Patricia E. (Pat) Gossett, M.A., LPC
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Please read this document carefully as it contains important information that affects you and our professional relationship.

COUNSELING AGREEMENT & INFORMED CONSENT

Thank you for choosing me, Pat Gossett, M.A., LPC, for your counseling needs. These documents are designed to ensure that you understand our professional relationship, provide me with your consent for counseling, & collect pertinent information that will assist me in the counseling process.

CONFIDENTIALITY

All communication between you and your counselor will be held in confidence in accordance with the law and professional standards and will not, except under the circumstances explained below, be disclosed to anyone without your written authorization. ***Recording of counseling sessions is prohibited by Client, any Collateral Participant, or Pat Gossett, M.A., LPC.*** Exceptions include, but may not be limited to, the following:

- imminent harm to self or others, including information regarding any sexually transmitted diseases
- suspicion of abuse or neglect of the elderly or disabled
- suspicion of abuse (sexual or otherwise) or neglect of children
- compliance with a court order to do so
- child custody case suits in which the mental health of a party is an issue
- fee disputes between the therapist and the client
- a negligence suit brought by client against therapist or filing of a complaint w/ the licensing board
- processing third party payer forms, obtaining payment for third party payers, answering required questions from third party payers in order for client benefits to continue ***(Please be aware, if you are filing with your insurance carrier, your carrier has the right to request from me a copy of your session notes at any time without your knowledge to conduct an internal audit. I cannot be held responsible for the confidentiality of records released in this way.)***

Please note that exceptions to confidentiality are extremely rare; however, if they should occur, it is my policy whenever possible, to discuss with you any action being considered. Legally I am not obligated to seek your permission, especially if I need to secure your safety or the safety of others. If disclosure of confidential information does become necessary, I will release only the information necessary to protect you or someone else.

Texas law requires Licensed Professional Counselors to notify medical or law enforcement personnel in the event of imminent harm to self or others. You may designate an individual that I may call in an emergency; however, please note that notification is not limited to that person and may involve medical or law enforcement personnel as deemed appropriate.

Please initial here that you have read and understand the above "Confidentiality" section_____

RECORD-KEEPING

If I terminate practicing as a counselor, it will become necessary for another counselor to take possession of my files & records. By signing this Agreement you are giving me your consent to allow another licensed mental health professional selected by me to take possession of all your records.

FEES / LENGTH OF SESSION

My fee per session is $100.00, payable by cash, credit card (Master Card, Visa or Discover only) or check, and is collected at the beginning of each session. Sessions typically last for 55-60 minutes. Your promptness will allow you to take full advantage of your appointments. I accept certain insurance company assignments. If I am a provider with your insurance carrier, I will file a claim for some amount of reimbursement through your carrier. You are responsible for payment of your portion at the time services are rendered. If your carrier requires that you meet a certain annual deductible dollar amount and you have not met that amount, you will be charged at the provider reimbursement rate of your insurance carrier per session. If I am not a provider for your insurance carrier and you wish to file a reimbursement claim, upon your request I will provide you with a receipt for all fees paid in order that you may do so. ***Be aware, I file insurance for clients as a courtesy. You are responsible for any and all charges for each counseling session appointment, regardless of insurance coverage.***

Be advised that insurance companies require that a diagnosis be given regarding your mental health before they will agree to reimburse a medical professional for services rendered. Any diagnosis made will become a part of your permanent medical records. Upon your request, I will inform you of the diagnosis that will be submitted concerning you to your insurance carrier.

