Counseling • Education • Consultation
2013 Elm Street • Manning House • Manchester, NH 03104-2528
Phone (603) 627-2702 • Fax (603) 627-3643 • Website pcs-nh.org
Satellite Offices in Bedford, Nashua & Portsmouth

NOTICE OF H.I.P.A.A. PRIVACY PRACTICES

Acknowledgment:

I hereby acknowledge that I received this Notice of H.I.P.A.A. Privacy Practices on __________20_____

Signed: ____
Client or Responsible Party

Please Print: ____

Please Print: ____
Responsible Party (if applicable)

PERSON TO CONTACT IN EVENT OF AN EMERGENCY:

NAME: ____

RELATIONSHIP: __________________________ TEL. NO:__________________________

REFERRED TO PCS BY: _________________ RELATIONSHIP TO THIS REFERRAL:___________

ADDRESS: ____

MAY WE THANK THE PERSON WHO REFERRED YOU? Yes No

CLIENT INFORMATION FORM

NAME:			DATE:
STREET ADDRESS (Required):			D/O/B:
P. O. BOX (if applicable):	APT. # (if applicable):		SEX: M F
CITY:	STATE:	ZIP:	SSN:
PHONE: Home: ____________________ Work: ____________________ Cell: _____________________	OK to leave a message? Yes No Yes No Yes No		EMAIL ADDRESS:

ETHNIC BACKGROUND: Native American/ Alaskan Native ___ Asian/Pacific Islander ___ Hispanic ___
Black/African-American ___ White/Caucasian ___ Other _________________

REASONS FOR SEEKING COUNSELING: ____

COUNSELING HISTORY: IF NO PRIOR TREATMENT, CHECK HERE AND OMIT FOLLOWING SECTION: ( )

PREVIOUS THERAPIST(S)	DATES OF TREATMENT	REASON FOR SEEKING COUNSELING	REASON FOR TERMINATION

SYMPTOMS & CHANGES IN FUNCTIONAL IMPAIRMENT: IF PRESENT, PLEASE CHECK TO WHAT DEGREE

	Mild	Mod.	Severe
Anxiety			
Panic Attacks			
Decreased Energy			
Depressed Mood			
Delusions			
Hallucinations			
Hyperactivity			
Sleep Disturbance			
Physical Health			
Work/School			

	Mild	Mod.	Severe
Hopelessness			
Activities of daily living			
Family/Relationships			
Inattention			
Irritability/Mood instability			
Impulsivity			
Obsessions/Compulsions			
Significant weight change			
Suicidal thoughts			
Homicidal thoughts			

HISTORY OF ABUSE: (PHYSICAL, EMOTIONAL, VERBAL, SEXUAL, RELIGIOUS) **Yes** ______ **No** ______

PCS Client Intake Packet

CLIENT INFORMATION FORM

NAME: ____

FAMILY INFORMATION:

RELATIONSHIP STATUS: __Single __Living Together __Married/Partnered __Separated __Divorced __Widowed				
SPOUSE/PARTNER'S NAME:				
MOTHER'S NAME:		FATHER'S NAME:		
SIBLINGS NAMES:				
NAMES & AGES OF CHILDREN LIVING WITH YOU:	NAMES & AGES OF CHILDREN NOT LIVING WITH YOU:		NAMES & AGES OF OTHER ADULTS LIVING WITH YOU:	
PREVIOUS MARRIAGE(S) OR PARTNERSHIP(S):	DATE(S):	DATE(S) OF DIVORCE:	CHILDREN FROM THIS MARRIAGE/PARTNERSHIP:	ARE THESE CHILDREN LIVING WITH YOU?

EDUCATION:

CIRCLE LAST YEAR COMPLETED:	Grade School: 1 2 3 4 5 6 7 8 High School: 9 10 11 12 College: 1 2 3 4 +
OTHER TRAINING:	
MILITARY SERVICE:	
HOBBIES/LEISURE ACTIVITIES:	

EMPLOYMENT HISTORY:

OCCUPATION:
PRESENT EMPLOYER:
LENGTH OF EMPLOYMENT:

RELIGIOUS/SPIRITUAL BACKGROUND:

RELIGIOUS AFFILIATION:	PRACTICING?	YES	NO
CHILDHOOD RELIGIOUS AFFILIATION:			

CLIENT INFORMATION FORM

NAME: ____

MEDICAL HISTORY: LIST ALL IMPORTANT ILLNESSES, INJURIES AND HOSPITALIZATIONS, PAST AND PRESENT

DATE OF MOST RECENT PHYSICAL EXAMINATION:	RESULTS:	
PCP's NAME:	PHONE:	
STREET ADDRESS:	CITY:	ZIP:
LIST ALL CURRENT MEDICATIONS:	NONE ( )	

HEALTH CONDITIONS: HAVE YOU HAD OR DO YOU HAVE NOW ANY OF THE FOLLOWING CONDITIONS?

