Shanna Severn Psychotherapy, LLC
Located at SUN Holistic Health
28900 SW Villebois Dr. Suite D
Wilsonville, OR 97070
Ph: 971-264-0915 – Fax: 503-570-7900
Email: Shanna@sseverncounselingandwellness.com
Http://sseverncounselingandwellness.com

Welcome Letter

Hello and Welcome. I am so pleased you have considered SUN Holistic Health to join you on your journey towards wellness. I am humbled by your choice and look forward to working with you.

You will find all the necessary paperwork attached. In order to make the most of our time together, I ask that you read through and complete the enclosed forms and return them to me before our first appointment. This will allow time for me to evaluate your treatment options. Please return the completed form in person or by mail to the address above.

The contents of this packet include:

1. Scheduling your first appointment
2. Professional Disclosure Statement
3. Informed Consent & Confidentiality
4. Fees
5. Teen Intake Questionnaire
6. Child Development Background Form

If you have any questions please do not hesitate to call 971-264-0915, as I am here to help and wish for you to have an informative, comfortable and supportive experience.

I look forward to meeting you!

Sincerely,

Shanna Severn, M.S., NCC

Scheduling your first appointment

The wait time to schedule your first appointment is dependent on your availability and the open time slots I have available. I do not schedule new clients until there is a consistent open time slot in which to see them. Many clients prefer to schedule after work or school, and as a result, usually are the least available times. If you have flexibility in your schedule this will increase your odds of getting an appointment sooner.

I currently only see clients three days each week. Please let me know your preferred times for scheduling. I will call as soon as my appointment times match your availability.

If you prefer not to wait to begin your therapy, I can suggest several excellent therapists who may have current openings. Please feel free to call to get referral names.

Name_____ **Date** _____

The times appointments will be scheduled are below: Please mark an **X** what ***times*** work best for you and a √ for your ***preferred*** time.

Tuesday	Wednesday	Thursday
☐ 11:00 am – 11:45 am	☐ 11:00 am – 11:45 am	☐ 12:00 pm – 12:45 pm
☐ 12:00 pm – 12:45 pm	☐ 12:00 pm – 12:45 pm	☐ 1:00 pm – 1:45 pm
☐ 1:00 pm – 1:45 pm	☐ 1:00 pm – 1:45 pm	☐ 2:00 pm – 2:45 pm
☐ 2:00 pm – 2:45 pm	☐ 2:00 pm – 2:45 pm	☐ 3:00 pm – 3:45 pm
☐ 3:00 – 3:45 pm	☐ 3:00 pm – 3:45 pm	☐ 4:00 pm – 4:45 pm
☐ 4:00 – 4:45 pm	☐ 4:00 pm – 4:45 pm	☐ 5:00 pm – 5:45 pm
☐ 5:00 pm – 5:45 pm	☐ 5:00 pm – 5:45 pm	☐ 6:00 pm – 6:45 pm
☐ 6:00 pm – 6:45 pm	☐ 6:00 pm – 6:45 pm	☐ 7:00 pm – 7:45 pm

Also please indicate how often:

☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Other_____

Shanna Severn, M.S., NCC
Professional Disclosure Statement
Email: Shanna@sseverncounselingandwellness.com
PHONE: 971- 264-0915

PROCESS OF THERAPY: I view counseling as a collaborative effort with the goals of therapy focused on resolving problems or issues that you present. Active participation and honesty with thoughts, feelings and behaviors will promote more success. Together we will regularly review your goals, including your thoughts and feelings expressed regarding the therapy process. I like to begin by getting to know you and hearing about your concerns, what you have tried so far, what has not helped and what has improved your situation. Then we usually discuss what successful completion of therapy would look like for you. Next we will set a course to achieve your goals. Using this plan, we will both know what you are achieving, and when you are done. Therapy may result in decisions about changing behaviors, employment, substance use, schooling, housing or relationships. Sometimes a decision that is positive for you may at times be challenging for others in your life.

