

# 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:**   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:** \_\_\_\_\_

**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](http://www.thecenter4counseling.com)

## The Center for Counseling & Wellness

### Client Intake Signature Form and Virtual Care Emergency Contact Information

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](http://thecenter4counseling.com).

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

In emergency situations for Virtual Care, contact: \_\_\_\_\_ at \_\_\_\_\_  
Local Police Department Phone #

For disruption of service for Virtual Care, contact: \_\_\_\_\_ at \_\_\_\_\_  
Landline or other cell phone Phone#

My Client Support Person for Virtual Care is: \_\_\_\_\_ at \_\_\_\_\_  
Name Phone#

My email address is: \_\_\_\_\_

Updated 10/14/2022

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 | Email: [admin@thecenter4counseling.com](mailto: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)

<b>Sliding Fee Scale:</b>  Agreed Amount: _____  Staff Initials: _____	<b>Third Party Payor:</b>  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](http://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 | 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 for 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 | Email: admin@thecenter4counseling.com



**The Center for Counseling & Wellness**  
**Counseling Services Consent Agreement for Collaterals**

You are participating in therapy because a spouse, member of your family, or a friend has asked you to be involved. Your participation is important, and is sometimes essential, to the resolution of issues. This document is to explain your rights and responsibilities, and the limits of your rights, in your role as a collateral in therapy.

**WHO IS A COLLATERAL?**

A collateral is usually a spouse, family member, or friend, who participates in therapy with the “identified client” but is not identified formally as the recipient of counseling services.

**THE ROLE OF COLLATERALS IN THERAPY**

The role of a collateral will vary greatly. For example, a collateral might attend only one session to provide information to the therapist and never attend another session. In another case a collateral might attend all therapy sessions and be invested in the therapy process with his/her relationship with the client as a focus of the treatment.

**BENEFITS AND RISKS**

You may experience emotional distress as you engage therapy. Also, you may grow and benefit from the process and find your life enriched in some way. Psychotherapy is a positive experience for many, but it is not helpful to all people.

**PROFESSIONAL RECORDS**

No record or chart will be maintained on you in your role as a collateral. Notes about you may be entered into the identified client’s chart. However, except in the case of the parent or guardian of a minor child, you have no right to access that chart without written consent of the identified client. You will not carry a diagnosis, and there is no individualized treatment plan for you.

**PROFESSIONAL FEES**

As a collateral you have no financial obligation to the identified client or to me unless you are financially responsible for the client. You will not be billed.

## **CONFIDENTIALITY**

The Center will maintain your confidence. There are exceptions:

- If the counselor suspects you are abusing or neglecting a child or a vulnerable adult, he/she will file a report with the appropriate agency.
- If you are a danger to yourself (suicidal), he/she will take actions to protect your life even if he/she must reveal your identity to do so.
- If you threaten serious bodily harm to another, he/she will take necessary actions to protect that person even if he/she must reveal your identity to do so. You are expected to maintain the confidentiality of the identified client (your spouse, friend, or child) in your role as a collateral.

## **DO COLLATERALS EVER BECOME A FORMAL CLIENT?**

Collaterals typically discuss their own issues in therapy, especially issues that interact with issues of the identified client. The therapist may recommend formal therapy for a collateral. These are some examples of when this might occur.

- It becomes evident that a collateral is in need of mental health services. In this circumstance the collateral needs to have a counselor, diagnosis, and chart records kept.
- Parents, being seen as collateral as their child is being treated, would benefit from couples therapy to improve their relationship so they can function effectively as parents.

Most often, but not always, the counselor will refer you to another counselor for treatment in these situations. There are two reasons the referral may be necessary.

- Seeing two members of the same family, or close friends, may result in a dual role, and potentially cloud the counselor's judgment. Making a referral helps prevent this from happening.
- The counselor must keep a focus on the original primary task of treatment of the identified patient. For example, if the clinician started treating a child's behavioral problem then takes on couples therapy with mom and dad to address their relationship issues, the original focus of therapy with the child may be lost. A referral helps the counselor to stay focused. One exception to these guidelines is when a family therapy approach can be effectively and ethically used to treat all members of the family, or each member of the couple.

## **RELEASE OF INFORMATION**

The identified client is not required to sign an authorization for release of information (ROI) to the collateral when a collateral participates in therapy. The presence of the collateral with the consent of the identified client is adequate. However, it is recommended that the client sign a ROI. This provides some assurance that full consent has been given to the counselor for the client's confidential information to be discussed with the collateral in therapy. The ROI is also helpful to the counselor on those occasions when receiving a telephone call from a collateral or when the counselor calls a collateral for one reason or another. In most instances the counselor cannot take a call from a collateral without a ROI.

## PARENTS AS COLLATERALS

Counselors specializing in the treatment of children have long recognized the need to treat children in the context of their family. Participation of parents, siblings, and sometimes extended family members, is common and often expected. Parents in particular have more rights and responsibilities in their role as a collateral than in other treatment situations where the identified client is not a minor.

- The parent has a legal right to access the medical record of the minor child. The child may need some measure of confidentiality with the counselor. The counselor will negotiate the terms of what is best for your child with you early in the child's treatment. He/she will always inform you if it is found that your child is a danger to himself or others.
- If you are participating in therapy with your minor child you should expect your counselor to request that you examine your own attitude and behaviors to determine if you can make positive changes that will be of benefit to your child.

## SUMMARY

If you have questions about therapy, our procedures, or your role in this process please discuss them with the counselor. Remember the best way to assure quality and ethical treatment is to keep communication open and direct with the counselor. By signing below you indicate you have read and understood this document.