Condition			Condition		
Arthritis	Y	N	Asthma/Breathing Problems	Y	N
Blindness or seeing double	Y	N	Chronic Lung Disease (including Bronchitis and Emphysema)	Y	N
Congestive Heart Failure	Y	N	Fibromyalgia	Y	N
Deafness or trouble hearing	Y	N	Head Injury	Y	N
Sciatica or chronic back problem	Y	N	Diabetes	Y	N
Angina	Y	N	Cancer	Y	N
Heart Attack or Myocardial Infarction	Y	N	Hypertension or High Blood Pressure	Y	N
Kidney Disease	Y	N	Stroke	Y	N
Water/Fluid Retention	Y	N	Female Hormone Replacement	Y	N
Pain	Y	N	Obesity	Y	N
Anorexia/ Bulimia	Y	N	Thyroid Problem	Y	N
Constipation	Y	N	Other	Y	N

RATE YOUR CURRENT HEALTH: ___EXCELLENT ___GOOD ___FAIR ___POOR

CLIENT INFORMATION FORM

NAME: ____

ADDICTION HISTORY:

HAVE YOU EVER BEEN TREATED FOR AN ALCOHOL/DRUG PROBLEM?	Y	N
DO YOU HAVE CONCERNS ABOUT YOUR CURRENT USE OF ALCOHOL OR OTHER DRUGS?	Y	N
HAVE OTHERS EXPRESSED CONCERN ABOUT YOUR USE OF ALCOHOL OR OTHER DRUGS?	Y	N
DO YOU HAVE CONCERNS ABOUT YOUR ENGAGEMENT IN OTHER KINDS OF BEHAVIORS, SUCH AS COMPULSIVE GAMBLING, HOARDING, ADDICTIVE SEXUAL BEHAVIORS, CHRONIC OVER-SPENDING, OVEREATING, OR COMPULSIVE EXERCISING?	Y	N
DO YOU CURRENTLY USE TOBACCO PRODUCTS SUCH AS CIGARETTES, CIGARS, OR PIPE TOBACCO?	Y	N
DO YOU HAVE CONCERNS ABOUT YOUR CONSUMPTION OF CAFFEINE, SUCH AS COFFEE, TEA, SPORTS DRINKS, OR SODA?	Y	N

OTHER RELEVANT INFORMATION: ____

____

____

____

____

CLIENT INFORMATION:

NAME: ____ DATE OF BIRTH:______________________________

RELATIONSHIP TO INSURED: SELF_______SPOUSE/PARTNER_________CHILD_______OTHER__________

SUBSCRIBER INFORMATION:

NAME OF SUBSCRIBER:	SUBSCRIBER S D/O/B:
ADDRESS (If different):	
SOC. SEC. NO. OF SUBSCRIBER:	
EMPLOYER:	
GROUP PLAN NAME:	GROUP NO:
PRIMARY CARRIER:	POLICY NO:
SECONDARY CARRIER:	POLICY NO:

METHOD OF PAYMENT

	I will pay the full fee **each session**.
	Bill my insurance company for what I owe. I will pay **each session** any deductible and/or co-payment and amounts in excess of my limits of coverage.

Make all checks payable to: PCS

We accept VISA, MASTERCARD, DISCOVER, and AMERICAN EXPRESS.

PATIENTS OR AUTHORIZED PERSONS SIGNATURE. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. SIGNED DATE	I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED. SIGNED (INSURED OR AUTHORIZED PERSON) DATE

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AGREEMENT TO TREATMENT

I have received and reviewed with my therapist the following information:

Confidentiality
Professional Ethics and Complaints
Physical Exam
Emergency Coverage
Cancellations and Termination of Psychotherapy
Fees and Insurance Coverage
Photo Identification

I understand that pastoral counseling and psychotherapy are accepted approaches to treating emotional problems. In most cases, persons so treated receive benefit from the treatment. There may be risks associated with this treatment; the results are not guaranteed and depend on a number of variables.

CANCELLATION POLICY

Pastoral Counseling Services requires a 24-hour notice if you need to cancel an appointment. We cannot bill an insurance company for a missed appointment. The policy of the center is that the client will be charged for a missed appointment at the contracted rate allowed by your insurance company, up to $70.

Client: ______________________________________ Date: ______________________

Therapist: ____________________________________ Date: ______________________

Date:________________________________

INITIAL FEEDBACK FORM

As a means of monitoring and improving the quality of the care we provide, we would like to get some feedback from you about your first experiences at PCS. The information you provide will be used in our evaluation process and will remain confidential. After each statement, please circle the appropriate response:

1 = Strongly Disagree   2 = Disagree Somewhat   3 = Agree Somewhat   4 = Agree Strongly

	Statement					
1.	My initial phone call/email was responded to in a timely fashion.	1	2	3	4	
2.	The directions to PCS were clear and helpful.	1	2	3	4	
3.	I was greeted in a professional manner by the PCS staff.	1	2	3	4	
4.	The waiting room was neat, clean, and comfortable.	1	2	3	4	
5.	The information on the PCS forms was clear.	1	2	3	4	
6.	The information on the PCS website was useful.	1	2	3	4	N/A

Other Comments:

Name (Optional) : ________________________