INTAKE INFORMATION PROFILE

GENERAL INFORMATION

Name _____ Age _____ Gender _____

Occupation _____ Employer _____

Address _____

Home Telephone _____ Cell _____ Work _____

Marital Status: Married _____Divorced _____ Widowed _____Separated _____Single ____

Education: High School (last grade completed) _____College _____ (how many years)

Other Training? (list type and years) _____

HEALTH INFORMATION

Please rate your physical health: Very good _____Good _____Average ____Declining ____

Recent weight changes: Lost _____Gained _____

List important present or past illnesses or injuries _____

_____

Physician's name _____Date of last exam? _____

Presently taking medication? _____ If so, what? _____

For what reason are you taking the medication? _____

Have you been treated by a psychiatrist? _____When? _____How long? _____

Name of psychiatrist, if applicable _____

SPIRITUAL INFORMATION

Currently attend/member of a church? ____Which one? _____

How long? _____Times per month attending _____

Religious background of spouse? _____Does your spouse attend with you? ___

Other religious background? _____

Are you a Christian? _____How long? _____

On a scale of 1-10 (ten being highest) rate your present relationship

with God _____with prayer _____with Bible study _____

EMOTIONAL INFORMATION

Have you ever had a severe emotional upset or trauma? _____Explain _____

_____

Have you ever had counseling in the past? Yes _____No _____

If yes, list counselor or therapist and dates _____

_____

What was the outcome? _____

Please circle the following words which best describe you now

active ambitious self-confident persistent nervous hardworking impatient impulsive moody

often blue excitable imaginative calm submissive self-conscious lonely sensitive

depressed serious easy-going shy good-natured introvert likeable leader quiet

Suicide Risk Assessment

Have you ever had feelings or thoughts that you didn't want to live? ( ) Yes ( ) No

If YES, please answer the following. If NO, please skip to the "Substance Abuse" section.

Do you **currently** feel that you don't want to live? ( ) Yes ( ) No

How often do you have these thoughts? _____

When was the last time you had thoughts of dying? _____

Has anything happened recently to make you feel this way? _____

On a scale of 1-10 (10 being strongest), how strong is your desire to kill yourself currently? __

Would anything make it better? _____

Have you ever thought about how you would kill yourself? _____

Is the method you would use readily available? _____

Have you planned a time for this? _____

Is there anything that would stop you from killing yourself? _____

Do you feel hopeless and/or worthless? _____

Have you ever tried to kill or harm yourself before? _____

Do you have access to guns? If yes, please explain. _____

Substance Abuse:

Do you use caffeine? ___ Amount per day? _____ Alcohol? ____Amount per day? _____

Recreational drugs? _____ If so, what substances? _____

Please list any other addictions: _____

MARITAL INFORMATION

Spouse's Name_____Age_____Phone_____

Address_____Occupation_____ _____

Education H.S. ____College How many years? __ Willing to come for counseling? _____

Has either of you filed for divorce? ___ Date of marriage? _____

Your ages at marriage: His_____ Hers_____ Length of dating_____ Engagement_____

Number of previous marriages: His _____Hers ____

Children's names and ages: _____

FAMILY OF ORIGIN INFORMATION

Were you reared by anyone other than your birth parents? ___ If yes, please explain _____

_____

Did one or both of your parents die while you were a child? ____ How old were you? _____

Are your parents divorced? ___ When? ___ Age of parents, if living: Mother ____Father _____

Father's occupation _____ Mother's occupation_____

Was your parents' marriage: unhappy _____average _____happy _____very happy _____

As a child were you closest to: father ___ mother ___someone else ___ (whom?) _____

Was your childhood unhappy ___average ____happy ____very happy ____

Please list your siblings in birth order, giving their age and including yourself in the list _____

_____

EXPECTATIONS FOR COUNSELING

What brings you here at this time? _____

_____

Have you done anything about this concern so far? ___ If so, please explain _____

_____

What do you hope to get from this counseling experience? _____

_____

Other information you feel I should know _____

_____

May I contact you by email? Yes ___No ____ If so, please provide your email address

_____

Please place a checkmark next to any of the following symptoms that you may have experienced in the past year. If any symptoms are repeated on this form, please check them again. Thank you!

