New Growth Counseling Services

Introduction to Individual Counseling

Welcome to counseling. We look forward to meeting with you and getting started. People and their situations are often very complex – your therapist will need to understand as much of the context as possible in order to help with a solution. The following paperwork (though extensive) is designed to give your therapist the context quickly. Please complete it and bring it to your initial appointment.

- The informed consent is your formal agreement to enter therapy – please be sure that you understand all the items, if not, ask your therapist about them before you sign the form.
- The questionnaire follows – please fill it out completely as your therapist will need all of this information.

Thank you for completing these forms.

Sincerely,

New Growth Counseling Services

Brief Mood Survey*

Instructions. Use checks (✓) to indicate how depressed, anxious or angry you've been feeling **over the past week, including today. Please answer all the items.**

Depression	0—Not at all	1—Somewhat	2—Moderately	3—A lot	4—Extremely
1. Sad or down in the dumps					
2. Discouraged or hopeless					
3. Low self-esteem					
4. Worthless or inadequate					
5. Loss of pleasure or satisfaction in life					
Total Items 1 to 5 ➔					

Suicidal Urges	0—Not at all	1—Somewhat	2—Moderately	3—A lot	4—Extremely
1. Do you have any suicidal thoughts?					
2. Would you like to end your life?					
Total Items 1 to 2 ➔					

Anxiety	0—Not at all	1—Somewhat	2—Moderately	3—A lot	4—Extremely
1. Anxious					
2. Frightened					
3. Worrying about things					
4. Tense or on edge					
5. Nervous					
Total Items 1 to 5 ➔					

Anger	0—Not at all	1—Somewhat	2—Moderately	3—A lot	4—Extremely
1. Frustrated					
2. Annoyed					
3. Resentful					
4. Angry					
5. Irritated					
Total Items 1 to 5 ➔					

Relationship Satisfaction*

Instructions. Use checks (✓) to show how satisfied or dissatisfied you feel in your closest personal relationship.

Please answer all 5 items.

	Dissatisfied				Satisfied		
	0—Very	1—Moderately	2—Somewhat	3—Neutral	4—Somewhat	5—Moderately	6—Very
1. Communication and openness							
2. Resolving conflicts and arguments							
3. Degree of affection and caring							
4. Intimacy and closeness							
5. Overall satisfaction							

The person I had in mind was __________________________ Total Items 1 to 5 ➔ ______

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New Growth Counseling Services - Informed Consent

Your signature at the bottom of this page means that you understand and consent to the following policies and procedures:

Counseling is a collaborative process between therapist and patient(s) who work together on mutually agreed upon goals. Participation is voluntary and is only effective when both patient(s) and therapist are actively striving for the patient's growth and change. Patients realize that participation in therapy can involve discussing issues that may be distressing – however, therapy is designed to help patients personally and in their relationships. When minors are involved, it may be necessary that parent(s)/guardian(s) participate in the counseling process with their child(ren) at the discretion of the therapist. Some problems may be best resolved with the participation of other family members or close relations.

Appointments are made in advance and start and end on time – a session lasts 50 minutes. If a patient is late, the session will still cost full price and end at the pre-arranged time. 24-hour advance notice is expected for cancellation or rescheduling. Any patient who fails to cancel, cancels at the "last minute," or doesn't attend a regularly scheduled session *will be held responsible for full payment of the missed session.* Lateness, or cancellations made by the therapist will be rescheduled.

Emergencies: in the event of an emergency dial 911 or (888) 724-7240. The therapist will discuss emergencies with you and may provide emergency contact information at their discretion. As a rule, most telephone calls will be returned during normal business hours on weekdays. Some therapists are only available part-time.

Payment is expected at the time of service and will be collected at the beginning of the session. Any check that is returned for insufficient funds will be assessed a $25 fee.

Confidentiality is vital to trust - all sessions are confidential. This means the therapist will not discuss any aspect of the session or case with anyone outside of therapy without prior written consent of patient(s). It is important that a patient (especially children) has a confidential relationship with their therapist.

