Capitol Hill Consortium for Counseling & Consultation LLC
650 Pennsylvania Avenue SE, Suite 440, Washington, DC 20003
P | 202.544.5440 **F |** 202.544.3004

PATIENT REGISTRATION FORM

PATIENT NAME (FIRST, MIDDLE, LAST)	GENDER: FEMALE ☐	MALE ☐
PATIENT ADDRESS:		
TELEPHONE NUMBERS HOME WORK CELL EMAIL		
AGE	DATE OF BIRTH (MM/DD/YYYY)	MARTIAL STATUS
NAME OF EMPLOYER/ SCHOOL	SOCIAL SECURITY NO.	

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY	SECONDARY INSURANCE COMPANY
NAME OF POLICY HOLDER DATE OF BIRTH	NAME OF POLICY HOLDER DATE OF BIRTH
POLICY NUMBER GROUP NUMBER	POLICY NUMBER GROUP NUMBER

RESPONSIBLE PARTY

RESPONSIBLE PARTY IS: ☐ PATIENT ☐ PRIMARY POLICY HOLDER ☐ SECONDARY POLICY HOLDER

RESPONSIBLE PARTY'S NAME AND DATE OF BIRTH (FIRST, M, LAST, DOB)	HAS THE RESPONSIBLE PARTY BEEN COURT-ORDERED? TO PAY MEDICAL BILLS? ☐ YES ☐ NO
ADDRESS	IF YES, WE ASK THAT YOU HAVE THAT PERSON SIGN AN AUTHORIZATION FORM.
TELEPHONE NUMBER	RELATIONSHIP TO PATIENT ☐ PARENT/GUARDIAN ☐ SPOUSE ☐ OTHER

EMERGENCY CONTACT
IN THE EVENT OF AN EMERGENCY WHO SHOULD WE CONTACT

NAME OF EMERGENCY CONTACT	RELATIONSHIP TO PATIENT ☐ PARENT/GUARDIAN ☐ SPOUSE ☐ OTHER
TELEPHONE NUMBERS HOME WORK CELL	

BILL AND PAYMENT POLICY

PAYMENT IS REQUIRED AT THE TIME SERVICES ARE RENDERED. ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT AND THE RESPONSIBILITY OF THE PATIENT. OUR STAFF WILL ASSIST YOU IN COMPLETING ANY FORMS NECESSARY TO EXPEDITE REIMBURSEMENT FROM INSURANCE CARRIERS AT NO ADDITIONAL CHARGE.

IF A PERSON OTHER THAN PATIENT (PATIENT'S SPOUSE OR PARENT) HAS ACCEPTED FINANCIAL RESPONSIBILITY FOR MEDICAL BILLS, A SIGNED CONSENT TO THAT AFFECT MUST BE ON FILE. OUR STAFF WILL GLADLY EXPLAIN OR ASSIST YOU WITH ANY ASPECT TO THIS POLICY.

AUTHORIZATION AND RELEASE

I, _____, HERBY AUTHORIZE CCCC TO APPLY FOR BENEFITS ON MY BEHALF FOR COVERED SERVICES RENDERED TO ME AND/OR MY DEPENDENTS.

FINANCIAL INFORMATION

CCCC RESERVES THE RIGHT TO CHARGE A 30% ATTORNEY FEE AND 15% INTEREST, IF REFERRED TO COLLECTIONS. IF I PAY FOR SERVICES WITH A CHECK, TELECHECK WILL REFER THE AVAILABILITY OF MY FUNDS. I UNDERSTAND THAT I WILL BE CHARGED A $25.00 RETURN CHECK FEE, IF MY CHECK IS RETURNED BY MY FINICIAL INSTITUTION/BANK. I ALSO UNDERSTAND THAT THERE IS A CANCELLATION FEE OF $75.00 FOR BROKEN OR MISSED APPOINTMENTS UNLESS A TWO DAY (48-HOUR) NOTICE IS GIVEN. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. EITHER THE ABOVE-NAMED CARRIER OR I MAY REVOKE THIS AUTHORIZATION AT ANY TIME IN WRITING.

