Still Waters
PROFESSIONAL COUNSELING, LLC

Welcome to Still Waters, where you'll find health care professionals dedicated to providing you with the highest level of quality care. We want your experience here to be positive and growth promoting. We know that the decision to enter counseling is often difficult and your counselor will be glad to answer any questions you may have about the counseling process, his or her education and experience, or any concerns you may have.

For change to occur it is necessary to form and experience a trusting, emotionally safe relationship with your counselor, and in the context of that relationship to increase one's awareness of self, challenge one's assumptions, learn new skills, establish appropriate boundaries in relationships with others, and experience and let go of pain from the past. Your counselor's task is to assist in this process. Our aim is to provide consultation, evaluation, and counseling services for clients dealing with issues impacting their well-being.

We have designed this packet to inform you about us and about your rights as a client.
The packet includes:

- Professional Services Agreement
- Notice of Privacy Practices to Protect your Health Information (NPP)
- Acknowledgement of Receipt of NPP and Signature denoting your Consent to Receive Professional Services
- Insurance Verification Form
- Life Functioning Inventory

To help us serve you better, please take your time, read, and complete the information requested in this packet. We ask that you return the following forms to your first appointment with your therapist:

- Acknowledgement of Receipt of NPP and Signature denoting your Consent to Receive Professional Services
- Insurance Verification Form
- Life Functioning Inventory

If you have any questions and would like to receive further information, talk to your counselor during your first appointment.

Thank you,

Robyn J. Kittrell, Ph.D., HSPP
Robin M. Lett, Ph.D., HSPP
Jodi Nixon, Ph.D., HSPP
Carol Dean, Ph.D., HSPP
Paula Emke-Francis, Ph.D., HSPP
Kali Wolken, M.A., LMHC
Brian Hart, M.A., LMHC
George Gaither Ph.D., HSPP

David Smith, M.A., LMHC
Christina Smith M.A., LMHC
James Linville M.A., LMHC
Beth Trammell, PhD, HSPP
Jackie Camp, Ph.D., HSPP
Joel Chandler, M.A.
Amanda Charboneau, M.A. LMHC
Abby Nethaway, Ph.D., HSPP

Still Waters
PROFESSIONAL COUNSELING, LLC

PROFESSIONAL SERVICES AGREEMENT

Still Waters offers a variety of services including individual, couples and family counseling, testing and assessment services, professional consultation, training and supervision, and medical nutrition counseling and nutrition education. This agreement contains information about Still Waters' professional services and business policies. It is our intention to keep you well informed as to the nature of the services we provide. Then, you can make a good decision about whether Still Waters can meet your needs. Upon reading this document, your signature will be requested, which will represent an agreement between you and your counselor to enter into a professional relationship. You may revoke this agreement in writing at any time.

Thoughts About Counseling

Entering counseling takes courage. People often come to counseling when they are at a crossroads. The path that they have been on has not taken them where they want to go and they come to counseling in search of help and direction. In order for change to take place, the counselor must join with them at the crossroads and together, embark on a voyage of discovery. The success of the journey depends on the relationship that develops between the counselor and client and therefore it is important for the counselor to: create an atmosphere that is collaborative, relaxed, safe and focused; instill hope; create a shared meaning; listen to the client's story; gather information; and work together with the client to establish realistic and attainable goals. Counseling entails making meaningful connections between affective experiences, cognitions, and behavior. The experiences of each person in counseling will be different, because what happens in counseling depends on you and your needs. How you choose to use each session, your particular counselor's approach and experience, and your own knowledge, insight, experience, and motivation will help determine the course and outcome of counseling. Counseling requires an active effort on your part. In order for counseling to be most successful, you will have to work on things talked about both during sessions and during the week.

Professional counseling services can have benefits and risks. Insight and inner awareness often creates a state of disequilibrium and decreased satisfaction in counseling. Since counseling most often involves discussing unpleasant aspects of your life and your family history, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. At times you may feel worse before you begin to feel better. Therefore it is helpful to understand that a sense of disequilibrium can be a desirable step in your healing process. Professional counseling has been shown to have many benefits as it can lead to improved relationships, solutions to specific problems, increased awareness, and a significant reduction in feelings of distress. Although there are no guarantees of what you will experience during the process of counseling, your active participation in the counseling process is necessary for progress to be made. Thus, we encourage you to attend all scheduled sessions.

We at Still Waters are committed to rendering services in a professional manner consistent with accepted ethical standards. Please note that it is impossible to guarantee any specific results regarding your counseling goals. However, together we will work to achieve the best possible results.

Your First Appointment

When you come to your first appointment, please bring with you: completed intake paperwork, insurance card(s), and a valid photo ID. If the client is a minor, we will expect the photo ID of a parent/guardian.

The initial appointment is an approximate 50 minute face to face meeting with a counselor. It is an opportunity to share information about your personal history and current situation and receive an evaluation of your needs. By the end of the appointment, your counselor will be able to offer his/her first impressions/recommendations of how best to proceed. If you decided to continue with counseling, your goals for counseling and a tentative plan to achieve these goals will be discussed. During the initial appointment, your counselor will also provide you information about his/her qualifications and practice orientation. You should evaluate this information and decide if you feel comfortable working with your counselor. Professional counseling involves a large commitment of time, money, and energy so it is important to select a counselor with whom you are comfortable. The initial appointment is also a good time to ask questions and address any concerns you may have about counseling. If at the end of the initial meeting some alternative treatment seems indicated, information and/or an appropriate referral will be made.

Appointments

Appointments are set for a specific time and the appointments run for 45 to 50 minutes. *If you find that you must cancel or reschedule an appointment, please notify the office at least 24 hours in advance.* It is difficult to reassign your appointment time to another client on such short notice. Therefore, *a $50.00 fee (which is not covered by insurance) will be charged for appointments cancelled less than 24 hours in advance.*

Smoking Policy

We are a healthcare providers' office and are completely smoke-free and tobacco free. This *includes* electronic cigarettes and any other tobacco related paraphernalia.

Contacting Your Counselor

Due to work schedules, your counselor may not immediately be available by phone. However, your counselor will make every effort to return your call on the same day you make it, with the exception of weekends and holidays.

Emergencies

If an emergency arises, please call (765) 281-2952 and leave a message that you are in crisis. Your counselor will return your call as soon as possible. If you are unable to reach your counselor and feel that you can't wait for your counselor to return your call, contact your family physician or go to the nearest

emergency room. If your counselor is unavailable for an extended time, you will be provided with the name and number of another Still Waters' counselor to contact, if necessary.