- **Secrets** within relationships sometimes can be destructive or counter-productive to the goals of therapy. If a patient divulges such a secret to the therapist, the therapist will use his discretion about revealing it. Generally, the therapist will ask the patient to divulge the secret – if the therapist believes the secret is destructive or counter-productive to the counseling process, he may refuse to continue working with the patient until the patient reveals the secret. In cases of danger, the therapist may reveal the secret to maintain safety.

Limits of confidentiality: The following are exceptions to confidentiality and *MUST BE REPORTED* to the appropriate service and/or police. Please note – these reports are mandated by law and may be made without your consent or written permission.

1. If a patient(s) become a danger to himself/herself, steps will be taken to keep the person safe.
2. If the patient should become a danger to another identifiable person(s), the potential victim(s) will be warned and the police will be notified.
3. Any suspicion of child abuse (including physical, sexual, and/or emotional abuse as well as child neglect or endangerment) whether past or present, previously reported or not, will be reported.
4. Any suspicion of abuse or neglect of an elder or dependent adult will be reported to Adult Protective Services.

I authorize New Growth Counseling Services staff / therapist to leave voice messages at my home or with a family member or friend regarding appointments, billing issues, or other pertinent information regarding my Behavioral Health Care.

YES / NO (choose one) ____________________
Signature

I agreed to the above policies:____
Signature Date

Email / text communications with New Growth Counseling

Please read the following disclosures about communicating with **New Growth Counseling** (NGCS):

1. NGCS does not conduct therapy, give advice, or communicate about therapy via email, text, instant message, or any other “telemedicine” technologies. Therapy is face-to-face. NGCS will only use texts/emails for the purposes of arranging meetings. If you have an urgent need to connect with your therapist and want a response, you must call by phone. NGCS will make every attempt to respond to your call in a timely manner.
2. Employees of NGCS may opt-out of texting or emailing with you for various reasons. They may also participate in texting and emailing with you. This is handled individually between you and the person you are working with.
3. Email /texting and other forms internet-based communications are non-secure and non-confidential form of communication. Hackers and unauthorized users can also attempt to access emails through malicious software such as spyware or a virus that may be located on your computer unbeknownst to you. Other people may look at your computer/phone when you are not aware.
4. Many people still feel comfortable communicating via email / text because they have taken measures to secure their computer/phone. Despite this fact, there is no guarantee that such measures will work 100%.
5. Emails /texts sent and received are stored on computers / phones of NGCS clinicians and on your computer until deleted. NGCS may or may not delete such emails and texts.
6. In addition, whenever you send an email/ text, it is stored in cyberspace and the authorities can access these emails / texts under various circumstances – this is not a policy of NGCS, but is due to the nature in which email / texts are transmitted using the internet and other services or networks. For more information on this, please contact your Internet Service Provider, email service, or cell phone provider.

By signing below, I agree that I understand the disclosures listed above regarding communicating with NGCS using email or text. I also agree that if I send an email / text to NGCS and request a response via email, that I am willing to accept the above-stated risks:

If you do not want to correspond via email do not sign your name – instead, write “declined.”

Print Name:______________________________Signature_________________________________Date:___________

Permission for NGCS to initiate emails /texts to you

Sign below if you give your permission for NGCS to initiate sending emails/ texts to you. Example: NGCS may be the first one to send an email / text to you to cancel an appointment due to sickness. If you do not wish to have NGCS initiate emails to you, do not sign your name – instead, write “declined.”

Print Name:______________________________Signature_________________________________Date:___________

Print your email clearly:____

New Growth Counseling Services

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I understand that New Growth Counseling Services (NGCS hereafter) uses administrative staff to perform basic clerical and bookkeeping duties that are ordinary and typical to run a therapy practice. NGCS clerical staff will ONLY have access to the following types of information about those attending therapy:

1. Demographic information (names, addresses, telephone numbers, dates of birth, etc.) taken from client intake questionnaire.
2. Billing information (names, dates, charges, payments, payment methods, diagnostic codes, etc.).
3. Emergency contacts – in the unlikely event that your therapist becomes so ill or incapacitated that he/she is unable to contact me/us, staff may contact me/us regarding logistical issues (for example, staff may call to cancel an appointment when my therapist is sick).

