

Stonebriar Counseling Associates – Bob Good, M.A.,ThM., LPC, CART

Name:		Today's Date:
Address:		Date of Birth: Age:
City, State, Zip	Primary Phone:	Race/Ethnicity: Caucasian / African-American / Hispanic / Asian / Other:
Cell/Work/Alternate Phone:	E-mail Address:	Marital Status: Single / Married / Divorced / Widowed

Client Initial Assessment

Your Reason(s) for Coming to Counseling (Please briefly describe below.)

Referral Information

How did you hear about SCA/Bob Good (who referred you)?		
Are you being required to come to counseling by anyone (probation, CPS, etc.)? If YES, who?	YES	NO

Your Counseling/Treatment History (Please list any current or past counseling, psychiatric care, or substance abuse treatment.)

Date	Provider	Problem/Issue	Duration	Outcome

About Your Family (Please provide the following information. *When noting relation, note step-, half-, adoptive, etc.*)

Name	Age	Relation	In Home? (Y/N)	Living? (Y/N)	Substance Abuse (Y/N)

Your School Information (for students only)

School Name/Location:	Current Grade Level:
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Extra-Curricular Activities (i.e., band, sports, FFA, Student Council, Clubs, etc.):

Your Employment Information

Employer (If unemployed, list most recent employer):

City:

Currently Employed? Yes / No

Hours per Week:

Position:

Your Spiritual Beliefs/Church Information

Describe your spiritual beliefs:

Church Membership:
Are you active?

Information About Suicide/Self-Harm

Have you ever thought about committing suicide? NO YES When/Explain:

Have you ever attempted suicide or hurt yourself? NO YES When/Explain:

Have you ever known anyone who committed suicide? NO YES When/Explain:

Significant Life Events (Indicate any that apply to you.)

Event/Situation	YES or NO	When/Who/Other Information
Death of a Parent		
Divorce of Parents		
Death of a Brother/Sister		
Death of Other Family Member		
Chronic Illness of Family Member		
Multiple Moves		
Loss of Good Friend(s)		
Abandoned by Parent(s)		
Chronic Illness/Hospitalization of Self		
Struggles w/Sexual Identity/Orientation		
Other:		

Information About Abuse You Have Suffered or Witnessed

Emotional - Includes chronic discord between parents, yelling, screaming, cursing. YES NO
Explain:

Physical - Includes hitting (w/hands or other object); pushing; withholding food, water, sleep. YES NO
Explain:

Sexual - Includes words, looks, and touching:
Explain:

YES

NO

About Your Substance Use History (Complete the information and circle your drug of choice.)

Substance	AGE of <u>First Use</u>	DATE of Last Use	Days Used in Past 30 Days?	Amount Used at a Time	Frequency of Use (How Often)	Method of Use (smoke, snort, IV, etc)
Alcohol						
Marijuana						
Amphetamines / Methamphetamines						
Powder Cocaine						
Crack Cocaine						
Heroin						
Other Opiates (Morphine, Methadone, Oxycontin, Hydrocodone, Codeine, Demerol, Dilaudid, Vicodin, Lorcet, Percodan)						
Benzodiazapines (Sedatives, Anxiolytics, Xanax, Valium, Soma, Librium, Klonopin, Ambien, Versed, Restoril, Halcion, Sonata, Dalmane)						
Ecstasy						
GHB, Ketamine						
DXM (Corecedin, cough syrup)						
PCP						
LSD, Mushrooms, or other hallucinogens						
Inhalants						
Steroids						
Tobacco						
Other Substances						

Your Legal Status

Currently on Probation? YES NO

Probation Officer's Name:

On Probation for:

Scheduled end date:

Arrests in past year:

Charges pending:

Charges Pending in Court? YES NO Explain:

Child Protective Services Status

Current CPS Involvement? YES NO

CPS Worker's Name:

If Yes, have your children been removed from the home? YES NO

If Yes, whose care are the children in currently?

If CPS is involved, please describe the circumstances:

Your Interest in Counseling / Treatment

On a scale from 1 to 10, how interested are you in receiving counseling services at this time ?

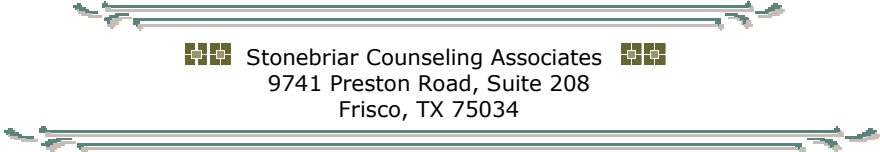


1 2 3 4 5 6 7 8 9 10

Not at all interested

Somewhat Interested

Very Interested

Is There Anything Else You Want The Counselor To Know?


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Personal Information

Church Membership _____ Are you active? _____

Medical Doctor _____ Medications _____

Who referred you?

