



*Building Solid Foundations for Every Season of Life*

**ACKNOWLEDGEMENT OF RECEIPTS OF NOTICE OF PRIVACY PRACTICES & CONSENT TO TREAT**

**NOTICE OF PRIVACY PRACTICES:**

I have read and have been offered a copy of the Notice of Privacy Practices and Clients Rights document.

**Client Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Staff Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**CONSENT TO TREATMENT:**

Your signature below indicates that you have read all the information in our informed consent (located at cornerstonecounseling.co) and agree to treatment by our agency and to abide by our policies during our professional relationship.

**Client Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Staff Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS:**

I consent that \_\_\_\_\_ may be treated as a client as Cornerstone Counseling. When it is necessary to schedule appointments during school hours Cornerstone will provide a school excuse slip. We ask for your cooperation in order to provide the timeliest treatment for you and your children.

\_\_\_\_\_ Provided Court Documentation for Custody of Minor child/children if applicable (Per CSWMFT Board Directive)

\_\_\_\_\_ Court Documentation not provided Reason: \_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Staff Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

It is your right to refuse to sign this document.

For Office Use Only

The reason that a standard acknowledgement (such as the above) of the receipt of the notice of privacy practices was not obtained because:

- \_\_\_ Client refused to sign
- \_\_\_ Communication barriers prohibited obtaining the acknowledgement
- \_\_\_ An emergency situation prevented this office from obtaining it
- \_\_\_ Other: \_\_\_\_\_

**CORNERSTONE COUNSELING OF BELLEVUE, LLC  
ADULT PERSONAL HISTORY FORM**

Please complete the following information to the best of your ability. Your counselor will review this information as part of the assessment process. This information will be very helpful to your counselor in deciding the best course of treatment for you. If you are uncomfortable or have difficulty answering any of the questions you may leave them blank and discuss them with your counselor. We appreciate your patience in completing this form.

Client Name: \_\_\_\_\_

Date: \_\_\_\_\_

**I. Presenting Problem:**

Who referred you for services? (check all that apply)

- Self  Family  Spouse  Friend  Employer  Court  Family Doctor/other health care provider  
 Other (please explain): \_\_\_\_\_

Why are you seeking counseling at this time and/or why did any of the above refer you to counseling?

\_\_\_\_\_  
 \_\_\_\_\_

**II. Social History:**

Identify your current marital status:

- Single, never married  Married  Divorced  Living with significant other (unmarried)  
 Separated  Widowed

Living Situation			
Identify your type of living situation: <input type="checkbox"/> Own home <input type="checkbox"/> Rent home <input type="checkbox"/> Friend's home <input type="checkbox"/> Relative's home <input type="checkbox"/> Other:			
List household members (name)	Relationship to you	Age	Circle which best describes the quality of relationship with each household member.
			Poor Fair Good Excellent
			Poor Fair Good Excellent
			Poor Fair Good Excellent
			Poor Fair Good Excellent
			Poor Fair Good Excellent
Significant family members (not living with you)	Relationship to you	Age	Circle which best describes the quality of relationship with each person.
			Poor Fair Good Excellent
			Poor Fair Good Excellent
			Poor Fair Good Excellent
			Poor Fair Good Excellent

Would you like any family members involved in your treatment?  Yes  No

If yes, list who you would like involved in your treatment here. \_\_\_\_\_

Community Resources: Do you currently use any of the following community resources?

- Yes  No If yes, check all that apply.
- AA/ NA/ Al Anon  Health Department  Dept. of Job and Family Services  
 NAMI  Church  Other(s): Please list below

**Leisure and Recreation Activities:**  
 How do you spend your free time? Check all that apply.

Activity	√	When was the last time you did this?
Outdoor activities (i.e. fishing, gardening, etc.)		
Hobbies & crafts (i.e. scrapbooking, sewing, painting, etc.)		
Attending social activities, events, & groups		
Physical activities (i.e. sports, exercise, etc.)		
Caring for pets		
Spending time with friends		
Reading		
Watching TV		
Surfing the internet		
Social Media		How many hours per day:

Are you currently satisfied with your social life?  Yes  No If no, please comment: \_\_\_\_\_

Have you ever been a victim of any of the following? Check all that apply.  Physical Abuse  
 Sexual Abuse  Emotional Abuse  Verbal Abuse  Neglect  Exploitation (taken advantage of)

**III. Cultural and Ethnic Section**

What is your ethnic/cultural heritage (i.e. Irish, African American, etc.)? \_\_\_\_\_

What were your family's beliefs about the following?