You are responsible for keeping your appointments. When you set your appointment, that time is reserved just for you. If you are unable to attend your appointment I require a 24-hour cancellation/reschedule notice. This notice offers me the opportunity to give the appointment time to another client. **The cost for a cancellation of less than 24 hrs. or missed appointment is $100.00. Insurance cannot be billed for missed appointments and you are fully responsible for this charge.**

If I am subpoenaed by either a client or client's legal representative, the following fees apply: For any subpoena that requires me to make an in-person statement or be physically present for any legal proceeding:

1. Preparation time (including submission of records): $200 / hour
2. Phone calls: $200 / hour
3. Depositions: $500 / hour
4. Time required in giving testimony $500 / hour
5. Mileage: $ 0.54 / mile
6. Time away from the office due to depositions or testimony $250 / hour
7. All attorney fees & costs incurred by me as a result of the legal action.
8. Filing a document with the court: $100
9. The minimum charge for a court appearance $5000

A retainer of $2500.00 is to be paid at least 48 hours prior to the court date. If the costs for the testifying process exceed the amount of the retainer then those fees will be billed to the client and/or their legal representative.

For any subpoena of client records, files or the production of any other written statements:

1. Preparation time for treatment summaries or production of other new documentation: $100 / hour (my standard rate for clinical services per hour).
2. Printing costs: $25.00 for the first 20 pages & $.50 per page thereafter.

All legal fees are due upon receipt of the invoice.

Please initial here that you have read and understand the above "Fees / Length of Session" section _____

AFTER HOURS EMERGENCIES

If you experience an emergency requiring immediate action after hours, you are instructed to call 911 or go to your nearest medical emergency room for assistance. I do not return any client communications on Sunday. Crisis management calls to me will be brief and aimed at stabilizing the situation for processing at your next scheduled appointment.

Please initial here that you have read and understand this section_____

EMAILS / TEXT MESSAGES / TELEPHONE CALLS

Please limit text messaging and emails to matters having to do with scheduling of appointments or billing issues, and save all other matters for discussion during your scheduled session time (unless I have instructed you otherwise for special considerations).

Any phone calls lasting more than 10 minutes will be billed at $25.00 for the first 15 minutes, and in $25.00 increments for 16-29 minutes, 30-44 minutes, etc.

Any emails that are not related to appointments or billing issues will be billed at $25.00 per response from me.

Please initial here that you have read and understand this section_____

THE COUNSELING PROCESS AND PROFESSIONAL RELATIONSHIP

Because individuals and issues vary, length of treatment is hard to determine ahead of time. Some clients need only a few counseling sessions to achieve their goals while others may require much longer. Please note that it is impossible to guarantee any specific results regarding your counseling goals. There is a chance that you will feel worse before you feel better. During the process, you may increase your level of awareness, possibly causing initial pain and anxiety. You may experience changes that could result in disruptions and turmoil. We will discuss and work through whatever changes you make. Together we will work to achieve the best possible results for you. If counseling is successful, you should feel that you are able to face life's challenges in the future without my support or intervention.

You can expect that therapy will end when you have received the maximum benefits or obtained what you were seeking. You have the right to end the counseling relationship at any time.

I would hope, however, that you would discuss this decision with me first. If you or I feel you are no longer benefiting from our time together, we will end the relationship by mutual consent. You are best served while I am seeing you for counseling if our relationship stays strictly professional and if our sessions concentrate exclusively on your concerns. Our contact will be limited to sessions you will arrange with me. *Please do not invite me to social gatherings, offer me gifts, or ask me to relate to you in any way other than in the professional context of our counseling sessions.* If I should run into you outside the counseling office, I will not acknowledge you unless you first acknowledge me. This is in order to protect your privacy with regard to counseling. I assure you that my services will be rendered in a professional manner consistent with accepted ethical standards.

Please initial here that you have read and understand the above "The Counseling Process" section_____

COMPLAINT

If you have any complaints, please discuss them with me. If you are not satisfied with the resolution of the problem, you have the right to call the Complaints Management & Investigations (1-800-942-5540), or write to Texas State Bd. of Professional Counselors, P. O. Box 141369 , Austin, TX 78714.

Please initial here that you have read & understand above "After Hours ER" & "Complaint" sections_____

I, the Client, understand my rights and responsibilities as described in this document and request Pat Gossett, M.A.,LPC, to provide counseling services to me.

