Age Identified Gender Relationship to client

_____
_____
_____
_____

Describe any past or current significant issues in intimate relationships:_____
_____

Describe any past or current significant issues in family relationships:_____
_____

MEDICAL HISTORY

Describe current physical health ( ) Good ( ) Fair ( ) Poor
_____

List name of primary care physician:
_____

List name of psychiatrist (if any):
_____

List any known allergies:
_____

Describe any serious hospitalizations, surgeries, or accidents (give age and description of health problem):
_____
_____
_____

SUBSTANCE USE HISTORY:

Substance Used	Age when first used	Current Use? (Yes/No)	Age when last used	Frequency	Amount

Describe Substance Use Treatment History (if any):_____
_____

Consequences of Substance Use (check all that apply):

( ) hangovers	( ) withdrawal symptoms	( ) sleep problems	( ) binges	( ) seizures
( ) assaults	( ) medical conditions	( ) job loss	( ) blackouts	( ) arrests
( ) overdose	( ) tolerance changes	( ) relationship conflict	( ) suicidal/homicidal impulse	

SOCIO-ECONOMIC HISTORY (check all that apply):
Social Support System: ( ) supportive network ( ) few friends ( ) no friends ( ) distant from family of origin

Education: Highest Level of Education attained _____ College Major _____ Degree_____
Learning Problems ( ) Yes ( ) No If Yes, Describe _____
Problems in School Environment _____

Sexual history: ***Please leave the following areas blank if you prefer not to answer***
Current Gender Identity: _____ Sexual Orientation: _____
Sex Assigned at Birth: _____ Preferred Pronouns: _____
( ) sexually dissatisfied ( ) currently sexually active ( ) sexually satisfied ( ) history of unsafe sex ( ) pornography use
age of first sexual experience _____

Employment: Current work place_____ Number of jobs in past 5 years_____
( ) employed and satisfied ( ) employed and dissatisfied ( ) unemployed ( ) coworker conflicts
( ) supervisor conflicts ( ) unstable work history ( ) disabled Comments:_____

Military: ( ) never in military ( ) served- no incident ( ) served-with incident ( ) deployment
If served, what branch_____ How long?_____

Financial situation: ( ) no current financial problems ( ) large indebtedness ( ) poverty ( ) impulsive spending

Legal history: ( ) no legal problems ( ) on parole/probation ( ) court ordered treatment ( ) arrests not substance related ( ) arrests substance related ( ) jail/prison time ( ) describe last legal difficulty _____

Cultural/spiritual/recreational history: Cultural identity (ethnicity)_____
( ) currently active in recreational activities ( ) formerly active in recreational activities ( ) currently engaged in hobbies
( ) currently participate in spiritual activities

Describe any other issues that may contribute to current problems:_____
_____
_____
_____
_____
_____