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: ______________

Email address (for follow up purposes):________________________________Years of Education: _______

Phone: Home:_____________________ Work: _________________Alternate: __________________

Date of Birth: _______/______/______ Age: _________ Social Security Number: ______-______-______

(Optional Information) Race: _________ *Religious Preference:* ________________________________

Gender: __________ Number of people in your household: Adults: __________ Children: ___________

email address (for United Way purposes): ____

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:	○	○	PCP referral needed:	○	○			
Pays for LISW-CP, LPC, LMFT	○	○	Deductible:	○	○	If yes:	Total amount:	$________________
Pre-cert required:	○	○					Amount paid:	$________________
# of covered visits:	___________		Co-pay:	○	○	If yes:	Amount:	$________________

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: _____-_____ Relationship: ____________
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
Job problems	○	○
Relationship problems	○	○
Sexual problems	○	○
Been arrested/ problems with legal authorities	○	○
Trouble managing my own affairs (food, clothing, shelter, work, school)	○	○
Taking medication	○	○
Previous drug or alcohol Treatment	○	○
If so, when? ______.		
Drinking too much or taking too many drugs	○	○

	Yes	No
Having headaches	○	○
Having stomach pains	○	○
Believe I am being followed/plotted against	○	○
Having a specific fear	○	○
Extreme nervousness or panicky feelings	○	○
Difficulty controlling anger	○	○
Thinking about harming others	○	○
Have an eating disorder	○	○
Feeling lonely	○	○
Trouble concentrating	○	○
Trouble expressing myself	○	○

	Yes	No
Trouble being assertive	○	○
Trouble making decisions	○	○
Feeling sad	○	○
Crying spells	○	○
Trouble sleeping	○	○
Feeling hopeless	○	○
Losing appetite	○	○
Suicidal thoughts	○	○
Past suicide attempts	○	○
Psychiatric hospitalizations	○	○
If so, when? ______.		
I have experienced…		
Physical abuse	○	○
Sexual abuse	○	○
Rape	○	○
Emotional abuse	○	○

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.

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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.