Brazos Valley Christian Counseling

New Client Information Packet

Thank you for choosing **Brazos Valley Christian Counseling** for your counseling needs. The following pages contain:

- Informed Consent Form
- Patient Information/Financial Policy Form
- Patient/Insurance Information Form
- Notice of Privacy Practices
- Background Information Form

Please complete each of the attached pages and bring them with you to your first appointment.

If you have any questions prior to your appointment, please feel free to call us at 979-260-6700.

Again, thank you for choosing **Brazos Valley Christian Counseling**. We look forward to meeting with you soon.

Brazos Valley Christian Counseling

4444 Carter Creek Pkwy, Suite 204, Bryan, TX 77802
979-260-6700 (phone) 979-260-3366 (fax)*

Informed Consent

**Please initial next to each section after you have read and understood the section and any questions you had about the section were answered to your satisfaction.*

_____ **Emergency/Crisis:** Please know that we do not provide a 24-hour crisis counseling service. Should you experience an emergency necessitating immediate mental health attention, immediately call 9-1-1 or go to the nearest emergency room for assistance.
***Please note that this includes both emails and phone messages. Please do not email or call me in the case of crisis or emergency.**

_____ **Assessments:** Brazos Valley Christian Counseling does offer some psychological assessments in order to (1) to help clarify or identify the problem areas more comprehensively for you and your counselor (2) to use the assessments as a direct way of ascertaining an additional measure of therapeutic progress. Before an assessment is administered, your permission and understanding of the purpose of the assessment will be ascertained. Furthermore, all assessment results will be reviewed with you.

_____ **Counseling Relationship:** During the time we work together, we will meet weekly for approximately 50 minutes per session. Although our session may be very intimate psychologically, we have a professional relationship rather than a social one. Please do not invite me to social gatherings, offer me gifts, ask me to write references for you, or ask me to relate to you in any way other than the professional context of our counseling sessions. You will best be served if our sessions concentrate exclusively on you (adult counseling situations) or your child's concerns (parent consultations for child or adolescent counseling).

_____ **Effects of Counseling:** At any time, you may initiate a discussion of possible positive or negative effects of entering, not entering, continuing, or discontinuing counseling. While benefits are expected from counseling, specific results are not guaranteed. Counseling is a process of personal exploration and may lead to major changes in your life perspectives and decisions. These changes may affect significant relationships, your job, and/or your understanding of yourself. Some of these life changes could be temporarily distressing. The exact nature of these changes cannot be predicted. Together we will work to achieve the best possible results for you.

_____ **Client Rights:** If a divorce or a separation of parents has occurred, a current copy of the relevant court documents is required for a second session. If joint custody exists, the parent not bringing the child will also be contacted via letter with an intake form and an invitation to that parent to call with

any questions and to participate in their child's counseling---It is Brazos Valley Christian Counseling's policy to involve both parents (unless parental rights have been restricted by a court order) in the treatment process.

Some clients need only a few counseling sessions to achieve their goals; others may require months or even years of counseling. As a client, you are in complete control and may end our counseling relationship at any time though it is requested that you participate in a termination session. You also have the right to refuse or discuss modification of any of my counseling techniques or suggestions that you believe might be harmful.

I assure you that my counseling services will be rendered in a professional manner consistent with the current ethical practices promulgated by the Ethical Codes of the Texas State Boards of Examiners of Licensed Psychologists and the HIPAA security and privacy rules. If at any time for any reason you are dissatisfied with my services, please let me know so that existing issues can be worked through.

_____ **Referrals:** Should you and/or I believe that a referral is needed; I will do my best to provide some alternatives, including programs and/or people who may be available to assist you. You will be responsible for contacting and evaluating those referrals and/or alternatives.

_____ **Cancellation:** In the event that you will not be able to keep an appointment, please give notification within 24 hours in advance. Unless cancelled at least 24 hours in advance, our policy is to charge for missed/cancelled appointments at the rate of $75.00. Please help us serve you better by keeping scheduled appointments.

_____ **Records and Confidentiality:** All of our communications become part of the clinical record. Records are the property of Brazos Valley Christian Counseling. Adult client records are disposed of ten years after the file is closed. Guardians or conservators do have access to child-client files and will need to sign for consent of services (within joint custody cases, only one guardian or conservator is needed to sign for consent for the child). Minor client records are disposed of ten years after the client's 18th birthday.