Limits of Confidentiality

The law protects the privacy of all communication between a client and a counselor. In most situations, information about your treatment can only be released if you sign a written authorization form that meets certain legal requirements imposed by HIPAA and/or Indiana law. However, in the following situations, no authorization is required:

- Your counselor may occasionally find it helpful to consult other health and mental health professionals about a client. During consultations, your counselor will make every effort to avoid revealing your identity. Other professionals are legally bound to keep the information confidential. If you have no objections, your counselor will not inform you of a consultation unless it is important to your work together. All consultations will be noted in your Clinical Record (which is called "PHI" in the "Notice of Psychologist's Policies and Practices to Protect the Privacy of your Health Information."). Your counselor will also need to communicate information to his/her colleague who is providing emergency coverage if your counselor is unavailable.
- You should be aware that Still Waters Professional Counseling, LLC employs an office manager and administrative assistants. In most cases, protected information will be shared with these individuals for administrative purposes, such as scheduling, billing, and quality assurance. Our staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without our permission.
- If a coroner or medical examiner requests information in the performance of that individual's duties, then Still Waters may be required to provide it for them.
- If a patient files a complaint or lawsuit against an individual counselor of Still Waters, relevant information regarding that client may be disclosed in order for the agency to defend itself.

There are situations in which we are legally obligated to take actions, which are believed to be necessary in an attempt to protect others from harm and we may have to reveal some information about a client's treatment. These situations are unusual in this practice; however, it is important that you be aware of them.

- If there is reason to believe that a child is a victim of child abuse or neglect, the law requires that a report be filed with the appropriate government agency, usually the local child protection service. Once such a report is filed, we may be required to provide additional information.
- If there is reason to believe that someone is an endangered adult, the law requires that a report be filed with the appropriate government agency, usually the adult protective services unit. Once such a report is filed, Still Waters may be required to provide additional information.
- If a client communicates an actual threat of physical violence against an identifiable victim or makes statements indicating imminent danger that the patient will use physical violence or other means to cause serious personal injury to others, Still Waters may be required to disclose information in order to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client.
- If a client communicates an imminent threat of serious physical harm to him/herself, the center may be required to disclose information in order to take protective actions. These actions may include initiating hospitalization or contacting family members or others who can assist in providing protection.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that is designed to protect the privacy of patient information, provide for the electronic and physical security of health and patient medical information, and simplify billing and other electronic transactions by standardizing codes and procedures. The HIPAA Privacy Rule, which came into effect in April of 2003, creates a minimum federal standard for the use and disclosure of Protected Health Information (PHI) by health care organizations. One of the requirements of the Privacy Rule is that we give to you a Notice of Privacy Practices (NPP) that describes your rights and protections regarding your health care records (PHI). This document is included as part of the Intake Forms Packet that you will need to read prior to your initial appointment. The law requires that your signature be obtained acknowledging that you were provided with this information. Although these documents are long and sometimes complex, it is important that you read them carefully before your first session. We can discuss any questions you have about the procedures at that time.

We at Still Waters are committed to maintaining your confidentiality and the privacy of psychological and medical records and will continue to adhere to psychologist's ethical guidelines, as well as, state and federal law. Furthermore, your counselor will make every effort to discuss confidentiality procedures with you before taking any action and will limit disclosure to what is necessary. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you might have now or in the future. The laws governing confidentiality can be quite complex and in situations where specific advice is required, formal legal advice may be needed.

Minors and Parents

Clients under 18 years of age who are not emancipated, and their parents, should be aware that the law may allow parents to examine their child's treatment records. Because privacy in counseling is often crucial to successful progress, particularly with teenagers, it is Still Water's policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, they will be provided only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. When counseling is complete, a summary of their child's treatment will be provided. Any other communication will require the child's authorization, unless it is the counselor's judgment that the child is in danger or is a danger to someone else, in which case parents will be notified. Before giving parents any information, all matters will be discussed with the child, and if possible, any objections he/she may have will be handled accordingly.

Professional Fees

Payment terms

We require payment at the time of your office visit. Depending on your insurance policy benefits, this payment could be for a co-payment, coinsurance, deductible, or for the entire services rendered at that visit. For your convenience, we accept cash, personal check, Visa, MasterCard and Discover. We strive to be flexible and understanding of individual circumstances, and we are happy to help with payment arrangements. There is a $25.00 fee charged for each returned check in addition to the amount of the check. Payment is YOUR responsibility: Our relationship is with you, to provide quality healthcare to you and/or your dependent.

Standard Rates

Intake Assessment (1st appointment only)…….……....	$200.00
Individual Psychotherapy……..……	$135.00
Family and Couples Counseling……	$160.00
Neuropsychological Testing Services..…….....	$160.00 (per hour)
Psychological Testing Services……..	$150.00 (per hour)
Cancelled/Missed appointments without 24 hr. notice……...	$50.00
Court Appearances……..	$200.00 (per hour)
Phone sessions……	$65.00 (up to half hour)

Insurance Reimbursement

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. Still Waters can provide you with whatever assistance possible in helping you receive benefits to which you are entitled; however, you, not your insurance company, are responsible for full payment of fees. It is very important that you understand what services are covered under your mental health benefits. If you have any questions whether a service will be covered, you should contact your insurance company before the service is provided. This phone number is usually located on your insurance card. We will provide you with whatever information we can and will call the company on your behalf to clear up any confusion.

It is essential that you provide us with complete and accurate information so that we may properly submit billing information to your insurance company (i.e. home address, phone numbers, name and birth date of the subscriber/person who has the insurance policy). We will make every effort to submit claims to your insurance company and promptly provide you with our statements. We will file your claims with your insurance company as a courtesy after services are provided; however, if you notify us not to file it with your Payer we will honor your request. Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for our services yourself to avoid the problems described above [unless prohibited by contract].

Due to the rising cost of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more counseling after a certain number of sessions. While much can be accomplished in short-term counseling, some patients feel that they need more services after insurance benefits end. [Some managed-care plans will not allow your counselor to provide services to you once your benefits cease. If this is the case, we will do our best to find another provider who will help you continue your counseling.]

Fees involving Legal Services

Any fees relating to foreseen or unforeseen legal action that require your counselor to reproduce records or participate in depositions or court appearances will be the responsibility of the person who is responsible for the uninsured portion of a client's bill. This is without regard to who files the subpoena or initiates the legal action. It is the signor's responsibility to obtain reimbursement from any other party. Fifty percent (50%) of the estimated charges must be paid in advance.

Additional means of Collection

In consideration of the services provided to our clients, the client/responsible party guarantees payment in full of the client's account in accordance with the financial arrangements made at the time of service, or if no arrangements are made, in event of default in payment, reasonable collection agency fees equal to thirty (30%) percent of the delinquent balance and reasonable attorney fees, shall be added to the amount due on the account, plus any applicable court costs.

By providing a cell number, I give prior express consent to receive calls and text messages from the creditor or its third party debt collector at that number, including calls and messages made by using an auto dialer or prerecorded message.

Note to guardians and/or divorced parents of dependents and primary insurance holders: The statement of your dependent will be sent you and you are expected to make prompt payment. Even if you do not believe you are the "responsible party" we expect you to make a payment, and then you can take action on your own to recoup from the party you believe responsible.

Your cooperation with these policies will assure equitable treatment of insurance and non-insurance patients.