_____ _____
Client Signature Date

_____
Client Printed Name

_____ _____
Client Address Client Telephone Number (Primary)

_____ _____
City, State, Zip Code Additional Client Telephone Number

_____ _____
Patricia E. Gossett, M.A., LPC Date

Patricia E. (Pat) Gossett, M.A., LPC
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500 Turtle Cove, Suite 220
Rockwall, Texas 75087

CLIENT INFORMATION

Name_____ Employer_____
Male_____ Female_____ Position held_____
Home Address_____ Work Address_____
City_____ST_____Zip_____ City_____St_____Zip_____
Home Phone_____ Work Phone_____
Cell Phone_____ Employed: Full Time_____Part Time_____
Social Security No._____
Date of Birth_____Age_____ Email address_____

SPOUSE INFORMATION (If Applicable)

Name_____ Employer_____
Home Address_____ Work Address_____
City_____ST_____Zip_____ City_____St_____Zip_____
Home Phone_____ Work Phone_____
Cell Phone_____ Employed: Full Time_____Part Time_____
Email address_____ Date of Birth_____Age_____

EMERGENCY CONTACT INFORMATION

The information you provide below is your authorization for me to contact these individuals should I deem it an emergency situation and/or necessary for your safety, or the safety of others, during the course of your treatment with me. T<u>his authorization fulfills HIPPA requirements for consent to release information.</u>

Psychiatrist Name_____ City_____ Telephone ___._____

Primary Care Physician_____ City _____ Telephone _____

Other _____ Relationship to Client_____

Other name contact telephone number _____

_____ _____
Your Signature *Date*

Patricia E. (Pat) Gossett, M.A., LPC
500 Turtle Cove, Suite 220 Rockwall, TX 75087 214-909-0829

PATIENT CONSENT FOR USE AND / OR DISCLOSURE OF HIPAA DEFINED PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, _____, hereby stated that by singing this Consent, I
(Please print full legal name)
acknowledge and agree as follows:

The Provider's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice ("Information and Informed Consent") includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Provider to provide treatment to me, and also necessary for the Provider to obtain payment for that treatment and to carry out her health care operations. The Provider explained to me that the Privacy Notice will be available to me in the future at my request. The Provider has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

The Provider reserves the right to change her privacy practices that are described in her Privacy Notice, in accordance with applicable law.

I understand and consent to the following means of contact as deemed professionally necessary by Provider:

Yes_____ No_____	Telephoning my home and leaving a message on my answering machine or with the individual answering the telephone
Yes_____ No_____	Telephoning my office and leaving a message on my phone mail or with the individual answering the phone
Yes_____ No_____	Telephoning my cell phone and leaving a message on my voice mail or with the individual answering the phone
Yes_____No_____	Leaving a text message on my cell phone
Yes_____No_____	Leaving an email message at this address: _____

The Provider may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Provider to treat me and obtain payment for that treatment, and as necessary for the Provider to conduct its specific health care operations.

I understand that I have a right to request that the Provider restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Provider is not required to agree to any restrictions that I have requested. If the Provider agrees to a requested restriction, then the restriction is binding on the Provider.

I understand that this Consent is valid for seven years and that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Provider has already taken action in reliance on this consent.

I understand that if I revoke this consent at any time, the Provider has the right to refuse to treat me.

I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Provider will not treat me.

I have read and understand the foregoing notice. My questions have been answered to my full satisfaction.

_____	_____	_____
Printed Name of Patient	**Signature of Patient**	**Date Signed**

Symptom Checklist

Please check all that apply, then please CIRCLE items that are especially bothersome to you.