Most of our communication is confidential, but the following limitations and exceptions do exist:

a. if you are a danger to yourself or someone else;
b. if you disclose sexual contact with a mental health professional;
c. if I am ordered by a court to disclose information;
d. if you direct me to release your records;
e. if I am otherwise required by law to disclose information;
f. if there is a reason to believe that abuse or neglect of a child, elderly or disabled person has occurred or is likely to occur.

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Should you request a copy of your counseling records, please be aware that a $30.00 record preparation fee will be incurred and a "Release of Records" form must be signed. An overall counseling summary, in lieu of records, may be requested for a fee of $30.00 as well. If records are subpoenaed, this does not indicate an automatic release of records and we may choose to seek a court order quashing the subpoena or providing protection should disclosure be deemed not in the client's best interest.

To further protect your confidentiality, if I see you in public, I will only acknowledge you if you approach me first. In the case of marriage or family counseling, I will keep confidential (within limits cited above) anything you disclose to me without your family member's knowledge. However, I encourage open communication between family members, and I reserve the right to terminate our counseling relationship if I judge the secret to be detrimental to the therapeutic process.

By your signature below, you are indicating that you have read and understood this document, or that any questions you had about this document were answered to your satisfaction. You acknowledge your commitment to comply with all of its terms and requirements and acknowledge understanding and agreement with my financial obligations.

_____

Client's Signature (over the age of 12) Date

_____

Guardian's Signature Date

_____

Counselor Date

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PATIENT INFORMATION/FINANCIAL POLICY

We are committed to providing our patients with the best possible care, and are pleased to discuss our professional fees with you at any time. Your clear understanding is important to our professional relationship. Please read the policy and sign the Patient Information Form to acknowledge you have read and understood our financial policy.

A full session is considered 45-50 minutes, leaving 10-15 minutes for paperwork. We accept cash, checks and major credit cards.

REGARDING INSURANCE ASSIGNMENT

If prior arrangements are made with this office to file your insurance or if we have a contract with your insurance company to file claims, please read our policy below in reference to filing insurance claims for our patients.

TO ACHIEVE THIS, WE MUST HAVE ALL CURRENT INSURANCE INFORMATION ON FILE BEFORE YOUR ACCOUNT MAY BE PLACED ON ASSIGNMENT. PLEASE NOTIFY US IMMEDIANTLY OF ANY CHANGES IN YOUR INSURANCE COVERAGE. ALSO, PLEASE UNDERSTAND THE FOLLOWING.

1. All charges will be filed to primary coverage only.
2. Waiting for insurance payment is a courtesy and may be withdrawn at any time.
3. Insurance payments should be made in 30 days. The maximum time limit the office extends for insurance payments is 45 days. Therefore, the fees must be paid in full by the patient if no payment is received by that time, or the patient must come by our office to make arrangements to pay the balance with a monthly payment plan.
4. The patient must stay current with payment of their deductible and with their percentage of responsibility (i.e. If the insurance pays 80% of the charges, the patient pays 20%). This amount must be paid at the time of service. All information that this office gives you in reference to your benefits and is not a guarantee of payment by your insurance company. Therefore, any amount that we collect in advance or quote to you as being your responsibility is only an estimate. You are ultimately responsible for any and all balances due on your account after your insurance.
5. This office does not promise that an insurance company will pay. Nor does this office promise that an insurance company will or should pay the fees as charged
6. This office will not enter into a dispute with an insurance company over reimbursement or the amount of the reimbursement. That is the patient's obligation. However, we will provide any assistance or information necessary.
7. The fees at this office may be higher or lower than those charged by other offices. A schedule of services and current fees may be secured from the receptionist. Please familiarize yourself with these.

SHOULD YOU HAVE ANY PROBLEMS WITH YOR ACCOUNT, OR HAVE QUESTIONS ON FILING OF CLAIMS, FEES, BILING, OR RECORDS, PLEASE COTACT OUR OFFICE MANAGER.

I understand that the services or items I have requested and/or received may not be covered under insurance as being medically necessary for my care. I understand that insuring agents determine the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I requested and receive if these services or items are determined not to be reasonable and/or medically necessary for my care.