Clerical staff will not have access to information about the content of counseling and therapy sessions. Clerical staff will not have access to information about any communications (such as telephone, email, mail) that pertain to counseling and therapy matters.

I further understand that administrative staff will send me a monthly statement which acts as a receipt for payments received. It includes billing information (such as a diagnosis, billing codes, patient name, etc.) and is typically sent to me via email. Please check only one:

☐ I will accept monthly statements by email. Please send them to the following email address:

please print clearly: ____

☐ I do not want my monthly statement sent via email. Please give them to me directly at sessions or have them mailed to me.

Signature: ____________________________________ Date: ________________________

Adult Questionnaire

Today's Date

First Name	Last Name	M.	Current Age	Place of Birth

Primary address of patient - Street Address	City	State/Zip

Other Address (if applicable)	City	State/Zip

Home Phone	OK to leave message?	Work phone	OK to leave messages?	Cell Phone	OK to leave messages?

Gender	please circle **only** one
male / female	single / married / cohabiting / separated / divorced / widowed

how long since married/cohabiting?	how long since separated,/divorced/widowed?	ever been married before?	how many times?	partner ever been married before?	how many times?
		yes / no		yes / no	

	yourself	**your spouse / partner**
race / ethnicity		
religion / denomination		
date of birth		
sexual orientation		
names & ages of children conceived with current spouse/ partner		
names & ages of children conceived with previous spouse(s)/ partner(s)		
highest level school completed		
current occupation		
current employer / school		
hours worked each week		
how long worked here?		
second jobs		
how long at this job?		
hours worked each week		
any problems at work / school?		
unemployed?		
why?		
how long unemployed?		

	yourself	**your spouse / partner**
last physical exam date		
results of exam?		
current physical problems		
any head injuries / seizures? when?		
any major illness past or present? what & when?		
any operations? what & when?		
any prior hospitalizations? for what & when?		
any family history of alcoholism?	**Y / N** who?	**Y / N** who?
any family history of depression?	**Y / N** who?	**Y / N** who?
any family history of mental illness?	**Y / N** who?	**Y / N** who?
list personal strengths		
list personal weaknesses		
list personal hobbies		

Please list **everyone** who lives in the household at least two days / week - please list from oldest to youngest

Full name	Date of Birth	Age	School / occupation

Who can I call in case of an emergency?	Phone	City	Relationship to patient

Why are you coming to counseling at this time?____

____

____

____

Are you being pressured to come to counseling? By whom and why?____

____

Have you been referred? **Yes / No** by whom?____

May I have your permission to thank the person/agency who referred you? **Yes / No** ____________________
signature authorization

What problems are you wanting to address in counseling?:____

____

____

____

How long have these problems existed? ____

____

____

What makes these problems worse? ____

____

____

What makes these problems improve? ____

____

____

Overall, how motivated are you to change these problems? **Circle one:**

Very motivated----------------------------not motivated
10 – 9 – 8 – 7 – 6 – 5 – 4 – 3 – 2 – 1

What do you expect from therapy?____

____

____

Is anyone currently getting counseling? **Yes / No** Who?________________ why?____________________

for how long?_______________ With whom?______________________ telephone ___________________

Any hospitalizations for mental health reasons? **Yes / No** who?____________________________________

When?______________________ Why? ______________________________ Where?_________________

Has anyone received help for any drug / alcohol use? **Yes / No**

who? ________________ what for? ________________________________ when?_____________________

who? ________________ what for? ________________________________ when?_____________________

Is anyone currently under the care of a physician for physical problems? **Yes / No** **w**ho?_________________

For what? ____________________________With whom? _________________telephone:_______________

Name of patient's primary physician______________________________ Telephone____________________

Has anyone ever been arrested and/or committed a crime? **Yes / No** who?___________________________

When ________________________ For what?____

Outcome of situation____

If need be, would other relatives be willing to come into therapy sessions? **Yes / No**

If not why?____

____

Problems and Other Symptoms

Please check any of the following which may apply to **anyone in the household.** Please check issues even if they do not relate to the primary reasons you are coming to counseling.

