

Adult

Counseling Ministry

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

___ **Jim Trent, Director of Counseling Ministries**
Licensed Mental Health Counselor - License #MH1400

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License # ISW507

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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:

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

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

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FACE SHEET

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

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. Previous Address (if less than 3 yrs. at current address) _____
6. Guarantor's Employer: _____ Work Phone () _____
Occupation _____
7. Spouse Name: _____
8. Spouse Work Phone: () _____

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

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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

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 1st 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. _____

Living Arrangements:

___ Satisfactory? ___ Unsatisfactory?

Where do you currently live? _____ How long there? _____

With whom are you living? _____

Describe your current relationships with family members

Support System:

Who can you count on for support? *Circle as many as apply.*

Parents Spouse Siblings Employer Church Pastor Therapist Neighbor(s)

Extended Family Close Friend Self-help Group Community Services Co-Worker Medical Dr.

Other _____

Financial Situation: Describe briefly your financial situation. _____

Marital History (if applicable):

When were you married? _____ Name and age of spouse _____

Previous marriage ___ Yes ___ No If yes, date of divorce _____

Any children from this marriage? _____

What is your perception of your current marriage (include communication patterns, problems, sexual relations).

List names and ages of children. How do you get along with each one?

Name Age Comment

Name	Age	Comment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Religious/Cultural Factors:

Please list any issues which are important or may have affected you in regard to religion or ethnic/cultural background. _____

What is your religious background? _____

Do you currently attend church, synagogue, or mosque? ___ Yes ___ No

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

<u>Like</u>	<u>Dislike</u>
_____	_____
_____	_____
_____	_____

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 _____