Please check any of the following which are / may have been particularly stressful to you:

Recent	Past	
_____	_____	Job related stress
_____	_____	Marital conflict
_____	_____	Death or loss of loved one; Relationship to this person_____
_____	_____	Conflict with children
_____	_____	Children with behavior problems
_____	_____	Conflict with parent(s) or extended family
_____	_____	Feeling stress due to recalling memories of trauma or stress in my life
_____	_____	Family member with an alcohol or drug problem
_____	_____	Being abused by someone
_____	_____	Financial pressure

Any of the following symptoms for (*all* of these) MOST OF THE DAY, NEARLY EVERY DAY, FOR PERIODS LONGER THAN SEVERAL DAYS AT A TIME:

Recent	Past	
_____	_____	Depressed or sad mood
_____	_____	Loss of interest or pleasure in things I'm normally interested in
_____	_____	Difficulty going to sleep
_____	_____	Difficulty staying asleep or waking up too early
		What are the average number of hours you are sleeping per night? _____
_____	_____	Sleeping too much
_____	_____	Increased appetite / weight gain (Number of lbs you have gained: _____)
_____	_____	Decreased appetite / weight loss (Number of lbs you have lost _____)
_____	_____	Fatigue / Poor energy level
_____	_____	Decreased activity (work / social / physical / sexual – circle those that apply)
_____	_____	Poor concentration or slowed thinking
_____	_____	Thoughts of suicide
_____	_____	Excessive feelings of guilt or worthlessness

Any of the following symptoms for (*all* of these) MORE DAYS THAN NOT, FOR MONTHS AT A TIME:

Recent	Past	
_____	_____	Excessive anxiety or worry for no good reason
_____	_____	Trembling, twitching or feeling "shaky"
_____	_____	Muscle tension or muscle aches
_____	_____	Easily fatigued
_____	_____	Dry mouth
_____	_____	Dizziness or lightheadedness
_____	_____	Nausea, diarrhea, or other stomach problems
_____	_____	Frequent urination
_____	_____	Irritability
_____	_____	Trouble falling or staying asleep

Panic attacks (any period of extreme, increased anxiety lasting from a few minutes up to several hours) with any of the following symptoms:

Recent	Past	
_____	_____	Panic attacks / anxiety attacks
_____	_____	Persistent worry that I will have a panic attack
_____	_____	Heart pounding or racing heart
_____	_____	Trembling or shaking
_____	_____	Sweating
_____	_____	Choking
_____	_____	Nausea or stomach problems
_____	_____	Feelings of unreality
_____	_____	Numbness or tingling sensations
_____	_____	Feeling of smothering or shortness of breathe
_____	_____	Fear of dying
_____	_____	Fear of going crazy or doing something uncontrolled
_____	_____	Chest pain or discomfort
_____	_____	Dizziness, unsteady feelings or faintness
_____	_____	Flushes, hot flashes or chills
_____	_____	Avoiding situations or places that may cause panic or severe anxiety

Any of the following symptoms for (*all* of these) MOST OF THE DAY, NEARLY EVERY DAY, FOR MORE THAN FOUR (4) DAYS AT A TIME:

Recent	Past	
_____	_____	Euphoric or "high" mood
_____	_____	Irritable mood
_____	_____	Decreased need for sleep without feeling tired
_____	_____	Increased energy level

Recent	Past	
_____	_____	Increased activity (work / social / physical / sexual – circle those that apply)
_____	_____	Thoughts speeded up or racing thoughts
_____	_____	Increased talkativeness or being much more socially outgoing
_____	_____	Making decisions too impulsively
_____	_____	Going on spending sprees

Check any of the following relating to your alcohol or drug use:

Recent	Past	
_____	_____	I've felt alcohol or drugs were causing a problem for me
_____	_____	I have felt guilty about my use
_____	_____	Others have annoyed me about my use
_____	_____	I have had a desire (or made unsuccessful efforts) to cut down or control my use
_____	_____	I've tried unsuccessfully to control my use
_____	_____	I've used alcohol or drugs more often or in larger amounts than I intended
_____	_____	I've had to increase my use of alcohol or drugs to get the desired effect
_____	_____	I've had problems with withdrawal (shakes, nervousness, insomnia, etc.) when I've cut down or stopped using alcohol or drugs
_____	_____	I've been to a meeting of Alcoholics Anonymous, Narcotics Anonymous, or Celebrate Recovery (circle any / all that apply)