_____1. CONSENT FOR TREATMENT (ALL PATIENTS MUST INTITIAL)

I hereby give consent for myself or the above named patient to be treated/tested by Roy R. Luepnitz. If the above named patient is a minor who is or has been involved in any court proceedings, I have/will provide proof, by the attached court documents, that I have the legal right to request treatment for the

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above named minor (If marital therapy, both parties must sign consent for treatment).

_____2. FINANCIAL RESPONSIBILLITY
I hereby accept financial responsibility for all therapy sessions, diagnostics, testing, letters reports, conferences, phone calls, and crisis intervention initiated by me or initiated in my behalf. All billings are made in quarter- hour increments. (Minimum of 15 minutes).

_____3. ASSIGNMENT OF INSURANCE BENEFITS/RELEASE OF INFORMATION
I hereby authorize my insurance carrier to pay benefits directly to Roy R. Luepnitz, Ph.D. for services provided to myself or my insured dependent, realizing I am responsible for all services provided. I hereby authorize the release of pertinent information required by my insurance carrier to process insurance claims for payment to Roy R. Luepnitz, Ph.D.

_____4. MISSED /CANCELED APPOINTMENTS
Unless cancelled at least 24 hours in advance, our policy is to charge for missed/canceled appointments at the rate of $75.00. Please help us serve you better by keeping scheduled appointments.

_____5. FINANCIAL POLICY
I acknowledge that I have read, understand and accept the attached financial policies of this office.

_____6. LIMITS OF CONFIDENTIALITY-This office may disclose confidential information only:

a. If there is evidence or reason to believe that a situation of abuse and/or neglect of a child, elderly or handicapped person exists. By law, this information must be reported to the Texas Department of Protective and Regulatory Services or the police.
b. To a government agency if the disclosure is required by law.
c. To a medical or law enforcement personnel if the professional determines that there is a probability of imminent physical injury by the patient to the patient or others; or there is a probability of immediate mental or emotional injury to the patient.
d. To a qualified personnel for management audits, financial audits, program evaluations or research step.
e. To a person who has the written consent of the patient, or a parent if the patient is a minor, or a guardian if the patient has been adjudicated as incompetent to manage the patients personal affairs.
f. To the patients personal representative if the patient is deceased.
g. To individuals, corporations, or governmental agencies involved in paying or collecting fees for a mental or emotional health services provided by a professional.
h. To health care personnel of a penal or other custodial institution in which the patient is detained if the disclosure is for the sole purpose of providing health care to the patient.
i. Judicial or administrative Proceedings

If you have been adjudicated or currently on probation or parole please initial number 7.

_____7. I authorize Dr. Luepnitz and his staff to communicate verbally and in writing with my probation officer(s), parole officer(s) and/or judicial official(s).

If patient is a minor please initial and sign number 8.

_____8. CONFIDENTIALITY FOR MINORS (if applicable)

_____ I agree to grant confidentiality for minor child unless there is a probability of imminent danger to the child.
_____ I do not agree to grant minor confidentiality.

_____ _____
Name of child Date

My signature below indicates my understanding of legal authorization for said terms and conditions, in 1-7 above in connection with treatment of the above named patient.

_____ _____ _____
Patient Responsible Party Initials Date

_____ _____ _____
Responsible Party (if not patient) Initials Date

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Patient/Insurance Information

Date:

Patients Name _____SS#_____
Address_____City_____
Zip Code_____DOB___/___/____Sex_____male_____female
Hm#_____wk#_____other_____

Subscribers Name_____SS#_____
Patient Relationship_____(self, spouse, child, etc)
Address_____City_____
Zip Code_____HM#_____WK#_____
Employment_____Address_____
City_____Zip Code_____

RESPONSIBLE PARTY INSURANCE INFORMATION:

Insurance Company_____
Effective Date_____Telephone_____
Policy ID#_____Group #_____
Contact Person_____

PreCertify_____%Coverage_____CoPay_____Deductible_____# of visits_____

Notes:

_____
_____
_____
_____
_____

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NOTICE OF PRIVACY PRACTICES

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

We are required by The Health Insurance Portability & Accountability Act of 1996 (HIPAA) to provide confidentiality for all medical/mental health records and other individually identifiable health information in our possession. This Notice is to inform you of the uses and disclosures of confidential information that may be made by **Brazos Valley Christian Counseling**, and of your individual rights and **Brazos Valley Christian Counseling's** legal duties with respect to confidential information.