PHILOSOPHY AND APPROACH: As a counselor, I follow a holistic approach which acknowledges psychological, biological, sociological, familial, cultural and environmental which I believe contribute to one's overall health, development and life perspectives. My personal style and core philosophy is to try to see through the eyes of each person and acknowledge each person's worth and value. The theoretical orientations I follow most are: Adlerian, Person-Centered, and Existential theories with a mind-body focus. If you have any other questions about my theoretical orientations, please do not hesitate to ask.

FORMAL EDUCATION AND TRAINING: I am recognized as a National Certified Counselor by the National Board of Certified Counselors. I graduated with a Master's of Science degree in Mental Health Counseling (MHC) from Capella University. I earned my Bachelor of Science in Psychology, with a minor in Sociology at Utah State University in 2006. I recently completed a Gambling Specialist Pre-Certification course at Lewis and Clark College in 2012. I have worked and interned at various mental health settings, which have provided me with immense experience working with diverse clientele whom have been diagnosed with a range of mental health issues. These included: moderate to severe and persistent mental illness, dual diagnoses, eating disorders, domestic violence, trauma related to violence, medical issues or intergenerational, grief and loss, and relationship difficulties. Each program had various treatment modalities which helped develop the holistic approach I take towards counseling and being with clients. Some of these modalities included: cognitive behavior therapy, client-centered, multicultural sensitivity, mindfulness, guided imagery, psychoeducation on relationships and process group therapy.

HOURS AND LENGTH OF SESSION: All services are by appointment only. Sessions are 45 minutes in duration. In order for counseling to be effective, it is important you attend all regularly scheduled appointments. If you are unable to attend an appointment, please call at least 24-hours in advance. If you fail to show without giving a 24-hour notice to more than two appointments, you risk losing your appointment slot. If an appointment must be cancelled, you may leave a message for me at 971-264-0915. If you need help after hours, please call the ***Clackamas County Crisis line at 503-655-8585.***

FEES: I offer a free 30 minute consultation for you to ask any questions you may have about therapy and to determine if we would be a good fit. I am unable to accept insurance at this time. My standard fee is $80.00 per hour and I offer several lower fee slots for those suffering financial hardship.

CLIENT RIGHT AND COUNSELOR ETHICS: As a counselor, I adhere to the American Counseling Association Code of Ethics. As a client you have the following rights:

- To expect that I have met the qualifications of the American Counseling Association and the National Board of Certified Counselors
- To obtain a copy of the ethics codes I follow;
- To ask questions or voice your opinion to either of my supervisors;
- To be assured of privacy and confidentiality while receiving services as defined by rule and law, including the following exceptions:
    1) **Reporting suspected or known abuse of children, (including witnessing domestic violence), animals, elderly persons, mentally disabled or developmentally disabled.**
    2) **Reporting imminent danger to client's self or others**
    3) **Reporting information required in court proceedings, or by insurance companies or other relevant agencies.**
    4) **Defending claims brought by the client against the counselor.**
- To be free from being the object of discrimination on the basis of race, religion, gender identity, sexual orientation, socioeconomic status, or other unlawful category while receiving services.

Consent to Treatment:
Your signature below indicates that you understand and agree to the above conditions in order to receive treatment.

_____

Client Signature Date

_____

Parent/Guardian Signature (if applicable) Date

_____

Clinician Signature Date

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Informed Consent for Treatment & Confidentiality

I, Shanna Severn, am a counselor and hold a Master's of Science degree in Mental Health Counseling and am a National Certified Counselor.

