Adult

Counseling Ministry
9999 Chemstrand Road, Pensacola, FL 32514
850-471-3430 www.pbbassociation.com

___Jim Trent, Director of Counseling Ministries
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Welcome to our Office!
Thank you for choosing us to help you with your counseling needs. We want to take this opportunity to explain policies and procedures of the Practice at the Pensacola Bay Baptist Association.

APPOINTMENTS;
We consider our appointments very important. Counseling is a commitment to work together. We pray you will also share in this commitment. Please do not miss sessions if possible. Therapy sessions are 45-50 minutes. Fee and cancellation policy are described under "Financial Responsibility" below.

LIMITS OF CONFIDENTIALITY:
Information discussion in the counseling setting is held confidential and will not be shared without the written permission of the client except under the following conditions.

- The client threatens to harm self or another person.
- The client reports the abuse of a child, a person who is elderly, or a person who is disabled.
- The client reports sexual exploitation by a counselor, therapist or other mental health professional.
- Your counseling records by a state or federal court of law if legal action is taken against you.

RECORD MAINTENANCE AND EMERGENCY SITUATIONS;
Psychotherapy records must be maintained in my possession according to state laws. Copies of your records or a summary of such records will be provided and may be conditioned upon your payment of the reasonable cost of reproduction and time to prepare such records.

If you should experience an emotional or behavioral crisis and I cannot be reached immediately be telephone, you and your family members are instructed to contact the "HELP" Line at 438-1617, dial 911, or present yourself at the nearest hospital emergency room.

FINANCIAL RESPONSIBILITY;
You are responsible for full payment of all services regardless of insurance coverage. A sliding fee scale is available for those who financially qualify. Verification is necessary when using sliding fee scale. At the completion of each session you will receive a receipt of service that is appropriate to file with your insurance for reimbursement. Please make checks payable to **PBBA (Pensacola Bay Baptist Association)**.
A minimum **return check** fee of $7 will be charged. Fees are as follows:

First Session:	**$90.00 (45-50 minutes)**	**AGREED FEE AMOUNT $______________________**
Individual Session:	**$80.00 (45-50 minutes)**	**BASED ON SLIDING FEE SCALE**
Family/Couple Session:	**$90.00 (45-50 minutes)**	***PLEASE BRING INCOME VERICATION IF USING THE SLIDING FEE SCALE**.

We are now accepting the following major credit cards!
Visa, MasterCard, & Discover

No fees will be charged for appointments canceled 24 hours or more prior to appointment date and time. Half fees will be charged for no shows or last minute cancellations. Voice mail is available 24 hours a day, and messages are checked daily.

I have read the Office, Financial and Confidential Policies outlined in this document and agree to comply with these policies. I agree to the limits of confidentiality.

______________________________	______________	______________________________	______________
Client's Signature	Date	Parent or Guardian's Signature	Date
______________________________	______________		
Counselor's Signature	Date		

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FACE SHEET

1. Patient Name:____
   (Last) (First) (MI) (Nickname)

2. Address______________________________ 3. Home Phone: (   )________________

   ____
   (City) (State) (Zip)

4. Work Phone: (   ) __________ 5. Birth date: __________ Age: ______

6. Sex: M F 7. Marital Status: S M D W 8. Employer: ____________________

9. Occupation: ________________________ 10. Student/School: ____________________

11. If dependent child, are custodial parents: _____Married _____Separated _____Divorced _____Other

12. Religion________________ 13. REFERRED BY: ______________________________

14. IN CASE OF EMERGENCY NOTIFY: Name: ______________________________

    Relationship________________ Phone (   ) ____________________

FINANCIALLY RESPONSIBLE PARTY

1. Guarantor Name:____________________________ Birth date:______________________
   (Last) (First) (MI)

2. Guarantor Address____
   (City) (State) (Zip)

3. Guarantor Relationship to Patient (circle one): Spouse Mother Father Sibling Other Relative Friend

4. Home Phone: (   ) ____________

5. Previous Address (if less than 3 yrs. at current address) ______________________________

6. Guarantor's Employer: ____________________ Work Phone (   ) ____________

   Occupation________________

7. Spouse Name: ____________________ 8. Spouse Work Phone: (   ) ____________________

I understand I am financially responsible for all service rendered to me or the client and agree to pay charges for such services present and future at the time services are provided.

Client Signature____ Date: ________________

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Consent to Treatment

I do hereby seek and consent to take part in the treatment by the therapist names below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or any procedures provided by this therapist. I acknowledge that I have been informed counseling can be a painful process. I have had all my questions answered fully.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court system.)

I know I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel or do not show, I will be charged for the missed appointment.

I am aware that an agent of my insurance company or third-party payer may be given information about the type(s), cost(s) and providers of any service or treatments I receive. I understand payment for service is due at the end of each session, and I am responsible for full payment regardless of insurance coverage.

My signature below shows I understand and agree with all of these statements.

__________________________________ __________________________

Signature of client (parent, guardian or other representative) Date

__________________________________ __________________________

Printed Name Relationship to Client

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian or other representative.) My observations of this person's behavior and responses give me no reason to believe this person is not fully competent to give informed consent and willing consent.

