

Pensacola Bay Baptist Association

Counseling Ministry

9999 Chemstrand Road, Pensacola, FL 32514

850-471-3430 www.pbbassociation.com

___ **Jim Trent, Director of Counseling**
Licensed Mental Health Counselor
License #MH 1400

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Registered Clinical Social Work - Intern
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Registered Mental Health – Intern
License # IMH7785

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)	*BRING INCOME VERIFICATION TO RECEIVE SLIDING FEE

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

No fees will be charged for appointments cancelled 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: _____ 3. Home Phone: () _____
(City) (State) (Zip)
4. Work Phone: () _____ 5. Birth date: _____ Age: _____
6. Sex: M F 7. Marital Status: S M D W 7. Employer: _____
8. Occupation: _____ 9. Student/School: _____
10. If dependent child, are custodial parents: ___Married ___Separated ___Divorced ___Other
11. Religion _____ 12. REFERRED BY: _____
13. 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. Guarantor's Employer: _____ Work Phone () _____ Occupation _____
6. Spouse Name: _____ 7. Spouse Work Phone: () _____

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

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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CHILD AND ADOLESCENT CONSENT FOR TREATMENT

PATIENT: _____ Birth date: _____

I certify that I am the father/ mother/ guardian of the above named child/adolescent and that I do have legal custody of the above named child/adolescent. I hereby give my authorization and consent for the above named child/adolescent to receive outpatient assessment/therapy from the Counseling Ministry affiliated with Pensacola Bay Baptist Association.

Date: _____

Signature: _____

Printed Name: _____

Relationship to Client: _____

Date: _____

Signature: _____

Printed Name: _____

Relationship to Client: _____

**Child and Adolescent Assessment
PARENT QUESTIONNAIRE**

Name of Child

Date of Birth

Age

PREGNANCY PROBLEMS

Please check the following for the mother of this child:

- | | TRUE | NOT TRUE | DON'T KNOW |
|--|-------------|-----------------|-------------------|
| 1. Had bleeding during the first 3 month | _____ | _____ | _____ |
| 2. Had bleeding during the second 3 months | _____ | _____ | _____ |
| 3. Had bleeding during the last 3 months | _____ | _____ | _____ |
| 4. Gained less than 15 pounds, specify: | _____ | _____ | _____ |
| 5. Gained more than 30 pounds, specify: | _____ | _____ | _____ |
| 6. Had pre-eclampsia or toxemia | _____ | _____ | _____ |
| 7. Had to take medications; list: | _____ | _____ | _____ |
| 8. Took narcotic drugs; list: | _____ | _____ | _____ |
| 9. Drank alcohol; amount: | _____ | _____ | _____ |
| 10. Had previous miscarriage; number: | _____ | _____ | _____ |
| 11. Had premature baby(ies) | _____ | _____ | _____ |
| 12. Smoked 1 pack or more of cigarettes daily | _____ | _____ | _____ |
| 13. Labor lasted less than 2 hours | _____ | _____ | _____ |
| 14. Labor lasted more than 12 hours | _____ | _____ | _____ |
| 15. Had a difficult labor | _____ | _____ | _____ |
| 16. Was put to sleep for delivery | _____ | _____ | _____ |
| 17. Was given medication for labor; specify: | _____ | _____ | _____ |
| 18. Delivery was normal | _____ | _____ | _____ |
| 19. Delivery was breech, caesarian, forceps, induced | _____ | _____ | _____ |
| 20. How was the mother's health during the pregnancy of this child/adolescent? ___good ___ fair ___don't know | | | |
| 21. How old was the mother when this child/adolescent was born? _____ | | | |
| 22. Was this child/adolescent born on schedule? ___8 mths. or earlier ___term (8-10 mths) ___after 10 mths ___don't know | | | |
| 23. What was this child's adolescent's birth weight? ___pounds ___ounces | | | |
| 24. Is this child/adolescent adopted? ___yes ___no If yes, at what age? _____ | | | |
| 25. Number of previous pregnancies: _____ | | | |
| 26. Number of living children: _____ | | | |

NEWBORN INFANT PROBLEMS

(First month of life)