SIGNATURE

I CERTIFY THAT ALL THE INFORMATION ON PAGE (1) ONE IS CORRECT TO THE BEST OF MY KNOWLEDGE AND I ALSO AGREE TO THE INFORMATION IN THE BILL AND PAYMENT POLICY, AUTHORIZATION AND RELEASE AND FINANCIAL INFORMATION SECTIONS OF THIS FORM. I ALSO AUTHORIZE THIS SIGNATURE FOR CLAIMS SUBMISSIONS.

SIGNATURE OF PATIENT (PARENT/GUARDIAN IF MINOR CHILD: **DATE:**

PROVIDER SIGNATURE:	**DATE:**

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HIPAA Notification – Notice of Clinician's Policies & Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGIAL & MEDICAL INFORMATION ABOUT YOU MAY BE USED & DISCLOSED & HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your written authorization. To help clarify these terms, here are some definitions:

- PHI refers to information in your health record that could identify you.
- Treatment is when I provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychotherapist.
- Payment is when I obtain reimbursement for your health care. Examples of payment include when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations include quality assessment and improvement activities, case management, care coordination, and business-related matters such as audits and administrative services.
- Use applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- Disclosure applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.
- Authorization is your written permission to disclose confidential mental health information. All authorizations to disclose information must be on a specific legally required form.

II. Other Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. Under circumstances when I am asked for information for purposes outside of treatment, payment, or health care operations, I will obtain an authorization from you before releasing this information.

I will also need to obtain an authorization before releasing your Psychotherapy Progress Notes, which are notes that I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorization (of PHI or Psychotherapy Progress Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that:

(1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures without Authorization

I may use or disclose PHI without your consent or authorization under any of the following circumstances:

- Child Abuse – If I know or have reasonable cause to suspect that a child known to me in my professional capacity has been or is in immediate danger of being mentally abused, physically abuse, sexually abused, or neglected, I must immediately report such knowledge or suspicion to the appropriate authorities.
- Adult and Domestic Abuse – If I believe that an adult is in need of protective services because of abuse or neglect by another person, I must report this belief to the appropriate authorities.
- Health Oversight Activities – If the D.C. Board of Psychology is investigating me or my practice, I may be required to disclose PHI to the Board.
- Judicial and Administrative Proceedings – If you are involved in a court proceeding and a request is made for information about the professional services I provided you and/or the records thereof, such information is privileged under D.C. law, and I will not release information without the written authorization of you or you legally appointed representative or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- Serious threat to Health or Safety – If I believe disclosure of PHI is necessary to protect you or another individual from a substantial risk of imminent and serious physical injury, I may disclose the PHI to the appropriate authorities and/or individuals.
- Worker's Compensation – If I am treating your for Worker's Compensation purposes, I must provide periodic developmental reports, treatment records, and bills upon request to you, the D.C. Office of Hearings and Adjudication, your employer, or your insurer, or their representatives.

Your signature below serves as an acknowledgement that you have received the HIPAA notice.

Printed Name

Signature Date

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Consent for Treatment Agreement

Please read and initial beside each section indicating that you are aware and understand the policies of our office. If you have questions, please discuss with your clinician.

I. Evaluation and Diagnostic Procedures

_____ INITIALS

a. The initial evaluation and diagnostic process may take up to 3 – 4 sessions.
b. The initial evaluation will consist of clinical interview and may also include interviews with significant others, psychological testing and/or referrals to other specialists.
c. Treatment will consist of individual, group, couple, and/or family psychotherapy, as well as possible adjunctive psycho-educational or skill building services. Frequency is determined by the clinician's recommendation, scheduling availability, and the nature of the problem. Session frequency is typically weekly, and this may increase or decrease over the course of treatment.
d. Treatment may also consist of referral to a psychiatrist for psychopharmacological recommendations. CCCC does NOT have a psychiatrist on staff; a referral list is available. Collaboration with your primary care physician is desirable and other specialists will be referred to and collaborated with on an as needed basis.
e. Because therapy is the process of dealing with feelings, thoughts, and behavior it may feel worse before it gets better. If I believe I am in crisis, I will contact my clinician or designee, or go to my nearest hospital emergency room for evaluation.

