



St. Andrew's Anglican Church
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Lewis Center, Ohio 43035

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St. Luke's Anglican Church
565 S. Cleveland-Massillon Rd.
Akron, Ohio 44333

Confidential Case History Questionnaire

(Please complete all three pages, printing clearly. If additional space is needed, please feel free to write on the back.)

Client's Name: _____
First Middle Last

Marital Status *(check all that apply)*: Married Divorced Separated Single Widowed

Spouse's Name, if applicable: _____
First Middle Last

Children's Name(s) and Ages, if applicable: _____

Address: _____
City State ZIP Code

Phone: _____
Home Work Cell

Employer: _____ Duties: _____

Previous Counseling: When? _____ Where? _____

Current Medications and Dosages: _____

Monitoring Physician: _____

Is this also your Primary Care Physician? ____ Yes ____ No If "No", give name: _____

Have you ever been hospitalized for emotional reasons? ____ Yes ____ No

If "Yes", when? _____ Where? _____

Have you ever had a serious head injury? ____ Yes ____ No

If "Yes", when? _____ Outcome? _____

Please take some time to reflect on the answers to each of the following questions.

Briefly describe your relationship with members of your family of origin. If any family member is deceased, describe your current feelings about your past relationship. Use the back of the sheet to complete your answer, if necessary.

(Father) _____

(Mother) _____

(Siblings) _____

Where are you in the birth order? (Check all that apply)

- Oldest Youngest Middle Only Twin Adopted

List any other significant caretakers (grandparents, aunts, uncles, nannies, babysitters, etc.) and describe your feelings about the relationship:

Describe your feelings about your relationship with your spouse. _____

Generational History: Is there any significant genetic history/family history from previous generations, including any mental health diagnosis?

If previously married, describe your relationship with your ex-spouse during the marriage, since the marriage, and your understanding of why the relationship ended.

What dysfunctions impede healthy relationships with your family? _____

What is your earliest memory? _____

What is your happiest memory? _____

What is your saddest memory? _____

Describe any major losses in your life (including deaths, child loss, major disappointments, etc.): _____

Have you ever known anyone who attempted or committed suicide? _____

Have you ever thought of suicide? What happened? _____

Describe briefly how you feel about your eating habits. _____

Do you engage in any physical exercise? Yes No Explain: _____

As a Christian Counseling Ministry, we would ask for a brief description of your relationship with God. _____

Have you ever been involved in occult activities? Yes No If yes, explain: _____

Is there any additional information you feel your counselor should have? _____

Policies and Procedures

As a Christian counseling ministry, *Family Counseling Ministries* believes all healing, whether spiritual, physical or emotional, comes from God. Our counseling focus is on individual, marriage, and family through the process of inner healing. Thus, there will be occasions when time is given to prayer as well as psychotherapy. *Family Counseling Ministries* focuses on the process of integrating one's faith and science.

Appointments and Clinical Hour: Appointments may be scheduled from 10 a.m. to 7:15 p.m. throughout the week. For scheduling purposes and courtesy to other clients, each session is one hour (60 minutes) in length, with the exception of the initial intake session. It will be a two-hour session (billed as two hours), allowing sufficient time to review your case history and begin the counseling process. Occasionally a session will run past the scheduled time. When this happens, the client will be billed per ½ hour. Therefore, we ask for your patience if you are waiting when this occurs. You will be given your full time for each session.

It is our goal to assist each client in becoming functional as soon as possible, while keeping the cost of counseling down. Therefore, we ask that specific issues that have developed between sessions be addressed at the beginning of the session with the counselor. This will provide adequate time to deal with the issues and the emotional content. If emergencies arise between sessions, please call 330-573-8519. Messages are checked regularly throughout the day. We will get back to you as soon as possible.

No-Show Policy: In the event that a client fails to keep an appointment, 50% of the hourly rate will be billed to his account, but not less than \$35. Please notify us of the need to cancel your appointment 24 hours in advance. In this way, we will make every effort to respect and show courtesy to others waiting for counseling services. We understand that emergency situations sometimes arise. We will accommodate you as best we are able.

PRIVACY NOTICE

(effective 4/01/03; Federal deadline 4/14/03)

In compliance with the Federal Government's Health Insurance Portability and Accountability (HIPAA) of 1996, this office states our sincere intention to maintain and protect your medical information. Your privacy is secured by limiting access of information as follows:

- Family Counseling Ministries does not bill insurance companies.
- Information shared in counseling and maintained in your file will not be disclosed without your written authorization for purposes needed in your treatment and care.

If you feel your medical information has been misused, complaints may be filed with this office or with the Human Services Office of the Inspector General.

Any changes to this policy will be posted. Concerns and questions regarding this policy may be directed to the office manager at 330-573-8519.

If you wish other parties to have access to your personal information, please list names here:

I have read and understand the Privacy Policy above.

Date: _____

PRINTED NAME _____

SIGNATURE _____

Fee Policy/Sliding Scale

It is our policy to make quality counseling available at a reasonable cost to the client. As a tax-exempt, not-for-profit organization, we attempt to supplement the fees paid with private contributions. Therefore we offer the following:

Gross Household Income	Check One	\$ / Hour
0 - \$20,000	<input type="checkbox"/>	\$40
\$21,000 - \$33,000	<input type="checkbox"/>	\$50
\$34,000 - \$46,000	<input type="checkbox"/>	\$60
\$47,000 - \$59,000	<input type="checkbox"/>	\$70
\$60,000 - \$74,000	<input type="checkbox"/>	\$80
\$75,000 - \$90,000	<input type="checkbox"/>	\$90
\$91,000 – and up	<input type="checkbox"/>	\$100

Family Counseling Ministries does not bill insurances. Therefore fees are set below reasonable and customary rates. Although federal laws have recently been enacted in an effort to protect the clients' privacy with insurance companies, by not billing an insurance company we can further assure your privacy. If you desire, we will provide you with a receipt for services on *Family Counseling Ministries* letterhead.

We ask that you pay *at the time of the session*, unless other arrangements have been made. In that case, you will be billed at the agreed rate.

By signing this form, I am agreeing to all of the above provisions.

Name (Please print) _____

Signature: _____

Date: _____

