



Instructions

Please read the following carefully to ensure that your application is complete, so that an appointment can be scheduled in a timely fashion.

1. Make sure all spaces are filled in. **Failure to do so will result in your paperwork being returned to you for completion.**
2. Each person attending the counseling sessions must complete the FCD Client Assessment form and attached problem survey. **Please make sure that if this is counseling for a minor child that ALL paperwork is completed (adult paperwork included).**
3. **Complete the financial information and enclose a copy of your pay check stub(s), unemployment pay stub, tax return, and/or food stamp reimbursement as proof of income for the sliding fee scale. If you're not able to return this information with the paperwork, it will be returned to you for completion.**
4. ***If you have insurance***, please fill out the insurance information and enclose a copy of your insurance card (front and back). If you're not able to return a copy of your card with the paperwork, you must bring it to your first appointment.
5. ***If this is court ordered counseling***, please be sure to enclose a copy of the court order and/or DSS Treatment Summary with your application. **NOTE: Your application will be considered incomplete until we receive a copy of this order.**
6. Return all forms to Compass of Carolina in the envelope provided.
7. If you have any further questions, please feel free to call Nicole Sheppard at (864) 467-3434 ext. 3328 or from outside Greenville at 1-800-203-9692.

***NOTE: You will be required to pay before each appointment, including your first session. During your telephone interview, you were given an estimate as to what your fee may be, so please be prepared to pay. Your fee will be officially set at your first appointment by the Intake Specialist.**

FCD Client Assessment Form

Client Questionnaire

Personal Information: **NOTE: PLEASE READ INSTRUCTION PAGE COMPLETELY!**

Today's Date: _____ Employer: _____ Occupation: _____
 Name: _____ Marital Status: _____
 Address: _____ Marriage Date: _____
 _____ Divorce Date: _____
 _____ Years of Education: _____
 Phone: Home: _____ Work: _____ Alternate: _____
 Date of Birth: ____/____/____ Age: _____ Social Security Number: ____ - ____ - ____
 Sex: _____ Number of people in your household: Adults: _____ Children: _____
 (Optional Information) Race: _____ Religious Preference: _____

Please List the Following Information about Each Person That Lives in Your Household:

Name	Sex	Relationship	Age	Years of Education	Marital Status	Employer

Insurance Information:

Primary Care Physician (PCP) _____ Phone Number of PCP _____
 Name and Phone Number of Insurance Company _____

*** A Copy of Your Insurance Card Must Be Provided ***

Please complete the following if you are insured by another individual's policy:

Full Name of Insured: _____ Relationship to Client: _____
 Address: _____ Phone Number: _____ - _____
 Social Security Number: ____ - ____ - ____ Employer: _____
 Insured's Date of Birth: ____/____/____

Office Use Only

Verification of Benefits:

Date Contacted: _____ Phone Number (if different from above) _____

	Yes	No		Yes	No		
Mental Health Benefit:	<input type="radio"/>	<input type="radio"/>	PCP referral needed:	<input type="radio"/>	<input type="radio"/>	If yes:	Total amount: \$ _____
Pays for LMSW/LPC:	<input type="radio"/>	<input type="radio"/>	Deductible:	<input type="radio"/>	<input type="radio"/>		Amount paid: \$ _____
Pre-cert required:	<input type="radio"/>	<input type="radio"/>	Co-pay:	<input type="radio"/>	<input type="radio"/>	If yes:	Amount: \$ _____
# of covered visits:	_____						

FCD Client Assessment Form

Client Questionnaire

1) Do you have any emergency health care needs we should be aware of: Yes No

If yes, please specify: _____

Doctor's name: _____ Phone: _____

2) Who would we contact in case of an emergency? Name: _____

Home phone: _____ - _____ Work Phone: _____ - _____

3) Are you in any imminent danger or at risk of future harm? Yes No

If yes, please specify: _____

4) Do you presently receive any public assistance? Yes No

5) What is your gross income? Annually: _____ (or) Monthly: _____

(or) Weekly: _____ (or) Bi-Weekly: _____

6) Have you or any family member had counseling previously? Yes No

If yes, please list: Roughly when were the services provided? _____

Who provided these services? _____

Maiden name (if services were previously received at Compass)? _____

What was the major issue at that time? _____

7) Are you or any family member currently under a doctor's care or taking medication? Please list who and what medication(s). Continue on the back of this sheet if necessary.