II. Confidentiality

_____ INITIALS

a. I understand that my insurance company or other payment source for my treatment require diagnostic and treatment planning information in order to pay for services rendered. In addition, I understand that it is generally desirable for my clinician to provide clinical information to other professionals I am involved with to coordinate care.
b. The office will not release any information without my knowledge and consent, except in the following circumstances, as applicable:
    1. In the event of a subpoena, or if a judicial system mandates the release of records.
    2. When clinicians have information indicating that a child under age 18 or adult over age 65 is (or has been depending on jurisdictions) abused or neglected, the clinician is a mandated reporter and legally required to report to child/adult protective services.
    3. If I am a danger to myself or others, my clinician will do whatever is ethical to protect me or others. This may include hospital admission, notification of emergency contacts, relatives, and/or police. I also understand that my clinician has a duty to warn individuals identified who are at risk to be harmed.

III. Communication Outside of Session

_____ INITIALS

a. Texting and email communication are not confidential and are not meant to be therapeutic methods of communication, but can be useful for scheduling purposes.
b. Please circle below to authorize the following methods of communication:

Home Phone	Cell Phone	Office Phone
Mail	Email	Text
Facsimile	Other:_____	

IV. Clinician Consultation and Supervision

_____ INITIALS

a. CCCC clinicians often consult with each other when they consider they may benefit from clinical support and feedback from colleagues at CCCC. Clinicians may also consult with each other when working with the same clients (e.g. couples, DBT referrals, family, etc.). CCCC clinicians maintain confidentiality so that only the information that will benefit the client(s) and that the client and clinician have agreed upon will be shared with a collaborating clinician.

b. Some of our clinicians are under clinical supervision and will share client information with their supervisors. Clients will be informed of this when they first meet with the clinician.

V. Scheduling, Fees, Missed Appointments

_____ INITIALS

a. Payment is expected at the time services are rendered and paid before my sessions begin. This includes co-pays, deductibles, self-pay fees, etc.

b. I am responsible and not my insurance company for co-payments, coinsurances, and deductibles. I am also responsible for services not covered or denied by my insurance company, such as, but not limited to: psycho-educational services, workshops, paperwork for school or work, letters, and legal matters. The clinician will inform me of the time and cost of the non-covered services and make arrangement with you for payment. All costs for services provided that are not covered by insurance are my responsibility, including payments expected from my insurance carrier which have been denied. Payments not made at the time of service are subject to a 1.5% fee increase every 30 days of non-payment.

c. There is a charge of $75.00 for missed appointments or late cancellations, unless a 48-hour notification is given. Medicaid clients and Military personnel are not subject to this fee. Payment is expected at the next scheduled appointment.

d. Appointments are scheduled through administrative staff in collaboration with clinicians. If I need an emergency appointment, I will contact the office or other instructions given to me by my clinician.

e. Services beyond those covered by my insurance company are provided on a self-pay basis, workman's compensation, or other agreed upon payment source.

VI. Reasons for Termination

_____ INITIALS

a. The practice's policy around late cancellations and no shows is as follows: after 3 late cancellations or no shows, clients can lose their standing appointment on their clinician's schedule; 3 more after that and they can lose their ability to stay in the CCCC practice. Clinicians have discretion regarding how and in what way they manage this expectation.

b. My clinician may terminate treatment at CCCC under the following circumstances:

1. Failure to comply with the treatment plan/recommendations by the clinician.
2. Failure to maintain my financial responsibilities.
3. Six late cancellations or no shows for scheduled appointments.

VII. Couples, Family, Group Psychotherapy

_____ INITIALS

a. I will keep information revealed by others confidential.

b. Group clinicians may have a separate consent form for their specific group.

c. Medical records from couples therapy cannot be released without both parties' consent.

I, _____ have read and understand the various aspects
(name of patient or parent of minor child)

of psychotherapy such as evaluation and method of treatment for myself or my child,

_____.
(name of minor child, if applicable)

DO NOT SIGN UNTIL YOU HAVE DISCUSSED THESE POLICIES WITH YOUR CLINICIAN

_____

Patient/ Parent/Legal Guardian's Signature Date

_____

Clinician Signature Date

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Authorization to Disclose Protected Health Information to Primary Care Physician

Communication between behavioral health providers and your Primary Care Physician (PCP) is important to ensure that you receive comprehensive and quality health care. This form will allow your Behavioral Health Provider to share Protected Health Information (PHI) with your PCP. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress, and medication if necessary.