- | | TRUE | NOT TRUE | DON'T KNOW |
|---|-------------|-----------------|-------------------|
| 1. Born with cord around neck | _____ | _____ | _____ |
| 2. Injured during birth | _____ | _____ | _____ |
| 3. Had trouble breathing | _____ | _____ | _____ |
| 4. Got yellow (jaundiced) | _____ | _____ | _____ |
| 5. Turned blue (cyanosis) | _____ | _____ | _____ |
| 6. Was a twin or triplet | _____ | _____ | _____ |
| 7. Had an infection | _____ | _____ | _____ |
| 8. Was given medications, specify: | _____ | _____ | _____ |
| 9. Had seizures | _____ | _____ | _____ |
| 10. Needed oxygen | _____ | _____ | _____ |
| 11. Was in hospital more than five days | _____ | _____ | _____ |
| 12. Born with a heart defect | _____ | _____ | _____ |
| 13. Born with other defect(s), specify: | _____ | _____ | _____ |
| 14. Had trouble sucking | _____ | _____ | _____ |
| 15. Had skin problems | _____ | _____ | _____ |
| 16. Colic | _____ | _____ | _____ |
| 17. Sleep problems | _____ | _____ | _____ |

DEVELOPMENTAL FACTORS

When did your child/adolescent do the following:
(If you cannot recall the age, write either early, normal, or late.)

	Never	0-3	4-6	7-12	13-18	19-24	2-3	3-4	4-5	5-7	Since
		mo.	mo.	mo.	mo.	mo.	yrs.	yrs.	yrs.	yrs.	yrs.
1. Hold up head											
2. Roll front to back											
3. Sit alone											
4. Crawl											
5. Walk alone											
6. Speak single words (not mama or dada)											
7. String two or more words together											
8. Toilet trained (bladder control)											
9. Toilet trained (bowel control)											
10. Attend pre-school											
11. Attend kindergarten											
12. Have difficulty separating from parents											
13. Thumb-sucking											
14. Fear of animals, darkness, etc.											
15. Nightmares											
16. Hurt self, others, animals											
17. Play with fire											
18. Run away											
19. Temper tantrums											
20. Open masturbation											
21. Afraid to go to school											
22. Behavior problems at school											
23. Academic problems at school											

- How would you rate the activity level of the child/adolescent as an infant/toddler?
 very active active average less active not active
- Approximately how long did toilet training take from onset to completion?
 less than 1 month 1-2 months 2-3 months more than 3 months

MEDICAL HISTORY

Please rate your child/adolescent in each of the following areas:

	GOOD	FAIR	POOR
1. Health			
2. Hearing			
3. Vision			
4. Gross motor coordination			
5. Fine motor coordination			
6. Speech articulation			

- Has your child/adolescent had any chronic health problems (e.g. asthma, diabetes, heart condition)? No Yes
 If yes: _____
- When was the onset of any chronic illness? Birth 0-1 yr 1-2 yrs 2-3 yrs 3-4 yrs
 Over 4 yrs
- Check which of the following illness this child/adolescent has had:
 mumps chicken pox measles whooping cough scarlet fever pneumonia
 encephalitis otitis media lead poisoning seizures other
- Check if this child/adolescent has had any accidents resulting in the following:
 broken bones head injury stomach pumped lost teeth severe lacerations
 severe bruises eye injury stitches
- How many accidents has this child/adolescent had? one 2-3 4-7 8-12 over 12
- Check if this child/adolescent has had surgery for any of the following conditions:
 tonsillitis appendicitis leg or arm burns adenoids digestive disorder

___ eye, ear, nose or throat ___ hernia ___ urinary tract
 ___ other _____

13. How many times? ___ once ___ twice ___ 3-5 times ___ 6-8 times ___ 8 times or more
 14. How long was your child/adolescent in the hospital? ___ one day ___ 2-3 days ___ 4-6 days ___ 1-4 weeks ___ 1-2 month

Please check the following problems:

- | | YES | NO | DON'T KNOW |
|--|-----|-----|------------|
| 15. Suspicion of alcohol or drug use | ___ | ___ | ___ |
| 16. History of physical/sexual abuse | ___ | ___ | ___ |
| 17. Sleeping problems | ___ | ___ | ___ |
| 18. Is this child/adolescent a restless sleeper | ___ | ___ | ___ |
| 19. Does this child/adolescent have bladder control problems: At night? ___ Yes ___ No | | | |
| If yes, how often? _____ | | | |
| During the day? ___ Yes ___ No | | | |
| If yes, how often? _____ | | | |
| If yes, did this child/adolescent ever have bladder control? ___ Yes ___ No | | | |
| If yes, explain: _____ | | | |
| 20. Did this child/adolescent have bowel control problems: At night? ___ Yes ___ No | | | |
| If yes, how often? _____ | | | |
| During the day? ___ Yes ___ No | | | |
| If yes, how often? _____ | | | |
| If yes, did the child/adolescent ever have bowel control? ___ Yes ___ No | | | |
| If yes, explain: _____ | | | |
| 21. Does this child/adolescent have any appetite control problems? ___ overeats ___ average ___ under-eats | | | |