Any of the following disturbances in eating or maintaining normal weight:

Recent	Past	
_____	_____	Insistence on maintaining body weight below expected for age and height
_____	_____	Intense fear of gaining weight or becoming fat even though underweight
_____	_____	I feel "fat" even when others see me as underweight
_____	_____	Eating binges
_____	_____	Feeling of lack of control of eating during eating binges
_____	_____	Vomiting or using laxatives to prevent weight gain
_____	_____	Being over-concerned about body weight and shape

Check any of the following that apply:

Recent	Past	
_____	_____	I tend to do things on impulse which end up being damaging to me or others
_____	_____	I have mood swings (depression, irritability, anger) lasting up to several hours
_____	_____	I have tried to commit suicide

Recent	Past	
_____	_____	I have made cuts, burns, or other injuries to myself without wanting to kill myself
_____	_____	My mood often shifts from being either overconfident to having low self-esteem
_____	_____	I have a hard time sympathizing with other's pain
_____	_____	I often feel others do not understand me
_____	_____	I tend to get very hurt or angry when I am criticized or rejected by someone
_____	_____	I tend to need a lot of reassurance or approval from others
_____	_____	I am very concerned about my appearance
_____	_____	Others often expect too much of me

Check any of the following that apply at any time:

Recent	Past	
_____	_____	Hearing voices that sound real even though they are not actually there
_____	_____	Vivid voices in my head that do not seem like my ideas
_____	_____	Feeling that others might be putting thoughts in my head
_____	_____	Feeling others might be able to read my thoughts
_____	_____	Others feel I am too suspicious or paranoid
_____	_____	Feeling others might be talking about me

Any of the following problems relating to a past severe trauma or stress:

Recent	Past	
_____	_____	I have had an experience that was so traumatic that nearly anyone would have been seriously stressed by it
_____	_____	History of relatives hurting my physically or touching me in sexual areas
_____	_____	History of unwanted sexual contact
_____	_____	I have memories or dreams of a stressful event I have trouble putting out of my head
_____	_____	I sometimes have flashbacks of past events or I act or feel as though I am re-living a stressful event from the past
_____	_____	I try to avoid situations or people that remind me of a stressful event in the past
_____	_____	I have frequent nightmares

Any of the following obsessions or compulsions:

Recent	Past	
_____	_____	Excessive doubting, or repeated, forced unreasonable thoughts, images or sounds that I cannot get out of my mind
_____	_____	Urges to check things, wash things, or count repeatedly

Recent	Past	
_____	_____	Excessive concern about coming into contact with germs or dirt
_____	_____	Excessive concern with right / wrong or morality
_____	_____	Excessive need for things to be exact or symmetrical
_____	_____	Recurrent, excessive pulling out of hair on any area of the body resulting in hair loss

Please list any other CURRENT symptoms you may be experiencing that have not been listed above.

_____
_____
_____
_____

_____ _____

Client Signature **Date**

_____

Client Printed Name

COUNSELING GOALS

When beginning or re-entering the counseling process (individual), it is important to think about what you want to accomplish during our sessions together, as well as for yourself as you move through life. Questions to ask yourself might be: What will be present (either in you or in your life) that isn't there now? What behaviors will have changed or be adopted to bring healthier elements into your life and into your relationships?

Individuals: Please state your goals in a positive way. Be thoughtful about what you want to change in yourself. Remember when thinking about your goals, you cannot change others – only yourself.

Couples: If you are engaged in marriage counseling with your spouse, please list those specific issues regarding your relationship with your spouse that are problematic for you and in which you are seeking change.

