Thera-volve, LLC
Shanna Severn, LPC, MS, NCC
30150 SW Parkway Ave. Suite 300
Wilsonville, OR 97070
Ph: 971-264-4505
F: 503-914-4744

Welcome Letter

Hello and Welcome. I am so pleased you have considered Thera-volve to join you on your journey towards wellness. I am humbled by your choice and look forward to working with you.

You will find all the necessary paperwork attached. In order to make the most of our time together, I ask that you read through and complete the enclosed forms and return them to me before our first appointment. This will allow time for me to evaluate your treatment options. Please return the completed form in person or by mail to the address above.

The contents of this packet include:

1. Scheduling your first appointment
2. Professional Disclosure Statement
3. Informed Consent & Confidentiality
4. Fees
5. Adult Intake Questionnaire

If you have any questions please do not hesitate to call 971-264-4505, as I am here to help and wish for you to have an informative, comfortable and supportive experience.

I look forward to meeting you!

Sincerely,

Shanna Severn, LPC, M.S., NCC, EMDR

Scheduling your first appointment

The wait time to schedule your first appointment is dependent on your availability and the open time slots I have available. I do not schedule new clients until there is a consistent open time slot in which to see them. Many clients prefer to schedule after work or school, and as a result, usually are the least available times. If you have flexibility in your schedule this will increase your odds of getting an appointment sooner.

I currently only see clients three days each week. Please let me know your preferred times for scheduling. I will call as soon as my appointment times match your availability.

If you prefer not to wait to begin your therapy, I can suggest several excellent therapists who may have current openings. Please feel free to call to get referral names.

Name_____ **Date**_____

The times appointments will be scheduled are below: Please mark an **X** what ***times*** work best for you and a √ for your ***preferred*** time.

Tuesday	Wednesday	Thursday
	☐ 3:00 pm -3:45 pm	
☐ 4:00 pm – 4:45 pm	☐ 4:00 pm – 4:45 pm	☐ 4:00 pm – 4:45 pm
☐ 5:00 pm – 5:45 pm	☐ 5:00 pm – 5:45 pm	☐ 5:00 pm – 5:45 pm
☐ 6:00 pm – 6:45 pm	☐ 6:00 pm – 6:45 pm	☐ 6:00 pm – 6:45 pm
☐ 7:00 pm – 7:45 pm	☐ 7:00 pm – 7:45 pm	☐ 7:00 pm – 7:45 pm
☐ 8:00 pm – 8:45 pm	☐ 8:00 pm – 8:45 pm	☐ 8:00 pm – 8:45 pm

Also please indicate how often:

☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Other _____

Shanna Severn, LPC, M.S., NCC
Professional Disclosure Statement
30150 SW Parkway Ave. Suite 300
Wilsonville, OR 97070
PHONE: (971) 264-4505

PROCESS OF THERAPY: I view counseling as a collaborative effort with the goals of therapy focused on resolving problems or issues that you present. Active participation and honesty with thoughts, feelings and behaviors will promote more success. Together we will regularly review your goals, including your thoughts and feelings expressed regarding the therapy process. I like to begin by getting to know you and hearing about your concerns, what you have tried so far, what has not helped and what has improved your situation. Then we usually discuss what successful completion of therapy would look like for you. Next we will set a course to achieve your goals. Using this plan, we will both know what you are achieving, and when you are done. Therapy may result in decisions about changing behaviors, employment, substance use, schooling, housing or relationships. Sometimes a decision that is positive for you may at times be challenging for others in your life.