As a client you have rights and responsibilities when you seek consultation.
These include:

1. **THE RIGHT TO REFUSE TREATMENT:** You have the right to request a change of therapy, be referred to another therapist, or discontinue therapy at any time. If you are not satisfied with therapy or have questions about the treatment, please speak with me about these concerns. If my services are not meeting your needs, I will be happy to refer you to another therapist.
2. **THE RESPONSIBILITY OF THE CLIENT FOR CHOOSING THE PROVIDER AND TREATMENT MODALITY WHICH BEST SUITS HIS/HER NEEDS:** I will make an assessment and suggest possible treatment models that may be helpful to you. I am knowledgeable on the different theories, but you are the expert on "you." With this noted I ask for your feedback. If you feel a treatment model does not meet your needs, please do not hesitate to discuss this with me.
3. **TERMINATION:** After the first couple of meetings, I will assess if the therapy process can benefit you. I don't accept clients who I am unable to help. When this happens I will give you a number of referrals. If at any point during therapy I assess that I am not effective in helping you reach your goals, I am obligated to discuss it with you and, if appropriate, to terminate treatment. If this happens I will give you a number of referrals that may be of help to you. If you request it and authorize it in writing, I will talk to the counselor of your choice in order to help with the transition. If at any time you want another professional's opinion or wish to consult with another therapist, I will assist you with referrals, as long as I have your written consent I will provide the essential information needed. You also have the right to terminate therapy at any time.
4. **THE EXTENT OF CONFIDENTIALITY PROVIDED BY LAW:** Under Oregon State law, Counselors are obligated to respect client confidentiality. Things discussed in therapy cannot be disclosed to anyone else without your written permission. ***HOWEVER, THERE ARE SOME EXCEPTIONS.*** These include:
    a. **CHILD, DEPENDENT AND ELDER ABUSE/NEGLECT:** By law I am a mandatory reporter, which means I am required by law to report any known or ***suspected*** abuse to the Department of Human Services.
    b. **HARM TO ANOTHER:** If I believe someone is about to endanger another person, I have a right to warn and protect the intended victim, to any extent possible. This is in effect for the duration of therapy and even after termination of therapy.
    c. **HARM TO ONESELF/SUICIDE:** If I believe someone is immediately likely to harm him/herself, I will try to protect the person by notifying the emergency contact, a family member, law enforcement, or the Mental Health Department. This can include information communicated to me from other people. This is in

effect for the duration of therapy as well as after termination of therapy.

d. **EVALUATIONS:** If you meet with me for an evaluation requested by another professional (i.e. counselor, lawyer, physician), I will routinely send a written report of my findings to that professional. I will obtain written consent from you in advance authorizing me to make such a disclosure.
e. **LITIGATION LIMITATIONS:** Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that: should there be legal proceedings such as, but not limited, to divorce and custody disputes; injuries; lawsuits; etc., neither you nor your attorney, nor anyone else acting on your behalf will call on me to testify in court or at any other proceeding, nor will a disclosure of your counseling records be requested unless otherwise agreed upon. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the therapy records and/or testimony from me. The chances of any legal involvement being beneficial for clients are minimal and can actually be detrimental.
f. **COUPLES/FAMILY THERAPY:** In couple and family therapy, or when different family members are seen individually, even over a period of time, confidentiality and privilege do not apply between the couple or among family members, unless otherwise agreed upon. I will use my clinical judgment when revealing such information. I will not release records to any outside party unless she or he is authorized to do so by <u>all</u> adult family members who were part of the treatment.
g. **CHILD/MINOR THERAPY:** The parents or legal guardians of the child/minor, have rights to general information about what takes place in the child's therapy, to information about the child's progress in therapy, to information about any dangers the child might present to self or others, and, upon request, to obtain copies of the child's treatment record. The parents understand that it is usually best not to ask for specific information about what was said in therapy sessions because this might break the trust between the child and the counselor.
h. **GROUP THERAPY:** In group therapy, confidentiality is stressed to all individuals agreeing to treatment. If confidential information is not protected by all group members, group trust and growth could be hindered. I will keep all group members information confidential, except for any limitations explained in this document. I expect that all information heard in group therapy is respected and kept private by all group members.
i. **CONSULTATION:** As a Counselor there are times I am may consult with other professionals regarding clients; however, each client's identity remains completely anonymous, and confidentiality is fully maintained unless there is foreseeable harm or a written release has been authorized. Consultation may also be considered with other SUN Holistic Health practitioners' to coordinate care.
j. **EMAILS, CELL PHONES, COMPUTERS AND FAXES:** Computers, e-mail, and cell phone communication (including text messaging) can be accessed by unauthorized people and can compromise confidentiality. E-mails, in particular, are vulnerable because servers have unlimited, direct access to all e-mails that go through them. My e-mails are not encrypted. Faxes can be sent to the wrong address. My computers are equipped with firewall, virus protection and password. All backups are stored securely. Please notify me if you decide to avoid or limit the use of any or all communication devises. If you communicate confidential information via e-mail or text, I will assume that you have made an