List your counseling goals / problematic issues below. (You don't have to have six goals, or you can have more goals than 6. Use the back of this page if you need more space.) *Please don't rush this assignment and give ample thought to your answers!*

1. _____
   _____
   _____
2. _____
   _____
   _____
3. _____
   _____
   _____
4. _____
   _____
   _____
5. _____
   _____
   _____
6. _____
   _____
   _____

Name _____ **Date**_____

Client History

Client Name:_____ **Date:** _____
(Please Print)

If you need more room in answering any question, please continue on the back of that sheet at about the same space as the question in located.

CLIENT GENERAL INFORMATION:

- **People living in your home with you:**
  - Name: Age: Relationship:

    _____ _____ _____
    _____ _____ _____
    _____ _____ _____
    _____ _____ _____
    _____ _____ _____
    _____ _____ _____

- **Immediate family members (children, spouse) NOT living in your home:**
  - Name: Age: Relationship: City / State

    _____ _____ _____ _____
    _____ _____ _____ _____
    _____ _____ _____ _____
    _____ _____ _____ _____

- **Current health issues:**
  - Please list all physical, mental, and/or emotional issues for which you are currently being treated:

    How long?
    - _____
    - _____
    - _____
    - _____

- **Past health issues:**
  - Please list all physical, mental, and/or emotional issues for which you have been treated in the past, but for which you are no longer receiving treatment:

    What year(s)?
    - _____
    - _____
    - _____
    - _____

- **Current care:**
  - Medical doctors, NP, PA, Psychiatrist, Psychologist, Licensed Counselor currently seeing:

Name:	Specialty:	City:	Reason seeing:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

- **Current prescription medications:**
  - Medication Name /Mg / Dose: Start Date (Mo/Year) Reason for medication:

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
(Use back of paper if necessary)

- **Drug / Alcohol history:**
  - Do you use any of the following?

Substance:	Yes:	No:	Amount & Frequency (Daily/Wkly):	Date last used:
Tobacco	____	____	_____	_____
Caffeine	____	____	_____	_____
Alcohol	____	____	_____	_____
Marijuana	____	____	_____	_____
Cocaine	____	____	_____	_____
Amphetamines	____	____	_____	_____
Methamphetamine	____	____	_____	_____
LSD / Psychedelics	____	____	_____	_____
Heroin	____	____	_____	_____
Pain killers (not prescribed by dr)	_____	____	_____	_____
Benzodiazepines (not prescribed by dr)	_____	____	_____	_____

FAMILY OF ORIGIN:

- **Family history of mental or emotional distress:**
  - Please list any blood relative(s) who have any history of the following:

Relationship to Client:

- Major depression _____
- Bipolar disorder _____
- Schizophrenia _____
- Anxiety _____
- Alcoholism _____
- Drug addiction _____

Relationship to Client:

- ADHD / LD _____
- Eating disorder _____
- Other: _____

- **Father / father figure**: _____ Birth father _____ Step-father _____ Other:_____
  - Is your father / father figure still living? ____ Yes ___ No If no, please answer the following:
    - How old was he when he died? _____ In what year did he die? _____
    - How old were you when he died? _____
    - What was the cause of his death? _____
  - Describe your father's personality:_____
    _____
    _____
  - Describe your relationship with your father:
    - as a child: _____
      _____
      _____
    - as an adult: _____
      _____
      _____
- **Mother / mother figure**: _____ Birth mother _____ Step-mother _____ Other:_____
  - Is your mother / mother figure still living? ____ Yes ___ No If no, please answer the following:
    - How old was she when he died? _____ In what year did she die? _____
    - How old were you when she died? _____
    - What was the cause of her death? _____
  - Describe your mother's personality:_____
    _____
    _____
  - Describe your relationship with your mother:
    - as a child: _____
      _____
      _____
    - as an adult: _____
      _____
      _____
- **Your parent's marriage:**
  - What kind of marriage did your parents create?
    _____

_____

_____

_____

- Did their relationship change over the years? If so, how and when (during what periods in life)?

