

# NASHVILLE CHRISTIAN COUNSELING CENTER

## Acknowledgement of Therapist–Client Agreement and HIPAA Notice

With my signature below, I acknowledge that I have read the “Therapist–Client Services Agreement” available on the Nashville Christian Counseling Center (NC3) website, understand its content, and agree to abide by the terms therein:

- I. Counseling Services
- II. Appointments
- III. Limits on Confidentiality
- IV. Clinical Records
- V. Minors and Parents
- VI. Professional Fees
- VII. Billing and Payments
- VIII. Insurance Reimbursement
- IX. Emergencies

I also acknowledge that I have received a copy of the “Notice of Privacy Practices and Patient Rights” from my NC3 therapist as required by the Health Insurance Portability and Accountability Act (HIPAA), and I understand the circumstances under which my Protected Health Information (PHI) can be disclosed.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

**Initial Client Questionnaire**  
(Please print clearly)

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Today's Date

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

\_\_\_\_/\_\_\_\_/\_\_\_\_      \_\_\_\_\_  
Date of Birth      Age

\_\_\_\_\_  
Spouse/Partner's Name (if applicable)

\_\_\_\_/\_\_\_\_/\_\_\_\_      \_\_\_\_\_  
Date of Birth      Age

\_\_\_\_\_  
Emergency Contact Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Phone

Highest level of education completed (circle one):

Jr. High      GED      High School      2-year college      4-year college      Graduate degree

Pending legal issues? No \_\_\_\_ Yes \_\_\_\_ If yes, what? \_\_\_\_\_

**Marital Status:**  Single       Engaged       Married (number of times: \_\_\_\_\_)  
 Separated       Widowed       Divorced (number of times: \_\_\_\_\_)

**Client Contact Information:**

To best ensure privacy and confidentiality, please list acceptable methods of contact, if messages are permitted, and the best days/times to reach you.

Home phone: \_\_\_\_\_ Message: Y N Days/Time: \_\_\_\_\_

Work phone: \_\_\_\_\_ Message: Y N Days/Time: \_\_\_\_\_

Cell phone: \_\_\_\_\_ Message: Y N Days/Time: \_\_\_\_\_

Email: \_\_\_\_\_

Mailing address: \_\_\_\_\_

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

**TREATMENT INFORMATION:**

Referred by: \_\_\_\_\_

Have you participated in previous counseling or psychological services with a psychiatrist, psychologist, therapist, pastor, or lay counselor? No \_\_\_\_ Yes \_\_\_\_ If yes, please circle the type above.

Reason(s) for previous counseling? \_\_\_\_\_

Counselor's name and location: \_\_\_\_\_

Dates seen: \_\_\_\_\_

What were the results? \_\_\_\_\_

Briefly describe what brings you to initiate counseling now? \_\_\_\_\_

**CONFIDENTIAL**

Please check all topics that currently apply to your reason(s) for seeking therapy:

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Anger                  | <input type="checkbox"/> Depression         | <input type="checkbox"/> Anxiety         | <input type="checkbox"/> Suicidal thoughts   |
| <input type="checkbox"/> Loss/Grief             | <input type="checkbox"/> Worry              | <input type="checkbox"/> Finances        | <input type="checkbox"/> Self-injury         |
| <input type="checkbox"/> Self-esteem            | <input type="checkbox"/> Marital problems   | <input type="checkbox"/> Family problems | <input type="checkbox"/> School/Education    |
| <input type="checkbox"/> Guilt/Shame            | <input type="checkbox"/> Apathy             | <input type="checkbox"/> Pornography     | <input type="checkbox"/> Sexual problems     |
| <input type="checkbox"/> Mood shifts            | <input type="checkbox"/> Health concerns    | <input type="checkbox"/> Job stress      | <input type="checkbox"/> Fear/Phobia         |
| <input type="checkbox"/> Communication          | <input type="checkbox"/> Sleep difficulties | <input type="checkbox"/> Relationship(s) | <input type="checkbox"/> Crying spells       |
| <input type="checkbox"/> Spiritual/Religious    | <input type="checkbox"/> Abuse history      | <input type="checkbox"/> Substance abuse | <input type="checkbox"/> Divorce/Separation  |
| <input type="checkbox"/> Medical/Pain           | <input type="checkbox"/> Legal problems     | <input type="checkbox"/> Adjustment      | <input type="checkbox"/> Disordered eating   |
| <input type="checkbox"/> Obsessive thoughts     | <input type="checkbox"/> Body image         | <input type="checkbox"/> Withdrawn       | <input type="checkbox"/> Lying/Deceitfulness |
| <input type="checkbox"/> Other (specify): _____ |   |  |  |

What are your goals for therapy? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**FAMILY (household):**

Name	Relationship	Age	Gender

Has there been a history of the following within your family (if yes, check "previously" or "currently"):

	Previously	Currently	Briefly Describe
Alcoholism			
Drug use			
Mental illness			
Domestic violence			
Verbal/Emotional abuse			
Sexual abuse			
Sexual addiction			
Divorce/Separation			
Infidelity/Affairs			
Financial problems			

**HEALTH HISTORY:** List your current healthcare provider(s), using the back of this form if necessary.

Name	Specialty	Location	Phone	Last visit
		-----		
		-----		

**CONFIDENTIAL**

List any and all diseases, illnesses, important accidents or injuries that involved surgery, hospitalization, loss of consciousness, convulsions/seizures, or diagnosis (not including pregnancies). Some examples are: heart disease or surgery, cancer, diabetes, high blood pressure, respiratory illness, bone or joint problems, high cholesterol, arthritis, emphysema, hepatitis, HIV, stroke, seizures, **or a mental illness diagnosis.**

Illness/Injury/Surgery	Age	Treatment received	Treated by	Result

**Medications/Drugs:**

List all medications or drugs you regularly take, or have taken, within the past year: prescribed, over-the-counter, etc. This would also include tobacco, alcohol, and marijuana products.

Medication/Drug	Amount	Taken for:	Prescribed and supervised by:

**For women only:**

Please describe any important and applicable medical information regarding: menstruation (associated pain or unusual frequency, duration, or heaviness); hysterectomy; or menopause:

\_\_\_\_\_

\_\_\_\_\_

**Health habits (lifestyle):**

Rate your physical activity level (1 = "little-to-none" and 5 = "very active"): \_\_\_\_\_

In what kind of physical exercise or activities do you participate? \_\_\_\_\_

\_\_\_\_\_

How often do you exercise or are physically active (average per week)? \_\_\_\_\_

How much coffee, cola, tea, or other caffeine products do you consume each day/week? \_\_\_\_\_

Do you have any problems getting enough sleep? No \_\_\_\_\_ Yes \_\_\_\_\_

How many hours do you sleep per night on average? \_\_\_\_\_

Please check any of the following sleep problems that you have experienced *within the past six months*:

- Sleep rhythm       Insomnia (unable to sleep)       Hypersomnia (over sleeping)  
 Nightmares       Sleep walking       Narcolepsy (unexpectedly falling asleep)

Are you involved with art such as dance, painting, music, etc? No \_\_\_\_\_ Yes \_\_\_\_\_

What type of music do you listen to most often? \_\_\_\_\_

How often do you watch T.V.? \_\_\_\_\_

Which shows do you watch most often? \_\_\_\_\_

Do you enjoy reading? No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, what types of material do you read?

\_\_\_\_\_

Please describe any current or chronic pain issues: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