- _ A persistent sad, anxious or "empty" mood
- _ Sleeping too little or sleeping too much
- _ Reduced appetite and weight loss or increased appetite and weight gain
- _ Loss of interest or pleasure in activities once enjoyed
- _ Restlessness or irritability
- _ Persistent physical symptoms that don't respond to treatment
- _ Difficulty concentrating, remembering, or making decisions
- _ Fatigue or loss of energy
- _ Feeling guilty, hopeless or worthless
- _ Thoughts of death or suicide (D)
- _ Disorganized thinking
- _ disorganized speech
- _ difficulty expressing your emotions
- _ diminished or loss of contact with reality
- _ withdraw from other people
- _ hallucinations
- _ feelings of grandiosity (SC)
- _ Restlessness or feeling on edge
- _ Get tired easily
- _ Concentration problems and mind going blank
- _ Irritability
- _ Muscle tension
- _ Problems falling or staying asleep (GA)
- _ Preoccupation with details, lists, order, organization, rules, or schedules
- _ Perfectionism that interferes with the completion of the task
- _ Excessive devotion to work
- _ Place great value on rules
- _ Difficulty throwing out worn-out, useless, or worthless objects, with no sentimental value
- _ Insist others work or do task exactly as they should
- _ View money as something to hoarded
- _ Told by others that you are stubborn and rigid
- _ Thoughts or impulses that are distressful, persistent and recurrent. These thoughts or impulses may not just be worries of real-life problems. You are aware that these thoughts or impulses are only a product of your own mind and you try to actively suppress, ignore, or neutralize them with other actions.
- _ Engage in repetitive behavior physical or mental that can not be controlled. (E.g., washing hands, checking locks, praying over and over again, counting or saying words repeatedly) These actions help you to prevent or reduce some distressful situation. (O)

_ Re-experience a trauma over and over again in dreams, nightmares or painful memories
_ Anxiety
_ Irritability
_ Depression
_ Diminished ability to experience emotion or intimacy
_ Problems falling or staying asleep (P)
_ Persistent fear of social or performance situations
_ Feel that your behavior will be scrutinized by others and lead to embarrassment (SP)
_ Have different personality states that surface in your life on a recurring basis (DID)
_ Feel detachment or distance from your own experience, body, or self (feel like you are in a dream or spaced out)
_ Feel out of control of your actions and movements
_ Feel like the external world is unreal or distorted (DD)
_ Refuse to eat which leads to a below normal body weight
_ Binge eating followed by self-inducing vomiting, misusing laxatives, fasting, or excessive exercise (E)
_ Act on a certain impulse, that is potentially harmful, but they cannot resist (I)
_ Believe that others are exploiting, harming, or trying to deceive you
_ Experience doubts about friends or associates loyalty or trustworthiness
_ Believes that if you confides in others, this information somehow will be used against you
_ Finds demeaning or threatening meanings in people's remarks or events
_ Find it hard to forgive and bear grudges
_ Find that people are out to attack your character or reputation
_ Believes there maybe infidelity of your sexual partner (PA)
_ Avoid activities with other people
_ Avoid getting involved due to a fear of not being liked by others
_ Restrain yourself in intimate relationships due to a fear of shame or ridicule
_ Concern you may be rejected or criticized by others
_ Stay away from new situations with people due to feelings of inadequacies
_ Views yourself as inferior, socially inept, or personally unappealing
_ Take few if any personal risks in the engagement of new activities, for a fear of being embarrassed (AV)
_ Rapid changes in mood
_ Find yourself going to about any lengths to avoid feeling abandoned
_ Find yourself in relationships that are often difficult or stormy
_ Have difficulty figuring out who you are and what you stand for
_ Impulsive in areas of your life that are self damaging such as sex, spending, eating, driving recklessly or etc.
_ Have you ever thought about or actually cut or scratched yourself intentionally
_ Frequently have feelings of emptiness