Concluding Remarks

Professional counseling is a cooperative endeavor entailing mutual respect, consideration, and responsibility between you and your counselor. The policies outlined above are designed to educate you on our office procedures and to ensure that your counseling is productive. Should you have questions about any policy or procedure, whether mentioned here or not, please feel free to discuss it with your counselor. Also, please feel free to discuss any concerns and questions about your counseling.

Still Waters
PROFESSIONAL COUNSELING, LLC

NOTICE OF PRIVACY PRACTICES TO PROTECT YOUR HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

Still Waters may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *written authorization.* To help clarify these terms, here are some definitions:

- "*PHI*" refers to information in your health record that could identify you.
- "*Treatment, Payment, and Health Care Operations*"
  – *Treatment* is when we provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another psychologist.
  – *Payment* is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  – *Health Care Operations* are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within our office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of our office, such as releasing, transferring, or providing access to information about you to other parties.
- "*Authorization*" is your written permission to disclose confidential mental health information. All authorizations to disclose must be on a specific legally required form.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. In those instances when we are asked for information for purposes outside of treatment, payment, or health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your Psychotherapy Notes. "*Psychotherapy Notes*" are notes we have made about our conversation during a private, group, joint, or family counseling session, which are kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that

authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage. The law provides the insurer the right to contest the claim under the policy.

To Others Involved in Your Healthcare - We may disclose to a member of your family, a relative, a close friend or any other person, that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- *As Required By Law* - We may use or disclose your PHI to the extent that is required by law.

- *Child Abuse* – If we believe that a child is a victim of child abuse or neglect, we must report this belief to the appropriate authorities.

- *Adult and Domestic Abuse* – If we believe or have reason to believe that an individual is an endangered adult, we must report this belief to the appropriate authorities.

- *Health Oversight Activities* – If the Indiana Attorney General's Office (who oversees complaints brought against psychologists instead of the Indiana Sate Psychology Board) is conducting an investigation into our practice, then we are required to disclose PHI upon receipt of a subpoena.

- *Judicial and Administrative Proceedings* – If the patient is involved in a court proceeding and a request is made for information about the professional services we provided you and/or the records thereof, such information is privileged under state law, and we will not release information without the written authorization of you or your legally appointed representative or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- *Serious Threat to Health or Safety* – If you communicate to us an actual threat of violence to cause serious injury or death against a reasonably identifiable victim or victims or if you evidence conduct or make statements indicating an imminent danger that you will use physical violence or use other means to cause serious personal injury or death to others, we may take the appropriate steps to prevent that harm from occurring. If we have reason to believe that you present an imminent, serious risk of physical harm or death to yourself, we may need to disclose information in order to protect you. In both cases, we will only disclose what we feel is the minimum amount of information necessary.

- *Worker's Compensation* – We may disclose PHI regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information. You must put this request in writing. However, we are not required to agree with your request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing a therapist. On your request, Still Waters will send your bills to another address.)

- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of your mental health record except in limited circumstances. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.

- *Right to Amend* – You have the right to request an amendment and/or addendum to your mental health record. Your request must be in writing and give a reason for the request. We may deny your request. If we accept your request, we do not delete any information already in your records. If necessary, we will discuss with you the details of the amendment process further.

- *Right to an Accounting* – You have the right to receive an accounting of certain disclosures of PHI. You must put your accounting request in writing. If necessary, we will discuss with you the details of the accounting process further.

- *Right to a Paper Copy* – You have the right to obtain a paper copy of this notice from us when you receive care at Still Waters.

Psychologist's Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.

- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your PHI. We will notify you of the breach as soon as possible but no later than sixty (60) days after the breach has been discovered.

- We will follow the duties and privacy practices described in this notice and give you a copy of it.

- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes; however, we are required to abide by the terms currently in effect.

- If we revise our policies and procedures, the new notice will be available upon request, in our office, and on our website.

V. Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the HIPAA Privacy Officer, Robyn Palsrok, at Still Waters Professional Counseling at (765) 281-2952.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

This notice was originally effective on April 14, 2003, and was revised on September 23, 2013.

Still Waters
PROFESSIONAL COUNSELING, LLC

Acknowledgment of Receipt of Privacy Practices *to Protect your Health Information*
The Still Waters Professional Counseling "Notice of Privacy Practices to Protect your Health Information" provides information about how we may use and disclose protected health information about you. Our Notice of Privacy Practices is subject to change.

I acknowledge that I have received the Notice of Privacy Practices.

_____ _____
Signature of Client or Client's Representative Date

_____
Name Printed

Consent to Receive Psychological Services

The Still Waters Professional Counseling "Psychological Services Agreement" provides information about its professional services and business policies.

I acknowledge that I have received the Psychological Services Agreement, am consenting to receive mental health services at Still Waters, and agree to the financial policies as stated. I understand that the services my therapist provides fall within the scope of the provider's license, certification, and training.

_____ _____
Signature of Client or Client's Representative Date

_____
Name Printed

Consent for Insurance Payment

I authorize the use of this signature on all insurance submissions under HIPAA guidelines. I also authorize release of any and all *pertinent* information needed about me, in order to determine benefits payable for related services, to insurance carriers, the healthcare financing administration & their agents. I request the payment of authorized Medicare benefits and/or other insurance benefits be made on my behalf to Still Waters Professional Counseling, LLC for services provided to me. I understand that my therapist reserves the right to charge me for missed visits as outlined in the Professional Services Agreement. I also understand that there will be an additional $25 fee for any check issued to Still Waters Professional Counseling, LLC returned with non-sufficient funds.

_____ _____
Signature of Client or Client's Representative Date

_____
Name Printed

LIFE FUNCTIONING INVENTORY

This form is intended to help your counselor become better acquainted with you and, in turn, serve you better. Please print the information requested or checkmark the appropriate responses. You may omit any item, but try to be as thorough as possible. Thank you.

SECTION A: Basic Client Information

Full Name:_____
Address:_____
City/State/Zip:_____ H**ome**
Phone:_____

Work Phone:_____ **Cell Phone**:_____

Fax:_____

E-mail:_____

Do you have any objections to being contacted by telephone, mail, e-mail, etc…
❒ yes ❒ no

How would you like to be contacted? _____

SS#:_____

Date of Birth:_____

Age:_____ **Gender**: ❒male ❒female

Emergency Contact Name:_____

Relationship:_____
Address:_____
City/State/Zip:_____
Home Phone:_____
E-mail:_____

Referred by: _____

SECTION B: Presenting Problem Analysis

1. **Briefly describe the problem or concern you most wish help with currently**:

   _____
   _____
   _____
   _____

2. **How would you rate the intensity of the problem or concern that led you to seek professional services?**
   (please circle)

Extremely Intense		Moderately Intense		Not Intense
5	4	3	2	1

3. **Approximately how long have you had the current problem or concern?**
   _____

4. **In what ways have you attempted to cope with this problem or concern?**
   _____
   _____
   _____

5. **How would you rate the effectiveness of these coping strategies?** (please circle)