I _____ _____ _____ _____
(Member Name) (Insurance Name) (Policy Number) (Date of Birth)

authorize _____, to release protected health information related to my evaluation and treatment to
(Provider Name - Please Print)

PCP Name: _____ **PCP Phone:** _____

PCP Address: _____ _____ _____ _____
(Street Number, Street Name, Building & Suite Number) (City) (State) (Zip Code)

Information Below to be Completed by Behavioral Health Provider

I saw _____ **on** _____ **for** _____
(Patient Name - Please Print) (Date(s) of Service) (Reason or Diagnosis)

Summary: _____

_____

The following medication was or will be started: _____
(indicate medication name and dosage/frequency)

If no medication is indicated, check the following as appropriate:

_____ Medication Not Prescribed _____ Patient Refused Medication _____ Try Psychotherapy Before Trying Medication

Treatment Recommendations:

Lab Tests for the Following: _____ CBC _____ Thyroid Studies _____ Chemistry Panel _____ EKG

Other Treatment Recommendations: _____

_____

If you have any questions or would like to discuss this case in greater detail, please call me at: _____
(Phone Number)

_____ _____ _____
(Provider Signature) (Provider Printed Name) (Licensure)

Patient Rights

- You can end this authorization (permission to use or disclose information) any time by contacting: _____ .
- If you make a request to end this authorization, it will not include information that has already been used or disclosed based on your previous permission. For more information about this and other rights, please see the applicable Notice of Privacy Practices.
- You cannot be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
- You have a right to a copy of this signed authorization. Please keep a copy for your records.
- You do not have to agree to this request to use or disclose your information.

Patient Authorization

I, the undersigned understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire on the date specified below, within one (1) year or less from the date of signature. I have read and understand the above information and give my authorization: **PATIENT PLEASE CHECK ONE**

_____To release any applicable mental health / substance abuse information to my primary care physician.
_____To release only medication information to my primary care physician.
_____To release the date of my first visit following my hospitalization from _____ through _____ to my primary care physician.
_____I DO NOT give my authorization to release any information to my primary care physician.

_____ _____ _____ _____ _____
(Patient Signature) (Date) (Expiration Date) (Signature of Patient's Authorized Rep.) (Date)

IF SIGNED BY PATIENT'S AUTHORIZED REPRESENTATIVE, DESCRIBE RELATIONSHIP TO PATIENT: _____

PROVIDER: PLEASE SEND A COPY OF THIS SIGNED FORM TO THE PCP AND KEEP THE ORIGINAL IN THE TREAMENT RECORD

NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse patient records (42 CFR Part 2), you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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Personal History Form

NAME:	AGE:	DATE:

CURRENT MENTAL HEALTH SERVICES

Please describe your reasons for seeking mental health services:

How much time has elapsed since the time you initially contacted CCCC to your appointment?

Same day 1-2 days Same week More than a week

Please rate your sense of urgency from 1-5 (1 = "not at all urgent" to 5 = "life threatening")
A. When you initially contacted us:
B. The day of your scheduled appointment:

Please describe your goals for treatment in order of importance:

Please use this space for any additional information you would like us to know:

SOCIAL HISTORY (check all that apply)		
Relationship Status:	Current Relationship Satisfaction:	Social Support System:
□ single, never married	□ very satisfied with relationship	□ supportive network
□ dating (mos/yrs) _____	□ satisfied with relationship	□ few friends
□ engaged (mos/yrs) _____	□ somewhat satisfied with relationship	□ substance-use based friends
□ married (mos/yrs) _____	□ dissatisfied with relationship	□ no friends
□ divorced (mos/yrs) _____	□ very dissatisfied with relationship	□ concerns about friendships
□ separated (mos/yrs) _____	Intimate Relationship:	Sexual History:
□ live-in (mos/yrs) _____	□ never been in a serious relationship	Sexual orientation:
□ widow (mos/yrs) _____	□ not currently in a relationship	□ currently sexually active
□ prior marriages (self) _____	□ currently in a serious relationship	□ previously sexually active
□ prior marriages (partner) _____	□ concerns about intimate relationship	□ practicing safe sex
Cultural identity (ethnicity, religion):		
Describe cultural issues that contribute to current problem:		
Describe participation in community/spiritual/recreational activities:		
Describe previous participation in community/spiritual/recreational activities:		
Describe current hobbies:		
Describe current living situation:		

PROBLEM CHECK LIST (Rank 0-3)

0 = None - this has not happened to me

1 = Mild - The problem has been happening to me and is only having a small impact on my life.

