



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 <input type="checkbox"/>		MALE <input type="checkbox"/>	
PATIENT ADDRESS:					
TELEPHONE NUMBERS HOME		WORK		CELL	
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	
POLICY NUMBER		GROUP NUMBER		POLICY NUMBER	
				GROUP NUMBER	
RESPONSIBLE PARTY					
RESPONSIBLE PARTY IS: <input type="checkbox"/> PATIENT <input type="checkbox"/> PRIMARY POLICY HOLDER <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO		
ADDRESS			IF YES, WE ASK THAT YOU HAVE THAT PERSON SIGN AN AUTHORIZATION FORM.		
TELEPHONE NUMBER			RELATIONSHIP TO PATIENT <input type="checkbox"/> PARENT/GUARDIAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER		

EMERGENCY CONTACT

IN THE EVENT OF AN EMERGENCY WHO SHOULD WE CONTACT

NAME OF EMERGENCY CONTACT		RELATIONSHIP TO PATIENT <input type="checkbox"/> PARENT/GUARDIAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER	
TELEPHONE NUMBERS HOME		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:

Caring, Committed Counseling in your Community

www.cccmentalhealth.com



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

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL & 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

- 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.

INITIALS

II. Confidentiality

- 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.

INITIALS

III. Communication Outside of Session

- 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:

INITIALS

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

IV. Clinician Consultation and Supervision

- 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.

INITIALS

V. Scheduling, Fees, Missed Appointments

- 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.

INITIALS

VI. Reasons for Termination

- 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.

INITIALS

VII. Couples, Family, Group Psychotherapy

- 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.

INITIALS

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



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

- o You can end this authorization (permission to use or disclose information) any time by contacting: _____
- o 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.
- o You cannot be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
- o You have a right to a copy of this signed authorization. Please keep a copy for your records.
- o 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 TREATMENT 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.

BIOLOGICAL MOTHER

NAME:

AGE AT TIME OF BIRTH:

CURRENTLY LIVING? YES NO

OCCUPATION:

EDUCATION:

SPECIAL EDUCATION / LEARNING PROBLEMS:

MEDICAL PROBLEMS:

MENTAL HEALTH PROBLEMS (IF ANY):

LIST MATERNAL RELATIVES THAT HAVE OR DO EXPERIENCE THE SAME PROBLEMS THE CHILD IS FACING

BIOLOGICAL FATHER

NAME:

AGE AT TIME OF BIRTH:

CURRENTLY LIVING? YES NO

OCCUPATION:

EDUCATION:

SPECIAL EDUCATION / LEARNING PROBLEMS:

MEDICAL PROBLEMS:

MENTAL HEALTH PROBLEMS:

LIST PATERNAL RELATIVES THAT HAVE OR DO EXPERIENCE THE SAME PROBLEMS THE CHILD IS FACING

NAME OTHER CHILDREN IN FAMILY & RELATION (BROTHER, SISTER, STEP-SIBLING)		AGE	MEDICAL, SOCIAL, SCHOOL PROBLEMS
PREGNANCY & DELIVERY HISTORY			
DID ANY OF THE FOLLOWING OCCUR DURING PREGNANCY:	YES	NO	WHAT / WHEN / HOW MUCH
excessive vomiting			
threatened miscarriage			
hospitalization			
toxemia			
operations			
excessive blood loss			
smoking			
drinking			
drug use (Rx and Illicit)			
DELIVERY INFORMATION			
DURATION OF PREGNANCY:		DURATION OF LABOR:	
TYPE OF LABOR:	<input type="radio"/> spontaneous	<input type="radio"/> induced	
TYPE OF DELIVERY:	<input type="radio"/> normal	<input type="radio"/> breech	<input type="radio"/> caesarean
COMPLICATIONS:	<input type="radio"/> cord around neck	<input type="radio"/> hemorrhage	<input type="radio"/> injury
DESCRIBE OTHER COMPLICATIONS:			
POST-DELIVERY PERIOD			
Child discharged after how many days:			
Child had: <input type="radio"/> jaundice <input type="radio"/> cyanosis (turned blue) <input type="radio"/> infection <input type="radio"/> other:			
INFANCY PERIOD			
Were any of the following present for this child:			
<input type="radio"/> did not enjoy cuddling	<input type="radio"/> difficult to comfort	<input type="radio"/> difficult to nurse	<input type="radio"/> difficulty sleeping
<input type="radio"/> overly active	<input type="radio"/> difficult to calm	<input type="radio"/> excessive irritability	
<input type="radio"/> colic	<input type="radio"/> head banging	<input type="radio"/> overly passive/inactive	
Temperament of infant/toddler:	Describe infant/toddler behavior (low, moderate/normal, excessive)		
How active were they?			
How distractible were they?			
How adaptable to change were they?			
Ability to deal with new situations?			
Intensity of emotional expression?			
Predictable sleeping, eating, excretion?			
Describe mood?			

