Northwest Counseling, Inc.

CONFIDENTIAL CLIENT INFORMATION

Northwest Counseling, Inc. 910 NW 7th St #6, Bentonville, AR 72712
479-855-5704 www.NCIcares.com office@ncicares.com

Please fill out (either electronically or by hand), print, sign (at all red X's) and bring with you to your first appointment.
We cannot guarantee your confidentiality transmitting information over electronic means.
Please complete one set of forms per person if a couple.

1. CLIENT INFORMATION

Date of first appointment ____________________

I am here for: ☐ Individual ☐ Couples ☐ Family

Name ____________________ ____________________
Last First

Nickname ____________________

Address ____________________

City ____________________

State ____________________ Zip ____________________

Birthdate ____________________ Sex ☐ M ☐ F

☐ Married ____ years ☐ Single ☐ Engaged

☐ Living with ____ years ☐ Divorced

☐ Partnered ____ years ☐ Separated ☐ Widowed

How many times have you been married? ______

Employer/School ____________________

Occupation ____________________

☐ Full Time ☐ Part Time ☐ Unemployed

☐ Retired ☐ Homemaker ☐ Disabled

☐ Full time student ☐ Part time student

Spouse's Name ____________________

Spouse's Birthdate ____________________

Spouse Employer ____________________

Spouse's Occupation ____________________

2. INSURANCE INFORMATION

Subscriber's Name ____________________
(if different than client)

Birthdate ____________________

Address ____________________

City ____________________ State ____ Zip ________

Insurance Company ____________________

ID# ____________________

Client is listed as: ☐ Insured/Self ☐ Spouse ☐ Child

Is spouse covered on this plan? ☐ Y ☐ N

Is client covered by Secondary Ins.? ☐ Y ☐ N

Secondary Subscriber ____________________

Birthdate ____________________

Address ____________________

City ____________________ State ____ Zip ________

Insurance Company ____________________

ID# ____________________

Client is listed as: ☐ Insured/Self ☐ Spouse ☐ Child

For Insurance Claims:
I authorize the release of any medical or other information necessary to process insurance claims for services rendered by Northwest Counseling, Inc. I also authorize payment of medical benefits to Northwest Counseling, Inc. for services rendered.

X ____________________
Signature of Client

3. CONTACT INFORMATION

Mobile # ____________________ is it ok to text/leave a message? ☐ Y ☐ N

Work # ____________________ is it ok to leave a message? ☐ Y ☐ N

Home # ____________________ is it ok to leave a message? ☐ Y ☐ N

Personal email ____________________ is it ok to contact via email? ☐ Y ☐ N

Work email ____________________ is it ok to contact via work email? ☐ Y ☐ N

IN CASE OF EMERGENCY, CONTACT

Name ____________________ Mobile # ____________________ Relationship ____________________

Your confidentiality is very important to us. We cannot guarantee your confidentiality via electronic communication (e.g., someone else might see a text message or hear a voicemail, etc.). By indicating your permission below you agree that you understand this and that we can contact you via the indicated method above to confirm appointments.

Print Name ____________________ Signature X ____________________

4. CHILDREN/OTHERS IN HOUSEHOLD

e.g. children in & out of home, relatives living in home, long-term guests, roommates

Last Name	First Name	Relationship	Age	Sex	Living at Home
				☐ M ☐ F	☐ YES ☐ NO
				☐ M ☐ F	☐ YES ☐ NO
				☐ M ☐ F	☐ YES ☐ NO
				☐ M ☐ F	☐ YES ☐ NO
				☐ M ☐ F	☐ YES ☐ NO

5. GENERAL HEALTH INFORMATION

Please check any of the following issues that apply to you:

- ☐ Allergy/Sinus
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Chronic Pain
- ☐ Diabetes
- ☐ Digestive Problems
- ☐ Eating Disorder
- ☐ Epilepsy
- ☐ Head Injury
- ☐ Hearing Problem
- ☐ Heart Disease
- ☐ Heartburn/Acid Reflux
- ☐ High Blood Pressure
- ☐ Low Blood Sugar Issues
- ☐ Migraines/Headache
- ☐ Muscle/Joint Pain
- ☐ Nausea
- ☐ Sleeping Disorder
- ☐ Thyroid/Hormone Problem
- ☐ Vision Problem
- ☐ None of the Above
- ☐ ____________________
- ☐ ____________________

Have you ever been hospitalized or had surgery? ☐ Yes ☐ No If yes, please describe with dates:

Do you have any allergies? ☐ Yes ☐ No If yes, please list:

____

Substance	Past Use	Current Use	Quantity	Frequency
Alcoholic Beverages	☐ Y ☐ N	☐ Y ☐ N		
Tobacco Products	☐ Y ☐ N	☐ Y ☐ N		
Illicit Drugs	☐ Y ☐ N	☐ Y ☐ N		
Abuse of OTC or Rx Drugs	☐ Y ☐ N	☐ Y ☐ N		