2 = Moderate- The problem is having a noticeable impact on my quality of life and day-to-day functioning

3 = Severe - The problem is having a major impact of my quality of life and day-to-day functioning

symptoms	0	1	2	3	symptoms	0	1	2	3	symptoms	0	1	2	3
appetite changes					harming others					sexual concerns/questions				
sleep problems					violent thoughts					body image worries				
fatigue/low energy					self-harm/self-cutting					irregular eating				
low motivation					thought of hurting					using laxatives				
poor concentration					thoughts of ending my life					binging/vomiting				
indecisiveness					feeling overwhelmed					alcohol use				
health problems					hopelessness					drug use				
weight gain/loss					withdrawing from others					physical assault/abuse				
impulsive behavior					worthlessness					sexual assault/abuse				
moody high/lows					critical of self					verbal assault/abuse				
unhappiness					guilt/shame					learning disability				
aggressive behavior					feeling high without drug use					academic concerns				
irritability/anger					overly energetic					work/career concerns				
anxiety					fears/phobias					undecided about life				
feelings of panic					obsessive thoughts					work/school direction				
agitated/restless					compulsive behaviors					lying/stealing				
depressed					grief/loss					legal problems				
friend/peer problems					death of loved one					other:				
financial problems					relationship problems					other:				
family problems					difficulty trusting others					other:				

SUBSTANCE ABUSE HISTORY (check all that apply)

□ No history of use or abuse of any of the substances listed

Substance used:	When first used:	When last used:	Frequency:	Amount:
□ alcohol				
□ inhalants (glue, gas)				
□ amphetamines/ speed				
□ PCP				
□ caffeine				
□ opiates (e.g. heroin)				
□ crack cocaine/cocaine				
□ hallucinogens (e.g. LSD)				
□ marijuana or hashish				
□ nicotine/cigarettes				
□ barbiturates/downers				
□ prescription drug overuse				
□ ecstasy				
□ other				

Substance abuse treatment history:

Type of treatment	Age(s)	Length of Treatment	Outcome
□ outpatient			
□ inpatient			
□ 12-step program			
□ stopped on own			
□ other _____			

Events experienced with substance use (check all that apply):

□ hangovers	□ withdrawal symptoms	□ suicidal impulses
□ seizures	□ medical conditions	□ relationship conflicts
□ blackouts	□ tolerance changes	□ binges
□ blackouts	□ loss of control	□ job loss
□ overdose	□ sleep disturbances	□ arrests / violations of law
□ violent impulses/behavior	□ assaulted by others	□ other violations

□ other (explain)

EMPLOYMENT, ACADEMIC, LEGAL HISTORY

Employment	Financial Situation	Legal History
□ no concerns at this time	□ no concerns at this time	□ none
□ employed and satisfied	□ conflicts over finances	□ theft
□ employed and dissatisfied	□ debt problems	□ alcohol/drug related
□ conflicts at work	□ other	□ criminal history
□ unemployed	_____	□ other _____
Career	**Academic Situation**	**Academic History**
□ no concerns at this time	□ no concerns at this time	□ poor academic performance
□ need direction choosing major	□ poor academic performance	□ known/suspected learning disability
□ need direction in choosing career	□ learning disability affects academics	□ special education history
□ need information about work	□ test anxiety	□ no academic problems

MENTAL HEALTH HISTORY

Please list prior mental health providers:

Name of Provider	Phone	Dates/duration	Reason for therapy	Was it helpful?

Please list prior inpatient/ hospitalizations:

Name of Hospital/Facility	Phone	Dates/duration	Reason for therapy	Was it helpful?

Please list prior or current psychological medication prescriptions:

Medication/Dosage	Start/End Date	Physician	Phone	Was it helpful?