- New Life Radio Network Fellowship Church
 SCA Web Site Pastor (please give name) _____
 School (please give name) _____
 Physician (please give name) _____
 Family/Friend (please give name) _____
 Yahoo Yellow Pages Allen Community Web Page
 Focus On The Family McKinney Community Web Page
 Google Search Blue Cross/Blue Shield Web Page

What drew you *most* to **Stonebriar Counseling Associates**? _____ Church referral

_____ Christian Influence _____ Convenient Hours





_____ Convenient Location _____ Affordable Cost _____ Personal Referral

CLIENT INFORMATION AND CONSENT

I WELCOME YOU! It is my desire to insure that your participation in counseling is a most productive and satisfying one. In order to facilitate a therapeutic relationship, I have set forth certain information, which will enable you to make an informed consent to counseling.

Therapist

My name is Bob Good, Th.M., M.A., LPC and I am a Licensed Professional Counselor (#19134) engaged in providing mental health care services to clients directly as an independent contractor/provider for Stonebriar Counseling Associates.


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Mental Health Services

While it may not be easy to seek help from a mental health professional, it is hoped that through therapy you will change in the following ways: 1) gain greater insight into your situation and feelings, 2) develop expanded conceptualizations of your life, relationships, circumstances, and future; 3) move toward resolving your concerns; and, 4) forge a life plan that promotes greater realization of your human potential, happiness, and success. As your therapist, using my knowledge of human development and behavior, human change process, and Cognitive Behavioral Therapy, I will make observations about situations as well as suggestions for new ways to approach them. It will be important for you to explore your own feelings and thoughts and to try new approaches in order for change to occur. You may bring other family members to a therapy session if you feel it would be helpful or if recommended by your therapist.

Appointments

Appointments are made by calling 214-642-8737 Monday through Saturday between the hours of 9:00 A.M. and 5:00 P.M. Please call to cancel or reschedule at least 24 hours in advance, or you will be charged for the missed appointment. Third-party payments will not usually cover or reimburse for missed appointments. If you experience a life threatening emergency please go to your nearest ER or call 911.

Number of Visits

The number of sessions depends on many factors and will be assessed and discussed by the therapist.

Length of Visits

Therapy sessions are 45-50 minutes in length but may take longer for testing assessment.

Relationship

Your relationship with the therapist is a professional and therapeutic relationship. In order to preserve this relationship and abide by the ethical standards of the Texas State Board of Examiners of Professional Counselors (§ 681.32 Texas Administrative Code, Chapter 681), it is imperative that the therapist refrain from any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship.

Gifts, bartering, and trading services are not appropriate and should not be shared between you and the therapist.

Cancellations

Cancellations must be received **at least 24 hours** before your scheduled appointment; otherwise **YOU will be charged the customary fee for that missed appointment**. You are responsible for calling to cancel or reschedule your appointment.





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Payment for Services

The charge for your sessions is **\$110.00/hr**. Payment is expected at the time services are rendered. I accept personal checks and cash **and major credit cards**. If payment becomes a hardship for you, please discuss this with me so we can arrange a suitable payment plan. If I am listed as a provider for your insurance plan, I will collect your co-pay and file your insurance for you. For out of network plans, you will be provided a receipt so that you can file for insurance reimbursement. Insurance benefits usually cover only “medically necessary” treatment, requiring a mental health diagnosis. **Any diagnosis made will become part of your permanent insurance records and may have implications concerning future applications for life insurance, long-term care insurance, or future health coverage in the event of a change in health care plans.** If you have concerns regarding your diagnosis, please discuss these with me. **Within contract guidelines, the undersigned therapist will look to you for full payment of your account, and you will be responsible for payments of all charges including NSF Bank charges.** Although it is the goal of the undersigned therapist to protect the confidentiality of your records, there may be times when disclosure of your records or testimony will be compelled by law. Confidentiality and exceptions to confidentiality are discussed below. In the event disclosure of your records or testimony is required by law, **payment will be expected from you, regardless of whose attorney subpoenas my involvement.** Patient records will not be released without written consent, unless court ordered to do so. Please note: a subpoena does not constitute a court order. **For legal proceedings that require my response, I bill \$150.00 per hour** (includes time spent responding to subpoenas, depositions, time spent waiting to testify, driving time to the court, etc.).

