

## Adult

### Counseling Ministry

9999 Chemstrand Road, Pensacola, FL 32514  
850-471-3430 www.pbbassociation.com

— **Rachael Croley, Director of Counseling Ministries**  
**Licensed Clinical Social Worker - License #SW 6156**

— **Jim Trent**  
**Licensed Mental Health Counselor- License # MH 1400**

— **Vaunda Yenzer**  
**Registered Mental Health Counselor Intern-License IMH# 3524**

— **Erin King**  
**Registered Clinical Social Worker**  
**License# ISW5046**

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### Welcome to our Office!

Thank you for choosing us to help you with your counseling needs. We want to take this opportunity to explain policies and procedures of the Practice at the Pensacola Bay Baptist Association.

### APPOINTMENTS:

We consider our appointments very important. Counseling is a commitment to work together. We pray you will also share in this commitment. Please do not miss sessions if possible. Therapy sessions are 50 minutes. Fee and cancellation policy are described under "Financial Responsibility" below.

### LIMITS OF CONFIDENTIALITY:

Information discussion in the counseling setting is held confidential and will not be shared without the written permission of the client except under the following conditions.

- The client threatens to harm self or another person.
- The client reports the abuse of a child, a person who is elderly, or a person who is disabled.
- The client reports sexual exploitation by a counselor, therapist or other mental health professional.
- Your counseling records by a state or federal court of law if legal action is taken against you.

### RECORD MAINTENANCE AND EMERGENCY SITUATIONS:

Psychotherapy records must be maintained in my possession according to state laws. Copies of your records or a summary of such records will be provided and may be conditioned upon your payment of the reasonable cost of reproduction and time to prepare such records.

If you should experience an emotional or behavioral crisis and I cannot be reached immediately by telephone, you and your family members are instructed to contact the "HELP" Line at 438-1617, dial 911, or present yourself at the nearest hospital emergency room.

### FINANCIAL RESPONSIBILITY:

You are responsible for full payment of all services regardless of insurance coverage. A sliding fee scale is available for those who financially qualify. Verification is necessary when using sliding fee scale. At the completion of each session you will receive a receipt of service that is appropriate to file with your insurance for reimbursement. Please make checks payable to **PBBA (Pensacola Bay Baptist Association)**.

A minimum **return check** fee of \$7 will be charged. Fees are as follows:

<b>First Session:</b>	<b>\$90.00 (50 minutes)</b>	<b>AGREED FEE AMOUNT \$ _____</b>
<b>Individual Session:</b>	<b>\$80.00 (50 minutes)</b>	<b>BASED ON SLIDING FEE SCALE</b>
<b>Family/Couple Session:</b>	<b>\$90.00 (50 minutes)</b>	<b>*PLEASE BRING INCOME VERIFICATION IF USING THE SLIDING FEE SCALE.</b>

We are now accepting the following major credit cards!  
Visa, MasterCard, & Discover

No fees will be charged for appointments canceled 24 hours or more prior to appointment date and time. Half fees will be charged for no shows or last minute cancellations. Voice mail is available 24 hours a day, and messages are checked daily.

I have read the Office, Financial and Confidential Policies outlined in this document and agree to comply with these policies. I agree to the limits of confidentiality.

\_\_\_\_\_  
Client's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Guardian's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Counselor's Signature

\_\_\_\_\_  
Date

# Pensacola Bay Baptist Association

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### FACE SHEET

1. Patient Name: \_\_\_\_\_  
(Last) (First) (MI) (Nickname)
2. Address: \_\_\_\_\_ 3. Home Phone: ( ) \_\_\_\_\_  
(City) (State) (Zip)
4. Work Phone: ( ) \_\_\_\_\_ 5. Social Security #: \_\_\_\_\_ 6. Birth date: \_\_\_\_\_ Age: \_\_\_\_\_
7. Sex: M F 8. Marital Status: S M D W 9. Employer: \_\_\_\_\_
10. Occupation: \_\_\_\_\_ 11. Student/School: \_\_\_\_\_
12. If dependent child, are custodial parents: \_\_\_Married \_\_\_Separated \_\_\_Divorced \_\_\_Other
13. Religion \_\_\_\_\_ 14. REFERRED BY: \_\_\_\_\_
15. IN CASE OF EMERGENCY NOTIFY:  
Name: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone ( ) \_\_\_\_\_

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### FINANCIALLY RESPONSIBLE PARTY

1. Guarantor Name: \_\_\_\_\_ Birth date: \_\_\_\_\_  
(Last) (First) (MI)
2. Guarantor Address \_\_\_\_\_  
(City) (State) (Zip)
3. Guarantor Relationship to Patient (circle one): Spouse Mother Father Sibling Other Relative Friend
4. Home Phone: ( ) \_\_\_\_\_ 5. Social Security # \_\_\_\_\_ 6. Drivers License # \_\_\_\_\_
7. Previous Address (if less than 3 yrs. at current address) \_\_\_\_\_
8. Guarantor's Employer: \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ Occupation \_\_\_\_\_
9. Spouse Name: \_\_\_\_\_ 10. Spouse Work Phone: ( ) \_\_\_\_\_

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### INSURANCE

1. Primary Insurance Co. Name: \_\_\_\_\_ Phone :( ) \_\_\_\_\_  
Insurance Co. Address: \_\_\_\_\_
2. Subscriber's Name: \_\_\_\_\_ Relationship to Patient: Self Spouse Parent Other  
Employer: \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ Occupation \_\_\_\_\_  
Birth date: \_\_\_\_\_ Group ID# \_\_\_\_\_ Social Security# \_\_\_\_\_

I understand I am financially responsible for all service rendered to me or the client and agree to pay charges for such services present and future at the time services are provided.