CURRENT MEDICAL STATUS

Current height:	Current weight:
Describe current medical conditions and treatment:	
List current medications (dosage, condition):	

MEDICAL HISTORY

Provide age, type, and description of medical problem

Childhood Disease:
Medical Operation/ Hospitalization:
Head Injury: (lost consciousness, how long?)
Convulsions:
Coma:
Persistent high fevers:
Vision/Hearing problems:
Allergies:
Asthma:
Poisoning:
Tics:

SLEEP PATTERNS

settle down to sleep easily	yes	no	experience night terrors	yes	no
sleep through the night	yes	no	experience sleep walking	yes	no
experience nightmares	yes	no	experience sleep talking	yes	no
sleep restlessly	yes	no	snore	yes	no

DEVELOPMENTAL MILESTONES	OCCURRED EARLY	OCCURRED ON TIME	OCCURRED LATE
smiled			
sat without support			
crawled			
stood without support			
walked without help			
bladder trained during day			
bladder trained during night			
rode tricycle			
rode bike w/o training wheels			
buttoned clothing w/o help			
tied shoe laces w/o help			
spoke first words			
spoke in phrases			
spoke in sentences			
named colors			
said alphabet			
began to read			

PHYSICAL COORDINATION	POOR	AVERAGE	GOOD
walking			
running			
throwing			
catching			
shoelace tying			
buttoning			
writing			
athletic abilities			

Does child have more accidents than other children?

ACADEMIC HISTORY

Current School Name:

Grade Started at this School:	Current Grade Year:
--------------------------------------	----------------------------

Preschool Name:
Describe any academic difficulties:

Kindergarten Name:
Describe any academic difficulties:

Elementary School Name:
Describe any academic difficulties:

Middle School Name:
Describe any academic difficulties:

High School Name:
Describe any academic difficulties:

ACADEMIC FUNCTIONING

ACADEMIC AREA	GOOD	GRADE LEVEL	BELOW GRADE LEVEL	VERY DEFICIENT
intelligence relative to others same age				
comprehend & follow directions				
reading				
spelling				
mathematics				
other:				

ACADEMIC FUNCTIONING *(Continued)*

Type of classroom in which child is currently placed:

Accommodations child receives:

Does child utilize school counseling/resource rooms:

In what ways does your child learn best?

Child's favorite subject and why:

Child's least favorite subject and why:

How do you see your child's academic future? Why?

How could your child be best helped at school? Why?

PROBLEM BEHAVIORS

Circle "H" for behaviors occurring at home and "C" for behaviors in school classroom

HOME/CLASSROOM BEHAVIORS	NEVER		HARDLY EVER		MODERATE		OFTEN		USUALLY	
interrupts	H	C	H	C	H	C	H	C	H	C
learns from experience	H	C	H	C	H	C	H	C	H	C
destroys property	H	C	H	C	H	C	H	C	H	C
fight	H	C	H	C	H	C	H	C	H	C
easily frustrated	H	C	H	C	H	C	H	C	H	C
disturbs others	H	C	H	C	H	C	H	C	H	C
overly sensitive	H	C	H	C	H	C	H	C	H	C
short attention span	H	C	H	C	H	C	H	C	H	C
doesn't follow directions	H	C	H	C	H	C	H	C	H	C
excessive energy	H	C	H	C	H	C	H	C	H	C
sullen/sad	H	C	H	C	H	C	H	C	H	C
immature for age	H	C	H	C	H	C	H	C	H	C
extreme mood changes	H	C	H	C	H	C	H	C	H	C
doesn't complete chores	H	C	H	C	H	C	H	C	H	C
poor memory	H	C	H	C	H	C	H	C	H	C
immediate rewards work	H	C	H	C	H	C	H	C	H	C
delayed rewards work	H	C	H	C	H	C	H	C	H	C
PEER BEHAVIOR <i>(check one)</i>	NEVER		HARDLY EVER		MODERATE		OFTEN		USUALLY	
isolates from others										
inconsiderate/selfish										
not accepted by others										
influences others to misbehave										
easily influenced										
RESPONSE TO AUTHORITY	NEVER		HARDLY EVER		MODERATE		OFTEN		USUALLY	
tries hard to please										
fearful										
anxious										
openly defiant										
passively uncooperative										
physically aggressive										

DISCIPLINE AND PARENTING

Describe behavior management strategies used with child and effectiveness of each:

Spanking:

Loss of Privileges:

Time out:

Other:

Describe injuries resulting from corporal punishment:

Have you participated in parenting classes or training:

ACTIVITIES/HOBBIES

(list activities and how well child performs each)

OTHER PROFESSIONAL(S) INVOLVED WITH CHILD'S CARE

PROFESSIONAL/INSTITUTION	DATES	SERVICES PROVIDED



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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
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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
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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
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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