

**WELLNESS QUESTIONNAIRE**  
**Brenda Stockdale, PhD cand., MA, REACE, CWP**  
 Director of Behavioral Medicine  
 6030 Bethelview Rd, Suite 403, Cumming, GA 30040

**VM: 678-393-0066 O: 770-205-6068 HIPAA Secure Email: support@brendastockdale.com**  
**www.brendastockdale.com**

Today's Date:		Referred By:			
Last Name		First Name		MI	Date of Birth
Address				Age	Sex M_____ F_____
City		State	Zip Code	Place of Birth	
Primary Phone:		Email:		Skype or Zoom ID:	
Employed By:				Occupation:	
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Significant Other Relationship					Number of Hours Worked Per Week:
Presently Living With: <input type="checkbox"/> Parents <input type="checkbox"/> Spouse <input type="checkbox"/> Roommate <input type="checkbox"/> Partner <input type="checkbox"/> Alone <input type="checkbox"/> Other					
Highest Level Of Education: <input type="checkbox"/> Elementary <input type="checkbox"/> High School <input type="checkbox"/> College <input type="checkbox"/> Other (List)					
Counseling/Therapy Experience:					
Please Describe The Health of Your IMMEDIATE Family – Include Any Diseases or Disturbances:					
Father:					
Mother:					
Siblings:					
1.					
2.					
3.					
4.					
Grandparents:					
Children:					
1.					
2.					
3.					
4.					
If Living, What is Your Parents' Current Marital Status?					
Have You Had Any Previous Marriages?				If Yes, How Many?	
<input type="checkbox"/> Yes <input type="checkbox"/> No					
Please List Any Serious Accidents, Surgeries or Illnesses You Have Had In The Past:					

<p>If Needed Please Use a Separate Page to List Any Acute or Chronic Symptoms Related To Your Health: (i.e. digestive system, headaches, pains, breathing, skin, palpitations, anxiety etc.)</p>
<p>What Medications Are You Taking?</p>
<p>Do you follow any particular diet? What do you typically eat for breakfast, lunch, dinner and snacks?</p>
<p>What Kinds of Work Interests You?</p>
<p>Please Use a Separate Page as Needed to List The Most Significant Events And Time Periods In Your Life (For example: Experiences that shaped your beliefs, character, and spiritual beliefs. Important people in your life, trauma, creative accomplishments).</p>
<p>Sleep Patterns/Habits: How Many Hours of Sleep You Need To Feel Good? How Many Do You Actually Get? Is Your Sleep Interrupted?</p>
<p>What Are Your Predominant Moods and/or Temperament? Are Your Moods and Feelings Affected Easily? Do These Vary Extremely? What Are The Triggers?</p>
<p>How Would You Describe Your Personality?</p>
<p>What Are Your Creative Attributes? Are You Fulfilled Creatively? (please list briefly)</p>
<p>Are There Any Significant Stress Factors In Your Social Environment, Work, or Personal Relationships?</p>
<p>Other Concerns – And/Or Your Goals For Our Time Together (Creatively - Professionally – In Your Relationships – Family – Personally – Health...)</p>

**All Information On This Form Is Confidential. If I will be consulting with your physician or other healthcare provider a signed consent is required.**

If you are experiencing serious mental health problems that potentially require emergency assistance, I will be happy to refer you to a qualified clinical psychologist or psychiatrist.

**Fee Schedules:** The initial session is unique. In this extended session, I spend an hour and forty-five minutes getting to know you, reviewing what is most relevant to you—including items on your health questionnaire that you wish to discuss—along with how to get the most out of our work together. The fee is \$300: half is paid at the time of booking and is fully refundable with a 2-business day notice. Future sessions are \$135 per 1-hour (60-minute session) and prorated accordingly for extra time or brief phone and email responses. If you prefer to work in larger blocks of time we can arrange that with prior notice. If you need to reschedule a session, the fee for a missed appointment is waived when a 2-business day notice is given. Without this advance notice a \$135 fee will be incurred.

**Insurance Reimbursement:** If you have been referred by your physician a medical diagnostic code can be used as the basis for treatment. The form may be submitted to your medical health insurance (not the mental health division) for reimbursement. Once submitted your insurance carrier has a right to your records; for this reason, some choose not to submit. Keep in mind that policies and benefits vary considerably. For clients without a medical referral, personal and professional development can often be deducted as a business expense. See your accountant to determine if this would apply to you.

**Contacting Me:** My voice mail is: 678-393-0066. The office number is: 770-205-6068. I will return your call within 2-business days. If you do not receive a return call I have not received your message. As always, in the event of an emergency you should call 911 or go to your nearest emergency room.

**Email:** I do not check email regularly. Please keep in mind gmail is not encrypted. For confidential communication please use my HIPAA (encrypted) email: [support@brendastockdale.com](mailto:support@brendastockdale.com).

**Professional Records:** To keep track of our work together and facilitate the best approach, I take notes during our sessions together. If you wish a summary of your records I can prepare that for you. The fee schedule is the same for time spent in responding to information requests.

**Confidentiality:** Our discussions and any related material are between us. If a consult with your physician might be beneficial, it is only done with your consent in writing. Please keep me informed of medication, herbs, supplements or other changes you may make while seeing me because the body and mind are interrelated. Exceptions to confidentiality include information about intent to seriously harm an individual (self included). If you choose to have phone consultations, please be aware that **some means of wireless communication may not be secure from eavesdropping**, so if you agree to their use you are indicating your agreement to utilize a communication medium that may not be entirely confidential. **Skype utilizes encryption protocols** that meet the Federal Information Processing Standards for electronic transmission under HIPAA. However, it does not have a protocol for notification when a data breach has occurred.

**HIPAA:** I have read and understand the HIPAA policy related to disclosure of information and received a copy if I so choose.

**Indemnity:** Although there are no guarantees on the outcomes from biobehavioral methods, most people report significant progress on their goals. Nevertheless, each party agrees to indemnify, defend, and hold harmless the other party and its agents, officers, and employees from and against any and all liability, expense, including defense costs and legal fees incurred in connection with claims for damages of any nature whatsoever including but not limited to, bodily injury, death, personal injury, financial or business losses, or property damage arising from such party's performance of failure to perform in obligations hereunder.

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

Client Signature (Electronic Signature is Acceptable): \_\_\_\_\_

**Iler Consulting, LLC**  
**Brenda Stockdale, PhD cand., MA, REACE, CWP**  
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**Initial**

\_\_\_\_: I have received a copy of Iler Consulting's Notice of Privacy Practices (HIPAA)

\_\_\_\_: I consent to allow Brenda Stockdale and staff to discuss my health issues with friends or family members or other health professionals that I have contact the office on my behalf.

\_\_\_\_: I specifically also allow these listed people to discuss my health issues with Brenda Stockdale and staff:

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\_\_\_\_: I do not wish to have my health issues discussed with anyone other than myself. *(Only check this line if you are excluding the above 2 HIPAA consents)*. However in case of an emergency please call: Name: \_\_\_\_\_ #: \_\_\_\_\_ (Relationship to patient: \_\_\_\_\_)

\_\_\_\_: I have read and agree with the Disclosure and Consent form.

\_\_\_\_: I have read and agree with the Policies and Procedures of Iler Consulting.

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

Client Signature (Electronic Signature is Acceptable): \_\_\_\_\_