Client Signature \_\_\_\_\_ Date: \_\_\_\_\_

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### Consent to Treatment

I do hereby seek and consent to take part in the treatment by the therapist names below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or any procedures provided by this therapist. I acknowledge that I have been informed counseling can be a painful process. I have had all my questions answered fully.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court system.)

I know I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel or do not show, I will be charged for the missed appointment.

I am aware that an agent of my insurance company or third-party payer may be given information about the type(s), cost(s) and providers of any service or treatments I receive. I understand payment for service is due at the end of each session, and I am responsible for full payment regardless of insurance coverage.

My signature below shows I understand and agree with all of these statements.

\_\_\_\_\_  
Signature of client (parent, guardian  
or other representative)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship to Client

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian or other representative.) My observations of this person's behavior and responses give me no reason to believe this person is not fully competent to give informed consent and willing consent.

\_\_\_\_\_  
Therapist

\_\_\_\_\_  
Date

**Pensacola Bay Baptist Association**  
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**Adult Checklist of Concerns**

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Please mark all of the items that apply to you and feel free to add any others at the bottom.

- Abuse—physical, sexual, emotional, neglect (of children or elderly)
- Aggression, violence
- Alcohol use
- Anger hostility, arguing, irritability
- Anxiety, nervousness
- Attention, concentration, distractibility
- Career concerns, goals and choices
- Childhood issues (your own childhood)
- Codependence
- Confusion
- Compulsions
- Custody of Children
- Cruelty to Animals
- Decision making, indecision, mixed feelings, putting off decisions
- Delusions (false ideas)
- Dependence
- Depression, low mood, sadness, crying
- Divorce, separation
- Drug use—prescription medications, over-the-counter medication, street drugs
- Eating problems—overeating, under eating, appetite, vomiting
- Emptiness
- Failure
- Fatigue, tiredness, low energy
- Fears, phobias
- Financial or money troubles, debt, impulsive spending, low income
- Friendships
- Gambling
- Grieving, mourning, deaths, losses, divorce
- Guilt
- Headaches, other kinds of pains
- Health, illness, medical concerns, physical
- Inferiority feelings
- Interpersonal conflicts
- Impulsiveness, loss of control, outbursts
- Irresponsibility
- Judgment problems, risk taking
- Legal matters, charges, suits
- Loneliness
- Marital problems
- Memory problems
- Menstrual problems, PMS, menopause

- Mood swings
- Motivation, laziness
- Nervousness
- Obsessions, compulsions
- Oversensitivity to rejection
- Panic or anxiety attacks
- Perfectionism
- Pessimism
- Procrastination
- Relationship problems
- School problems
- Self-centeredness
- Self-esteem
- Self-neglect, poor self-care
- Sexual issues, dysfunctions, conflicts, desire differences, other
- Shyness, oversensitivity
- Sleep problems—too much, too little, insomnia, nightmares
- Smoking and tobacco use
- Stress, relaxation, stress management, stress disorders, tension
- Suspiciousness
- Suicidal thoughts
- Temper problems, self-control, low frustration tolerance
- Threats, violence
- Thought disorganization and confusion
- Weight and diet issues
- Withdrawal, isolating
- Work problems, employment, workaholic/overworking, can't keep a job

**Please use this space to write any other concerns or issues.**

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**Psychosocial Assessment**

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Name: \_\_\_\_\_

Record# \_\_\_\_\_

Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Therapist: \_\_\_\_\_

DIRECTIONS: Please answer the following questions as fully as possible.

Problem Assessment

Present Problem - Precipitating Stressors: "In recent months, I have worried a lot about: *Please circle all that apply:*

Marital issues                      Health issues                      Job issues                      Financial issues

Parent/child issues Issues of past (guilt, abuse, neglect, family of origin issues, etc.)

Other \_\_\_\_\_

Symptoms: *Please circle all that apply:*

Change in sleep pattern                      Decreased concentration                      Change in appetite

Increased anxiety                      Decreased energy                      Suicidal feelings

Decreased motivation                      Other \_\_\_\_\_

Suicidal/Homicidal Ideation:

Have you attempted to commit suicide or homicide in the past?    Yes    No

If yes, how? \_\_\_\_\_

Is there a history of suicide in your nuclear and/or extended family?    Yes    No

Have you ever inflicted burns or wounds to yourself?    Yes    No

Are you presently suicidal/homicidal?    Yes    No

What event(s) in the recent past has/have prompted you to seek counseling? \_\_\_\_\_

\_\_\_\_\_

Describe additional problems you are experiencing. \_\_\_\_\_

\_\_\_\_\_

When did these problems develop? \_\_\_\_\_

\_\_\_\_\_

Circle any recent losses you have experienced.