PHILOSOPHY AND APPROACH: As a Licensee, I follow a holistic approach which acknowledges psychological, biological, sociological, familial, cultural and environmental which I believe contribute to one's overall health, development and life perspectives. My personal style and core philosophy is to try to see through the eyes of each person and acknowledge each person's worth and value. The theoretical orientations I follow most are: Psychodynamic, CBT, Humanistic, EMDR, and Existential theories with a mind-body focus. If you have any other questions about my theoretical orientations, please do not hesitate to ask

FORMAL EDUCATION AND TRAINING: I am recognized as a National Certified Counselor by the National Board of Certified Counselors. I graduated with a Master's of Science degree in Mental Health Counseling (MHC) from Capella University. I earned my Bachelor of Science in Psychology, with a minor in Sociology at Utah State University. I have completed basic training in EMDR (Eye Movement Desensitization and Reprocessing) Therapy and use this modality when needed. I have also had extensive continuing education in the treatment of trauma and trauma informed care.

I have worked and interned at various mental health settings, which have provided me with immense experience working with diverse clientele whom have been diagnosed with a range of mental health issues. These included: moderate to severe and persistent mental illness, substance abuse, mood, behavioral and eating disorders, domestic violence, trauma related to violence, medical issues or intergenerational, grief and loss, and relationship difficulties. Each program had various treatment modalities which helped develop the holistic approach I take towards counseling and being with clients.

AS A LICENSEE of the Oregon Board of Licensed Professional Counselors and Therapists, I abide by its Code of Ethics**.** To maintain my license I am required to participate in continuing education, taking classes dealing with subjects relevant to this profession.

CONTACTING ME:
I am often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. At these times, you may leave a message on my confidential voice mail and your call will be returned as soon as possible. I will always try to call back in a 24 hour period for non-urgent matters. If you feel you cannot wait for a return call or it is an emergency situation, go to your local hospital, call 911 or call the ***Clackamas County Crisis line at 503-655-8585.*** .

HOURS AND LENGTH OF SESSION: All services are by appointment only. Intakes are 60 minutes in duration. Sessions thereafter are 45 minutes in duration. In order for counseling to be effective, it is important you attend all regularly scheduled appointments. If you are unable to attend an appointment, please call at least 24-hours in advance. If you fail to show without giving a 24-hour notice to more than two appointments, you risk losing your appointment slot. If an appointment must be cancelled, you may leave a message for me at 971-264-4505.

Appointment reminders are available but information is not securely protected. If you would like to opt in for appointment reminders, please initial here _____ and mark the following type(s)

- ❒ Text Reminders
- ❒ Email Reminders
- ❒ Phone Reminders

FEES: I offer a free 20 minute consultation for you to ask any questions you may have about therapy and to determine if we would be a good fit. My standard fee for individual therapy is $160.00 per 45 minute session, $200.00 per 50 minute session for couples therapy and the initial intake is $245.00. I do offer several lower fee slots for those suffering financial hardship, have no insurance or are indigent. If you wish to seek reimbursement from insurance for the services I provide to you, I can give you a receipt that contains the information that most insurance companies require, and you may submit this directly to your insurance provider. You are fully responsible for the up-front and ongoing payment of your fees, and I cannot guarantee you will be able to obtain reimbursement.

AS A CLIENT OF A LICENSEE, YOU HAVE THE FOLLOWING RIGHTS:

- To expect that a licensee has met the qualifications of training and experience required by state law;
- To examine public records maintained by the Board and to have the Board confirm credentials of a licensee;
- To obtain a copy of the Code of Ethics (Oregon Administrative Rules 833-100);
- To report complaints to the Board;
- To be informed of the cost of professional services before receiving services;
- To be assured of privacy and confidentiality while receiving services as defined by rule and law, including the following exceptions:
    1) **Reporting suspected or known abuse of children, (including witnessing domestic violence), animals, elderly persons, mentally disabled or developmentally disabled.**
    2) **Reporting imminent danger to you or others**
    3) **Reporting information required in court proceedings, or by insurance companies or other relevant agencies.**
    4) **Providing information concerning licensee case consultation or supervision**
    5) **Defending claims brought by you against me.**
- To be free from being the object of discrimination on the basis of race, religion, gender identity, sexual orientation, socioeconomic status, or other unlawful category while receiving services.