MEDICAL HISTORY

Describe current physical health (good/fair/poor):

List current medications (dosage/reason):

List allergies

Describe current medical conditions and treatment:

Describe significant illnesses or events in the past

Is there a history of any of the following in your family:

□ Alzheimer's disease/dementia	□ cancer	□ high blood pressure
□ behavioral problems	□ diabetes	□ developmental disability
□ birth defects	□ heart disease	□ other

□ other chronic or serious health problems:

Describe any serious hospitalizations or accidents:

Date	Age	Reason

List any disabilities:

FAMILY OF ORIGIN HISTORY

Family of Origin	Age	Education	Occupation	Ethnicity/Culture
Mother				
Father				
Stepmother				
Stepfather				
Brother				
Brother				
Sister				
Sister				
Other:				

Parents' Current Status	Childhood Home Environment
□ married to each other	□ very few problems
□ separated (mos/yrs):	□ moderate problems
□ divorced (mos/yrs):	□ significant problems
□ mother remarried _____ times	□ witnessed physical/emotional/verbal/sexual abuse
□ father remarried _____ times	□ experienced physical/emotional/verbal/sexual abuse
□ mother involved with someone	Current Family Support
□ father involved with someone	□ estranged (from _____)
□ mother deceased (mos/yrs):	□ supportive with some tension
□ father deceased (mos/yrs):	□ very supportive

Mental Health History of Family Members:

Describe mental health and substance abuse history for family members:

Describe mental health or substance abuse history for family members:

Provide additional information about your family that is important for us to know:

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Counseling Services Questionnaire-Initial Appointment

Your Answers to the following questions will help us improve our services. Please circle the number that best represents your response to each item.

Name of Clinician Seen: _____

How did you hear about us?
1) Insurance website 2) Physician referral 3) Friend referral _____
4) Found Online: a. Psychology Today (clinician bios) b. General Search
5) Other_____

Today's Date: _____

Your Name: _____
(optional)

For Questions 1-2	Not Good at All 1	Fair 2	Good 3	Very Good 4

1. When you came into CCCC initially, how were you feeling? 1 2 3 4
2. How do you feel now? 1 2 3 4

For Questions 3-13	Strongly Disagree 1	Disagree 2	Agree 3	Strongly Agree 4

3. Counseling will help me work on my problem. 1 2 3 4
4. Counseling will help me know myself better. 1 2 3 4
5. Counseling will help me improve my relationships with others. 1 2 3 4
6. Counseling will help me develop better ways to cope. 1 2 3 4
7. Counseling will help me improve my academic/work performance. 1 2 3 4
8. My Counselor understood my reasons for seeing counseling. 1 2 3 4
9. My Counselor will help me meet my goals for counseling. 1 2 3 4
10. My Counselor is able to help me benefit from counseling. 1 2 3 4
11. I was satisfied with my initial appointment for counseling. 1 2 3 4
12. My counselor encouraged my feedback. 1 2 3 4
13. I would recommend CCCC, LLC to others. 1 2 3 4

For Questions 14-19	Very Dissatisfied 1	Dissatisfied 2	Satisfied 3	Very Satisfied 4

14. Telephone contacts with CCCC. 1 2 3 4
15. Wait for initial interview appointment. 1 2 3 4
16. In-Person contact with receptionist. 1 2 3 4
17. Waiting Room. 1 2 3 4
18. Counseling center location. 1 2 3 4
19. Confidentiality 1 2 3 4

Please circle the adjectives that best describe your impression of your counselor:

Anxious	Calm	Prepared	Unprepared	Not Creative	Creative	Inexperienced	Experienced
Inaccurate	*Accurate*	*Insensitive*	*Sensitive*	*Not Insightful*	*Insightful*	*Judgmental*	*Non-Judgmental*
Patronizing	*Supportive*	*Lecturing*	*Not given to lecturing*	*Passive*	*Active*	*Made me feel uncomfortable*	*Made me feel comfortable*
Disrespectful	*Respectful*	*Rigid*	*Flexible*	*Silent*	*Interactive*	*Unprofessional*	*Professional*
Not Concerned about me	*Concerned about me*	*Not Skilled*	*Skilled*	*Cold*	*Warm*	*Confusing*	*Understanding*

Please list any suggestions you may have for improving our services:

What other types of services would you like to see our office offer?

Do you have any additional comments about your experience at CCCC?

Thank you for your comments. Please return this form to:

Capitol Hill Consortium for Counseling and Consultation
650 Pennsylvania Avenue SE. Suite 440 Washington D.C. 20003

Caring, Committed Counseling in your Community
www.ccccmentalhealth.com