CLIENT INFORMATION

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

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 relationship?	Are these children living with you?

EDUCATION:

SELECT 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/JOB TITLE:
EMPLOYER NAME:
LENGTH OF EMPLOYMENT:

RELIGIOUS/SPIRITUAL BACKGROUND:

RELIGIOUS AFFILIATION:	PRACTICING?	YES ○	NO ○
CHILDHOOD RELIGIOUS AFFILIATION:	PRACTICING?	YES ○	NO ○

MEDICAL HISTORY: LIST ALL IMPORTANT ILLNESSES, INJURIES & 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?

	Y	N		Y	N
ARTHRITIS	○	○	ASTHMA/BREATHING PROBLEMS	○	○
BLINDNESS OR SEEING DOUBLE	○	○	CHRONIC LUNG DISEASE (INCLUDING BRONCHITIS AND EMPHYSEMA)	○	○
CONGESTIVE HEART FAILURE	○	○	FIBROMYALGIA	○	○
DEAFNESS OR TROUBLE HEARING	○	○	HEAD INJURY	○	○
SCIATICA OR CHRONIC BACK PROBLEM	○	○	DIABETES	○	○
ANGINA	○	○	CANCER	○	○
HEART ATTACK OR MYOCARDIAL INFARCTION	○	○	HYPERTENSION OR HIGH BLOOD PRESSURE	○	○
KIDNEY DISEASE	○	○	STROKE	○	○
WATER/FLUID RETENTION	○	○	FEMALE HORMONE REPLACEMENT	○	○
PAIN	○	○	OBESITY	○	○
ANOREXIA/ BULIMIA	○	○	THYROID PROBLEM	○	○
CONSTIPATION	○	○	OTHER	○	○

RATE YOUR CURRENT HEALTH: EXCELLENT ○ GOOD ○ FAIR ○ POOR ○

ADDICTION HISTORY:

	Y	N
HAVE YOU EVER BEEN TREATED FOR AN ALCOHOL/DRUG PROBLEM?	○	○
DO YOU HAVE CONCERNS ABOUT YOUR CURRENT USE OF ALCOHOL OR OTHER DRUGS?	○	○
HAVE OTHERS EXPRESSED CONCERN ABOUT YOUR USE OF ALCOHOL OR OTHER DRUGS?	○	○
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?	○	○
DO YOU CURRENTLY USE TOBACCO PRODUCTS SUCH AS CIGARETTES, CIGARS, OR PIPE TOBACCO?	○	○
DO YOU HAVE CONCERNS ABOUT YOUR CONSUMPTION OF CAFFEINE, SUCH AS COFFEE, TEA, SPORTS DRINKS, OR SODA?	○	○

OTHER RELEVANT INFORMATION:

INSURANCE INFORMATION

PRIMARY Insurance Information

Relationship to Insured: ___ Self ___ Spouse/Partner ___ Child ___ Other

Insurance Co.: _____ Insurance Co. Phone: ( )_____

Policy Holder: _____ Date of Birth: _____ID/Policy #: _____

SECONDARY Insurance Information

Relationship to Insured: ___ Self ___ Spouse/Partner ___ Child ___ Other

Insurance Co.: _____ Insurance Co. Phone: ( ) _____

Policy Holder: _____Date of Birth: _____ ID/Policy #:_____

PLEASE PROVIDE INSURANCE CARD(S) FOR US TO COPY

METHOD OF PAYMENT

○	I will pay the full fee for each session at time of service.
○	Bill my insurance company for what I owe. I will pay each session, any deductible and/or co-payment, as well as any amount in excess of my insurance coverage limits.
○	I will provide new and/or updated insurance information as it becomes available.

We accept cash, checks, made payable to **"PCS"** or
VISA, MASTERCARD, DISCOVER and AMERICAN EXPRESS.

To the best of my knowledge, the above information is true and complete. I understand that I am responsible to pay for all services rendered to me, and that I am willing to make specific arrangements to pay whatever part is not covered by insurance on a timely basis. I authorize the release of any information necessary to process this claim. I authorize payment to be made directly to the healthcare provider(s) submitting my claims.

_____ _____
Insured's or Authorized Person's signature Date

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 & Exeter

AGREEMENT TO TREATMENT

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

☐ Confidentiality
☐ Professional Ethics and Complaints
☐ Emergency Coverage
☐ Cancellation Policy
☐ Fees and Insurance Coverage
☐ Termination of Psychotherapy

CANCELLATION POLICY

PCS 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 this agency is that the client will be charged for a missed appointment or late cancellation at the contracted rate allowed by your insurance company, up to a maximum of $**75**.
There are many unanticipated reasons why someone might have to cancel without adequate notice (for example, illness, transportation problems, and work demands). The only consistent exception to this policy however is when inclement weather poses a safety risk. Please talk to your therapist if you have any questions about this policy.

Client: _____ Date: _____

Therapist: _____ Date: _____

PCS
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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 ____/____/_____.
Today's date

Signed: _____
Client or Responsible Party

Please Print: _____
Client or Responsible Party (if applicable)

PERSON TO CONTACT IN EVENT OF AN EMERGENCY:

Name:_____

Relationship_____ **Phone#:** _____

REFERRED TO PCS BY: _____

RELATIONSHIP TO THIS REFERRAL: _____

MAY WE THANK THE PERSON WHO REFERRED YOU? Yes ○ No ○

ADDRESS: _____

_____

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

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

Other Comments:

Name (Optional) : _____ Date:_____