You may contact the Board of Licensed Professional Counselors and Therapists at:
3218 Pringle Rd. SE, #250 Salem, OR 97302-6312: Telephone 503-378-5499
Email: lpct.board@state.or.us Website: www.oregon.gov.OBLPCT
For additional information about this licensee, consult the Board's website

Consent to Treatment:
Your signature below indicates that you understand and agree to the above conditions in order to receive treatment.

_____

Client Signature Date

_____

Parent/Guardian Signature (if applicable) Date

_____

Clinician Signature Date

Office Use Only:
Intake Date _____Account # _____ Clinician Initial _____

Informed Consent for Treatment & Confidentiality

I, Shanna Severn, am a Licensed Professional Counselor, National Certified Counselor and hold a Master's of Science degree in Mental Health Counseling.

As a client you have rights and responsibilities when you seek consultation.

These include:

1. **THE RIGHT TO REFUSE TREATMENT:** You have the right to request a change of therapy, be referred to another therapist, or discontinue therapy at any time. If you are not satisfied with therapy or have questions about the treatment, please speak with me about these concerns. If my services are not meeting your needs, I will be happy to refer you to another therapist.
2. **THE RESPONSIBILITY OF THE CLIENT FOR CHOOSING THE PROVIDER AND TREATMENT MODALITY WHICH BEST SUITS HIS/HER NEEDS:** I will make an assessment and suggest possible treatment models that may be helpful to you. I am knowledgeable on the different theories, but you are the expert on "you." With this noted I ask for your feedback. If you feel a treatment model does not meet your needs, please do not hesitate to discuss this with me.
3. **TERMINATION:** After the first couple of meetings, I will assess if the therapy process can benefit you. I don't accept clients who I am unable to help. When this happens I will give you a number of referrals. If at any point during therapy I assess that I am not effective in helping you reach your goals, I am obligated to discuss it with you and, if appropriate, to terminate treatment. If this happens I will give you a number of referrals that may be of help to you. If you request it and authorize it in writing, I will talk to the counselor of your choice in order to help with the transition. If at any time you want another professional's opinion or wish to consult with another therapist, I will assist you with referrals, as long as I have your written consent I will provide the essential information needed. You also have the right to terminate therapy at any time.
4. **THE EXTENT OF CONFIDENTIALITY PROVIDED BY LAW:** Under Oregon State law, Counselors are obligated to respect client confidentiality. Things discussed in therapy cannot be disclosed to anyone else without your written permission. ***HOWEVER, THERE ARE SOME EXCEPTIONS.*** These include:
    a. **CHILD, DEPENDENT AND ELDER ABUSE/NEGLECT:** By law I am a mandatory reporter, which means I am required by law to report any known or ***suspected*** abuse to the Department of Human Services.
    b. **HARM TO ANOTHER:** If I believe someone is about to endanger another person, I have a right to warn and protect the intended victim, to any extent possible. This is in effect for the duration of therapy and even after termination of therapy.
    c. **HARM TO ONESELF/SUICIDE:** If I believe someone is immediately likely to harm him/herself, I will try to protect the person by notifying the emergency contact, a family member, law enforcement, or the Mental Health Department. This can include information communicated to me from other people. This is in effect for the duration of therapy as well as after termination of therapy.
    d. **EVALUATIONS:** If you meet with me for an evaluation requested by another professional (i.e. counselor, lawyer, physician), I will routinely send a written report of my findings to that professional. I will obtain written consent from you in advance authorizing me to make such a disclosure.
    e. **LITIGATION LIMITATIONS:** Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that: should there be legal proceedings such as, but not limited, to divorce and custody disputes; injuries; lawsuits; etc., neither you nor your attorney, nor anyone else acting on your behalf will call on me to testify in court or at any other proceeding, nor will a disclosure of your counseling records be requested unless otherwise agreed upon. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the therapy records and/or testimony from me. The chances of any legal involvement being beneficial for clients are minimal and can actually be detrimental.
    f. **COUPLES/FAMILY THERAPY:** In couple and family therapy, or when different family members are seen individually, even over a period of time, confidentiality and privilege do not apply between the couple or among family members, unless otherwise agreed upon. I will use my clinical judgment when revealing such information. I will not release records to any outside party unless she or he is authorized to do so by <u>all</u> adult family members who were part of the treatment.
    g. **CHILD/MINOR THERAPY:** The parents or legal guardians of the child/minor, have rights to general information about what takes place in the child's therapy, to information about the child's progress in therapy, to information about any dangers the child might present to self or others, and, upon request, to obtain copies of the child's treatment record. The parents understand that it is usually best not to ask for specific information about what was said in therapy sessions because this might break the trust between the child and the counselor.
    h. **GROUP THERAPY:** In group therapy, confidentiality is stressed to all individuals agreeing to treatment. If confidential information is not protected by all group members, group trust and growth could be hindered. I will keep all group members information confidential, except for any limitations explained in this document. I expect that all information heard in group therapy is respected and kept private by all group members.
    i. **EMAILS, CELL PHONES, COMPUTERS AND FAXES:** Computers, e-mail, and cell phone communication (including text messaging) can be accessed by unauthorized people and can compromise confidentiality. E-mails, in particular, are vulnerable because servers have unlimited, direct access to all e-mails that go through them. I am able to encrypt my emails, however information sent to me won't be encrypted unless you also use an encrypted service. Faxes can be sent to the wrong address. My computers are equipped with firewall, virus protection and password. All backups are