_ Frequently feel angry
_ Feel detachment or distance from your own experience, body, or self (feel like you are in a dream or spaced out) (BO)
_ Have a hard time in making everyday decisions with out getting reassurance and advice from others
_ Have others assume the responsibility for the major areas of your life
_ Have difficulty disagreeing with others for fear of being rejected
_ Difficulty in doing things on their own
_ Will do almost anything to get the support of others
_ Feel uncomfortable or helpless when alone
_ When one caring or supportive relationship ends, you are compelled to seek another
_ A fear of being left alone to care for yourself (DP)
_ Uncomfortable if you are not the center of attention
_ Interact with others in a provocative or seductive manner
_ Rapid changing of emotion
_ Use your appearance to draw attention
_ Have been told you are theatrical or very emotional
_ Easily influenced by others
_ Feel that most sociable relationships are intimate. (H)
_ Have fantasies or are preoccupied with your beauty, brilliance, ideal love, power, or success
_ Have a need to associate with people of high status
_ A need for excessive admiration from others
_ Have an expectation of being treated with favor by others
_ Expect an automatic compliance to your wishes
_ Sometimes use others to achieve your goals
_ Find it difficult to empathize with others
_ Often feel envious of others (NP)
_ Marked preoccupation with details, lists, order, organization, rules, or schedules
_ Marked perfectionism that interferes with the completion of the task
_ Excessive devotion to work
_ Excessive devotion and inflexible when it comes to ethics, morals, or values
_ Can not throw out worn-out, useless, or worthless objects, with no sentimental value
_ Insist others work or do task exactly as they would
_ View money as something to hoarded
_ Stubborn and rigid
_ Wish not to have or to enjoy close relationships with family or friends
_ Prefer solitary activities and life
_ Has little or no interest in sex with a partner
_ Have little or no pleasure when doing activities
_ Have few if any close friends other than relatives.
_ Do not feel emotions connected with praise or criticism (SCH P)

- Have increased energy, activity, and restlessness
- Have "high" or euphoric moods often
- Irritability
- Racing thoughts and talking very fast, jumping from one idea to another
- Distractibility, can't concentrate well
- Little sleep needed
- Unrealistic beliefs in one's abilities and powers
- Poor judgment at times
- Spending sprees
- A lasting period of behavior that is different from your usual behavior
- Increased sexual drive
- Abuse of drugs, particularly cocaine, alcohol, and sleeping medications
- Aggressive behavior such as yelling or hurting others (BP)

Schema Questionnaire

Name_____ Date_____

Rate each of the following statements in terms of how true it is for you. Please use the following scale:

1. Completely untrue for me
2. Mostly untrue for me
3. Mostly more true than untrue for me
4. Moderately true for me
5. Mostly true for me
6. Describes me perfectly

The first rating concerns how true the statement was for you as a child at various times in your childhood up to age 12. Then rate how true the statement is for you in your adult life. If the answer may be different for various periods of your adult life, then choose the rating that seems to apply to the last 6 months.