Issue	Comments (my family believed, taught, etc.)
Showing Emotion	
Using alcohol/ other drugs	
Having a mental illness	
Seeking help	
Death/dying	

Do you have any traditions that were special to you/your family (i.e. special holidays, foods, music, celebrations, etc.)?  
 \_\_\_\_\_

Will you let your family members know you are in treatment?  Yes  No

If not, please explain why: \_\_\_\_\_

Do you think family beliefs/ cultural beliefs will affect your counseling treatment?  Yes  No

If yes, please explain how: \_\_\_\_\_

**IV. Education, Employment, and Military Information**

Education History: (Check all that apply)  GED  HS Grad  Other degree:  
 College - # Years Degree/Major:

Highest grade completed: \_\_\_\_\_

Were you ever in special education classes in school?  Yes  No  
 If yes, why?

Do you have any history of learning difficulties?:  Yes  No  
 If yes, please specify:  
 Learning disability – Type:  
 Developmental Disability

Special school placement  
 Other:  
History of behavior problems/ disciplinary action at school:  
Detentions for:  
Suspensions for:  
Expulsions for:  
Any school problems (i.e. poor grades, acting out etc.) related to drug/alcohol use?  
 Yes  No If yes explain: \_\_\_\_\_

Do you have problems learning new information?  Yes  No  
If yes, please specify:  
 Inability to read or write  Difficulty retaining information  
 Difficulty concentrating  Other: \_\_\_\_\_

Employment: (Check all that apply)  
Employed:  Full time (35 hrs. or more per week)  Part time (<35 hrs per week)  Volunteer work  
 Unemployed – Date last worked: \_\_\_\_\_  
Not in Labor Force:  Disabled  Retired  Homemaker  Student  Living in institution  
 Other:  
If employed, name of employer: \_\_\_\_\_  
How long have you been employed with current employer? \_\_\_\_\_ yrs \_\_\_\_\_ months  
Satisfied with job?  Yes  No  
Job Performance History:  
How many jobs have you had in the last five years? \_\_\_\_\_ Comments: \_\_\_\_\_  
Identify your typical attendance habits at work:  Above average  Normal  Tardiness  Absenteeism  
Identify your typical work performance:  Excellent  Good  Average  Below Average  
Do you have any history of employment problems (i.e. due to drug/alcohol use, disciplinary actions, suspensions, problems relating to bosses/coworkers, termination, etc.)?  Yes  No  
If yes, please explain: \_\_\_\_\_  
Are you experiencing financial problems?  Yes  No Comments: \_\_\_\_\_  
If you are not employed do you want to work?  Yes  No  
If you are not employed are you able to work?  Yes  No

Military History: Were you ever or are you currently in the military?  Yes  No  
 Army  Navy  Air Force  Marines  Coast Guard  National Guard  
Reason for discharge and type:  
Date of discharge:

V. Legal History:  
Do you have a legal guardian of person?  Yes  No of estate?  Yes  No  
If yes, name: \_\_\_\_\_ Relationship to client: \_\_\_\_\_  
Phone #: \_\_\_\_\_

What is your current legal status?  N/A  On Probation  Detention  On Parole  
 Awaiting Charge  AoD Related Legal Problems  Court Ordered to treatment  Other: \_\_\_\_\_

Do you have a history of legal charges as a juvenile?  Yes  No  
If yes, please explain: \_\_\_\_\_  
Do you have a history of legal charges as an adult?  Yes  No

If yes, please explain: \_\_\_\_\_

Date of most recent charges: \_\_\_\_\_

Have you ever been convicted of a crime?  Yes  No

If yes, list crimes for which you have been convicted: \_\_\_\_\_

Have you ever been incarcerated?  Yes  No

If yes, complete the following:

Date of Incarceration	Location	Length of Incarc.	Reason(s) for Incarceration

Do you have a probation/parole officer?  Yes  No

If yes, list name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Do you have a valid driver's license?  Yes  No If no, why not? \_\_\_\_\_