stored securely. Please notify me if you decide to avoid or limit the use of any or all communication devices. If you communicate confidential information via e-mail or text, I will assume that you have made an informed decision that such communication may be intercepted as well as assume you desire to correspond on such matters via e-mail or text. Due to computer or network problems, emails may not be deliverable, and I may not check my emails daily. **Please do not use e-mail, text or faxes for emergencies.**

5. **EMAIL & PHONE CONSULTATIONS:** Occasionally, a client will request counseling via phone or e-mail rather than in person in the therapist's office. This has some complexities and disadvantages to the therapeutic process. I always recommend that you find a local therapist and meet face to face. Treating clients exclusively via phone consultations or e-mails may put therapists at a disadvantage because we cannot detect nonverbal cues, may not be able to accurately diagnose, may not always be aware of the resources available locally and may not be able to intervene as effectively as necessary in emergency situations.
    a. **TELEPHONE & EMERGENCY PROCEDURES:** If you need to contact me between office hours/days, please leave a message at 971-264-4505 and your call will be returned as soon as possible. If an emergency situation arises outside my office hours and you need to talk to someone immediately call the **Clackamas County Crisis Line at 503-655-8585.** You can also go to your nearest emergency room. If you are under the influence of a substance or otherwise unable to drive, have someone else take you or call a taxi.
6. **RECORDS AND YOUR RIGHT TO REVIEW THEM:** Both the law and the standards of the American Counseling Association require that we keep appropriate treatment records for at least seven years. Unless otherwise agreed to be necessary, I retain clinical records only as long as is mandated by Oregon law. You have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when I assess that releasing such information might be harmful in any way. In such a case I will provide the records to an appropriate and legitimate mental health professional of your choice. When more than one client is involved in treatment, such as in cases of couple and family therapy, I will release records only with the signed authorizations from ***all*** the adults (or all those who legally can authorize such a release) involved in the treatment.
7. **DUAL RELATIONSHIPS:** A dual relationship happens when you have contact with your therapist outside the counseling office. Not all of these relationships are unethical or avoidable. However, therapy never involves a sexual or romantic relationship with a client. I will assess carefully before entering into non-sexual and non-exploitative dual relationships with you. You may bump into someone you know in the waiting room or into me out in the community**. I will never acknowledge working with anyone without your written permission.** Many clients choose their therapist because they know of him or her before they enter into therapy or are personally aware of his or her professional work and achievements. Nevertheless, I will discuss with you the complexities, potential benefits and difficulties that may be involved in dual or multiple relationships. Dual or multiple relationships can enhance trust and therapeutic effectiveness but can also detract from it and often it is impossible to know that ahead of time. Please let me know if the dual or multiple relationships becomes uncomfortable for you in any way. I will always listen carefully and respond accordingly to your feedback and will discontinue the dual relationship if I find it interferes with the effectiveness of the therapy or the welfare of the client and the client also has the choice to do the same at any time.
8. **CANCELLATIONS:** Since the scheduling of an appointment involves the reservation of time specifically for you, no one else will be able to use that time if you cancel. **Therefore, I ask that you please give a 24 hour notice if you need to cancel an appointment. Please call as soon as you know you will not be able to keep a scheduled appointment.** The first 2 missed appointments (with notice) will be waived; any appointments missed after these three waived sessions will be charged half the rate of the session. If you miss an appointment and do not provide any notice, the full fee will be charged. **Note: Insurance will not cover missed appointments.** My voicemail is accessible at all hours, so please call 971- 264-4505.
9. **COLLECTION PROBLEMS:** If you do not pay for services rendered, I may refer your account to a collection agency or file a small claims court suit. Although no clinical information will be revealed, your name, address, dates and fees of service will be released, along with any other information that may help collection possible.
10. **MEDIATION AND ARBITRATION:** If a dispute arises between client and counselor, Mediation will be sought before, and as a pre-condition of, the initiation of arbitration. The mediator will be a neutral third party mutually agreed upon by you and me. The cost of such mediation, if any, shall be split equally, unless otherwise agreed upon. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement should be submitted to and settled by binding arbitration in Clackamas County, Oregon in accordance with the rules of the American Arbitration Association in effect at the time the demand for arbitration is filed.