\_\_\_\_\_  
Identified Client's Name

\_\_\_\_\_  
Print Collateral's Name

\_\_\_\_\_  
Collateral Signature

\_\_\_\_\_  
Date

## REVOCATION OF CONSENT

I hereby revoke my previous consent to share health information with the participating care providers who may provide treatment or health care services to the above.

\_\_\_\_\_  
(Signature of Client/Personal Representative)

\_\_\_\_\_  
(Relationship to Client)

\_\_\_\_\_  
(Date)



# The Center For Counseling & Wellness Biopsychosocial History Intake Form - Minor

Client Legal Name \_\_\_\_\_ Preferred Name \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_ pg 1

Person completing form: ( ) Client ( ) Other (eg. parent, guardian, doctor, sibling, teacher) If other print name and relationship to client \_\_\_\_\_

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	( )	( )	( )	( )	Binging/Purging	( )	( )	( )	( )
Mood swings	( )	( )	( )	( )	Food restricting/Anorexia	( )	( )	( )	( )
Emotionality	( )	( )	( )	( )	Laxative/Diuretic abuse	( )	( )	( )	( )
Irritability	( )	( )	( )	( )	Self-mutilation/injury	( )	( )	( )	( )
Agitation	( )	( )	( )	( )	Guilt	( )	( )	( )	( )
Elevated mood	( )	( )	( )	( )	Emotional trauma victim	( )	( )	( )	( )
Generalized anxiety	( )	( )	( )	( )	Physical trauma victim	( )	( )	( )	( )
Panic attacks	( )	( )	( )	( )	Sexual trauma victim	( )	( )	( )	( )
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 problems	( )	( )	( )	( )
Suicidal thoughts	( )	( )	( )	( )	Physical complaints	( )	( )	( )	( )
Homicidal thoughts	( )	( )	( )	( )	Other _____	( )	( )	( )	( )
Bedwetting	( )	( )	( )	( )	Other _____	( )	( )	( )	( )

Client Legal Name \_\_\_\_\_ Preferred Name \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_ pg 2

**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 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 \_\_\_\_\_

**IMMEDIATE FAMILY:**

**Parent's Marital Status:**

**Marital Status:**

- single, never married
- engaged \_\_\_\_ months
- married for \_\_\_\_ years
- divorced for \_\_\_\_ years
- partnered, not living together
- domestic partnership, living with partner
- civil union
- polyamorous/non-monogamous
- widowed/grieving loss of partner
- separated for \_\_\_\_ years
- live-in for \_\_\_\_ years
- \_\_\_\_ prior marriages (parent 1)
- \_\_\_\_ prior marriages (parent 2)

**Intimate Relationship**

- never been in a serious relationship
- not currently in a relationship
- currently in a serious relationship

**Relationship Satisfaction:**

- very satisfied with relationship
- satisfied with relationship
- dissatisfied with relationship
- very dissatisfied with relationship

**List all persons currently living in client's household:**

Name	Age	Identified	Gender	Relationship to client
_____				
_____				
_____				
_____				

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**List immediate family members not living in same household as client:**

Name	Age	Identified	Gender	Relationship to client
_____				
_____				
_____				
_____				

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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:

\_\_\_\_\_

**Is there a history of the following in the family:**

- Tuberculosis
- birth defects
- emotional problems
- mental retardation
- thyroid problems
- cancer
- other chronic or serious health problems:
- heart disease
- high blood pressure
- alcoholism/drug abuse
- stroke
- diabetes
- dementia

Describe any serious hospitalizations, surgeries, chronic illnesses, physical problems, eating disorders, 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):

- |                                    |  |   |  |                                   |
|------------------------------------|--|---|--|-----------------------------------|
| <input type="checkbox"/> hangovers | <input type="checkbox"/> withdrawal symptoms   | <input type="checkbox"/> sleep problems   | <input type="checkbox"/> binges            | <input type="checkbox"/> seizures |
| <input type="checkbox"/> assaults  | <input type="checkbox"/> medical conditions    | <input type="checkbox"/> blackouts        | <input type="checkbox"/> arrests           |                                   |
| <input type="checkbox"/> overdose  | <input type="checkbox"/> relationship conflict | <input type="checkbox"/> suicidal impulse | <input type="checkbox"/> homicidal impulse |                                   |

**SOCIO-ECONOMIC HISTORY** (check all that apply):

**Client lives with:** \_\_\_\_\_

**Living situation:**  housing adequate  homeless  housing overcrowded  housing dangerous

**Social Support System:**  supportive network  few friends  no friends  conflict in peer group

**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 \_\_\_\_\_

**School:** Name of school: \_\_\_\_\_ Grade \_\_\_\_\_ GPA \_\_\_\_\_ Repeated any grade?  Yes  No

If Yes, Grade repeated \_\_\_\_\_ Reason \_\_\_\_\_

Learning problems? Explain \_\_\_\_\_ 504 plan or IEP  Yes  No

Suspensions  Expulsions Reason \_\_\_\_\_

Favorite subject: \_\_\_\_\_ Least favorite subject \_\_\_\_\_

Extracurricular activities \_\_\_\_\_

Sports \_\_\_\_\_

Awards \_\_\_\_\_

Future career aspirations \_\_\_\_\_

**Family financial situation:**  no current problems  poverty  impulsive spending  unstable financial history

**Client's legal history:**  no legal problems  on probation  court ordered treatment  arrests  DSS involvement

incarcerations  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  attends church at (name of church) \_\_\_\_\_

Describe cultural issues that may contribute to current problems: \_\_\_\_\_  
\_\_\_\_\_