Is child protective services involved with your family?  Yes  No

If yes, why? \_\_\_\_\_

If yes, Name of case worker: \_\_\_\_\_

**VI. Spirituality:**

Do you believe in God or a Higher Power?  Yes  No

Do you identify yourself as a member of any particular faith?  Yes  No

If yes, please list faith: \_\_\_\_\_

Do you attend a church, synagogue, mosque, or other place of worship?  Yes  No Name of Place: \_\_\_\_\_

Has faith been a source of strength/support to you during difficult times in your life?  Yes  No

Do your spiritual beliefs ever contribute to feelings of worry or anxiety?  Yes  No

If yes, please explain: \_\_\_\_\_

What are your spiritual beliefs about suicide? \_\_\_\_\_

What are your spiritual beliefs about dying? \_\_\_\_\_

Do you see your faith playing a role in treatment?  Yes  No If yes, explain: \_\_\_\_\_

**VII. Alcohol/Drug Use History**

Have you ever used prescription drugs differently than how they were prescribed (i.e. higher dose or more frequent than prescribed) in the past year?  Yes  No

Have you used illegal drugs in the past year?  Yes  No

Have you used non-prescription drugs differently than the recommended dosage in the past year?  
 Yes  No

Have you drank more alcohol than you or someone else thought you should have in the past year?  
 Yes  No

Complete the following regarding your history of drug/alcohol use:	Date of last use	Amount typically used	How often?
Alcohol			
Cannabis (pot/marijuana/weed)			
Cocaine (any form)			
Opioids(Heroin, Percocet, Vicodin, Opana, etc)			

Sedatives			
Inhalants(Whippets, Nitrous, Poppers, Rush)			
Hallucinogens (acid/lsd/pcp/etc.)			
Stimulants (diet pills, speed, etc.)			
Club/designer drugs(ecstasy, Molly, GHB, Ketamine)			
Non-prescription (over the counter)			
Other (i.e. steroids, fat burners, etc.)			

Tobacco use:  Yes  No If yes, form (cigarettes, cigars, "chew", etc.)? Amount per week? \_\_\_\_\_  
 Caffeine use:  Yes  No If yes, form (coffee, pop, etc.)? Amount per week? \_\_\_\_\_

Have you had any of the following problems related to drug/alcohol use (check all that apply)?

- Health problems
- Legal problems
- Relationship problems (arguments/strained relationships with family, etc.)
- Employment problems (tardiness, poor performance, etc.)
- Financial problems (not paying bills, etc. due to money spent on drugs or alcohol)

Have you ever or are you currently receiving treatment for alcohol and/or drug use?  Yes  No

If yes, please complete the following:

Agency Name	Currently in Treatment	Past Treatment (list dates)	Please rate results of your treatment experience				
			1	2	3	4	5
			Not helpful	helpful	very helpful		

Client signature or signature of person completing this form on behalf of the client:

Date:

**CORNERSTONE COUNSELING OF BELLEVUE, LLC**

**Health History Questionnaire**

*Please notify staff if you need any assistance in completing this form.*

Client Name (First, MI, Last):	Date of Birth:
--------------------------------	----------------

**I. Any Allergies/drug sensitivities? Yes \_\_\_ No \_\_\_**

If yes specify below:

___ Food (Specify):
___ Medicine (Specify):
___ Other (Specify):

**II. Medications:** Are you currently taking any prescribed medication, over the counter medication, or herbal remedies? \_\_\_ Yes \_\_\_ No If yes, please complete the following:

Medication	Reason	Prescribed by:

**III. History of Medical Problems:** Please check "self" if any of the following health issues apply to you and/or check "family" if any apply to a family member.

Problem	Self	Family	List any treatment <u>YOU</u> have received for each problem identified.
Alcoholism/Drug Issues			
Anxiety			
Breathing Problems			
High Blood Pressure			
Cancer			
Depression			
Diabetes			
Epilepsy/Seizures			
Head Injury/Brain Tumor			
Heart Disease			
Hepatitis/Jaundice			
Kidney Disease			
Stomach/Bowel Problems			
Stroke			
Thyroid			
Have you tested positive for TB?			
Have you had exposure to TB?			
AIDS/HIV			
Sexual Problems			
Sleep Problems			
Suicidal attempts or thoughts			
Other?			

Any medical/surgical hospitalizations in the past year-please list reasons:

Do any of the medical problems you checked interfere with your daily living?	Yes	No
If yes, what problems and how?		