Counseling Risks & Benefits

I believe that most people have the ability to resolve their own problems with a counselor's assistance. While a counselor may offer tools for change it is the client's responsibility to use the tools suggested. You have the right to refuse any technique or collaborate with the therapist on modifications of the techniques suggested to you. As a client you have the right to discuss positive and negative effects of counseling with the therapist and are encouraged to do so. It is important that client's are aware there are risks, as well as benefits to therapy. You may experience interruptions in normal patterns, feelings and social relationships. In addition, some issues may worsen before they get better. As a client you are in complete control and may end the counseling relationship at any time. Should the client or therapist believe a referral is needed, referrals will be made within the agency or to another agency more appropriate for the client's needs. It is your responsibility to pursue referrals and recommendations.

Consent Agreement

I have read and understood this consent form and have had an opportunity to have my questions answered. I have been given a copy of this consent agreement for my records and I agree to the above limits of confidentiality and understand their meanings and ramifications. I voluntarily enter myself or family members into services with Shanna Severn, LPC, M.S., NCC. It is without pressure or coercion that I sign this consent.

Client Signature _____ ***Date***_____

Fees/Additional Charges

My fees are based on the amount of the time spent or reserved. I offer a free 20 minute consultation. After the initial consultation fees are based on a 45 minute session at $160 per individual psychotherapy or a 50 minute session at $200 per couple's therapy. The initial intake is based on a 60 minute session and is rated at $245.00. Group psychotherapy is 1 hour and 30 minutes and the standard fee is $45 a group session. Additional time for phone calls, preparing letters, conferring with other professionals will be pro-rated at $160/hour after the first 15 minutes. I do offer several lower fee slots for those suffering financial hardship. Please inquire if this is something of need. Psychological assessments, testing, and/or questionnaires are priced individually. I do offer books that may be checked out for therapy purposes. If you decide to check out a book and it is not returned, you will be charged a fee of what it costs to replace the book. Fees may increase during the course of treatment. If so, you will be notified in writing 30 days in advance.