SEXUAL MATURATION HISTORY

Did you notice any unusual behavior in your child/adolescent (i.e. cross dressing, excessive or public masturbation, sexual offenses, promiscuity, etc)? _____

At what age did your child/adolescent show adult body development? _____

At what age did your child/adolescent begin menstruating? _____

Was your child/adolescent prepared for these changes? _____

Were there any special problems with the onset of menstruation? _____

Does your child/adolescent appear comfortable with the opposite sex? ___ Yes ___ No

Is your child/adolescent sexually active? ___ Yes ___ No

Have there been any pregnancies or abortions? ___ Yes ___ No

TREATMENT HISTORY

1. Check the medications your child/adolescent has been prescribed and write in the length of time they were on medication:

MEDICATION	DURATION
Ritalin	
Tranquilizers	
Dexedrine	
Cylert	
Other	

2. Has this child adolescent ever had any of the following forms of psychological treatment? If so, how long did it last and when was it:

 Individual psychotherapy _____

 Group psychotherapy _____

 Family therapy with child _____

 Inpatient evaluation _____

Day hospital treatment _____

Residential treatment _____

FAMILY HISTORY

Check if there is any history of any of the following in the family:

- 1. ___ Learning Disabilities
- 2. ___ Mental Retardation
- 3. ___ Psychosis or Schizophrenia
- 4. ___ Depression
- 5. ___ Anxiety Disorder
- 6. ___ Tics or Tourettes
- 7. ___ Alcohol or Drug Abuse
- 8. ___ Arrests
- 9. ___ Physical or Sexual Abuse
- 10. ___ Hyperactivity
- 11. ___ Birth Defects
- 12. ___ Diabetes
- 13. ___ Nervous Breakdown

LIVING SITUATION

1. Last living situation of child/adolescent: (Circle One)

- a. Both parent's home
- b. One parent's home
- c. Legal guardian's home
- d. Relative's home
- e. Friend's home
- f. Other _____

2. Primary living situation for past year: (Circle one)

- a. Both parent's home
- b. One parent's home
- c. Legal guardian's home
- d. Relative's home
- e. Friend's home
- f. Other _____

Please describe the family home: ___ House ___ Apartment ___ Condo

___ Number of rooms ___ Number of bathrooms ___ Number of bedrooms

Please indicate who sleeps in each bedroom _____

Please describe your neighborhood _____

Who has taken care of the patient most of their life? _____

Who is the primary disciplinarian in the family? _____

Are they: ___ strict ___ lenient

Do parents agree on the issues of parenting, rules and discipline? ___ always ___ usually ___ sometimes ___ rarely

Have there been or are there currently any major changes or stresses in the family where the child was raised?

___ Yes ___ No If yes, please check all the following that applies:

	<u>In past</u>	<u>Current (6 months or less)</u>
Financial problems	_____	_____
Frequent moves	_____	_____
Job changes	_____	_____
Drinking/drug problems	_____	_____
Arguments between parents	_____	_____
Separation or divorce of parents	_____	_____
Remarriage of parent(s)	_____	_____

Separation from sibling(s)	_____	_____
Separation from other family member	_____	_____
Frequent physical punishment	_____	_____
Physical confrontations between parents	_____	_____
Separation from significant non-family member	_____	_____
Mental illness in family	_____	_____
Physical illness in family	_____	_____
Psychiatric hospitalization of a parent	_____	_____
Death in the family	_____	_____
Sexual promiscuity of incestuous behavior in family	_____	_____
Family feels isolated	_____	_____
Other _____	_____	_____

How has the family been changed by the patient's problem(s)? _____

What are the family's expectations of treatment? _____

What does the family see as their role in treatment? _____

What are the family's strengths? _____

What are the family's weaknesses? _____

SCHOOL HISTORY

1. Please summarize the child/adolescent's progress (e.g. academic, social, testing) within each of the following grade levels:

Preschool: _____

Kindergarten: _____

Grades 1-3: _____

Grades 4-6: _____

Grades 7-12: _____

2. Has the child/adolescent ever been in any type of special educational program, and if so, how long?

Learning disabilities class _____

Behavioral/emotional disorders class _____
Helping teacher/content mastery _____
Speech and language therapy _____
Other _____

3. Check any of the following that apply with this child/adolescent at school:

	In what grades
Oppositional _____	_____
Disrupt class _____	_____
Inattentive _____	_____
Refuse to go to school _____	_____
Fail to turn in work _____	_____
Disorganized _____	_____
Detention _____	_____
In-school suspension _____	_____
Out-of-school suspension _____	_____
Expelled from school _____	_____

