Introduction to Individual Counseling

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

- The informed consent is our formal agreement to enter therapy – please be sure that you understand all the items, if not, ask me about them before you sign the form.
- Two disclosure forms follow pertaining to the sharing of information as well as email communications – these are self-explanatory.
- The questionnaire follows – please fill it out completely as I will need all of this information.

I appreciate the opportunity to work with you. If you have any questions, feel free to call me directly, 760-494-4394,

Sincerely,

Jussi Light, M.A., LMFT

Jussi Light*, *M.A. *Licensed Marriage & Family Therapist* *MFC #39617*

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 800-479-3339. The therapist is available via telephone (760-494-4394 – sorry text messages are not received at this number) during business hours and will return emergency calls at his discretion. However, most phone calls will be returned during normal business hours on weekdays.

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 all patients (especially children) have a confidential relationship with their therapist.

- Individuals attending therapy due to a **court mandate** or as consequence or condition of probation/parole may have to waive their rights to confidentiality and the therapist may be able to communicate to your probation/parole officer regarding your case.
- If you have **health insurance** that covers services, a minimum of information will need to be exchanged to insure reimbursement – however, you will be required to sign an authorization to release information.
- **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 Jussi light 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

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I understand that Jussi Light uses administrative staff to perform basic clerical functions that are ordinary and typical to run his therapy practice. Jussi Light's staff will ONLY have access to the following types of information about those attending therapy:

1. Demographic information (names, addresses, telephone numbers, email addresses, 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 Jussi Light becomes so ill or incapacitated that he is unable to contact me/us, staff may contact me/us regarding logistical issues (for example, to cancel an appointment for Jussi when he is sick).

Staff will not have access to information about the content of counseling and therapy sessions. 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.

By singing below, I understand and agree to the contents of this form.

Name: _____ date: _____

Email communications with Jussi Light

Please read the following disclosures about communicating with Jussi Light using email:

1. Email is a 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.
2. Many people still feel comfortable communicating via email because they have installed firewalls or other programs designed to detect spyware, viruses, or other dangerous software. However, there is no guarantee that such programs will work 100%.
3. Sent and received emails are stored on both Jussi Light's and your computer until deleted. Jussi Light may or may not delete such emails. Generally, mundane emails (questions about appointments, billing, etc) will be deleted while other emails may be kept for archival purposes. Any such saved emails will be kept in a password-protected account that only Jussi Light has access to.
4. In addition, whenever you send an email, it is stored in cyberspace and the authorities can access these emails under various circumstances – this is not a policy of Jussi Light, but is due to the nature in which email is transmitted using the internet and other services or networks. For more information on this, please contact your Internet Service Provider or email service.
5. Jussi Light will use email to respond to emails that you send him. If you request that your billing statement be emailed to you, he will do so.
6. As a rule, Jussi Light does not conduct therapy via email. However, he may use email to handle certain questions/issues that pertain to therapy and related content if they can be easily and simply handled over email. He may also choose not to use email to handle such matters. He will tell you if this is the case.

By signing below, I agree that I understand the disclosures listed above regarding communicating with Jussi Light using email. I also agree that if I send an email to him 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 Jussi light to initiate emails to you

Sign below if you give your permission for Jussi Light to initiate sending emails to you. Example: Jussi may be the first one to send an email to you, rather than just responding to your emails.

If you do not wish to have Jussi Light initiate emails to you, do not sign your name – instead, write "declined."

Print Name:_____Signature_____Date:_____

Print your email clearly:_____

Adult Questionnaire

Today's Date

First Name	Last Name	M.	Date of birth	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 current 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 current 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	

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					
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				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 ➔ ____

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

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