Additional charges - You will also be charged the fees for any of the following events:

- A $15 fee for any check submitted to us to pay any sums for which you are obligated to pay in which the check is dishonored.
- A delinquency fee of $25 in the event you fail to timely pay any sum you owe and collection agency is used. If a collection action is initiated and prevailed, we will also seek reasonable attorney fees as the court allows.
- A $160 fee will be charged if you fail to keep an appointment ***and*** fail to give me a 24 hour cancellation notice.
- If subpoenaed to testify in court, $160 an hour will be charged for preparation and court proceedings.

Billing - I request that you pay for your services at the time of the session, by cash, card or check. If a card is used, I can provide you with a paper receipt or you can opt to have a receipt emailed to you through the payment processor (email is not protected by HIPAA). Initial here if you would like receipts emailed _____ If using insurance a paper one will be provided.

Insurance - If I am a provider in your plan, I will submit claims to our insurance company for you. Co-pays/co-insurance/deductibles or any other fees not covered by your plan are due at the time of each session. If I am **NOT** a provider for your plan, payment will be made to Thera-volve, in full at the time of each session. An invoice will be provided so you can seek reimbursement from your insurance provider.

PLEASE SIGN IF USING YOUR INSURANCE OR EMPLOYEE ASSISTANCE PROGRAM

"I authorize the release of any information necessary (including notes, treatment summaries and diagnosis) to my insurance plan or EAP to process claims, determine medical necessity, or to request additional sessions."

Signature_____**Date**_____

"I authorize payments of benefits to my provider" **Signature** _____

Missed Appointments - You may be charged full/half fee of services for sessions missed or cancelled without a 24 hour notice, with the exception of the three waived late cancellations. Note: Insurance will not pay for missed sessions, so payment would be for these sessions would be your responsibility and due at the following appointment.

Emergencies - Should you find yourself in need of assistance you may call 971-264-4505 and I will get back to you as soon as possible (usually within 24 hours). If you need **emergency** assistance please call the ***Clackamas County Crisis Line at 503-655-8585*** or visit your local emergency room.

I, _____*(Printed Name),* ***HAVE READ AND UNDERSTOOD ALL THE PRECEDING INFORMATION AND AGREE TO BE BOUND TO ALL OF THE PROVISIONS REGARDING CONSENT, CONFIDENTIALITY, FEES, CHARGES AND BILLINGS.***

Client Signature _____***Date*** _____

Clinician Signature _____***Date*** _____

ADULT INFORMATION QUESTIONNAIRE

Full Name _____ Today's Date_____ Referred by_____

Please provide the following information. This information will help me provide you with the best services possible. Please answer all questions to the best of your ability. Information you provide here is held to the same standards of confidentiality as our therapy

CLIENT INFORMATION:

Address _____

City_____ State_____ Zip Code _____

Phone [Home] _____ Cell_____ Work _____

Referred by_____ Preference for communication/messages _____

Birth Date_____ Place of Birth_____ Age_____

Gender _____Sexual Orientation_____ Preferred Pronoun_____

Email Address _____

Occupation/Job Title _____

Employer/School _____

Education _____ Highest Grade Completed_____ Primary Language_____

Religion/Spirituality _____Race/Ethnicity _____

INSURANCE INFORMATION

Primary Insurance Name _____ Secondary Insurance Name _____

Client ID # _____ Client ID # _____

Insured (if different) _____ Insured (if different)_____

Insured ID# _____ Insured ID # _____

Group # _____ Group # _____

Relationship _____ Relationship _____

Insured Birth Date _____ Insured Birth Date _____

Insured's Employer_____ Insured's Employer _____

Insurance Phone # _____ Insurance Phone # _____

RELATIONSHIPS/EMERGENCY CONTACT

Relationship Status: Single ☐ Married/Partnered ☐ Separated/Divorce ☐ Widowed ☐

Relationship Satisfaction? Yes ☐ No ☐ Length of Current Relationship_____

Spouse/Partner's Name _____

Spouse/Partner's Occupation _____

Emergency Contact _____

Emergency Contact Phone # _____

Guardianship (if applicable) _____

Address _____

Children [Ages, Names, Gender] _____

Pets? Yes ☐ No ☐ If so, type _____

BACKGROUND INFORMATION

Briefly describe reason for seeking counseling. _____

_____

_____

_____

What do you see as your strengths? How would your family and friends comment? _____