☑	problem	who has problem?		☑	problem	who has problem?
	alcohol use				inability to relax	
	angry outbursts				legal matters	
	anorexia or bulimia (past / present)				loneliness	
	anxiety				loss of interest in things	
	bad dreams				loss of sexual interest or desire	
	boredom				marriage problems	
	can't get motivated to do things they usually enjoy				memory problems	
	career choices				nervousness	
	crying easily				overeating	
	depression				parent - child conflict	
	difficulty concentrating				poor appetite	
	difficulty falling asleep or staying asleep				poor or decreased ambition	
	difficulty getting up in the morning				pornography use	
	difficulty making decisions				preoccupation with death	
	difficulty parenting				school problems	
	divorce				self-confidence	
	drug use				self-mutilation	
	easily annoyed or irritated				sexual problems	
	energy problems				shyness	
	extreme fear of places or events				stuttering	
	faintness or dizziness				suicidal attempts	
	fatigue				suicidal thoughts	
	feeling fearful				thoughts hard to get rid of	
	feeling inferior to others				trouble remembering things	
	feeling tense or nervous				uncontrollable outbursts of temper	
	financial problems				unhappiness	
	friendship problems				violent behavior	
	gambling				violent thoughts	
	guilt				work problems	
	impulsiveness				worrying about things	

Medication Survey

Current **Non-Psychiatric** Medications

person taking medicine	medicine	dose	purpose	how long on this medicine?

Current **Psychiatric** medications

person taking medicine	medicine	dose	purpose	how long on this medicine?

Previous Psychiatric Medications

Please list each drug chronologically, starting with the first medication ever given for an emotional problem

person taking medicine	medicine	dose	purpose	how long on this medicine?

Summary of Prior Counseling / Psychotherapy

Please begin with the FIRST therapist you ever had and move forward to the most recent therapist if you need more room, use back side.

	name of therapist and degree (MD, PhD, MFT, etc.)	start & end dates - - how often did you meet? (weekly?)	reasons for seeking treatment -- reasons for stopping treatment	what type of therapy? was it helpful? did you have any negative reactions?
1				
2				
3				
4				
5				
6				
7				

THANK YOU FOR FILLING OUT ALL THESE FORMS!

Substance use Checklist

I consume alcohol….	
	never
	1time/ month
	2-4 times / month
	2-4 times / week
	daily

When I drink, I usually drink….	
	none
	1-2 drinks or beers
	2-3 drinks or beers
	3-4 drinks or beers
	5+ drinks or beers

I get drunk….	
	never
	1x/ month
	1-4x/month
	2-4x / week
	daily

I've been drinking like this for the...	
	last month
	2-6 months
	6-12 months
	more than a year
	more than 3 years

My drinking has resulted in one or more of the following...	
	passing out
	sleep disturbances
	can't stop once I start
	blackouts
	relationship problems
	binges
	work/school problems
	seizures
	Assaults &/or arrests
	physical withdrawal
	legal problems
	medical complications

The following apply to me (check all that apply)	
	I rarely or never drink – not even socially
	I'm an occasional/ social drinker
	I'm not sure if I have a problem
	I probably have a problem
	I have a problem, and I want to stop
	I have a problem, but I don't want to stop

I've tried to control my drinking with....	
	Nothing!
	I stopped on my own
	I've attended AA / other 12-step program a **few times**
	I've attended AA / other 12-step program a **regularly**
	I attended day or outpatient treatment
	I attended inpatient / residential treatment
	I attended a community-based program (e.g., church program, etc.)
	I was forced to attend treatment of some kind

I currently use / I once used / I only ever tried….

	only tried	used regularly	age started	age stopped
none				
pot				
sedative				
stimulant				
cocaine				
meth				
inhalants				
Heroin/ opium				
prescription drugs				
LSD, mushrooms				
other				

The following apply to me (check all that apply)	
	I don't gamble
	I gamble occasionally
	I like to gamble
	Gambling has caused me problems
	I have gambled until all my money was gone
	I have gambled more than I planned to
	I like to gamble to escape worry or trouble
	I have borrowed money in order to gamble
	At times I've felt remorse after gambling
	I've lost time from work or school due to gambling