__________________________________ __________________________

Therapist Date

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Adult Checklist of Concerns

Name: ____ Date: ________________________

Please mark all of the items that apply to you and feel free to add any others at the bottom.

____Abuse–physical, sexual, emotional, neglect (of children or elderly)
____Aggression, violence
____Alcohol use
____Anger hostility, arguing, irritability
____Anxiety, nervousness
____Attention, concentration, distractibility
____Career concerns, goals and choices
____Childhood issues (your own childhood)
____Codependence
____Confusion
____Compulsions
____Custody of Children
____Cruelty to Animals
____Decision making, indecision, mixed feelings, putting off decisions
____Delusions (false ideas)
____Dependence
____Depression, low mood, sadness, crying
____Divorce, separation
____Drug use-prescription medications, over-the-counter medication, street drugs
____Eating problems–overeating, under eating, appetite, vomiting
____Emptiness
____Failure
____Fatigue, tiredness, low energy
____Fears, phobias
____Financial or money troubles, debt, impulsive spending, low income
____Friendships
____Gambling
____Grieving, mourning, deaths, losses, divorce
____Guilt
____Headaches, other kinds of pains
____Health, illness, medical concerns, physical
____Inferiority feelings
____Interpersonal conflicts
____Impulsiveness, loss of control, outbursts
____Irresponsibility
____Judgment problems, risk taking
____Legal matters, charges, suits
____Loneliness
____Marital problems
____Memory problems
____Menstrual problems, PMS, menopause

(Continued on next page)

____Mood swings
____Motivation, laziness
____Nervousness
____Obsessions, compulsions
____Oversensitivity to rejection
____Panic or anxiety attacks
____Perfectionism
____Pessimism
____Procrastination
____Relationship problems
____School problems
____Self-centeredness
____Self-esteem
____Self-neglect, poor self-care
____Sexual issues, dysfunctions, conflicts, desire differences, other
____Shyness, oversensitivity
____Sleep problems–too much, too little, insomnia, nightmares
____Smoking and tobacco use
____Stress, relaxation, stress management, stress disorders, tension
____Suspiciousness
____Suicidal thoughts
____Temper problems, self-control, low frustration tolerance
____Threats, violence
____Thought disorganization and confusion
____Weight and diet issues
____Withdrawal, isolating
____Work problems, employment, workaholic/overworking, can’t keep a job

Please use this space to write any other concerns or issues.

LIMITS OF CONFIDENTIALITY

The contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian or parent. The Health Insurance Portability & Accountability Act (HIPAA) even regulates and demands that psychotherapy notes (progress notes) require a specific signed release from the client. Noted exceptions to confidentiality are as follows:

Duty to Warn & Protect
When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and/or report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities.

Abuse of Children and Vulnerable Adults
If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Insurance Providers (when applicable)
Insurance companies and other third-party payers are given information they request regarding services to clients. Information that may be requested includes type of services, dates/times of services, diagnosis, treatment plan, progress of therapy, and summaries.

Judicial proceedings
If you are involved in a court proceeding and a request is made concerning your diagnoses or treatment, such information is confidential and will not be released unless there is a direct court order from a judge.

I have read and understood the limits of confidentiality listed above.

____

Client Signature (Client's Parent/Guardian if under 18) Date

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Psychosocial Assessment

Name: ____

Record#______________________

Age: ___________ Sex: ___________ Therapist: ____

DIRECTIONS: Please answer the following questions as fully as possible.

Problem Assessment
Present Problem - Precipitating Stressors: "In recent months, I have worried a lot about: *Please circle all that apply:*
Marital issues   Health issues   Job issues   Financial issues
Parent/child issues Issues of past (guilt, abuse, neglect, family of origin issues, etc.)
Other____

Symptoms: *Please circle all that apply:*
Change in sleep pattern   Decreased concentration   Change in appetite
Increased anxiety   Decreased energy   Suicidal feelings
Decreased motivation   Other____

Suicidal/Homicidal Ideation:
Have you attempted to commit suicide or homicide in the past? ___Yes ___No
If yes, how? ____
Is there a history of suicide in your nuclear and/or extended family? ___Yes ___No
Have you ever inflicted burns or wounds to yourself? ___Yes ___No
Are you presently suicidal/homicidal? ___Yes ___No

What event(s) in the recent past has/have prompted you to seek counseling? ___________________________________
____
____

Describe additional problems you are experiencing.____
____
____

When did these problems develop? ____
____
____

Circle any recent losses you have experienced.
Family   Health   Disruption of lifestyle   Job   Significant other
Other____

List your strengths and weaknesses.

Strengths	Weaknesses
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Psychiatric History

Please list any previous outpatient counseling experiences.

Place____

Length of time there____________________________ Dates_______________________________________

Have you ever been admitted to the hospital for mental health or addiction issues?