4. Have any additional instructional modifications been attempted?
 None behavior modification program daily/weekly report card
 other _____

5. Has this child/adolescent had any educational testing? Yes No
If yes, what _____ (and bring it with you to the appt.)

SOCIAL HISTORY

1. How does this child/adolescent get along with his/her brothers/sisters?
 Doesn't have any better than average average worse than average
2. How easily does this child/adolescent make friends? Easier than average average worse than average
3. On the average, how long does your child/adolescent keep friendships? less than 6 mths 6 mts-1 year
 more than 1 year
4. Is your child/adolescent able to form close relationships? Yes No
5. Personality traits of your child/adolescent: withdrawn anxious outgoing
 other _____
6. How would you describe a typical day for your child/adolescent: _____

CURRENT BEHAVIORAL CONCERNS

1. What are your primary concerns at this time? _____

2. What are other (related concerns)? _____

3. What strategies have been used to address these problems? (Check those that apply and circle those that have been successful):
 Verbal reprimands -time out (isolation) removal of privileges rewards
 physical punishment giving in to the child avoiding the child
4. On the average, what percentage of the time does your child/adolescent comply with initial commands?
 0-20% 20-40% 60-80% 80-100%
5. On the average what percentage of the time does your child/adolescent eventually comply with commands?

___0-20% ___20-40% ___60-80% ___80-100%

6. To what extent are you and your spouse consistent with respect to disciplinary strategies?

___Most of the time ___some of the time ___none of the time

What would you like to change about your family? _____

Is there anything else about the family that we should know in order to be more helpful? _____

Please mark any of the statements below which apply to your family.

	Yes	No
Our family is warm and loving	_____	_____
People are always fighting	_____	_____
Everyone goes his or her own separate way	_____	_____
People say what is on their mind	_____	_____

Signature

Date

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Adolescent Questionnaire

Confidential

NOTE: THIS FORM IS OPTIONAL! Any information you give me would help me to know more about you (rather than just what your parents say about you). If you would rather not, please feel free to answer only part or none of the questions. Please **DO NOT** show your parents your answers.

Name _____

Age _____

Whose idea was it for you to come here?

mine

parent(s)

other _____

How do you feel about being here?

It's fine with me

I don't care either way

I'm against it

What would you say is the reason you are here? _____

School

What school do you go to? _____

Anything you particularly like about it? _____

Anything you particularly don't like? _____

What activities (if any) are you in at school (such as sports, music, etc.)? _____

What subject(s) are you strongest in? _____

What subject(s) are you weakest in? _____

Activities and Interests

What do you do for fun? _____

What kind of music do you listen to? _____

Any current favorite artist, tape, or song? _____

Friends

How much time do you spend with friends? a lot of time some time not much time

Do you have a "best" friend? Yes No

If so, how long have you known him/her? _____

Can you talk to this person about serious problems in your life? () Yes () No

Do you have a boyfriend/girlfriend? () Yes () No

If so, how long have you been dating? _____

Do people at school tend to label your group of friends (e.g. skaters, metal heads, preps, etc.)?

() Yes () No

If so, what label would you usually be given? _____

Health

How would you rate your overall health? () good () fair () poor

Check all that apply to you:

- () I have headaches once a week or more.
- () I have gained 10 lbs. or more within the past 2 months.
- () I have lost 10 lbs. or more within the past 2 months.
- () I have difficulty falling asleep.
- () I wake up frequently during the night
- () I wake up very early and can't get back to sleep.
- () I feel tired much of the time
- () I have a hard time concentrating.
- () My memory is not as good as it used to be.

Check all the feelings that you often have:

- | | | |
|-------------------------|--------------------|--------------|
| ___happy | ___sad | ___angry |
| ___irritable/"touchy" | ___anxious/nervous | ___bored |
| ___confused | ___confident | ___shy |
| ___"hyped up"/energetic | ___guilty | ___depressed |
| ___worried | ___lonely | ___worthless |

Drug and Alcohol Use

	never	tried	rarely	monthly	weekly	daily
How often do you drink?	()	()	()	()	()	()
Smoke cigarettes?	()	()	()	()	()	()
Smoke marijuana?	()	()	()	()	()	()
Use other drugs?	()	()	()	()	()	()

Family

Fill in all that apply to you:

How well do you get along with your:

- mother _____
- father _____
- stepmother _____
- stepfather _____
- brother(s) _____
- sister(s) _____

stepbrother(s) _____

stepsister(s) _____

Please list any major changes in your life over the past five (5) years: _____

If there anything else you want me to know about you? _____

Thanks for filling this out. Your information will help me a lot in helping you and/or your family.