_____

_____

What do you see as your challenges? How would your family and friends comment? _____

_____

_____

What do you most want to change? _____

_____

_____

What do you most want to stay the same? _____

_____

_____

Have you had therapy before? Yes ☐ No ☐ Was it helpful? Yes ☐ No ☐

If you have had therapy before, describe your experience [include purpose, length of time, results] _____

_____

_____

Expectations of current therapy _____

_____

_____

Are you currently receiving treatment from other mental health care providers? Yes ☐ No ☐

If yes, please provide name, contact information and treatment being provided. _____

_____

_____

When was the last time you had a physical? _____

Are you currently under the care of a physician? Yes ☐ No ☐

If yes, please give name, contact info and reasons seeking care

_____

_____

Are you willing to sign a release of information to contact provider(s) and coordinate care? Yes ☐ No ☐

Are you currently taking any medications? Yes ☐ No ☐

If yes, please list **all** medication/supplements: name, dosage, reason for taking each med, and the prescribing physician(s). ___

_____

_____

Do you have any allergies to food, medication, seasonal etc. _____

Current Symptoms

Please **circle the number** to rate the following symptoms according to the degree to which they are troubling your current life. Also, **in the blank,** indicate **how long** these problems have affected you. **Scale 1=extremely troubling, 6=not troubling at all**

MOOD	1 2 3 4 5 6 _____	**Hurting Others**	1 2 3 4 5 6 _____
Tiredness	1 2 3 4 5 6 _____	**Hurting Self**	1 2 3 4 5 6 _____
Concentration	1 2 3 4 5 6 _____	**Dangerous Behavior**	1 2 3 4 5 6 _____
Appetite	1 2 3 4 5 6 _____	**Attention Deficit**	1 2 3 4 5 6 _____
Weight Gain/Loss	1 2 3 4 5 6 _____	**SUBSTANCE USE**	1 2 3 4 5 6 _____
	amount in last month _____	**Alcohol**	1 2 3 4 5 6 _____
Sleep	1 2 3 4 5 6 _____		Drinks/week _____
Nightmares	1 2 3 4 5 6 _____	**Drugs**	1 2 3 4 5 6 _____
Insomnia	1 2 3 4 5 6 _____		Type/week_____
Ambition	1 2 3 4 5 6 _____	**Caffeine**	1 2 3 4 5 6 _____
Unhappiness	1 2 3 4 5 6 _____		Drinks/week _____
Irritability	1 2 3 4 5 6 _____	**Tobacco**	1 2 3 4 5 6 _____
Depression	1 2 3 4 5 6 _____		Packs/week _____
Manic Behavior	1 2 3 4 5 6 _____	**RELATIONSHIPS**	1 2 3 4 5 6 _____
Suicidal Thoughts	1 2 3 4 5 6 _____	**Friends**	1 2 3 4 5 6 _____
ANXIETY	1 2 3 4 5 6 _____	**Marriage**	1 2 3 4 5 6 _____
Nervousness	1 2 3 4 5 6 _____	**Separation/Divorce**	1 2 3 4 5 6 _____
Panic Attacks	1 2 3 4 5 6 _____	**Children**	1 2 3 4 5 6 _____
Compulsive Behavior	1 2 3 4 5 6 _____	**Shyness**	1 2 3 4 5 6 _____
Obsessive Thoughts	1 2 3 4 5 6 _____	**Loneliness**	1 2 3 4 5 6 _____
Fears	1 2 3 4 5 6 _____	**Fear of Being Alone**	1 2 3 4 5 6 _____
HEALTH	1 2 3 4 5 6 _____	**Distancing Others**	1 2 3 4 5 6 _____
Bowel Troubles	1 2 3 4 5 6 _____	**Sexual Problems**	1 2 3 4 5 6 _____
Headaches	1 2 3 4 5 6 _____	**SELF CARE**	1 2 3 4 5 6 _____
Stomach Trouble	1 2 3 4 5 6 _____	**Work**	1 2 3 4 5 6 _____
Binging/Purging	1 2 3 4 5 6 _____	**Career Choices**	1 2 3 4 5 6 _____
THOUGHTS	1 2 3 4 5 6 _____	**Education**	1 2 3 4 5 6 _____
Making Decisions	1 2 3 4 5 6 _____	**Legal Matter**	1 2 3 4 5 6 _____
Memory	1 2 3 4 5 6 _____	**Finances**	1 2 3 4 5 6 _____
Confusion	1 2 3 4 5 6 _____	**Stress**	1 2 3 4 5 6 _____
Communicating	1 2 3 4 5 6 _____	**Incest**	1 2 3 4 5 6 _____
IMPULSE CONTROL	1 2 3 4 5 6 _____	**Grief/Loss**	1 2 3 4 5 6_____
Anger	1 2 3 4 5 6 _____	**Trauma**	1 2 3 4 5 6 _____
Temper	1 2 3 4 5 6 _____	**Learning Disabilities**	1 2 3 4 5 6 _____