Extremely Effective		Moderately Effective		Not Effective
5	4	3	2	1

SECTION C: Cultural Background

1. **What is your race/ethnicity?**

   ❒ White (non-Hispanic/Latino)
   ❒ Hispanic/Latino
   ❒ Black/African American
   ❒ Asian American
   ❒ American Indian/Alaska Native
   ❒ Native Hawaiian/Pacific Islander
   ❒ Multiracial (please specify):
   _____
   ❒ International (please specify):
   _____

2. **How much do you identify with your ethnic heritage**?
   ❒ not at all ❒ a little ❒ somewhat ❒ moderately ❒ strongly

3. **Religious or spiritual preference**:_____

4. **Are you currently active in your religion?** ❒ yes ❒ somewhat ❒ no

5. **Do you attend church?** ❒ yes ❒ no

   If yes, what church do you attend? _____

6. **Were you adopted?** ❒ yes ❒ no
   If yes, do you have a relationship with your biological parent(s)?
   ❒ yes ❒ no

7. **Does your family speak a language other than English at home?** ❒ yes ❒ no

   If yes, what language is spoken? _____

8. **Were you and both your biological parents born in the U.S.?** ❒ yes ❒ no

   If no, who was foreign-born, from what country, and what was the approximate age of immigration to the U.S.?
   _____
   _____

SECTION D: Family Background

1. **Please list the members of your current family**.

a. ***Father*** ***Age:***	***Occupation:***	***Education****:*
b. ***Mother*** ***Age:***	***Occupation:***	***Education****:*
c. ***Sibling one*** ***Age:***	***Occupation:***	***Gender****:* ❒male ❒female
d. ***Sibling two*** ***Age:***	***Occupation:***	***Gender****:* ❒male ❒female
e. ***Sibling three*** ***Age:***	***Occupation:***	***Gender****:* ❒male ❒female
f. ***Sibling four*** ***Age:***	***Occupation:***	***Gender****:* ❒male ❒female

2. **Is your father deceased?** ❒ yes ❒ no Year? _____

3. **Is your mother deceased?** ❒ yes ❒ no Year? _____

4. **What is/was your parents' marital status?**
   ❒ married ❒ divorced
   ❒ separated ❒ father remarried
   ❒ mother remarried

5. **Please list your step-family members**. (please circle "step" or "half")

a. ***Step-father*** ***Age:***	***Occupation:***	***Education****:*
b. ***Step-mother*** ***Age:***	***Occupation:***	***Education****:*
c. ***Step/half sibling one*** ***Age:***	***Occupation:***	***Gender****:* ❒male ❒female
d. ***Step/half sibling two*** ***Age:***	***Occupation:***	***Gender****:* ❒male ❒female
e. ***Step/half sibling three*** ***Age:***	***Occupation:***	***Gender****:* ❒male ❒female
f. ***Step/half sibling four*** ***Age:***	***Occupation:***	***Gender****:* ❒male ❒female

6. **What is your relationship status?**
   ❒ single ❒ divorced ❒ separated
   ❒ widowed ❒ married/committed relationship ❒ remarried

7. **What is your spouse's/partner's**: **Age?** _____
   Occupation? _____
   Education? _____
   Deceased? ❒ yes ❒ no **Year?** _____

8. **Please list any children of yours**.

a. ***Child one*** ***Age:***	***Adopted?*** ❒yes ❒no	***Gender****:* ❒male ❒female
b. ***Child two*** ***Age:***	***Adopted?*** ❒yes ❒no	***Gender****:* ❒male ❒female
c. ***Child three*** ***Age:***	***Adopted?*** ❒yes ❒no	***Gender****:* ❒male ❒female
d. ***Child four*** ***Age:***	***Adopted?*** ❒yes ❒no	***Gender****:* ❒male ❒female
e. ***Child five*** ***Age:***	***Adopted?*** ❒yes ❒no	***Gender****:* ❒male ❒female

9. **Please list any step-children of yours**.

a. ***Step-child one*** ***Age:***	***Gender****:* ❒male ❒female
b. ***Step-child two*** ***Age:***	***Gender****:* ❒male ❒female
c. ***Step-childthree*** ***Age:***	***Gender****:* ❒male ❒female
d. ***Step-child four*** ***Age:***	***Gender****:* ❒male ❒female
e. ***Step-child five*** ***Age:***	***Gender****:* ❒male ❒female

10. **Please check any past, present, or impending problems/issues in your family**:

❒ deaths
❒ divorce
❒ frequent relocations
❒ debilitating injuries/disabilities
❒ alcohol/drug abuse
❒ eating disorders
❒ Depression/BiPolar Disorder
❒ Anxiety/Panic Disorder
❒ other _____

❒ physical/sexual abuse
❒ financial crisis/unemployment
❒ legal problems
❒ attempted/completed suicide

❒ serious/chronic illness

❒ marital affairs/infidelity

Please specify family member(s), which problem/issue, and approximate year of occurrence.

_____
_____
_____

11. **In general, how happy or adjusted were you growing up?**

❒ poor ❒ unsatisfactory ❒ average
❒ substantial ❒ completely

12. **How much is your family a source of emotional support for you?**

❒ none ❒ little ❒ somewhat ❒ substantial ❒ always

13. **How much conflict do you currently experience with your parents?**

❒ none ❒ little ❒ sometimes ❒ substantial ❒ always

14. **Who in your family do you currently feel closest to?** _____

Most distant from? _____
In most conflict with? _____

SECTION E: Education Information and Work History

1. **Please indicate your educational level**.

❒ less than high school ❒ H.S. equivalent/GED
❒ high school diploma ❒ vocational
❒ some college (no degree completed)
❒ bachelor's degree ❒ master's degree
❒ doctoral degree ❒ other_____

2. **What was your major/minor/area of concentration?**
_____

3. **Did you experience any learning problems in school?**

❒ none ❒ little ❒ some
❒ substantial ❒ always/constant struggle

4. **How satisfied are you with your academic progress so far?** (please circle)

very satisfied satisfied very dissatisfied
5 4 3 2 1

5. **What barriers, if any, are impeding your academic progress?**
_____

6. **What is your current job and/or occupation?**
_____

7. **Where are you employed?**
_____

8. **How satisfied are you with your current job and or occupation?** (please circle)

very satisfied satisfied very dissatisfied

5 4 3 2 1

9. **Please list four most recent employers and dates of employment.**

a. ***Employer one:***	***Dates of employment:***
b. ***Employer two:***	***Dates of employment:***
c. ***Employer three:***	***Dates of employment:***
d. ***Employer four:***	***Dates of employment:***

10. **Have you ever been fired from a job?** ❒ yes ❒ no

    If yes, for what reason?

    _____

    _____

11. **Have you ever walked off of a job?** ❒ yes ❒ no

    If yes, for what reason?

    _____

12. **Were you ever in the military?**❒ yes ❒ no
    When/how long? _____

    For what reason were you discharged?

