TrueNorth Wellness Services

CONSUMER INFORMATION FORM

Welcome to TrueNorth Wellness Services. To assist us in getting to know you/your family member, please provide the following information as completely as possible.

Name of Client _____ **Today's Date** _____

Emergency Contact _____ Phone _____

Relationship_____ ***(Therapist: Add under Contacts)***

Physical Health/Medical Conditions ***(Therapist: Add under Medical Profile)***

Does client or an immediate family member have a history of any of the following?					
Illness/Disease	**Client**	**Others: specify**	**Illness/Disease**	**Client**	**Others: specify**
Alcohol/Drug Addiction			Heart Disease		
Anemia			Hepatitis/Liver Disease		
Arthritis			High/Low Blood Pressure		
Back problems			High Cholesterol		
Bladder problems			Hypoglycemia (low blood sugar)		
Blood disorders/Sickle cell			Kidney Disease		
Bowel problems/IBS			Lyme Disease		
Cancer			Mental Illness		
Chronic pain			Obesity		
Dementia			Pancreatic Disease		
Diabetes			Pregnancy		
Eating disorders- Anorexia/restricting			Respiratory (asthma, COPD, emphysema)		
Binge eating			Sexually Transmitted Diseases		
Bulimia/purging			Smoking		
Epilepsy/Seizures			Smokeless Tobacco		
Fibromyalgia			Stomach Ulcers/GI problems		
Head Injury (TBI)			Stroke		
Headaches/Migraines			Thyroid problems		
Heart Attack					

Client Height _____ Weight _____ ***(Therapist: Add under Medical Profile)***

Vision, Hearing, or Mobility impairments: _____
Any necessary accommodations: _____

Prescription Medications (Please list medications and dosages) ***(Therapist: Add under Medications)***

_____
_____
_____
_____
_____
_____
_____
_____

Non-prescription/Vitamins Used on a daily basis ***(Therapist: Add under Medications)***

Allergies (Include medication, food, and environmental allergies) ***(Therapist: Add under Allergies)***

PCP/Family Physician (Name, address, phone number) ***(Therapist: Add under External Providers)***

Is there anyone you would like to (or are required to) share information with about your treatment?
No _____ Yes _____ If so, please provide their name and relationship to client.
(Therapist: Add under Contacts and complete an ROI form)

Please describe the primary concern(s) that brings client/you to counseling

Please describe your goal or the changes client/you would like to see as a result of counseling

Please review the attached packet of information. If you have any questions regarding the information, please discuss it with the staff member completing your assessment session today. If you would like copies of any of the information to take with you, please inform the office staff. During your appointment, you will be asked to sign an electronic form confirming that you were provided with this information. Following is the acknowledgement statement that appears on the electronic form:

I acknowledge that TrueNorth Wellness Services has offered me the "Notice of Privacy Practices", as well as additional forms explaining client rights, confidentiality of records, attendance policies, financial policies, and non-discrimination policies.
I understand that I may be responsible for any charges not covered by my insurance. I understand that minimum necessary information will be released for the purpose of routine billing and operations. Further, I request payment of my benefits from my insurance company to TrueNorth Wellness Services for the treatment services rendered.
I have read and agree to the client rights and responsibilities.