informed decision that such communication may be intercepted as well as assume you desire to correspond on such matters via e-mail. Due to computer or network problems, emails may not be deliverable, and I may not check my emails daily. ***Please do not use e-mail, text or faxes for emergencies.***

5. **EMAIL & PHONE CONSULTATIONS:** Occasionally, a client will request counseling via phone or e-mail rather than in person in the therapist's office. This has some complexities and disadvantages to the therapeutic process. I always recommend that you find a local therapist and meet face to face. Treating clients exclusively via phone consultations or e-mails may put therapists at a disadvantage because we cannot detect nonverbal cues, may not be able to accurately diagnose, may not always be aware of the resources available locally and may not be able to intervene as effectively as necessary in emergency situations.
    a. **TELEPHONE & EMERGENCY PROCEDURES:** If you need to contact me between office hours/days, please leave a message at 971-264-0915 and your call will be returned as soon as possible. If an emergency situation arises outside my office hours and you need to talk to someone immediately call the ***Clackamas County Crisis Line at 503-655-8585.*** You can also go to your nearest emergency room. If you are under the influence of a substance or otherwise unable to drive, have someone else take you or call a taxi.
6. **RECORDS AND YOUR RIGHT TO REVIEW THEM:** Both the law and the standards of the American Counseling Association require that we keep appropriate treatment records for at least seven years. Unless otherwise agreed to be necessary, I retain clinical records only as long as is mandated by Oregon law. You have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when I assess that releasing such information might be harmful in any way. In such a case I will provide the records to an appropriate and legitimate mental health professional of your choice. When more than one client is involved in treatment, such as in cases of couple and family therapy, I will release records only with the signed authorizations from ***all*** the adults (or all those who legally can authorize such a release) involved in the treatment.
7. **DUAL RELATIONSHIPS:** A dual relationship happens when you have contact with your therapist outside the counseling office. Not all of these relationships are unethical or avoidable. However, therapy never involves a sexual or romantic relationship with a client. I will assess carefully before entering into non-sexual and non-exploitative dual relationships with you. You may bump into someone you know in the waiting room or into me out in the community**.** ***I will never acknowledge working with anyone without your written permission.*** Many clients choose their therapist because they know of him or her before they enter into therapy or are personally aware of his or her professional work and achievements. Nevertheless, I will discuss with you the complexities, potential benefits and difficulties that may be involved in dual or multiple relationships. Dual or multiple relationships can enhance trust and therapeutic effectiveness but can also detract from it and often it is impossible to know that ahead of time. Please let me know if the dual or multiple relationships becomes uncomfortable for you in any way. I will always listen carefully and respond accordingly to your feedback and will discontinue the dual relationship if I find it interferes with the effectiveness of the therapy or the welfare of the client and the client also has the choice to do the same at any time.
8. **CANCELLATIONS:** Since the scheduling of an appointment involves the reservation of time specifically for you, ***a minimum of 24 hours notice is required for re-scheduling or***

canceling an appointment. Unless we reach a different agreement, ***the full fee*** will be charged for sessions missed without 24 hours notice. My voice mail is available at all hours. That number is 971-264-0915