Child	Now	Description
_____	_____	1. I find myself clinging to the people that I'm close to as I fear they might leave me.
_____	_____	2. I worry a lot that the people that I love will find someone else that they prefer and then will leave me.
_____	_____	3. I am usually on the watch for people's ulterior motives. I am not able to trust people easily.
_____	_____	4. I cannot let my guard down around people because I feel they might hurt me.
_____	_____	5. I worry more than the average person about danger such as becoming ill, or harm coming to me.
_____	_____	6. I worry that I, or my family, will lose our money and become dependent on others or destitute.
_____	_____	7. I cannot cope well by myself. I feel I need other people to help me to get by.
_____	_____	8. My parents and I tend to become over involved in each other's problems and lives.
_____	_____	9. I have not had anyone to nurture me, care deeply, share themselves with me, or care deeply about what happens to me.
_____	_____	10. People have not been there to meet my emotional needs for empathy, understanding, advice, guidance, and support.
_____	_____	11. I feel I do not belong because I am different. I just don't fit in.
_____	_____	12. I'm boring and dull and just don't seem to know what to say socially.
_____	_____	13. If people knew my real defects then they could not truly love me.
_____	_____	14. I am ashamed of myself and am unworthy of love, respect from others, and attention.
_____	_____	15. I am not as capable, or intelligent, as most people when it comes to school or work.
_____	_____	16. I often feel inadequate because I don't measure up to others in terms of intelligence, talent, or success.
_____	_____	17. I feel that I have no choice but to give in to the wishes of others or else people will reject me or retaliate in some way.
_____	_____	18. People see me as doing too much for others and not taking care of myself.
_____	_____	19. I try to do my best because I just can't settle for good enough. I strive to be number one in what I do.
_____	_____	20. I have so much to get done that I have little time to relax and really enjoy myself.
_____	_____	21. I feel that I should not have to follow the normal rules in life that other people have to follow.
_____	_____	22. I have difficulty disciplining myself to finish routine boring tasks and to control my emotions.

* Adapted from work of Dr. Jeffrey Young

Adverse Childhood Experience (ACE) Questionnaire

Finding your ACE Score ra hbr 10 24 06

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** …
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often** …
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 _____

4. Did you **often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you **often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score

CONNECTIONS COUNSELING, LLC
900 Corbitt Drive
Wilmore, KY 40390
859-509-8468 o 859-806-9813

Request and Authorization for the Release of Information

Patient Information

Name:_____ Birth Date:_____

Social Security Number:_____

I, _____, authorize Connections Counseling, LLC. to: ☐ Receive from ☐ Disclose to

_____
Name of Agency or Facility

_____ _____
Street Address City/State/Zip

The following specific information will be received/disclosed from the above named patient's record:

☐ Evaluation/Assessment ☐ Progress Notes ☐ Discharge Summary

☐ Treatment/Service ☐ Other:_____

Date(s) of treatment:_____

I understand that the purpose of this disclosure is for:

☐ Use in treatment ☐ Other:_____

I hereby release the above named agency from all liability that may arise from the release of information requested. I expect that the information will be handled in a confidential manner.

Time Limitation: This authorization expires one year from the date of signature of the parent and/or guardian or client. This release is subject to revocation at any time.

PROHIBITION ON REDISCLOSURE: According to 45 CFR 164.508 c2Ciii health information may be redisclosed by the recipient. However, pursuant to KRS **304.17A-555, *Patient's Right of Privacy Regarding Mental Health or Chemical Dependency-Authorized Disclosure*** mental health/chemical dependency info may not be used and/or shared by the recipient of said information unless specific, written consent for redisclosure is authorized by the person to whom it pertains. Additionally, **Federal Regulations 42 CFR, Part 2** prohibits any further disclosure of this information without the specific written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

I acknowledge that I have read and fully understand this authorization.

_____ _____ _____
Client/Parent/Guardian Signature Relationship to Patient Date

_____ _____
Witness Date

Please send via mail: **Connections Counseling, LLC**
900 Corbitt Drive
Wilmore, KY 40390

Connections Counseling, LLC
900 Corbitt Drive
Wilmore, KY 40390

Alex Clark, M.A., M.Div., LMFT #169304 – 859-806-9813
Rhealynn Clark, M.A., LPCC #102212 – 859-509-8468

Informed Consent

1. **Counseling Approach**
   We use a variety of interventions to assist you. Depending on your needs, we may use Cognitive Behavioral Therapy, various Trauma and Attachment Therapy Modalities, Play Therapy, PCIT, TheraPlay, Sand Tray Therapy and/or Emotion Focused Therapy, or other therapies as needed. Your care may also include elements of Christian faith as appropriate.