_____

_____

_____

- Regarding your parents' marriage, elaborate on whether or not there was divorce / separation, domestic violence (physical, verbal, emotional), substance abuse, or other traumas worth noting.

_____

_____

_____(Use back of paper if necessary)

- Were there any miscarriages, abortions, sudden infant deaths (SIDS), or birth defects in your family? If yes, please elaborate. _____

_____

_____

- **Siblings:**
  - Names & ages in birth order (include yourself): _____

_____

_____

YOUR FORMATIVE YEARS:

- What was it like for you growing up in your family? (Consider birth order; adopted; twins; only child, emotions you mostly felt; etc.

_____

_____

- Were you and your siblings all parented the same way, or were there differences? Was anyone favored or picked on? _____

_____

_____

- Elaborate on any of the following issues if they were present during your childhood: divorce / separation; domestic abuse (physical, verbal, emotional), drug or alcohol abuse / addiction, hospitalizations (including serious accidents / injuries).

_____

_____

_____

_____

_____(Use back of paper if necessary)

- Were you a witness to any type of domestic violence in your home? If so, please elaborate.

_____

_____

_____

- Were there any incarcerations, disasters (floods, fires, tornados, etc.), crimes (victim or witness to) that occurred during your childhood? If so, please elaborate. _____

_____

_____

_____

- During your school years, did you have to deal with any of the following: bullying, learning differences, not passing a grade with your peers, or other issue that was emotionally impactful?

_____

_____

_____

_____

- Did you experience any religious trauma or abuse, and if so, please elaborate.

_____

_____

_____

- Did you graduate from high school? _____Yes _____No GED? _____Yes _____No
- What was your high school experience like? (Uneventful, involved, sports, extra-curricular activities, loner, lots of friends, etc.)

_____

_____

_____(Use back of paper if necessary)

OTHER EDUCATION:

- After leaving high school did you attend any institution of higher learning? ____Yes ____No
- If yes, please complete the following:

Name of school / college / university:	**Yrs. attended**:	**Certification / Degree obtained**:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

RELATIONSHIP HISTORY:

- Are you currently ____Single ____Married _____Divorced ____Widowed ___Living Together
- If applicable, length of current relationship: _____ Yrs. married?_____
- Divorce history:
  - How many times have you been divorced? _____
  - Please list your age at the time of divorce, year of divorce, duration of marriage:

Age:	Year:	Duration of marriage:
_____	_____	_____
_____	_____	_____
_____	_____	_____

- If you are currently married, or involved in a relationship, describe what that relationship is like (conflicts; abuse; separated; drug / alcohol issues; happy & without major conflict; etc).

_____

_____

_____

_____(Use back of paper if necessary)

ABUSE / TRAUMA HISTORY:

- Please briefly list here any experiences of trauma you have experienced in your life time. Some examples are military, sexual, criminal, prison, natural disaster. This is not an exhaustive list of examples. Please list anything that **for you** was a traumatic or emotionally charged experience.

_____

_____

_____

_____(Use back of paper if necessary)

SPIRITUALITY / FAITH:

- What is your religious preference? _____
- How often do you attend religious services? _____
- Where do you attend? _____
- Would you like your counseling to be based on Christian / Biblical principles? _____Yes _____ No

HOBBIES:

- List any hobbies or activities you pursue in your spare time: _____

_____

PERSONAL STRENGTHS:

- List those qualities you possess that you consider to be personal strengths:
  - _____
  - _____
  - _____

PERSONAL AREAS WHERE GROWTH MAY BE NEEDED:

- _____
- _____
- _____

OTHER IMPORTANT / RELEVANT INFORMATION:

- Elaborate on any other important / relevant information that has not been covered in this questionnaire that you think would be helpful for me to know.

_____

_____

_____

_____(Use back of paper if necessary)

How did you hear about me?_____ **If you were referred to me by an individual, if you feel comfortable doing so please, tell me their name:** _____

_____ _____

Client's printed name Date

_____

Client's Signature