6. CURRENT MEDICAL CARE / MEDICATION INFORMATION

Physician/Psychiatrist	Condition Treating	Medication/Supplement	Dosage

7. MENTAL HEALTH INFORMATION

Please check any of the following issues that apply to you:

- [ ] Financial Issues
- [ ] Health Issues
- [ ] Legal Issues
- [ ] Marital Issues
- [ ] Relationship Issues
- [ ] Sexual Issues
- [ ] Parenting Issues
- [ ] Work/Career Issues
- [ ] Divorce
- [ ] Separation
- [ ] Decreased Appetite
- [ ] Excessive Appetite
- [ ] Difficulty Sleeping
- [ ] Excessive Sleeping
- [ ] Abuse
- [ ] ADHD
- [ ] Aggressiveness
- [ ] Anger
- [ ] Anxiety
- [ ] Bipolar
- [ ] Chest Discomfort
- [ ] Compulsive Behavior
- [ ] Decreased Energy
- [ ] Depression
- [ ] Difficulty Breathing
- [ ] Difficulty Concentrating
- [ ] Fatigue
- [ ] Grief
- [ ] Guilt
- [ ] Hearing Voices
- [ ] Hopelessness
- [ ] Impulsiveness
- [ ] Irritability
- [ ] Lightheadedness
- [ ] Lonliness
- [ ] Loss of Enjoyment
- [ ] Memory Loss
- [ ] Mood Swings
- [ ] Nightmares
- [ ] Numbness/Tingling
- [ ] Obsessions
- [ ] Panic Attacks
- [ ] Phobias
- [ ] Poor Judgement
- [ ] PTSD
- [ ] Racing Heart
- [ ] Racing Thoughts
- [ ] Risky Behavior
- [ ] Sadness
- [ ] Sexual Abuse History
- [ ] Social Withdrawal
- [ ] Sweats/Chills
- [ ] Thoughts that scare you
- [ ] Trauma
- [ ] Visual Hallucinations
- [ ] Weight Gain/Loss

Briefly describe the problem(s) for which you are seeking counseling:

Describe how you have attempted to resolve the above issues:

What are your goals for counseling?

8. MENTAL HEALTH HISTORY

e.g., Individual, Marital, Family, Pastoral, Inpatient, Psychological Testing

Type of Therapy	Dates (mm/yyyy)	With Whom
	to	
	to	
	to	
	to	

Has anyone in your immediate family been treated for a psychological problem? ☐ Yes ☐ No

If yes, please list:

9. SPIRITUAL INFORMATION

Are you active in a church? ☐ Yes ☐ No ☐ Sometimes

Church name or denomination preference: ______________________

How important are spiritual/biblical matters as they relate to counseling? (circle or mark one)

1	2	3	4	5	6	7	8	9	10

Least Important — Most Important

10. HOW DID YOU FIRST HEAR ABOUT NCI?

Please check all that apply:

- ☐ Internet Search:
  - ☐ Google ☐ Yahoo ☐ ____________
  - Keyword(s) Searched: ____________
  - Did that lead you to:
    - ☐ PsychologyToday.com
    - ☐ FindChristianCounselor.com
    - ☐ Theravive.com
    - ☐ NCI Website (NCIcares.com)
    - ☐ Internet Phone Book
      - ☐ White ☐ Yellow
- ☐ Social Media: ☐ Facebook
  - ☐ LinkedIn ☐ Twitter ☐ ____________
- ☐ Insurance Provider List
- ☐ Castlight (Wal-Mart)
- ☐ Phone Book (Printed)
  - ☐ Yellow Pages (AT&T)
  - ☐ Green (Names & Numbers)
  - ☐ Red (ZipLocal)
- ☐ Business Network ____________
- ☐ Friend - Name ____________
- ☐ Co-worker - Name ____________
- ☐ Family Member ____________
- ☐ Pastor - Name ____________
  - Church ____________
- ☐ Judicial System - Name ____________
- ☐ Attorney - Name ____________
- ☐ Brochure/Advertisement ____________
- ☐ Other ____________

11. OTHER INFORMATION

Did you consult with your insurance to find out if NCI is in network with your insurance?

☐ Yes ☐ No ☐ I do not have Insurance

Did the fact that we were in or out of network with your insurance factor into your decision to choose NCI for counseling?

☐ 1. Not at all ☐ 2. Not much

☐ 3. Somewhat ☐ 4. Major influence

Did the office staff inform you about your benefits?

☐ Yes ☐ No

What was the main reason for choosing NCI for your counseling needs?

12. NOTICE OF PRIVACY PRACTICES

I acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

____
Print Name

X ____________________
Signature

____
Date Signed