    _____

SECTION F: Health and Social Issues

1. **How is your physical health at present?**
   ❒ poor ❒ fair ❒ satisfactory ❒ good ❒ excellent

2. **Please list any persistent physical symptoms or health concerns** (e.g., chronic pain, headaches, diabetes, etc.)

   _____

   _____

   _____

   _____

3. **Please list any prescribed medications you are presently taking**.

Name of Medication	How long you have been on the medication	Dosage and How often you take the medication	Doctor or Specialist that prescribed the medication	Comments

4. **Please list any over-the-counter medications; this also includes herbals, vitamin/dietary/mineral supplements.**

Name of medication	Dosage and how often you take the medication

5. **Who is your Primary Care Physician?**
   Name: _____
   Address:_____ Phone Number:_____
   Other Physicians you see?
   Name:_____
   Address:_____ Phone Number:_____
   Name:_____
   Address:_____ Phone Number:_____

6. **Are you having any problems with your sleep habits?**
   ❒ yes ❒ no **For how long?** _____

   If yes, check where applicable:
   ❒ sleeping too little ❒ sleeping too much
   ❒ poor quality sleep ❒ disturbing dreams
   ❒ other _____

7. **Are you having any problems with your memory?** ❒ yes ❒ no
   For how long? _____

8. **How many times per week do you exercise?** _____
   For how long? _____

9. **Are you having any difficulty with appetite or eating habits**? ❒ yes ❒ no

   If yes, check where applicable:
   ❒ eating less ❒ eating more ❒ binge eating
   ❒ restricting calories ❒ weight change (in past two months)

10. **Do you smoke cigarettes?** ❒ yes ❒ no
    For how long? _____

    In a typical day, how many cigarettes do you smoke?
    _____

11. **Do you regularly use alcohol?** ❒ yes ❒ no

    In a typical month, how often do you have 4 or more drinks in a 24 hr. period?
    _____

12. **Have you ever tried to cut down on the amount of alcohol you consume?**
    ❒ yes ❒ no
    When? _____

13. **Has anyone close to you ever been annoyed by your drinking?**
    ❒ yes ❒ no

14. **Do you consider your alcohol consumption to be a problem?**
    ❒ yes ❒ no ❒ unsure

15. **How often do you engage in recreational drug use?**
    ❒ daily ❒ weekly ❒ monthly ❒ rarely ❒ never

16. **Do you consider this drug use to be a problem?**
    ❒ yes ❒ no ❒ unsure

17. **Have you ever experienced legal problems?**
    ❒ yes ❒ no
    Nature of problem: _____
    _____
    _____

18. **In the past, how would you rate the quality of your peer relationships?**

    ❒ very poor ❒ unsatisfactory ❒ average ❒ good ❒ excellent

19. **Approximately how many significant intimate relationships, lasting six months or more, have you had? _____**

    Are you currently in one? ❒ yes ❒ no ❒ unsure

20. **Do you have any problems or worries about sexual functioning?** ❒ yes ❒ no

If yes, check where applicable:

❒ performance problem ❒ sexual impulsiveness
❒ lack of desire ❒ difficulty maintaining arousal
❒ worry about STD(s) ❒ other _____

21. **What is your sexual orientation?**
    ❒ heterosexual ❒ gay/lesbian ❒ bisexual ❒ unsure

22. **Besides family members, approximately how many people can you really count on currently for friendship or emotional support? _____**

23. **How do you spend your leisure time?**
    _____
    _____
    _____
    _____

SECTION G: Mental Health History

1. **Are you currently receiving psychiatric services, professional counseling, or therapy elsewhere?** ❒ yes ❒ no

   If yes, where? _____

2. **Have you ever had previous counseling or psychotherapy?** ❒ yes ❒ no

If yes, please specify the following:
Reason for counseling:_____

Counseling location: _____

Counseling date/duration: _____

3. **Have you ever been hospitalized for psychiatric reasons ?** ❒ yes ❒ no

   If yes, please specify the following:
   Reason for hospitalization: _____

   Hospital location: _____

   Dates/Duration of hospitalization: _____

4. **Have you ever been prescribed medication for psychiatric reasons?** ❒ yes ❒ no

   If yes, please specify the following:
   Name/dose of medication: _____

   Date/Duration of prescription: _____

   Physician who prescribed medication: _____

5. **Have you had suicidal thoughts recently?** ❒ yes ❒ no **How often?** ❒ daily ❒ weekly ❒ monthly ❒ rarely

   Have you had them in the past? ❒ yes ❒ no

   How often? ❒ daily ❒ weekly ❒ monthly ❒ rarely

6. **Have you ever intentionally inflicted harm upon yourself?** ❒ yes ❒ no

   How often? ❒ daily ❒ weekly ❒ monthly ❒ rarely

   Nature of harm: _____

7. **Have you ever intentionally hurt someone else?** ❒ yes ❒ no

   Nature of harm: _____

8. **Have you personally experienced significant abuse?**

   ❒ none ❒ unsure ❒ emotional ❒ physical ❒ sexual

9. **Have you ever experienced any form of traumatic experience?** ❒ yes ❒ no
   When? _____

   Nature of experience:
   _____

10. **Have you ever experienced sexual assault, unwanted sex, or uncomfortable touching?**

    ❒ frequently ❒ a few times ❒ once ❒ never ❒ unsure

11. **How does the future look to you?**
    ❒ poor ❒ fair ❒ neutral ❒ good ❒ excellent

12. **Please describe your future plans**.
    _____
    _____

13. **What do you hope to accomplish through counseling?**
    _____
    _____
    _____

14. **Is there anything else you would like your counselor to know about you?**
    _____
    _____
    _____
    _____
    _____
    _____

Thank you for your time and effort!

This document has been reviewed by:

Provider name(print): _____

Provider Signature:_____ Date_____

Still Waters
PROFESSIONAL COUNSELING, LLC

Each member of the couple is expected to fill out this form individually.

Name: _____ Date of Birth: _____

Partner's Name: _____ Date of Birth: _____

We are:

☐Dating
☐Engaged/Considering Marriage
☐Unmarried Living Together
☐Married Living Together
☐Considering Divorce
☐In The Process of Divorcing
☐Already Legally Divorced
☐Other_____

How long have you been in your current relationship? _____

Do you have children? ☐Yes ☐No
If so, are the children with a previous or current partner? _____
Please list names/ages and specify parents of each child:

Name	Age	Parents

Children live primarily with:

☐both, parents living together
☐both, parents living separately
☐me, separate from other parent
☐other parent, separate from me
☐other:_____

Reasons for Services/Relationship issues (Check all that apply):

☐Improve Communication
☐Trust Issues
☐Compatibility Issues
☐Frequent Arguing
☐Cheating/Affair(s)
☐Physical Aggression
☐Sexual Issues
☐Financial Issues
☐Dishonesty
☐Inability to Compromise
☐Parenting Issues
☐Other:_____

Does your partner, or anyone at home, hurt, hit or threaten you? ☐Yes ☐No

Have either of you threatened to separate/divorce/break-up as a result of the current problems in the relationship?