Optional Questions

What events or conditions happened in your life that impacted you? Include events that have empowered or hindered you? __

_____

_____

Describe any losses you have experienced (pets, family, friends, relationships, job, financial) _____

_____

_____

What activities do you do for fun? _____

_____

What activities have you let go of that you use to enjoy? _____

What physical health challenges are you experiencing now? _____

_____

What physical health challenges did you experience in the past?_____

_____

Describe your weekly physical activity._____

_____

When did you last see your Dr. for a check-up? _____

What illnesses run in your family?_____

_____

Have you or anyone in your family experienced trauma? (please list family member & describe) _____

_____

Have you or anyone in your family attempted or completed suicide? (please list family member) _____

_____

What legal issues have you faced (divorce, custody, mediation, lawsuits or arrests)? Please describe

_____

Self-Care Information

What do you do for relaxation and enjoyment?_____

_____

How does spirituality or religion assist you in managing your life? _____

_____

What do you value most in life? _____

_____

What are your hopes and dreams? _____

_____

If everything were better in your life, what would that look like?_____

_____

Anything else you feel is important to address?_____

_____

What I Want from Therapy

Client Name_____ Date _____

Therapy offers many things, all of which are often considered important for personal growth or healing to occur. With people having unique development, learning styles and desires, I want to be able to offer you, your own plan. Below are several reasons why people seek therapy. Please mark each statement in regards to your desires for your current therapy investment using the following scale.

Definitely Want		Maybe		Definitely Not	Don't Know
1	2	3	4	5	DK

1. I want insight into why things are the way they are.

1 2 3 4 5 DK

2. I want insight into how to change things in my life.

1 2 3 4 5 DK

3. I want a vision of the future possibilities for myself.

1 2 3 4 5 DK

4. I want skills and tools for managing my life.

1 2 3 4 5 DK

5. I want advice for managing my life.

1 2 3 4 5 DK

6. I want someone to listen and attend to my feelings.

1 2 3 4 5 DK

7. I want someone to listen and attend to my ideas.

1 2 3 4 5 DK

8. I want support and connection with a caring and objective person.

1 2 3 4 5 DK

9. I want someone to encourage me to make the changes I need.

1 2 3 4 5 DK

10. I want to be pushed to make changes in my life.

1 2 3 4 5 DK

11. I want handouts to work on outside of session.

1 2 3 4 5 DK

12. I want ideas of books to read that might help with my growth.

1 2 3 4 5 DK