#### IV. Functional Screening

Problem/Difficulty	YES	NO	Treatment received to help with the problem
Do you have problems with activities of daily living i.e. bathing, getting dressed or tying shoes?			
Do you have difficulty walking?			
Do you have any problems performing physical tasks at work or home?			
Do you use a walker, cane, wheelchair, or other ambulatory device?			
Do you exercise regularly? If yes, what type? How often?			
Do any of the issues checked yes interfere with your daily living? If yes, which ones and how do they interfere?			

#### V. Pain Screening

Do you currently experience physical pain?	Yes	No
If yes, please rate your pain on a scale from 0 (no pain) to 10 (severe/worst pain) (Circle the one that best describes your pain)		
<p style="text-align: center;">0   1   2   3   4   5   6   7   8   9   10</p> <p style="text-align: center;">No pain <span style="float: right;">Severe/worst pain</span></p>		
Please indicate the location of your pain.		
Are you receiving medical treatment for the pain?	Yes	No
Are you taking pain medication	Yes	No
Does the pain interfere with your daily living?	Yes	No
If yes, explain how:		

#### VI. Speech, Language, Vision, and Hearing Screening

Are you experiencing any of the following at this time? Please check "YES" or "NO".	YES	NO	If yes, list treatment and or services you received to help with these problems.
Do you ever have problems hearing others?			
Have you ever been tested for a hearing problem?			
Do people often ask you to repeat what you are saying?			
Is English your native language?			If no, what is?
Do you have difficulty seeing?			
Do any of the issues checked "yes" interfere with your daily living?			Yes   No
If yes what problems and how?			



**VII. Nutritional Screening**

Are you currently experiencing any of the following?	YES	NO	Details
Unplanned change in weight in the last 12 months?			If yes, identify the change. __Gain __Loss Have you received medical treatment for this? __Yes __No
Has your physician asked you to follow a special diet?			If yes, type:
Any problems with chewing/swallowing?			If yes explain: Have you received medical treatment for this? __Yes __No
Do any of the issues checked interfere with your daily living? If yes, what problems and how?			Yes      No

**VIII. Health Care**

Last Physical Examination	Date:	By whom?	Phone Number:	
Are your childhood immunizations up to date?			Yes	No
Have you had the flu shot this year?			Yes	No
Have you had a pneumonia vaccine in the last five years?			Yes	No
Pregnancy (If applicable) Are you pregnant at this time? If yes, expected delivery date?		Yes	No	N/A
Are you receiving prenatal care? If yes, by whom?		Yes	No	N/A

**Mental Health Treatment History:**

Have you previously had outpatient mental health treatment?       Yes     No

If yes, please complete the following:

Agency Name	Past Treatment Dates	Please rate your treatment experience (circle rating)		
		Not Helpful	Helpful	Very Helpful
		1	2	3
		1	2	3

Have you ever been hospitalized for psychiatric reasons?       Yes     No

If yes, please complete the following:

Hospital Name	Admit Date	Discharge Date	Reason for Entering Hospital

Have you in the past or do you currently have a mental health diagnosis?

Yes     No  
If yes, please list diagnosis:

Signature of person completing this form: \_\_\_\_\_

# Email Informed Consent Form

## Introduction

Cornerstone Counseling provides patients the opportunity to communicate with Cornerstone Counseling and its employees or agents by email. Transmitting confidential patient information by email, however, has a number of risks, both general and specific, that patients should consider before using email.

## Risk Factors

- Among general email risks are the following:
  - Email can be immediately broadcast worldwide and be received by many intended and unintended recipients.
  - Recipients can forward email messages to other recipients without the original sender's permission or knowledge.
  - Users can easily misaddress an email.
  - Email is easier to falsify than handwritten or signed documents.
  - Backup copies of email may exist even after the sender or the recipient has deleted his or her copy.
  