☐No, neither of us ☐Yes, I have ☐Yes, my partner has ☐Yes, both of us

If married, have either you or your partner consulted with an attorney about divorce?

☐Not married ☐No, neither of us ☐Yes, I have ☐Yes, my partner has ☐Yes, both of us

Do you perceive that either you or your partner has withdrawn from the relationship?

☐No, neither of us ☐Yes, I have ☐Yes, my partner has ☐Yes, both of us

Are you or your partner currently having an affair?

☐No, neither of us ☐Yes, I am ☐Yes, my partner is ☐Yes, both of us ☐Other_____

How many times have you had sexual relations with your partner in the past 30 days? _____

Are there any current or past concerns with addictions (alcohol, drugs, medications, food, sex, gambling, gaming or other)? ☐Yes ☐No

If yes, please explain:

_____

_____

Have there been any issues concerning infertility, abortion, or miscarriages? ☐Yes ☐No

If yes, please explain:

_____

_____

Have either your or your partner been in individual counseling before? ☐ Yes ☐No

If so, give a brief summary of concerns you addressed:

_____

_____

Briefly describe your reason for seeking couples counseling at this time:

_____

_____

What do you hope to accomplish through counseling?

_____

_____

Limits of Confidentiality with Couples

I understand that throughout the course of our work as a couple, both my partner and I are considered to be the "treatment unit." Our therapist may see a smaller part of the "treatment unit" (e.g., an individual) for one or more sessions. These sessions should be seen as part of the work the therapist is doing with the couple, unless otherwise indicated.

I am aware that Still Waters will keep one confidential record that will document all of our work as a couple (dates of sessions, progress notes, etc.). The contents of this medical record may not be released to any person without the written consent of **both** parties, except as required or permitted by law.

I understand that for administrative purposes these sessions will be billed under only one client name, per standard billing practices. However, billing codes and/or diagnosis may indicate "family" therapy.

By signing below, I acknowledge that I have read and understand the aforementioned policy, and chose to participate in couples therapy in agreement with this policy.

_____ _____

Printed name Date

_____

Signature

This section for office use.

Reviewed by:_____ Date:_____

Still Waters
PROFESSIONAL COUNSELING, LLC

Acknowledgment of Receipt of Privacy Practices *to Protect your Health Information*
The Still Waters Professional Counseling "Notice of Privacy Practices to Protect your Health Information" provides information about how we may use and disclose protected health information about you. Our Notice of Privacy Practices is subject to change.

I acknowledge that I have received the Notice of Privacy Practices.

_____ _____
Signature of Client or Client's Representative Date

_____
Name Printed

Consent to Receive Psychological Services

The Still Waters Professional Counseling "Psychological Services Agreement" provides information about its professional services and business policies.

I acknowledge that I have received the Psychological Services Agreement, am consenting to receive mental health services at Still Waters, and agree to the financial policies as stated. I understand that the services my therapist provides fall within the scope of the provider's license, certification, and training.

_____ _____
Signature of Client or Client's Representative Date

_____
Name Printed

Consent for Insurance Payment

I authorize the use of this signature on all insurance submissions under HIPAA guidelines. I also authorize release of any and all *pertinent* information needed about me, in order to determine benefits payable for related services, to insurance carriers, the healthcare financing administration & their agents. I request the payment of authorized Medicare benefits and/or other insurance benefits be made on my behalf to Still Waters Professional Counseling, LLC for services provided to me. I understand that my therapist reserves the right to charge me for missed visits as outlined in the Professional Services Agreement. I also understand that there will be an additional $25 fee for any check issued to Still Waters Professional Counseling, LLC returned with non-sufficient funds.

_____ _____
Signature of Client or Client's Representative Date

_____
Name Printed

LIFE FUNCTIONING INVENTORY

This form is intended to help your counselor become better acquainted with you and, in turn, serve you better. Please print the information requested or checkmark the appropriate responses. You may omit any item, but try to be as thorough as possible. Thank you.

SECTION A: Basic Client Information

Full Name:_____
Address:_____
City/State/Zip:_____ H**ome**
Phone:_____

Work Phone:_____ **Cell Phone**:_____

Fax:_____

E-mail:_____

Do you have any objections to being contacted by telephone, mail, e-mail, etc…
❒ yes ❒ no

How would you like to be contacted? _____

SS#:_____

Date of Birth:_____

Age:_____ **Gender**: ❒male ❒female

Emergency Contact Name:_____

Relationship:_____
Address:_____
City/State/Zip:_____
Home Phone:_____
E-mail:_____

Referred by: _____

SECTION B: Presenting Problem Analysis

5. **Briefly describe the problem or concern you most wish help with currently**:

_____
_____
_____
_____

6. **How would you rate the intensity of the problem or concern that led you to seek professional services?**
(please circle)

Extremely Intense		Moderately Intense		Not Intense
5	4	3	2	1

7. **Approximately how long have you had the current problem or concern?**
_____

8. **In what ways have you attempted to cope with this problem or concern?**
_____
_____
_____

5. **How would you rate the effectiveness of these coping strategies?** (please circle)

Extremely Effective		Moderately Effective		Not Effective
5	4	3	2	1

SECTION C: Cultural Background

9. **What is your race/ethnicity?**

❒ White (non-Hispanic/Latino)
❒ Hispanic/Latino
❒ Black/African American
❒ Asian American
❒ American Indian/Alaska Native
❒ Native Hawaiian/Pacific Islander
❒ Multiracial (please specify):
_____
❒ International (please specify):
_____

10. **How much do you identify with your ethnic heritage**?
❒ not at all ❒ a little ❒ somewhat ❒ moderately ❒ strongly

11. **Religious or spiritual preference**:_____

12. **Are you currently active in your religion?** ❒ yes ❒ somewhat ❒ no

13. **Do you attend church?** ❒ yes ❒ no

    If yes, what church do you attend? _____

14. **Were you adopted?** ❒ yes ❒ no
    If yes, do you have a relationship with your biological parent(s)?
    ❒ yes ❒ no

15. **Does your family speak a language other than English at home?** ❒ yes ❒ no

    If yes, what language is spoken? _____

16. **Were you and both your biological parents born in the U.S.?** ❒ yes ❒ no

    If no, who was foreign-born, from what country, and what was the approximate age of immigration to the U.S.?

