

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.

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

| Anxiety | | | | | |
|-----------------------------|--|--|--|--|--|
| 1. Anxious | | | | | |
| 2. Frightened | | | | | |
| 3. Worrying about things | | | | | |
| 4. Tense or on edge | | | | | |
| 5. Nervous | | | | | |
| Total Items 1 to 5 → | | | | | |

| Anger | | | | | |
|-----------------------------|--|--|--|--|--|
| 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 | | | 3—Neutral | Satisfied | | |
|--------------------------------------|--------------|--------------|------------|-----------|------------|--------------|--------|
| | 0—Very | 1—Moderately | 2—Somewhat | | 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 | | | | | | | |
| Total Items 1 to 5 → | | | | | | | |

The person I had in mind was _____

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](tel:8887247240). 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.

- **Interns** are pre-licensed counselors who are registered with the state of California and work under the clinical supervision of a licensed therapist. Interns are required to discuss and review cases with their supervisor as mandated by the professional and ethical codes of the profession – interns use audio / video recording to do this.
- **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: _____

Consent to receive treatment from Registered Interns / videotape consent

New Growth Counseling Services employees Marriage & Family Therapist (MFT) Registered Interns. Registered interns have received their Master's degree from an accredited program and are registered with the state of CA – they are bound by the laws and ethical guidelines that govern the profession. During their unlicensed period, they receive weekly supervision from a licensed therapist. The supervisor maintains your confidentiality at all times.

Interns videotape sessions to share at supervision with the goal of providing you the highest level of care possible. This allows the supervisor to clearly see your situation and offer additional feedback. You will benefit greatly from having a second professional behind the scenes contributing insights and ideas that the intern will implement in helping you reach your goals. Videotapes are destroyed after review.

I understand that my counselor Mitzi Steele is an MFT registered intern with the state of California (registration IMF# 88087). I also understand that she will be working under the supervision of Jussi Light, CA Licensed Marriage and Family Therapist #39617. I may contact Jussi by calling the main number, 760-494-4394. I further understand that my counselor will discuss my case and share videotapes of sessions with Jussi.

I agree and give my consent by signing this form:

Signature: _____ Date: _____

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 | <small>OK to leave message?</small> | Work phone | <small>OK to leave messages?</small> | Cell Phone | <small>OK to leave messages?</small> |
| | | | | | |

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 | | 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

| Full name | Date of Birth | Age | School / occupation |
|-----------|---------------|-----|---------------------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Who can I call in case of an emergency?

Phone

City

Relationship to patient

| 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** who? _____
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.

| <input checked="" type="checkbox"/> | problem | who has problem? | <input checked="" type="checkbox"/> | 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 | |

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.... | |
| <input type="checkbox"/> | never |
| <input type="checkbox"/> | 1time/ month |
| <input type="checkbox"/> | 2-4 times / month |
| <input type="checkbox"/> | 2-4 times / week |
| <input type="checkbox"/> | daily |

| | |
|-----------------------------------|---------------------|
| When I drink, I usually drink.... | |
| <input type="checkbox"/> | none |
| <input type="checkbox"/> | 1-2 drinks or beers |
| <input type="checkbox"/> | 2-3 drinks or beers |
| <input type="checkbox"/> | 3-4 drinks or beers |
| <input type="checkbox"/> | 5+ drinks or beers |

| | |
|--------------------------|-------------|
| I get drunk.... | |
| <input type="checkbox"/> | never |
| <input type="checkbox"/> | 1x/ month |
| <input type="checkbox"/> | 1-4x/month |
| <input type="checkbox"/> | 2-4x / week |
| <input type="checkbox"/> | daily |

| | |
|---|-------------------|
| I've been drinking like this for the... | |
| <input type="checkbox"/> | last month |
| <input type="checkbox"/> | 2-6 months |
| <input type="checkbox"/> | 6-12 months |
| <input type="checkbox"/> | more than a year |
| <input type="checkbox"/> | more than 3 years |

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

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

| | |
|--|---|
| I've tried to control my drinking with.... | |
| <input type="checkbox"/> | Nothing! |
| <input type="checkbox"/> | I stopped on my own |
| <input type="checkbox"/> | I've attended AA / other 12-step program a few times |
| <input type="checkbox"/> | I've attended AA / other 12-step program a regularly |
| <input type="checkbox"/> | I attended day or outpatient treatment |
| <input type="checkbox"/> | I attended inpatient / residential treatment |
| <input type="checkbox"/> | I attended a community-based program (e.g., church program, etc.) |
| <input type="checkbox"/> | 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) | |
| <input type="checkbox"/> | I don't gamble |
| <input type="checkbox"/> | I gamble occasionally |
| <input type="checkbox"/> | I like to gamble |
| <input type="checkbox"/> | Gambling has caused me problems |
| <input type="checkbox"/> | I have gambled until all my money was gone |
| <input type="checkbox"/> | I have gambled more than I planned to |
| <input type="checkbox"/> | I like to gamble to escape worry or trouble |
| <input type="checkbox"/> | I have borrowed money in order to gamble |
| <input type="checkbox"/> | At times I've felt remorse after gambling |
| <input type="checkbox"/> | I've lost time from work or school due to gambling |

