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.

1. CHILD INFORMATION

Date of first appointment _____

Name _____ (first) _____ (last)

Nickname _____

Address _____

City _____ State ___ Zip _____

Birthdate _____ Sex ☐ M ☐ F Age ____

Child's Mobile _____

Language spoken at home _____

2. SCHOOL INFORMATION

School _____ Grade _____

How does your child do in school academically?

_____

How does your child do in school behaviorally?

_____

Please provide any information regarding your child's education that you believe would be helpful to us:

_____

3. PARENTS/CAREGIVERS

Check all that apply **for Other, please specify:* _____

Full Name / Birthdate	Biological	Step	Full-Custodian	Joint-Custodian	Non-Custodian	Adoptive	*Other	Address (if other than child) / City, State, Zip	Place of Employment / Occupation

The person completing this form

Are you the legal custodian with respect to healthcare, including mental health decisions for your child? ☐ Yes ☐ No

Are you required to consult with the non-custodial parent with respect to healthcare decisions? ☐ Yes ☐ No ☐ N/A

Have you done so in this case? ☐ Yes ☐ No

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. CONTACT INFORMATION *(at least one parent)*

Name _____ Relationship _____
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

Name _____ Relationship _____
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 *(only if other than parent above)*

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 signing below, you verify your understanding of this and give your permission for us to contact you in the methods listed above in order to confirm appointments.

X _____
Signature

6. INSURANCE INFORMATION

Subscriber's Name _____
Birthdate _____
Address _____
(if different than child)
City _____ State ___ Zip _____
Insurance Company _____
ID# _____

Client is listed as ☐ Insured/Self ☐ Child

Is client covered by Secondary Insurance? ☐ Y ☐ N

2nd Subscriber's Name _____
Birthdate _____
Address _____
(if different than child)
City _____ State ___ Zip _____
Insurance Company _____
ID# _____

Client is listed as ☐ Insured/Self ☐ 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

7. GENERAL HEALTH INFORMATION

Please check any of the following issues that apply to your child:

- ☐ ADHD
- ☐ Allergy/Sinus
- ☐ Aspergers/Autism
- ☐ Asthma
- ☐ Bone/Muscle Issues
- ☐ Brain/Nervous System
- ☐ Cancer/Tumors
- ☐ Chronic Pain
- ☐ Diabetes
- ☐ Digestive Problems
- ☐ Ear, Nose, Throat Issues
- ☐ Eating Disorder
- ☐ Growth Issues
- ☐ Head Injury
- ☐ Hearing Problems
- ☐ Kidney/Urinary Issues
- ☐ Learning Disorder
- ☐ Migraine/Headaches
- ☐ Sensory Processing Disorder
- ☐ Sleep Disorder
- ☐ Speech Problems
- ☐ Vision Problems
- ☐ None of the Above
- ☐ _____

Has your child ever been hospitalized or had surgery? ☐ Yes ☐ No If yes, please describe with dates:

Does your child have any allergies? ☐ Yes ☐ No If yes, please list:

_____

Does your child have any substance abuse issues? ☐ Yes ☐ No If yes, please indicate below:

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		

Do any family members have any substance abuse issues? ☐ Yes ☐ No If yes, please indicate below:

Substance	Past Use	Current Use	Relationship to Child	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			

8. CURRENT MEDICAL CARE / MEDICATION INFORMATION

Physician/Psychiatrist	Condition Treating	Medication/Supplement	Dosage

9. MENTAL HEALTH INFORMATION

Please check the symptoms your child displays and list how often the symptom is displayed.

- ☐ Anger _____
- ☐ Anxiety _____
- ☐ Bed wetting _____
- ☐ Conduct problems _____
- ☐ Controlling _____
- ☐ Defecating in pants _____
- ☐ Defiance _____
- ☐ Depression _____
- ☐ Disassociates _____
- ☐ Drug or alcohol use _____
- ☐ Hyperactivity _____
- ☐ Hypervigilance _____
- ☐ Homicidal thought/action _____
- ☐ Isolation _____
- ☐ Lack of empathy _____
- ☐ Lack of motivation _____
- ☐ Low self esteem _____
- ☐ Lying _____
- ☐ Masturbation _____
- ☐ Nightmares _____
- ☐ Obsessions _____
- ☐ Over/Undereating _____
- ☐ Peer problems _____
- ☐ Phobias _____
- ☐ Poor impulse control _____
- ☐ Running away _____
- ☐ Sexually acting out _____
- ☐ Sexual themes in play _____
- ☐ Shy _____
- ☐ Sleeplessness _____
- ☐ Somatic symptoms headache/stomachache _____
- ☐ Stealing _____
- ☐ Tantrums _____
- ☐ Violent themes in play _____
- ☐ Wetting pants _____
- ☐ _____ _____
- ☐ _____ _____

Briefly describe the problem for which your child is seeking counseling:

Describe how you have attempted to resolve the above issue.

What would you like your child to accomplish in counseling?

10. MENTAL HEALTH HISTORY *e.g., Individual, Family, Pastoral, Inpatient, Psychological Testing*

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

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

If yes, please describe _____

11. 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

12. 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 _____

13. 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?

14. 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