    _____

    _____

SECTION D: Family Background

15. **Please list the members of your current family**.

a. ***Father*** ***Age:***	***Occupation:***	***Education****:*
b. ***Mother*** ***Age:***	***Occupation:***	***Education****:*
c. ***Sibling one*** ***Age:***	***Occupation:***	***Gender****:* ❒male ❒female
d. ***Sibling two*** ***Age:***	***Occupation:***	***Gender****:* ❒male ❒female
e. ***Sibling three*** ***Age:***	***Occupation:***	***Gender****:* ❒male ❒female
f. ***Sibling four*** ***Age:***	***Occupation:***	***Gender****:* ❒male ❒female

16. **Is your father deceased?** ❒ yes ❒ no Year? _____

17. **Is your mother deceased?** ❒ yes ❒ no Year? _____

18. **What is/was your parents' marital status?**

❒ married ❒ divorced
❒ separated ❒ father remarried
❒ mother remarried

19. **Please list your step-family members**. (please circle "step" or "half")

a. ***Step-father*** ***Age:***	***Occupation:***	***Education****:*
b. ***Step-mother*** ***Age:***	***Occupation:***	***Education****:*
c. ***Step/half sibling one*** ***Age:***	***Occupation:***	***Gender****:* ❒male ❒female
d. ***Step/half sibling two*** ***Age:***	***Occupation:***	***Gender****:* ❒male ❒female
e. ***Step/half sibling three*** ***Age:***	***Occupation:***	***Gender****:* ❒male ❒female
f. ***Step/half sibling four*** ***Age:***	***Occupation:***	***Gender****:* ❒male ❒female

20. **What is your relationship status?**

❒ single ❒ divorced ❒ separated
❒ widowed ❒ married/committed relationship ❒ remarried

21. **What is your spouse's/partner's**: **Age?** _____
Occupation? _____
Education? _____
Deceased? ❒ yes ❒ no **Year?** _____

22. **Please list any children of yours**.

a. ***Child one*** ***Age:***	***Adopted?*** ❒yes ❒no	***Gender****:* ❒male ❒female
b. ***Child two*** ***Age:***	***Adopted?*** ❒yes ❒no	***Gender****:* ❒male ❒female
c. ***Child three*** ***Age:***	***Adopted?*** ❒yes ❒no	***Gender****:* ❒male ❒female
d. ***Child four*** ***Age:***	***Adopted?*** ❒yes ❒no	***Gender****:* ❒male ❒female
e. ***Child five*** ***Age:***	***Adopted?*** ❒yes ❒no	***Gender****:* ❒male ❒female

23. **Please list any step-children of yours**.

a. ***Step-child one*** ***Age:***	***Gender****:* ❒male ❒female
b. ***Step-child two*** ***Age:***	***Gender****:* ❒male ❒female
c. ***Step-childthree*** ***Age:***	***Gender****:* ❒male ❒female
d. ***Step-child four*** ***Age:***	***Gender****:* ❒male ❒female
e. ***Step-child five*** ***Age:***	***Gender****:* ❒male ❒female

24. **Please check any past, present, or impending problems/issues in your family**:

❒ deaths
❒ divorce
❒ frequent relocations
❒ debilitating injuries/disabilities
❒ alcohol/drug abuse
❒ eating disorders
❒ Depression/BiPolar Disorder
❒ Anxiety/Panic Disorder
❒ other _____

❒ physical/sexual abuse
❒ financial crisis/unemployment
❒ legal problems
❒ attempted/completed suicide

❒ serious/chronic illness

❒ marital affairs/infidelity

Please specify family member(s), which problem/issue, and approximate year of occurrence.

_____
_____
_____

25. **In general, how happy or adjusted were you growing up?**

❒ poor ❒ unsatisfactory ❒ average
❒ substantial ❒ completely

26. **How much is your family a source of emotional support for you?**

❒ none ❒ little ❒ somewhat ❒ substantial ❒ always

27. **How much conflict do you currently experience with your parents?**

❒ none ❒ little ❒ sometimes ❒ substantial ❒ always

28. **Who in your family do you currently feel closest to?** _____

Most distant from? _____
In most conflict with? _____

SECTION E: Education Information and Work History

13. **Please indicate your educational level**.

❒ less than high school ❒ H.S. equivalent/GED
❒ high school diploma ❒ vocational
❒ some college (no degree completed)
❒ bachelor's degree ❒ master's degree
❒ doctoral degree ❒ other_____

14. **What was your major/minor/area of concentration?**
_____

15. **Did you experience any learning problems in school?**

❒ none ❒ little ❒ some
❒ substantial ❒ always/constant struggle

16. **How satisfied are you with your academic progress so far?** (please circle)

very satisfied satisfied very dissatisfied
5 4 3 2 1

17. **What barriers, if any, are impeding your academic progress?**
_____

18. **What is your current job and/or occupation?**
_____

19. **Where are you employed?**
_____

20. **How satisfied are you with your current job and or occupation?** (please circle)

very satisfied satisfied very dissatisfied

5 4 3 2 1

21. **Please list four most recent employers and dates of employment.**

a. ***Employer one:***	***Dates of employment:***
b. ***Employer two:***	***Dates of employment:***
c. ***Employer three:***	***Dates of employment:***
d. ***Employer four:***	***Dates of employment:***

22. **Have you ever been fired from a job?** ❒ yes ❒ no

    If yes, for what reason?

    _____

    _____

23. **Have you ever walked off of a job?** ❒ yes ❒ no

    If yes, for what reason?

    _____

24. **Were you ever in the military?**❒ yes ❒ no
    When/how long? _____

    For what reason were you discharged?

    _____

SECTION F: Health and Social Issues

24. **How is your physical health at present?**
    ❒ poor ❒ fair ❒ satisfactory ❒ good ❒ excellent

25. **Please list any persistent physical symptoms or health concerns** (e.g., chronic pain, headaches, diabetes, etc.)

    _____

    _____

    _____

    _____

26. **Please list any prescribed medications you are presently taking**.

Name of Medication	How long you have been on the medication	Dosage and How often you take the medication	Doctor or Specialist that prescribed the medication	Comments

27. **Please list any over-the-counter medications; this also includes herbals, vitamin/dietary/mineral supplements.**

Name of medication	Dosage and how often you take the medication

28. **Who is your Primary Care Physician?**
Name: _____
Address:_____ Phone Number:_____
Other Physicians you see?
Name:_____
Address:_____ Phone Number:_____
Name:_____
Address:_____ Phone Number:_____

29. **Are you having any problems with your sleep habits?**
❒ yes ❒ no **For how long?** _____

If yes, check where applicable:
❒ sleeping too little ❒ sleeping too much
❒ poor quality sleep ❒ disturbing dreams
❒ other _____

30. **Are you having any problems with your memory?** ❒ yes ❒ no
For how long? _____

31. **How many times per week do you exercise?** _____
For how long? _____

32. **Are you having any difficulty with appetite or eating habits**? ❒ yes ❒ no

If yes, check where applicable:
❒ eating less ❒ eating more ❒ binge eating
❒ restricting calories ❒ weight change (in past two months)

33. **Do you smoke cigarettes?** ❒ yes ❒ no
For how long? _____

In a typical day, how many cigarettes do you smoke?
_____

34. **Do you regularly use alcohol?** ❒ yes ❒ no

In a typical month, how often do you have 4 or more drinks in a 24 hr. period?
_____

35. **Have you ever tried to cut down on the amount of alcohol you consume?**
❒ yes ❒ no
When? _____