Ways in Which We May Use and Disclose Your Protected Health Information

We may use and disclose at our discretion your medical records for each of the following purposes only: treatment, payment, and health care operations.

- **Treatment** means providing, coordinating, or managing mental health care and related services. *For example* – use or disclosure by the health care provider in training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling.
- **Payment** means activities such as obtaining payment for the mental health care services we provide for you either from your insurance or another third party payer. *For example* – we may include information with a bill to a third party payer that identifies you, your diagnosis, and procedures performed.
- **Health care operations** include the business aspects of running our practice. *For example* – to evaluate our treatment and services, or to evaluate our staff's performance while caring for you.

We may contact you to provide appointment reminders or other services that may be of interest to you. We will disclose your protected heath information to any person *you identify* that is involved in your care or payment for your care. *For example* – a family member, relative, or close friend with whom you have asked us to communicate.

We will use and disclose your protected health information *when required by federal, state, or local law*. There are certain situations in which as a therapist I am required by ethical standards to reveal information obtained during therapy to other persons or agencies – even if you do not give permission. These situations are as follows: (a) if you are a danger to yourself or someone else; (b) if you disclose sexual contact with a mental health professional; (c) if I am ordered by a court to disclose information; (d) if you direct me to release your records; (e) if I am otherwise required by law to disclose information; (f) if there is a reason to believe that abuse or neglect of a child, elderly or disabled person has occurred or is likely to occur.

Any other uses and disclosures will be made only with your written authorization. You will be provided with an authorization form upon request. A separate form will be needed for each request for release of information. The authorization for release of records is valid until it expires or is revoked. You may revoke an authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. Please sign to indicate you understand our operational use of your information for treatment, payment, and health care operations as stated above.

_____ _____

Signature of Client Date

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Adult Background Information Form

Please answer all information as completely as possible. Information given is strictly confidential and beneficial in providing the best possible service. Feel free to ask for assistance, if needed.

Name: _____ Date of First Visit: _____
Last First MI

Home Phone: _____ (**May call:** Yes No **Message:** Yes No)

Work Phone: _____ (**May call:** Yes No **Message:** Yes No)

Cell Phone: _____ (**May call:** Yes No **Message:** Yes No)

Email Address:_____

Home Address:_____
Street City State Zip

Best time to contact you: _____ Occupation: _____

In case of emergency, I authorize Brazos Valley Christian Counseling to contact:

_____
Name: Last, First Relationship Phone

Gender: Male ___ Female ___ Date of Birth _____ Age _____

Ethnicity:
African American ____ Bi-racial ____ Hispanic/Latino____
Asian _____ Caucasian ____ Native American _____ Other _____

Are you currently in counseling elsewhere? Yes No

Are you seeking services because you are a victim of a crime? Yes No

Did it result in legal action? Yes No Are you currently on probation? Yes No

Have you ever seen a mental health professional (psychiatrist, psychologist, or a counselor)? Yes No
(If so, we may need your permission in order to communicate with that individual or agency).

Previous Mental Health Professional/Agency _____

Phone _____ Dates of Service _____ (beginning-ending)

Have you ever been hospitalized for mental health concerns? Yes No
If yes, please explain: _____

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How were you referred to Brazos Valley Christian Counseling? _____

Educational Level:

8th grade or below ____	Trade School ____	Master's Degree ____
High school ____	Some College ____	Ph.D. Degree ____
GED ____	College Graduate ___	

Marital Status (indicate all that apply and duration of each, ex. 1960-1980):

Never Married _____	Separated 1 _____	Divorced 1 _____	Widowed 1 _____
Married 1 _____	Separated 2 _____	Divorced 2 _____	Widowed 2 _____
Married 2 _____	Separated 3 _____	Divorced 3 _____	Widowed 3 _____
Married 3 _____			

If divorced, circle the number which best describes your relationship with your ex-spouse.

1_____2_____3_____4_____5
Hostile Frustrating Friendly

Are you currently involved in a custody dispute? Yes No (If yes, please explain)_____
_____

Current Living Arrangements:

Family of Origin _____	Relatives _____	Single _____
Married _____	Roommate(s) _____	Single parent with children _____
Married with children _____	Significant other _____	Other _____

Present Family
If married with children, list your family, beginning with the oldest member and include yourself.