Family Member	Medication
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

8) What do you see as the major problem/issue? _____

Please check the appropriate answer to each of the following yes/no questions.

	Yes No		Yes No		Yes No
<u>Job problems</u>	<input type="radio"/> <input type="radio"/>	<u>Having headaches</u>	<input type="radio"/> <input type="radio"/>	<u>Trouble being assertive</u>	<input type="radio"/> <input type="radio"/>
<u>Relationship problems</u>	<input type="radio"/> <input type="radio"/>	<u>Having stomach pains</u>	<input type="radio"/> <input type="radio"/>	<u>Trouble making decisions</u>	<input type="radio"/> <input type="radio"/>
<u>Sexual problems</u>	<input type="radio"/> <input type="radio"/>	<u>Believe I am being followed/plotted against</u>	<input type="radio"/> <input type="radio"/>	<u>Feeling sad</u>	<input type="radio"/> <input type="radio"/>
<u>Been arrested/problems with legal authorities</u>	<input type="radio"/> <input type="radio"/>	<u>Having a specific fear</u>	<input type="radio"/> <input type="radio"/>	<u>Crying spells</u>	<input type="radio"/> <input type="radio"/>
<u>Trouble managing my own affairs (food, clothing, shelter, work, school)</u>	<input type="radio"/> <input type="radio"/>	<u>Extreme nervousness or panicky feelings</u>	<input type="radio"/> <input type="radio"/>	<u>Trouble sleeping</u>	<input type="radio"/> <input type="radio"/>
<u>Taking medication</u>	<input type="radio"/> <input type="radio"/>	<u>Difficulty controlling anger</u>	<input type="radio"/> <input type="radio"/>	<u>Feeling hopeless</u>	<input type="radio"/> <input type="radio"/>
<u>Previous drug or alcohol Treatment</u>	<input type="radio"/> <input type="radio"/>	<u>Thinking about harming others</u>	<input type="radio"/> <input type="radio"/>	<u>Losing appetite</u>	<input type="radio"/> <input type="radio"/>
<u>If so, when?</u>	<input type="radio"/> <input type="radio"/>	<u>Have an eating disorder</u>	<input type="radio"/> <input type="radio"/>	<u>Suicidal thoughts</u>	<input type="radio"/> <input type="radio"/>
<u>Drinking too much or taking too many drugs</u>	<input type="radio"/> <input type="radio"/>	<u>Feeling lonely</u>	<input type="radio"/> <input type="radio"/>	<u>Past suicide attempts</u>	<input type="radio"/> <input type="radio"/>
		<u>Trouble concentrating</u>	<input type="radio"/> <input type="radio"/>	<u>Psychiatric hospitalizations</u>	<input type="radio"/> <input type="radio"/>
		<u>Trouble expressing myself</u>	<input type="radio"/> <input type="radio"/>	<u>If so, when?</u>	<input type="radio"/> <input type="radio"/>
				<u>I have experienced...</u>	<input type="radio"/> <input type="radio"/>
				<u>Physical abuse</u>	<input type="radio"/> <input type="radio"/>
				<u>Sexual abuse</u>	<input type="radio"/> <input type="radio"/>
				<u>Rape</u>	<input type="radio"/> <input type="radio"/>
				<u>Emotional abuse</u>	<input type="radio"/> <input type="radio"/>

10) Has this problem affected you at work? Definitely Somewhat Maybe Not Sure Not at All

11) Employment History:

Employer	Position	Length of Employment	Reason for Leaving
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-----	-----	-----	-----
-----	-----	-----	-----
-----	-----	-----	-----

12) Housing Status and History:

Location	Move in Date	Move out Date	Reason for Leaving

Please include any additional information you feel would be helpful.

Thank you for taking your time to complete this form. The information contained will assist Compass of Carolina in guiding you to the best resolution for your individual needs. If you have any questions or concerns, please ask your therapist. Compass of Carolina’s therapists strive to provide the best service for you and your family. We are glad to be able to serve you in any way we can.