2. **Goals**
   Specific goals will be developed and mutually agreed upon. The goals may be specific (change in behavior, improved relationships), or more general (less anxiety, better self-esteem). The length of therapy depends on the complexity/severity of your problems.

3. **Fees**
   Fees are on a sliding scale basis, and are due via cash, check, debit card, or credit card at the time of the session. HSA/FSA payments are also available. We do not bill insurance, but at your request, we can provide you a receipt that you can use to file your own claims. We cannot guarantee that an insurance company will reimburse you for services. A $40 fee will be charged for checks that are returned for insufficient funds. Services thereafter will be on a cash or debit/credit card only basis. Your fee for services will be based on a sliding scale according to your family's gross yearly income. Yearly income includes income such as child support payments, maintenance (alimony), and disability payments. Sessions are billed on an hourly rate for the first scheduled hour, and in fifteen-minute increments thereafter. Most sessions will last one hour, but there may also be times where Rhealynn or Alex can decide to provide additional time to complete the therapeutic work in session that day. At Rhealynn or Alex's discretion, sessions can be scheduled on Saturdays with an increased fee.

Please check on the line below to determine the hourly fee for services:

	Yearly Gross Income	Hourly Fee
_____	$0 thru $39,999	$ 65.00
_____	$40,000 thru $49,999	$ 75.00
_____	$50,000 thru $59,999	$ 85.00
_____	$60,000 thru $69,999	$ 95.00
_____	$70,000 thru $79,999	$105.00
_____	$80,000 thru $89,999	$115.00
_____	$90,000 and above	$125.00

4. **Sessions**
   Sessions will begin and end on time. If you arrive late for a session, your session time will be shortened and your normal fee will be expected. Please call 24 hours in advance if you need to change or cancel your appointment. Your appointment time has been reserved just for you. If you do not provide a 24-hour notice, you will be asked to pay for the missed session at the beginning of your next appointment. There will be a fee for a missed session.

5. **Benefits and Risks of Therapy for Minor Children**
   Therapy can be beneficial to your child in a variety of ways. Your child will receive emotional support, learn to understand feelings and problems, and be encouraged to try out new solutions to old problems. While therapy may provide significant benefits, it may also pose risks. Occasionally, a disagreement between parents and/or a disagreement between parents and counselor regarding the best interests of the child may occur. We can usually resolve such disagreements or agree to disagree, so long as this enables your child's therapeutic process. Therapy may also elicit uncomfortable thoughts, feelings, or memories.

6. **Confidentiality for Minor Children**

Therapy is most effective when a trusting relationship exists between the counselor and the child. Privacy is important in securing and maintaining that trust. Specific details of the information children share with their therapist in sessions can be shared with parents, but parents using that information in a negative interaction with the child can impar the child's trust in the safety of the therapeutic space. We will encourage children to be honest and forthcoming and to maintain an emotionally safe environment.

There are specific exceptions to confidentiality which include, but are not limited to:

- When there is risk of imminent danger to your child, we are required by law to take necessary steps to attempt to prevent such danger.
- When there is suspicion that a child is being abused or is at risk of abuse, we are mandated to take steps to protect individuals by informing the proper authorities.
- If there is known danger to another person, we are required by law to inform law enforcement.
- When we are ordered by a judge to disclose information, even after asserting professional privilege.
- You sign a release of information and authorize us to talk to someone else.
- You file a complaint or lawsuit, and while defending ourselves, Rhealynn, Alex, or Connections Counseling as an agency may disclose personal information.