9. **COLLECTION PROBLEMS:** If you do not pay for services rendered, I may refer your account to a collection agency or file a small claims court suit. Although no clinical information will be revealed, your name, address, dates and fees of service will be released, along with any other information that may help collection possible.
10. **MEDIATION AND ARBITRATION:** If a dispute arises between client and counselor, SUN Holistic Health will not be held liable. Mediation will be sought before,, and as a pre-condition of, the initiation of arbitration. The mediator will be a neutral third party mutually agreed upon by you and me. The cost of such mediation, if any, shall be split equally, unless otherwise agreed upon. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement should be submitted to and settled by binding arbitration in Clackamas County, Oregon in accordance with the rules of the American Arbitration Association in effect at the time the demand for arbitration is filed.

About Counseling

I believe that most people have the ability to resolve their own problems with a therapist's assistance. While a counselor may offer tools for change it is the client's responsibility to use the tools suggested. You have the right to refuse any technique or collaborate with the therapist on modifications of the techniques suggested to you. As a client you have the right to discuss positive and negative effects of counseling with the therapist and are encouraged to do so. It is important that client's are aware there are risks, as well as benefits to therapy. You may experience interruptions in normal patterns, feelings and social relationships. In addition, some issues may worsen before they get better. As a client you are in complete control and may end the counseling relationship at any time. Should the client or therapist believe a referral is needed, referrals will be made within the agency or to another agency more appropriate for the client's needs. It is your responsibility to pursue referrals and recommendations.

Consent Agreement

I have read and understood this consent form and have had an opportunity to have my questions answered. I have been given a copy of this consent agreement for my records and I agree to the above limits of confidentiality and understand their meanings and ramifications. I voluntarily enter myself or family members into services with Shanna Severn, M.S., NCC. It is without pressure or coercion that I sign this consent.

Client Signature _____ ***Date*** _____

Guardian Signature _____***Date*** _____

Clinician Signature _____ ***Date*** _____

Office Use Only:
Intake Date_____ Verbal Consent Client Initial_____ Clinician Initial _____

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Fees/Additional Charges

My fees are based on the amount of the time spent or reserved. I offer a free 30 minute consultation. After the initial consultation fees are based on a 45 minute session at $80 per individual psychotherapy. Group psychotherapy is 1 hour and 30 minutes - 2 hours and the standard fee is $45 a group session. Additional time for phone calls, preparing letters, conferring with other professionals will be pro-rated at $80/hour. I do offer several lower fee slots for those suffering financial hardship. Please inquire if this is something of need. At the first session we will sign a fee agreement, stating the agreed upon fee. Psychological assessments, testing, and/or questionnaires are priced individually. Fees may increase during the course of treatment. If so, you will be notified in writing 30 days in advance.

Additional charges - You will also be charged the fees for any of the following events:

- A $15 fee for any check submitted to us to pay any sums for which you are obligated to pay in which the check is dishonored.
- A delinquency fee of $25 in the event you fail to timely pay any sum you owe and collection agency is used. If a collection action is initiated and prevailed, we will also seek reasonable attorney fees as the court allows.
- An $80 fee will be charged if you fail to keep an appointment ***and*** fail to give me a 24 hour cancellation notice.

Billing - I request that you pay for your services at the time of the session, by cash or check.

Missed Appointments - The time scheduled for you is reserved exclusively for you. If you do not keep an appointment, no one else will be able to use that time. Therefore, I ask that you please give a 24 hour notice if you need to cancel an appointment. Please call as soon as you know you will not be able to keep a scheduled appointment. My voicemail is accessible at all hours 971-264-0915

Emergencies - Should you find yourself in need of emergency assistance during my office hours (Tuesday thru Wednesday) you may call 971-264-0915 and I will get back to you as soon as possible. If you need emergency assistance after my office hours, you may call the ***Clackamas County Crisis Line at 503-655-8585*** or your local emergency room.