Confidentiality

Discussions between a therapist and a client are confidential. No information will be released without the client’s written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: abuse or neglect of minors; abuse, neglect, or exploitation of the elderly; abuse of patients in mental health facilities (§681.33 TAC, Ch.681); criminal prosecutions (§611.004 Texas Health & Safety Code, Ch. 611); child custody cases (§ 611.006 Texas Health & Safety Code, Ch. 611); situations where the therapist has a duty to disclose, or where, in the therapist’s judgment, it is necessary to warn or disclose (§ 611.004 Texas Health & Safety Code, Ch. 611); fee disputes between the therapist and the client (§611.006 Texas Health & Safety Code, Ch. 611); or the filing of a complaint with the licensing board (§611.006 Texas Health & Safety Code, Ch. 611). If you have any questions regarding confidentiality, you should bring them to the attention of the therapist when you and the therapist discuss this matter further. By signing this information and consent form, you are giving your consent to the undersigned therapist to share confidential information with all persons mandated by law and with the agency that referred you, and you are responsible for providing payment for services rendered, and you are releasing and holding harmless the undersigned therapist from any departure from your right of confidentiality that may result.


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Duty to Warn

In the event that the undersigned therapist reasonably believes that I am a danger, physically or emotionally to myself or another person, I specifically consent for the therapist to warn the person in danger and to contact the following persons, in addition to medical and law enforcement personnel:

Name	Telephone Number
_____	_____
_____	_____
_____	_____

I consent for the undersigned therapist to communicate with me by mail and by phone at the following addresses and phone numbers, and I will IMMEDIATELY advise the therapist in the event of any change:

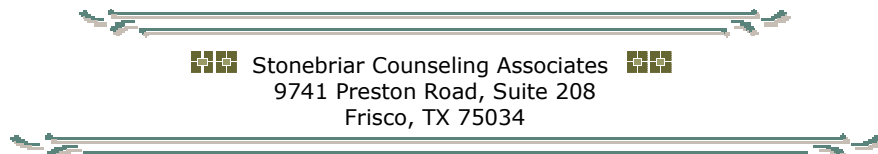
Address	Telephone Number
_____	_____

Risks of Therapy

Therapy is the Greek word for change. You may learn things about yourself that you do not like. Often, growth cannot occur until you experience and confront issues that induce you to feel sadness, sorrow, anxiety, or pain. The success of our work together depends on the quality of the efforts on both our parts, and the realization that you are responsible for lifestyle choices/changes that may result from therapy. Specifically, one risk of couple's therapy is the possibility of exercising the dissolution option.

After-Hours Emergencies

Your therapist is on call and can be reached for emergencies by calling 214-642-8737 to be paged. If it is a life-threatening emergency go to the ER or call 911. Emergencies are urgent issues requiring immediate action.



Therapist's Incapacity or Death

I acknowledge that, in the event the undersigned therapist become incapacitated or dies, it will become necessary for another therapist to take possession of my file and records. By signing this information and consent form, I give my consent to allowing a licensed mental health professional selected by the undersigned therapist to take possession of my file and records and provide me with copies upon request or to deliver them to a therapist of my choice.

Consent to Treatment

I voluntarily agree to receive Mental Health assessment, care, treatment or services, and authorize the undersigned therapist to provide such care, treatment or services, as are considered necessary and advisable.

I understand and agree that I will participate in the planning of my care, treatment or services, and that I may stop such care, treatment or services that I receive through the undersigned therapist at any time.

By signing this Client Information and Consent form, I the undersigned client, acknowledge that I have both read and understand all the terms and information contained herein. Ample initial opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

Client Date

Client Date

Drivers License Number (s)

Cell Phone (s)

As Witnessed by _____



Permission for Professional Services for a Minor:

I have the legal authority to seek and grant permission for professional services for a minor child, there being no legal decree disallowing my authority to assume such responsibility.

_____, Birth date ____/____/____,

_____, Birth date ____/____/____,

_____, Birth date ____/____/____,

_____, Birth date ____/____/____,

Client/Parent

Date

Client Family member signatures: All family members who are involved in this therapy need to sign below, indicating an understanding of these policies and procedures. If you have any questions, please discuss them with your therapist *before* you sign.

Client

Date

Client





Date

Client

Date

Client

Date



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Depression Self-Rating Test

Nearly 20 million Americans experience depression (National Institute of Mental Health website. Research at the National Institute of Mental Health Fact Sheet. Accessed November 28, 2004), but many will never seek treatment. The Depression Self-Rating Test is a simple 16-question quiz that can help identify common symptoms of depression and their severity. Remember-depression is more than just feeling down-it is a real medical condition that can be effectively treated.

Please complete the following questionnaire.

Name: _____ **Date of Birth :** _____ **Date:** _____

Instructions: Please *circle* the one response to each item that best describes you for the past seven days.