- Among specific patient email risks are the following:
  - Email containing information pertaining to a patient's diagnosis and/or treatment may be included in the patient's medical or financial records. Thus, all individuals who have access to the medical record or financial record will have access to the email messages.
  - Employees do not have an expectation of privacy in email that they send or receive at their place of employment. Thus, patients who send or receive email from their place of employment risk having their employer read their email.
  - If employers or others, such as insurance companies, read an employee's email and learn of medical treatment, particularly mental health, sexually transmitted diseases, or alcohol and drug abuse information, they may discriminate against the employee/patient. For example, they may fire the employee, not promote the employee, deny insurance coverage, and the like. In addition, the employee could suffer social stigma from the disclosure of such information.
  - Patients have no way of anticipating how soon Cornerstone Counseling and its employees and agents will respond to a particular email message. Although Cornerstone Counseling and its employees and agents will endeavor to read and respond to email promptly, Cornerstone Counseling cannot guarantee that any particular email message will be read and responded to within any particular period of time. Cornerstone Counseling's employees and agents may be traveling, be engaged in other duties, or be on a vacation or

a break and therefore be unable to continually monitor whether they have received email. Thus, patients should not use email in a medical or other emergency.

### Conditions for the Use of Email

- It is the policy of Cornerstone Counseling to make all email messages sent or received that concern the protected health information (“PHI”), defined as individually identifiable health information that includes medical, financial, demographic, and lifestyle information, part of that patient’s medical, financial, or other records, and Cornerstone Counseling will treat such email messages with the same degree of confidentiality as afforded other portions of the medical record. Cornerstone Counseling will use reasonable means to protect the security and confidentiality of email information. Because of the risks outlined above, Cornerstone Counseling cannot, however, guarantee the security and confidentiality of email communications.
- Thus, patients must consent to the use of email for confidential medical information after having been informed of the above risks. Consent to the use of email includes agreement with the following conditions:
  - All emails to or from the patient concerning diagnosis and/or treatment will be made a part of the patient’s records. As a part of medical record or other records, other individuals, such as other physicians, nurses, physical therapists, patient accounts personnel, and the like, and other entities, such as other health care providers and insurers, may have access to email messages contained in medical records.
  - Cornerstone Counseling may forward email messages within the facility as necessary for diagnosis, treatment, and reimbursement. Cornerstone Counseling will not, however, forward the email outside the facility without the consent of the patient or as required by law.
  - If the patient sends an email to Cornerstone Counseling one of its employees or agents will endeavor to read the email promptly and to respond promptly, if warranted. Cornerstone Counseling, however, can provide no assurance that the recipient of a particular email will read the email message promptly. **Because Cornerstone Counseling cannot assure patients that recipients will read email messages promptly, patients must not use email in a medical or other emergency.**
  - If a patient’s email requires or invites a response, and the recipient does not respond within a reasonable time, the patient is responsible for following up to determine whether the intended recipient has received the email and when the recipient will respond.
  - Because some medical information is so sensitive that unauthorized disclosure can be very damaging, **patients should not use email for communications concerning diagnosis or treatment of the following: AIDS/HIV infection; other sexually transmissible or communicable diseases, such as syphilis, gonorrhea, herpes, and the like; mental health or developmental disability; or alcohol and drug abuse.**

- Because employees do not have a right of privacy in their employer's email system, patients should not use their employer's email system to transmit or receive confidential medical information.
- Cornerstone Counseling cannot guarantee that electronic communications will be private. Cornerstone Counseling will take reasonable steps to protect the confidentiality of patient email, but Cornerstone Counseling is not liable for improper disclosure of confidential information not caused by Cornerstone Counseling's gross negligence or wanton misconduct.
- If the patient consents to the use of email, the patient is responsible for informing Cornerstone Counseling of any types of information that the patient does not want to be sent by email other than those set out above.
- Patient is responsible for protecting patient's password or other means of access to email sent or received from Cornerstone Counseling to protect confidentiality. Cornerstone Counseling is not liable for breaches of confidentiality caused by patient.
- **Any further use of email by the patient that discusses diagnosis or treatment by the patient constitutes informed consent to the foregoing.** You may withdraw consent to the future use of email at any time by email or written communication to Cornerstone Counseling attention: Staci Ringle

**EMAIL INFORMED CONSENT SIGNATURE PAGE**

I have read the above risk factors and conditions for the use of email, and I hereby consent to the use of email for communications to and from Cornerstone Counseling regarding my medical treatment.

\_\_\_\_\_  
Signature of Patient or Representative if Minor

\_\_\_\_\_  
Date of Signature

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date of Signature

\_\_\_\_\_  
Printed Name of Witness

Gave Client Copy \_\_\_\_\_ Client Declined Copy \_\_\_\_\_