Family                      Health                      Disruption of lifestyle                      Job                      Significant other

Other \_\_\_\_\_

List your strengths and weaknesses.

Strengths

Weaknesses

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Psychiatric History

Please list any previous outpatient counseling experiences.

Place \_\_\_\_\_

Length of time there \_\_\_\_\_ Dates \_\_\_\_\_

Have you ever been admitted to the hospital for mental health or addiction issues?

Place \_\_\_\_\_

Length of time there \_\_\_\_\_ Dates \_\_\_\_\_

Name of current doctor and/or therapist \_\_\_\_\_

List all medications you have taken *in the past* for anxiety, depression, and/or sleep. \_\_\_\_\_

Medical Information:

How would you describe your current condition of health? \_\_\_\_\_

Are you currently on any medication?  Yes  No

Name of medication \_\_\_\_\_ Dosage/frequency \_\_\_\_\_ Prescribing Physician \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Has it been more than a year since your last physical exam including blood tests?  Yes  No

Have you ever had an abortion?  Yes  No

Do you have allergies?  Yes  No If yes, explain \_\_\_\_\_

List any previous health problems, operative procedures, and medical hospitalizations:

Problem \_\_\_\_\_ Date \_\_\_\_\_ Treatment \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Substance Abuse History:

Describe your current usage or usage within the past year (including alcohol, caffeine and tobacco).

Substance \_\_\_\_\_ Amount \_\_\_\_\_ Frequency \_\_\_\_\_ Age of 1<sup>st</sup> use \_\_\_\_\_ Age regular use started \_\_\_\_\_ Last use \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you experienced a recent increase in the use of alcohol and/or other substances?  Yes  No

Do you see your current usage as a problem?  Yes  No If yes, when did it become problematic? \_\_\_\_\_

Please describe any previous experience with drugs or alcohol. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Describe any significant family history of substance abuse. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



Nutrition:

Have your eating habits changed recently?  Yes  No If yes, please describe \_\_\_\_\_

Has your weight fluctuated more than +/- 10 lbs. over the previous year?  Yes  No

Do you often eat out of depression, boredom, anger?  Yes  No If yes, please describe \_\_\_\_\_

Do you ever self-induce vomiting?  Yes  No

How do you feel about eating with others in a group? \_\_\_\_\_

Do you ever binge eat or feel your eating is out of control?  Yes  No If yes, please describe \_\_\_\_\_

If you use laxatives, water pills (diuretics), or diet medications, how often do you use them? \_\_\_\_\_

Legal History:

*Please explain all that apply:*

Charges as a minor \_\_\_\_\_

Charges presently \_\_\_\_\_

Arrests (How many) \_\_\_\_\_

Incarcerations (How many) \_\_\_\_\_

Parole \_\_\_\_\_

Convictions (How many) \_\_\_\_\_

Probation \_\_\_\_\_

Bankruptcy \_\_\_\_\_

Civil Suits \_\_\_\_\_

Child Custody Problems \_\_\_\_\_

Developmental History:

List members of your family or origin and how you got along with each one.

Family Member	Comment
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

What was your birth order? \_\_\_\_\_ of \_\_\_\_\_ children. Who primarily raised you? \_\_\_\_\_

How would you describe your childhood?  Traumatic  Painful  Uneventful

What were you like as a child (include friends, school, hobbies, and personality)? \_\_\_\_\_

Were there any unusual or traumatic experiences for you as a child?

Date	Age	Event
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What is your sexual orientation?  Heterosexual  Homosexual  Bisexual

Work Adjustment History:

Describe your current job/career \_\_\_\_\_

What do you like/dislike about your employment/career? Please list

Like

Dislike

_____	_____
_____	_____
_____	_____

Would you enjoy doing this job on a long-term basis? \_\_\_\_\_

If you could have any job/career, what would you choose? \_\_\_\_\_

Why would you choose this? \_\_\_\_\_

How do you deal with authority figures? \_\_\_\_\_

Describe your relationship with co-workers \_\_\_\_\_

Describe your job performance \_\_\_\_\_

Have you ever been fired  Yes  No If yes, explain \_\_\_\_\_

How many jobs have you held within the previous five years? \_\_\_\_\_

Military History:

List branch, dates, and duties. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Educational History:

What was school like for you? \_\_\_\_\_

Highest level achieved \_\_\_\_\_ What type of grades did you make? \_\_\_\_\_

Are you currently in school?  Yes  No If yes, what level? \_\_\_\_\_

Family:

Would it be beneficial for any members of your family to be involved in your treatment?  Yes  No

If yes, explain who and why. \_\_\_\_\_

\_\_\_\_\_

Miscellaneous:

Are there any other things that can be helpful for us to know about you? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature

Date