Place____

Length of time there____________________________ Dates_______________________________________

Name of current doctor and/or therapist____

List all medications you have taken *in the past* for anxiety, depression, and/or sleep.________________________

____

Medical Information:

How would you describe your current condition of health? ____

Are you currently on any medication? ___Yes ___No

Name of medication	Dosage/frequency	Prescribing Physician
____________________________	________________________	____________________________
____________________________	________________________	____________________________
____________________________	________________________	____________________________
____________________________	________________________	____________________________

Has it been more than a year since your last physical exam including blood tests? ___Yes ___ No

Have you ever had an abortion? ___ Yes ___ No

Do you have allergies? ___ Yes ___ No If yes, explain____

List any previous health problems, operative procedures, and medical hospitalizations:

Problem	Date	Treatment
____	____________	____________________________
____	____________	____________________________
____	____________	____________________________
____	____________	____________________________
____	____________	____________________________

Substance Abuse History:

Describe your current usage or usage within the past year (including alcohol. caffeine and tobacco).

Substance	Amount	Frequency	Age of 1st use	Age regular use started	Last use
______________	__________	__________	____________	___________________	___________
______________	__________	__________	____________	___________________	___________
______________	__________	__________	____________	___________________	___________
______________	__________	__________	____________	___________________	___________
______________	__________	__________	____________	___________________	___________

Have you experienced a recent increase in the use of alcohol and/or other substances? ___ Yes ___ No

Do you see your current usage as a problem? ___ Yes ___ No If yes, when did it become problematic?

____

Please describe any previous experience with drugs or alcohol.____

____

____

____

Describe any significant family history of substance abuse.____

____

____

____

Living Arrangements:

___ Satisfactory? ___ Unsatisfactory?

Where do you currently live? ________________________________ How long there? _____________________

With whom are you living? ____

Describe your current relationships with family members

____

____

Support System:

Who can you count on for support? *Circle as many as apply.*

Parents Spouse Siblings Employer Church Pastor Therapist Neighbor(s)

Extended Family Close Friend Self-help Group Community Services Co-Worker Medical Dr.

Other____

Financial Situation: Describe briefly your financial situation.____

____

____

____

Marital History (if applicable):

When were you married? __________________ Name and age of spouse__________________________________

Previous marriage ___ Yes ___ No If yes, date of divorce_______________________

Any children from this marriage? ____

What is your perception of your current marriage (include communication patterns, problems, sexual relations).

____

____

____

List names and ages of children. How do you get along with each one?

Name	Age	Comment
____________________________	__________	____
____________________________	__________	____
____________________________	__________	____
____________________________	__________	____

Religious/Cultural Factors:

Please list any issues which are important or may have affected you in regard to religion or ethnic/cultural background.____

____

____

What is your religious background? ____

Do you currently attend church, synagogue, or mosque? ___ Yes ___ No

Nutrition:

Have your eating habits changed recently? ___ Yes ___ No If yes, please describe__________________________

Has your weight fluctuated more than +/- 10 lbs. over the previous year? ___ Yes ___ No

Do you often eat out of depression, boredom, anger? ___ Yes ___ No If yes, please describe_________________

____

Do you ever self-induce vomiting? ___ Yes ___ No

How do you feel about eating with others in a group? ____

Do you ever binge eat or feel your eating is out of control? ___ Yes ___ No If yes, please describe_____________

____

____

If you use laxatives, water pills (diuretics), or diet medications, how often do you use them? ___________________

____

Legal History:

Please explain all that apply:

Charges as a minor____

Charges presently____

Arrests (How many) ____

Incarcerations (How many) ____

Parole____

Convictions (How many) ____

Probation____

Bankruptcy____

Civil Suits____

Child Custody Problems____

Developmental History:

List members of your family or origin and how you got along with each one.

Family Member	Comment
________________________________	____
________________________________	____
________________________________	____
________________________________	____
________________________________	____
________________________________	____
________________________________	____

What was your birth order? ________ of ________ children. Who primarily raised you? ___________________

How would you describe your childhood? ___ Traumatic ___ Painful ___ Uneventful

What were you like as a child (include friends, school, hobbies, and personality)? __________________________

____

____

____

Were there any unusual or traumatic experiences for you as a child?

Date	Age	Event
__________	______	____
__________	______	____
__________	______	____
__________	______	____

What is your sexual orientation? ___ Heterosexual ___ Homosexual ___ Bisexual

Work Adjustment History:
Describe your current job/career____
____
What do you like/dislike about your employment/career? Please list

Like	Dislike
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

Would you enjoy doing this job on a long-term basis? ____
If you could have any job/career, what would you choose? ____
Why would you choose this? ____
How do you deal with authority figures? ____
Describe your relationship with co-workers____
Describe your job performance____
Have you ever been fired ___ Yes ___ No If yes, explain____
____
How many jobs have you held within the previous five years? ____

Military History:
List branch, dates, and duties.____
____
____
____

Educational History:
What was school like for you? ____
Highest level achieved__________ What type of grades did you make? ___________________________
Are you currently in school? ___ Yes ___ No If yes, what level? __________________________________

Family:
Would it be beneficial for any members of your family to be involved in your treatment? ___ Yes ___ No
If yes, explain who and why.____
____

Miscellaneous:
Are there any other things that can be helpful for us to know about you? _____________________________
____
____
____
____
____

________________________________ ________________________________
Signature Date