

**Patient Information:**

Patient's Name (print): \_\_\_\_\_

Patient's Marital Status:  Married  Divorced  Single  Separated  Widowed

Patient's Employment Status:  Employed  Unemployed

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_\_ Cell Phone: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_\_

Work Phone: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_\_ Oth. Phone: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

How would you like to be notified?:  Phone  Text  Email  None

**Insurance Information:**

Insurance Company: \_\_\_\_\_

Insured Person: \_\_\_\_\_

Patient's Relationship to Insured:  Self  Spouse  Child

Insured's Street Address: \_\_\_\_\_

Insured's City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insured's Phone: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_\_ Insured's Gender: \_\_\_\_\_

Insured's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Insured's Employer: \_\_\_\_\_

Insured's ID # (from card): \_\_\_\_\_

Insured's Group # (from card): \_\_\_\_\_

Insurance Phone Number (back of card): (\_\_\_\_) - \_\_\_\_ - \_\_\_\_\_

How did you hear about us: \_\_\_\_\_

(Name)

(Company)

**Patient Health Information:**

**Symptoms:**

- Anxiety
- Depression
- Sleep problems
- Thoughts of suicide
- Panic
- Unusual thoughts
- Anger outbursts
- Changes in weight
- Crying spells
- Memory problems
- Sexual problems
- Relationship issues
- Treated unfairly
- Frequent pain
- Low energy
- Concentration issues
- Restlessness
- Nausea
- Eating disorder
- Legal problems
- Drug use
- Drinking problem
- Boredom
- Hopelessness
- Stress
- Shyness
- Work problems
- Confusion
- Guilt feelings
- Suspicion
- Loneliness
- Thoughts of hurting others
- Compulsions
- Worried
- Money problems
- Difficulty with decisions
- Specific fears
- Mourning
- Physical illness
- Poor motivation
- Feeling abandoned
- Meaninglessness
- Perfectionism
- Unusually sensitive
- Irritability
- Social withdrawal
- Feeling misunderstood
- Troublesome thoughts
- Religious concerns
- Disappointment
- Impulsive
- Hearing strange voices
- Feeling inferior
- Irrational thoughts
- Mood swings
- No problems or concerns

Enter any additional concerns or symptoms in the blanks below:


What stresses or life changes have you experienced recently?


Have you seen a therapist in the past?

YEAR	PROBLEM	THERAPIST OR CLINIC	HOW LONG



**Relationship history:**

How many times have you been married?

How old were you at the time of your marriages?

Briefly describe any problems in your current or past marriages or cohabitation relationships:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Education & Occupation:**

Are you currently.....  Working  In School  (Both)  (Neither)

Highest level of education so far?

What was your major or favorite subject?

How many hours per week are you working?

In what field do you usually work?

What is your current or most recent job title?

**Home Life:**

How do you spend personal time?  
(List hobbies, sports, clubs, groups,  
family activities, etc) \_\_\_\_\_  
\_\_\_\_\_

How many contacts do you have  
each month with friends outside  
of work or school?

Who can you talk with about  
personal feelings or private matters?

Are you satisfied with your romantic life?

Briefly describe what you like and  
dislike about your current romantic  
and friendship lives. \_\_\_\_\_  
\_\_\_\_\_

**Health:**

Check each accident or illness you have experienced:

- Recent surgery
- Head injury
- Seizures
- Thyroid problems
- Drug/alcohol abuse treatment
- Neurological disorder
- Chronic pain
- Headaches
- Diabetes
- Hormone problems
- Infertility
- Miscarriages

List any other chronic health problems you may have:

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How many hours do you sleep in an average night?

How many drinks containing alcohol do you consume in an average week?

Which recreational drugs have you used in the last year?

List prescriptions or over the counter medications you may take, along with the purpose of the medication. 

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Do you exercise? How? How often?

Do you use tobacco? How much?

Who is your primary care physician?

When was your last physical? \_\_\_\_/\_\_\_\_/\_\_\_\_

Are you concerned about your physical health?

List any addition things that it might be important for your therapist to know: 

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Patient Name: \_\_\_\_\_

PRIVACY PRACTICES POLICY:

**What Information Is Protected** 1. Information your doctors, and other health care providers put in your medical record 2. Conversations your therapist has about your care or treatment with others 3. Information about you in your health insurer’s computer system 4. Billing information about you at your clinic 5. Most other health information about you held by those who must follow these laws.

**Health Insurers and Providers who are covered entities must comply with your right to:** 1. Ask to see and get a copy of your health records 2. Have corrections added to your health information 3. Receive a notice that tells you how your health information may be used and shared 4. Decide if you want to give your permission before your health information can be used or shared for certain purposes, such as for marketing 5. Get a report on when and why your health information was shared for certain purposes 6. If you believe your rights are being denied or your health information isn’t being protected, you can file a complaint with your provider, health insurer or the U.S. Government.

**To make sure that your health information is protected in a way that does not interfere with your health care, your information can be used and shared:** 1. For your treatment and care coordination 2. To pay doctors and hospitals for your health care and to help run their businesses 3. With your family, relatives, friends, or others you identify

The following disclosures of your Personal Health Information require written authorization: 1) if the PHI is used or disclosed for marketing purposes; 2) if the disclosure constitutes a sale of PHI; 3) most uses and disclosure of psychotherapy notes. (Covered entities that don’t record or maintain psychotherapy notes are not required to include a statement in their NPPs about the authorization requirement.) Uses and Disclosures of PHI not covered by this Notice of Privacy Practices will only be made with the written permission of the individual and must state that this authorization may be revoked by the individual as “provided in the regulations”.

You may restrict certain disclosures of PHI to a health plan if you have paid for the service out of pocket, in full.

**You will be notified in writing if your unsecured PHI is compromised.**

**Acknowledgement of Privacy Practices Policy:** I acknowledge that I am aware of QCCounselor’s Notice of Privacy Practices . I understand that QCCounselor has the right to revise these information practices and to amend the Notice of Privacy Practices. I understand that in the event that the Notice is revised, the revised Notice will be posted at QCCounselor and I understand that I may obtain a current Notice of Privacy Practices at any time from the office manager at QCCounselor

\_\_\_\_\_  
Signature of Patient/Parent/Guardian/Representative Date

\_\_\_\_\_  
Printed Name Relationship to Patient

**Patient’s Agreement to be Treated and to be Financially Responsible:**

I acknowledge that the patient or other responsible party is responsible for payment of fees unless otherwise agreed upon. \_\_\_\_\_  
INITIAL

I further understand that I may be charged \$40 for any missed appointments or for appointments that are cancelled without 24 hour notice. \_\_\_\_\_  
INITIAL

I also understand that failure to meet the financial obligations related to my appointments and charges may result in disruption of service and/or being the subject of legal action which may include being turned over to a collection agency or sued in small claims court. \_\_\_\_\_  
INITIAL

I give my consent to be treated at QCCounselor.

I authorize QCCounselor to release information necessary for billing only to my insurance company and/or financially responsible party. I authorize QCCounselor to release treatment plans necessary for authorization to my insurance company. I also authorize QCCounselor to release information to the referring individual or organization and to my family physician. I further acknowledge and authorize that my records may be anonymously reviewed by other members of QCCounselor staff for the purpose of treatment review and crisis management. I direct the insurer to pay, without equivocation, directly to QCCounselor all benefits due as a result of my scheduled visits or charges.

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Signature of Patient/Parent/Guardian/Representative Date