Name	Age	Gender	Relationship to you (include step, half, etc.)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family of Origin Primary Household (Family in which you resided the majority of your life)
List your family members, by household, beginning with the oldest member (include parents & self):

Name	Age	Gender	Relationship to you (include step, half, etc.)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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Family of Origin Second Household (If Applicable)

Name	Age	Gender	Relationship to you (include step, half, etc.)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Mother's Marital Status (indicate all that apply and duration of each, ex. 1960-1980):

Married _____ Remarried _____ Divorced _____
Separated _____ Widowed _____ Unknown _____
Number of Marriages _____

Father's Marital Status (indicate all that apply and duration of each, ex. 1960-1980):

Married _____ Remarried _____ Divorced _____
Separated _____ Widowed _____ Unknown _____
Number of Marriages _____

HEALTH SECTION

Primary Care Physician: _____
Name

_____
Address Phone

Psychiatrist: _____
Name

_____
Address Phone

Physical Disability: Yes No (if yes, please explain)_____
Chronic Illness: Yes No (if yes, please explain)_____
Terminal Illness: Yes No (if yes, please explain)_____

Check the following items for a diagnosis or medication you are now receiving or have received:

Diagnosis	**Current**	**Past**	**Date of Diagnosis**	**Name of Medications**	**Dosage**
Depression	_____	_____	_____	_____	_____
ADHD	_____	_____	_____	_____	_____
ADD	_____	_____	_____	_____	_____
Learning Disability	_____	_____	_____	_____	_____

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Anxiety	_____	_____	_____	_____	_____
Panic Attack	_____	_____	_____	_____	_____
Manic-Depression (Bipolar)	_____	_____	_____	_____	_____
Schizophrenia	_____	_____	_____	_____	_____
Mood/Anger	_____	_____	_____	_____	_____
Tics	_____	_____	_____	_____	_____
Insomnia	_____	_____	_____	_____	_____
Obsessive/ Compulsive	_____	_____	_____	_____	_____
Addictions	_____	_____	_____	_____	_____
Convulsions	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____

(If you do not know the name and dosage of current medication, please bring the medication to your next session).

If you have been diagnosed, who have the diagnosis?
Counselor/Psychologist ____ Family Physician ___ Psychiatrist ___ School ___ Other _____
Name: _____ Phone: _____

List other medications you are currently taking:
Med. _____ Dosage _____
Med. _____ Dosage _____
Med. _____ Dosage _____

CURRENT CONCERNS

Indicate severity of up to 10 items (1-mild; 2-moderate; 3-severe) Circle the item that you see as the MOST significant issue).

_____ Abuse (physical, emotional, sexual)
_____ Adjustment to life changes (changing schools, parents divorcing, moving, getting married or divorced, aging, etc)
_____ Career dissatisfaction or decisions
_____ Disturbing memories (past abuse, neglect or other traumatic experiences)
_____ Drug or alcohol use (both legal and illegal drugs)

_____ Eating problem (purging, bingeing, overeating, hoarding, severely restricting diet)
_____ Family or Step-family relationship
_____ Feeling angry or irritable
_____ Feeling anxious (nervous, clingy, fearful, worried, panicky, obsessive-compulsive, lacking trust, etc)
_____ Feeling guilty or shameful
_____ Feeling sadness or depression or suicidal urges NOT related to grief
_____ Feeling sadness or depression or suicidal urges related to grief
_____ Health concerns (physical complaints and/or medical problems)
_____ Illegal behaviors (repeated run-ins with the law, etc)
_____ Learning/Academic difficulties
_____ Non-family relationship (roommates, friends, co-worker, boss, teacher, etc)
_____ Parent-Child relationship (discipline, adoption, single parent, etc)
_____ Personal growth (no specific problem)
_____ Religious or spiritual concerns
_____ Sexual functioning concerns
_____ Sexual identity concern
_____ Significant other/Spouse relationship
_____ Sleep problem (nightmares, sleeping too much or too little, etc)
_____ Speech problem (not talking, stuttering, etc)
_____ Unusual behavior (bizarre actions, speech, compulsive behavior, tics, motor behavior problems, etc)
_____ Unusual experiences (loss of periods of time, sensing unreal things, etc)
_____ Other (explain _____)