1. Falling asleep:

- 0 I never take longer than 30 minutes to fall asleep.**
- 1 I take at least 30 minutes to fall asleep, less than half the time.**
- 2 I take at least 30 minutes to fall asleep, more than half the time.**
- 3 I take more than 60 minutes to fall asleep, more than half the time.**

2. Sleep during the night:

- 0 I do not wake up at night.**
- 1 I have a restless, light sleep with a few brief awakenings each night.**
- 2 I wake up at least once a night, but I go back to sleep easily.**
- 3 I awaken more than once a night and stay awake for 20 minutes or more, more than half the time.**

3. Waking up too early:

- 0 Most of the time, I awaken no more than 30 minutes before I need to get up.**
- 1 More than half the time, I awaken more than 30 minutes before I need to get up.**
- 2 I almost always awaken at least one hour or so before I need to, but I go back to sleep eventually.**
- 3 I awaken at least one hour before I need to, and can't go back to sleep.**

4. Sleeping too much:

- 0 I sleep no longer than 7-8 hours/night, without napping during the day.
- 1 I sleep no longer than 10 hours in a 24-hour period including naps.
- 2 I sleep no longer than 12 hours in a 24-hour period including naps.
- 3 I sleep longer than 12 hours in a 24-hour period including naps.

5. Feeling sad:

- 0 I do not feel sad.
- 1 I feel sad less than half the time.
- 2 I feel sad more than half the time.
- 3 I feel sad nearly all of the time.

6. Decreased appetite:

- 0 There is no change in my usual appetite.
- 1 I eat somewhat less often or lesser amounts of food than usual.
- 2 I eat much less than usual and only with personal effort.
- 3 I rarely eat within a 24-hour period, and only with extreme personal effort or when others persuade me to eat.

7. Increased appetite:

- 0 There is no change from my usual appetite.
- 1 I feel a need to eat more frequently than usual.
- 2 I regularly eat more often and/or greater amounts of food than usual.
- 3 I feel driven to overeat both at mealtime and between meals.

8. Decreased weight (within the last two weeks):

- 0 I have not had a change in my weight.
- 1 I feel as if I've had a slight weight loss.
- 2 I have lost 2 pounds or more.
- 3 I have lost 5 pounds or more.

9. Increased weight (within the last two weeks):

- 0 I have not had a change in my weight.
- 1 I feel as if I've had a slight weight gain.
- 2 I have gained 2 pounds or more.
- 3 I have gained 5 pounds or more.

10. Concentration/Decision-making:

- 0** There is no change in my usual capacity to concentrate or make decisions.
- 1** I occasionally feel indecisive or find that my attention wanders.
- 2** Most of the time, I struggle to focus my attention or to make decisions.
- 3** I cannot concentrate well enough to read or cannot make even minor decisions.

11. View of myself:

- 0** I see myself as equally worthwhile and deserving as other people.
- 1** I am more self-blaming than usual.
- 2** I largely believe that I cause problems for others.
- 3** I think almost constantly about major and minor defects in myself.

12. Thoughts of death or suicide:

- 0** I do not think of suicide or death.
- 1** I feel that life is empty or wonder if it's worth living.
- 2** I think of suicide or death several times a week for several minutes.
- 3** I think of suicide or death several times a day in some detail, or I have made specific plans for suicide or have actually tried to take my life.

13. General interest:

- 0** There is no change from usual in how interested I am in other people or activities.
- 1** I notice that I am less interested in people or activities.
- 2** I find I have interest in only one or two of my formerly pursued activities.
- 3** I have virtually no interest in formerly pursued activities.

14. Energy level:

- 0** There is no change in my usual level of energy.
- 1** I get tired more easily than usual.
- 2** I have to make a big effort to start or finish my usual daily activities (for example: shopping, homework, cooking, or going to work).
- 3** I really cannot carry out most of my usual daily activities because I just don't have the energy.

15. Feeling slowed down:

- 0 I think, speak, and move at my usual rate of speed
- 1 I find that my thinking is slowed down or my voice sounds dull or flat.
- 2 It takes me several seconds to responds to most questions, and I'm sure my thinking is slowed.
- 3 I am often unable to respond to questions without extreme effort.

16. Feeling restless:

- 0 I do not feel restless.
- 1 I'm often fidgety, wringing my hands, or need to shift how I am sitting.
- 2 I have impulses to move about and am quite restless.
- 3 At times, I am unable to stay seated and need to pace around.

This section is to be completed by your therapist.

To Score:

Enter the highest score on any 1 of the 4 sleep items (1-4) _____

Item 5 _____

Enter the highest score on any 1 appetite/weight item (6-9) _____

Item 10 _____

Item 11 _____

Item 12 _____

Item 13 _____

Item 14 _____

Enter the highest score on either of the 2 psychomotor items (15&16) _____

Total Score (Range 0-27) _____

Scoring Criteria: Normal 0-5 Mild 6-10 Moderate 11-15

Severe 16-20 Very Severe 21+

Note: The above cutoff points are based largely on clinical judgment rather than on empirical data.

Copy 2000 A. John Rush, MD. Quick Inventory of Depressive Symptomatology (Self-Report) (QIDS-SR). Used with permission.