7. **Children and Legal Proceedings**

It is our policy not to testify in court custody/divorce hearings. If you are bringing your child for help during this stressful time in your family's life, then the therapist's work is directed toward helping your child in therapy. Participating in court proceedings is often counterproductive to your child's therapy process. By setting this policy at the beginning of therapy, the therapy room is kept as a safe place for your child to work through emotions. In some cases, at our discretion, we may agree to write a report about your child's progress in therapy. By signing this informed consent, I/we agree not to subpoena or ask for copies of my child's records for legal proceedings, or ask for court testimony/evaluations from Rhealynn Clark, Alex Clark, or Connections Counseling as an agency. I/we also agree to instruct our attorneys not to subpoena Rhealynn, Alex, or Connections Counseling as an agency or refer to Rhealynn, Alex, or Connections Counseling as an agency in a court filing. In the event that we are asked to appear in court or provide a deposition, there will be a fee of $200.00 per hour which includes travel time to and from the location requested.

8. **Benefits and Risks of Therapy for Adults**

Counseling may involve discussing relational, spiritual, psychological, and/or emotional issues that may be distressing. There is no guarantee of outcomes as a result of participating in upcoming sessions. At any point during the counseling process, we may deem it in your best interests to be referred to another professional. If you are involved in violence, substance abuse, or have threatening behavior, we may discontinue your therapy and give you an appropriate referral. You have the right to discontinue counseling at any time.

9. **Confidentiality for Adults**

The therapist will keep everything you say completely confidential, with the following exceptions:

- You sign a release of information and authorize us to talk to someone else.
- We determine that you are a danger to yourself or to others.
- You report information about the abuse of a child, elderly person, or a disabled individual who may require protection.
- You report information regarding someone else being in imminent danger.
- When we are ordered by a judge to disclose information even after asserting professional privilege.
- You file a complaint or lawsuit, and while defending themselves, Rhealynn, Alex, or Connections Counseling as an agency may disclose personal information.
- In couple and family guidance, we do not view confidentiality as applying between a couple and/or family members and will use clinical judgment regarding sharing information.

We will not reveal your identity as a client to others. Therefore, we will not address you first if we meet you somewhere in public. We will decline any social invitations, as once we engage in our role as your counselor, we will always remain in that role in order to best preserve confidentiality. These guidelines are not meant to be discourteous in any way. They are meant for your long-term protection.

10. **Telehealth**
    Prior to providing telehealth services, adult clients or parent/guardian(s) of a minor shall be required to produce a valid photo identification. Also, an initial assessment will be completed to determine if telehealth is an appropriate delivery of treatment. Telehealth may not be appropriate if there are, or likely to be, recurrent crises or emergencies, or if there is, or likely to become, a risk of harm to self or others. Telehealth services may be terminated at our discretion if we deem it is in your best interests to be referred to another professional or in-person care. You have the right to discontinue telehealth services at any time. Telehealth services will be synchronous and conducted via a HIPAA compliant platform with built in information encryption and security. In case of technological difficulties, the therapist will call the client to arrange alternate methods of delivery.

11. **Emergency Care**
    If you have an emergency, please call 911 or go to your local emergency room. We do not provide crisis stabilization or after-hours care. You can contact us between sessions via phone or email, and we will respond at our earliest convenience. If you cannot reach us and have an emergency, please call 911 or go to your local emergency room.

12. **Child Care and Safety on the Premises**
    No provision is made for child care. If your child/children is not participating in a session, please make other arrangements for his/her care. Connections Counseling is not responsible for any accidents or injuries to children who are unsupervised by their parents on the property.

13. **Homework**
    Homework is an important part of the growth that you will make and may be given at each session attended.

14. **Documentation Requests**
    We can provide written summaries of assessments, therapeutic progress, or other reports as needed. There is a fee associated with this service. All documentation and client information is stored securely behind 2+ sets of locks.

15. **Communication and Social Media Policy**
    We do not engage with active clients via social media platforms. Communication is maintained through the therapeutic relationship while clients are participating in services with us. You can contact us between sessions via phone or email, and we will respond at our earliest convenience. If you cannot reach us and have an emergency, please call 911 or go to your local emergency room.

Please sign below that you have read, understand, and agree to comply with the above policies.

Client(s) name (printed): _____

Client(s) signature(s): _____

Parent/guardian signature(s): _____

Date: _____

Email address (for Square invoices and correspondence): _____

Phone number: _____