I, _____, HAVE READ AND UNDERSTOOD ALL THE PRECEDING INFORMATION AND AGREE TO BE BOUND TO ALL OF THE PROVISIONS REGARDING CONSENT, CONFIDENTIALITY, FEES, CHARGES AND BILLINGS.

Client Signature _____ ***Date*** _____

Guardian Signature _____ ***Date*** _____

Clinician Signature _____ ***Date*** _____

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TEEN INFORMATION QUESTIONNAIRE

Full Name _____**Today's Date** _____

Please provide the following information. This information will help me provide you with the best services possible. Please answer all questions to the best of your ability. Information you provide here is held to the same standards of confidentiality as our therapy.

CLIENT INFORMATION

Address _____

City_____ State_____ Zip Code _____

Phone [Home] _____ Cell_____ Work_____

Preference for communication/messages _____

Birth Date_____ Place of Birth_____ Age____ Gender: M ☐ F ☐

Email Address _____

Driver's License #_____ Social Security #_____

School_____ Education Level_____Primary Language _____

Religion/Spirituality _____ Race/Ethnicity _____

Pets? Yes ☐ No☐ If so, type_____

PARENT/GUARDIAN INFORMATION

Mother's Name_____ Father's Name _____

Address_____ Address _____

City_____ Zip_____ City_____ Zip _____

Phone (H) _____ (W)_____ Phone (H)_____(W) _____

Phone (C)_____ Fax_____ Phone (C)_____ Fax_____

Employer_____ Employer_____

SS#_____ SS#_____

DOB_____Driver's Lic. #_____ DOB_____ Driver's Lic. # _____

Occupation_____ Occupation_____

Email_____ Email _____

Name of person to contact in case of emergency _____

Address_____Phone # _____

List members of your family and all others living in your home:

Name Age Relationship Occupation

_____

_____

_____

_____

_____

Who suggested you come here?_____

Contact Questions

Briefly describe reason for seeking counseling. _____

_____

_____

_____

What do you see as your strengths? How would your family and friends comment? _____

_____

_____

_____

What do you see as your challenges? How would your family and friends comment? _____

_____

_____

_____

What do you most want to change? _____

_____

_____

_____

What do you most want to stay the same?_____

_____

_____

_____

Have you had therapy before? Yes ☐ No ☐ Was if helpful? Yes ☐ No ☐

If you have had therapy before, describe your experience [include purpose, length of time, results] _____

_____

_____

Expectations of current therapy _____

_____

_____

_____

Current prescriptions/herbal supplements [include name, dosage, & reason] _____

_____

_____

_____

Background Information

What events or conditions happened in your life that impacted you? Include events that have empowered or hindered you? _____

_____

_____

Describe any losses you have experienced (pets, family, friends, relationships, job, financial)___

_____

_____

_____

What activities do you do for fun? _____

_____

_____

What activities have you let go of that you use to enjoy? _____

_____

_____

What physical health challenges are you experiencing now? _____

_____

_____

What physical health challenges did you experience in the past? _____

_____

Describe your weekly physical activity. _____

_____

When did you last see your Dr. for a check-up? _____

What medications are you currently taking? _____

_____

_____

_____

What illnesses run in your family? _____

_____

_____

Have you or anyone in your family experienced trauma? (please list family member & describe)

_____

_____

Have you or anyone in your family attempted or completed suicide? (please list family member) _____

_____

_____

What legal issues have you faced (divorce, custody, mediation, lawsuits or arrests)? Please describe _____

_____

Current Symptoms

Please **circle the number** to rate the following symptoms according to the degree to which they are troubling your current life. Also, **in the blank,** indicate **how long** these problems have affected you. **Scale 1=extremely troubling, 6=not troubling at all**