***Remember to circle the MOST significant issue.**

When did you first become concerned about this issue? _____

How have you attempted before now to deal with this issue? _____
_____

Other treatment you have received to address any of the concerns indicated above: None _____
Couples Counseling _____ Group Counseling _____ Individual Counseling _____
Family Counseling _____ Hospitalization _____ Other _____

FAMILY HISTORY/EXPERIENCES

(For each of the following items that apply, write in your approximate age at the time it occurred):

Raised by:
Adoptive parent(s) _____ Institution _____ Relatives _____
Foster parents _____ Natural parents _____ Single natural parent ____
Grandparents _____ Natural and step-parent _____ Other_____

Stressors in the Family:
Chronic illness of family member _____ Death of significant person _____ Domestic Violence ____
Family member absent (explain) _____
Family member's disability/major accident/illness _____
Family member emotional problems (explain) _____

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Family member suicide (explain) _____
Financial problems _____ Moved a lot _____ Parents arguing frequently _____ Parents divorced _____
Other _____

History of learning, emotional, behavioral problems: Yes No
(If yes, please explain) _____

History of alcohol/drug/substance abuse: Yes No
(If yes, please explain) _____

History of family violence: Yes No
(If yes, please explain) _____

History of criminal activity: Yes No
(If yes, please explain) _____

History of Protective orders: Yes No
(If yes, please explain) _____

Abused (check all that apply): Physically _____ Emotionally _____ Sexually_____
Neglected (check all that apply): Physically _____ Emotionally _____

School Problems (check all that apply):
Academic problems _____ Discipline problems _____ Severely teased _____ Unpopular _____
Other _____

Early Language/Speech Problems (explain): _____

Emotional Concerns (check all that apply):

Appetite change _____	Heard voices _____	Suicidal thoughts _____
Emotional problems _____	Loss of energy or fatigue _____	Suicidal attempts _____
Gained weight _____	Lost weight _____	Other _____

Behavior Problems (check all that apply):

Accident-prone _____	Aggressive behavior (explain) _____	
Alcohol/drug use _____	Attention problems _____	Frequent arguments _____
Hyperactive _____	Impulsive _____	Loner _____
Misbehaved a lot _____	Ran away _____	Taken advantage of _____
Temper outbursts _____	Trouble with the law _____	Other _____

Anxiety Symptoms (check all that apply):

Irritable _____	Obsessive worrying _____	Physical symptoms _____
Keyed up, on edge _____	Phobias _____	

Health/Physical Problems (check all that apply):

Asthma _____	Disability _____	Nervous stomach ____
Bedwetting _____	Dizziness _____	Neurological problems/exam _____

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Bone/joint/muscle _____ Headache _____ PMS _____
Chest pain _____ Heart palpitations _____ Serious overeating/undereating _____
Chronic illness _____ Hospitalization _____ Shortness of breath without exertion _____
Developmental delay(s) _____ Major accident _____ Sleep problem _____
Diarrhea _____ Major illness _____ Surgeries _____ Other _____

Dissociative Symptoms (check all that apply):
Amnesia of large parts of childhood after age 5 _____ Things of yours that are missing _____
Memories suddenly flashback _____ Trance-like episodes/lost track of time _____
Things appear but you do not know origin _____ Walk in sleep _____

Trauma/Stressor (check all that apply):
Child separated from parent (how long and when) _____
Death of a pet _____ Death of a significant person _____ Incarcerated family member _____
Medical _____ Natural disaster _____ Sexual Assault _____
Victim of trauma (unusual, terrifying experience) _____ Other _____

Interpersonal Problems (check all that apply):
Aggressive behavior (explain)_____
Bullied _____ Taken advantage of_____ Frequent arguments_____
Temper outbursts _____ Loner_____ Other_____

Specific to Adulthood (check all that apply):
Abortion _____
Changes in the last 12 months (getting married, becoming a parent, moves, change in employment) _____
Parenting/Discipline problems _____ Placing child for adoption _____ Sexual problem _____

I agree that the above information is accurate to the best of my ability. I also understand that if I have any questions regarding the above questions, I can ask my counselor at any time.

_____

Client/Guardian & Date