36. **Has anyone close to you ever been annoyed by your drinking?**
❒ yes ❒ no

37. **Do you consider your alcohol consumption to be a problem?**
❒ yes ❒ no ❒ unsure

38. **How often do you engage in recreational drug use?**
❒ daily ❒ weekly ❒ monthly ❒ rarely ❒ never

39. **Do you consider this drug use to be a problem?**
❒ yes ❒ no ❒ unsure

40. **Have you ever experienced legal problems?**
❒ yes ❒ no
Nature of problem: _____
_____
_____

41. **In the past, how would you rate the quality of your peer relationships?**

❒ very poor ❒ unsatisfactory ❒ average ❒ good ❒ excellent

42. **Approximately how many significant intimate relationships, lasting six months or more, have you had? _____**

Are you currently in one? ❒ yes ❒ no ❒ unsure

43. **Do you have any problems or worries about sexual functioning?** ❒ yes ❒ no

If yes, check where applicable:

❒ performance problem ❒ sexual impulsiveness
❒ lack of desire ❒ difficulty maintaining arousal
❒ worry about STD(s) ❒ other _____

44. **What is your sexual orientation?**
❒ heterosexual ❒ gay/lesbian ❒ bisexual ❒ unsure

45. **Besides family members, approximately how many people can you really count on currently for friendship or emotional support? _____**

46. **How do you spend your leisure time?**
_____
_____
_____
_____

SECTION G: Mental Health History

15. **Are you currently receiving psychiatric services, professional counseling, or therapy elsewhere?** ❒ yes ❒ no

If yes, where? _____

16. **Have you ever had previous counseling or psychotherapy?** ❒ yes ❒ no

If yes, please specify the following:
Reason for counseling:_____

Counseling location: _____

Counseling date/duration: _____

17. **Have you ever been hospitalized for psychiatric reasons ?** ❒ yes ❒ no

If yes, please specify the following:
Reason for hospitalization: _____

Hospital location: _____

Dates/Duration of hospitalization: _____

18. **Have you ever been prescribed medication for psychiatric reasons?** ❒ yes ❒ no

If yes, please specify the following:
Name/dose of medication: _____

Date/Duration of prescription: _____

Physician who prescribed medication: _____

19. **Have you had suicidal thoughts recently?** ❒ yes ❒ no **How often?** ❒ daily ❒ weekly ❒ monthly ❒ rarely

Have you had them in the past? ❒ yes ❒ no

How often? ❒ daily ❒ weekly ❒ monthly ❒ rarely

20. **Have you ever intentionally inflicted harm upon yourself?** ❒ yes ❒ no

How often? ❒ daily ❒ weekly ❒ monthly ❒ rarely

Nature of harm: _____
21. **Have you ever intentionally hurt someone else?** ❒ yes ❒ no

Nature of harm: _____

22. **Have you personally experienced significant abuse?**

❒ none ❒ unsure ❒ emotional ❒ physical ❒ sexual

23. **Have you ever experienced any form of traumatic experience?** ❒ yes ❒ no
When? _____

Nature of experience:
_____

24. **Have you ever experienced sexual assault, unwanted sex, or uncomfortable touching?**

❒ frequently ❒ a few times ❒ once ❒ never ❒ unsure

25. **How does the future look to you?**
❒ poor ❒ fair ❒ neutral ❒ good ❒ excellent

26. **Please describe your future plans**.
_____
_____

27. **What do you hope to accomplish through counseling?**
_____
_____
_____

28. **Is there anything else you would like your counselor to know about you?**
_____
_____
_____
_____
_____
_____

Thank you for your time and effort!

This document has been reviewed by:

Provider name(print): _____

Provider Signature:_____ Date_____

Still Waters
PROFESSIONAL COUNSELING, LLC

Each member of the couple is expected to fill out this form individually.

Name: _____ Date of Birth: _____

Partner's Name: _____ Date of Birth: _____

We are:

☐Dating
☐Engaged/Considering Marriage
☐Unmarried Living Together
☐Married Living Together
☐Considering Divorce
☐In The Process of Divorcing
☐Already Legally Divorced
☐Other_____

How long have you been in your current relationship? _____

Do you have children? ☐Yes ☐No
If so, are the children with a previous or current partner? _____
Please list names/ages and specify parents of each child:

Name	Age	Parents

Children live primarily with:

☐both, parents living together
☐both, parents living separately
☐me, separate from other parent
☐other parent, separate from me
☐other:_____

Reasons for Services/Relationship issues (Check all that apply):

☐Improve Communication
☐Trust Issues
☐Compatibility Issues
☐Frequent Arguing
☐Cheating/Affair(s)
☐Physical Aggression
☐Sexual Issues
☐Financial Issues
☐Dishonesty
☐Inability to Compromise
☐Parenting Issues
☐Other:_____

Does your partner, or anyone at home, hurt, hit or threaten you? ☐Yes ☐No

Have either of you threatened to separate/divorce/break-up as a result of the current problems in the relationship?

☐No, neither of us ☐Yes, I have ☐Yes, my partner has ☐Yes, both of us

If married, have either you or your partner consulted with an attorney about divorce?

☐Not married ☐No, neither of us ☐Yes, I have ☐Yes, my partner has ☐Yes, both of us

Do you perceive that either you or your partner has withdrawn from the relationship?

☐No, neither of us ☐Yes, I have ☐Yes, my partner has ☐Yes, both of us

Are you or your partner currently having an affair?

☐No, neither of us ☐Yes, I am ☐Yes, my partner is ☐Yes, both of us ☐Other_____

How many times have you had sexual relations with your partner in the past 30 days? _____

Are there any current or past concerns with addictions (alcohol, drugs, medications, food, sex, gambling, gaming or other)? ☐Yes ☐No

If yes, please explain:

_____

_____

Have there been any issues concerning infertility, abortion, or miscarriages? ☐Yes ☐No

If yes, please explain:

_____

_____

Have either your or your partner been in individual counseling before? ☐ Yes ☐No

If so, give a brief summary of concerns you addressed:

_____

_____

Briefly describe your reason for seeking couples counseling at this time:

_____

_____

What do you hope to accomplish through counseling?

_____

_____

Limits of Confidentiality with Couples

I understand that throughout the course of our work as a couple, both my partner and I are considered to be the "treatment unit." Our therapist may see a smaller part of the "treatment unit" (e.g., an individual) for one or more sessions. These sessions should be seen as part of the work the therapist is doing with the couple, unless otherwise indicated.

I am aware that Still Waters will keep one confidential record that will document all of our work as a couple (dates of sessions, progress notes, etc.). The contents of this medical record may not be released to any person without the written consent of **both** parties, except as required or permitted by law.

I understand that for administrative purposes these sessions will be billed under only one client name, per standard billing practices. However, billing codes and/or diagnosis may indicate "family" therapy.

By signing below, I acknowledge that I have read and understand the aforementioned policy, and chose to participate in couples therapy in agreement with this policy.

_____ _____

Printed name Date

_____

Signature

This section for office use.

Reviewed by:_____ Date:_____