MOOD	1 2 3 4 5 6 _____	Hurting Others	1 2 3 4 5 6 _____
Tiredness	1 2 3 4 5 6 _____	Hurting Self	1 2 3 4 5 6 _____
Concentration	1 2 3 4 5 6 _____	Dangerous Behavior	1 2 3 4 5 6 _____
Appetite	1 2 3 4 5 6 _____	Attention Deficit	1 2 3 4 5 6 _____
Weight Gain/Loss	1 2 3 4 5 6 _____	Food Management	1 2 3 4 5 6 _____
Amount in last month _____		**SUBSTANCE USE**	1 2 3 4 5 6 _____
Sleep	1 2 3 4 5 6 _____	Alcohol	1 2 3 4 5 6 _____
Nightmares	1 2 3 4 5 6 _____		Drinks/week _____
Insomnia	1 2 3 4 5 6 _____	Drugs	1 2 3 4 5 6 _____
Ambition	1 2 3 4 5 6 _____		Type/week _____
Unhappiness	1 2 3 4 5 6 _____	Caffeine	1 2 3 4 5 6 _____
Irritability	1 2 3 4 5 6 _____		Drinks/week _____
Depression	1 2 3 4 5 6 _____	Tobacco	1 2 3 4 5 6 _____
Manic Behavior	1 2 3 4 5 6 _____		Packs/week _____
Suicidal Thoughts	1 2 3 4 5 6 _____	**RELATIONSHIPS**	1 2 3 4 5 6 _____
ANXIETY	1 2 3 4 5 6 _____	Friends	1 2 3 4 5 6 _____
Nervousness	1 2 3 4 5 6 _____	Conflict with Parents	1 2 3 4 5 6 _____
Panic Attacks	1 2 3 4 5 6 _____	Parent Separated/Divorce	1 2 3 4 5 6 _____
Compulsive Behavior	1 2 3 4 5 6 _____	Sibling Conflict	1 2 3 4 5 6 _____
Obsessive Thoughts	1 2 3 4 5 6 _____	Shyness	1 2 3 4 5 6 _____
Fears	1 2 3 4 5 6 _____	Loneliness	1 2 3 4 5 6 _____
HEALTH	1 2 3 4 5 6 _____	Fear of Being Alone	1 2 3 4 5 6 _____
Bowel Troubles	1 2 3 4 5 6 _____	Distancing Others	1 2 3 4 5 6 _____
Headaches	1 2 3 4 5 6 _____	Sexual Problems	1 2 3 4 5 6 _____
Stomach Trouble	1 2 3 4 5 6 _____	**SELF CARE**	1 2 3 4 5 6 _____
Binging/Purging	1 2 3 4 5 6 _____	School Behavior	1 2 3 4 5 6 _____
THOUGHTS	1 2 3 4 5 6 _____	Learning Disabilities	1 2 3 4 5 6 _____
Making Decisions	1 2 3 4 5 6 _____	Career Choices	1 2 3 4 5 6 _____
Memory	1 2 3 4 5 6 _____	Grades	1 2 3 4 5 6 _____
Confusion	1 2 3 4 5 6 _____	Legal Matter	1 2 3 4 5 6 _____
Communicating	1 2 3 4 5 6 _____	Stress	1 2 3 4 5 6 _____
IMPULSE CONTROL	1 2 3 4 5 6 _____	Incest	1 2 3 4 5 6 _____
Anger	1 2 3 4 5 6 _____	Grief/Loss	1 2 3 4 5 6_____
Temper	1 2 3 4 5 6 _____	Trauma	1 2 3 4 5 6 _____

Self-Care Information

What do you do for relaxation and enjoyment? _____

_____

_____

How does spirituality or religion assist you in managing your life? _____

_____

_____

Who in your life helps to provide you with emotional support? _____

_____

_____

What do you value most in life? _____

_____

_____

What are your hopes and dreams? _____

_____

_____

If everything were better in your life, what would that look like? _____

_____

_____

_____

Anything else you feel is important to address? _____

Office use only: Date Received_____Acct # _____