**CLIENT INFORMATION**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred by: □Internet □Friend □Magazine/Newspaper Ad□ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sex: □ Male □ Female

Name you prefer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Length of Employment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Highest Level of School Completed: □9 □10 □11 □12 □GED College: □1 □2 □3 □4 □Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONTACT INFORMATION**

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_\_\_\_\_\_Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_ May we send mail here: □ Yes □ No  
Cell Phone: ( \_\_\_\_\_\_\_\_\_\_ ) \_\_\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May we leave a message here: □ Yes □ No  
Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_May we send a message here: □ Yes □ No

**REASONS FOR COUNSELING AND GOALS**

What do you hope to gain or change by coming for counseling? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**LEVEL OF DISTRESS**

Indicate how distressed you are by circling on the scale below *(1= Very Little Distress; 10=Extreme Distress)*:

1 2 3 4 5 6 7 8 9 10

Are you currently experiencing any suicidal thoughts? □ Yes □ No. Have you had them in the past? □ Yes □ No

Have you ever attempted suicide? □ Yes □ No. If yes, when & how?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any current thoughts of suicide? □ Yes □ No If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PREVIOUS COUNSELING**

Please list any previous counseling, psychiatric treatment, or residential/in-patient care you have received:

|  |  |  |  |
| --- | --- | --- | --- |
| Location | Therapist | Dates | Reason |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**LEGAL HISTORY**

Are you facing any pending civil or criminal litigation? □ Yes □ No  
Have you been subject to a restraining order in the last 10 years? □ Yes □ No  
Have you filed for a restraining order in the last 10 years? □ Yes □ No  
Have you experienced any litigation relating to divorce or child custody in the last 10 years? □ Yes □ No

Do you anticipate the possibility of litigation relating to divorce or child custody in the next 5 years? □ Yes □ No

**CURRENT STATUS**

**Please check any of the following physiological symptoms that apply to you presently or in the recent past**:

Headaches □ Past □ Present Visual Trouble □ Past □ Present Weakness □ Past □ Present

Insomnia □ Past □ Present Change in Appetite □ Past □ Present Hearing Voices □ Past □ Present

Dizziness □ Past □ Present Sleep Trouble □ Past □ Present Tension □ Past □ Present

Intestinal Trouble □ Past □ Present Tiredness □ Past □ Present Seeing Things □ Past □ Present

Stomach Trouble □ Past □ Present Trouble Relaxing □ Past □ Present Rapid Heart Rate □ Past □ Present

Hearing Noises □ Past □ Present Pain □ Past □ Present Other □ Past □ Present

How has your weight changed in the last 2-3 months? (If so, how?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please check any of the following problems that apply to you and/or your family.**

Abortion □ You □ Family Eating Problems □ You □ Family Trouble with Job □ You □ Family

Ambition □ You □ Family Being a Parent □ You □ Family Disaster □ You □ Family

Anxiety □ You □ Family Depression □ You □ Family Terminal Illness □ You □ Family

Bad Dreams □ You □ Family Unwanted Thoughts □ You □ Family Impulsive Behavior □ You □ Family

Career Choices □ You □ Family Children □ You □ Family Recent Loss □ You □ Family

Communication □ You □ Family Verbal Abuse □ You □ Family Anger □ You □ Family

Concentration □ You □ Family Memory □ You □ Family Self-Control □ You □ Family

Grief □ You □ Family Alcoholism □ You □ Family Fears □ You □ Family

Hopelessness □ You □ Family Loneliness □ You □ Family Friends □ You □ Family

Making Decisions □ You □ Family Finances □ You □ Family Other □ You □ Family

Marriage □ You □ Family Emotional Abuse □ You □ Family Temper □ You □ Family

Nervousness □ You □ Family Unhappiness □ You □ Family Apathy □ You □ Family

Physical Abuse □ You □ Family Sexual Abuse □ You □ Family Aggressiveness □ You □ Family

Pregnancy □ You □ Family Trauma □ You □ Family Alcohol Use □ You □ Family

Racing Thoughts □ You □ Family Loss of Control □ You □ Family Compulsivity □ You □ Family

Recent Death □ You □ Family Inferiority Feelings □ You □ Family Shyness □ You □ Family

Sexual Problems □ You □ Family Legal Matters □ You □ Family Drug Use □ You □ Family

Stress □ You □ Family Panic □ You □ Family Guilt □ You □ Family

**PERSONAL STRENGTHS**

Please list three things that you are proud of: Please list three personal strengths:  
1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RELATIONAL INFORMATION**

Current Marital Status: □ Single □ Engaged □ Married □ Separated □ Divorced □ Widowed

If married, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Number of previous marriages for you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If separated or divorced, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_If widowed, how long?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list family members and other household members (continue on back if necessary):

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name: | In home or Out of home? | Age: | Gender: | Relationship: |
|  |  |  |  |  |
|  |  |  |  |  |
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**MEDICAL INFORMATION**

Primary Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number: ( \_\_\_\_\_\_\_\_ ) \_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax number: ( \_\_\_\_\_\_\_\_ ) \_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently receiving medical treatment? □ Yes □ No. If yes, please specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all current medications you are taking, including those you seldom use or take only as needed.

|  |  |  |
| --- | --- | --- |
| Medication | Dosage | Purpose for Medication |
|  |  |  |
|  |  |  |
|  |  |  |

Are you taking these medication(s) according to your doctor’s recommendations. □ Yes □ No. If no, briefly explain:

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

List significant conditions, illnesses, surgeries, hospitalizations, traumas, or treatments you’ve had.

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

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

**VOLUNTARY MEDICAL RELEASE OF INFORMATION**

I authorize Ormond-by-the-Sea Counseling to release and or obtain medication records and relevant medical information from\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (*doctor’s name and office name*) for the purpose of providing continuity of quality mental health services.

*I understand that I do not have to sign this authorization and my refusal to sign will not affect my ability to obtain treatment.*

*I understand that I may revoke this authorization at any time by written request to Ormond-by-the-Sea Counseling .*

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Are you a recovering alcoholic or drug addict? □ Yes □ No □ Maybe If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TRAUMA/ABUSE HISTORY**

Have you ever experienced a severe trauma? □ Yes □ No □ Maybe If yes or maybe, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Have you ever been physically abused? □ Yes □ No □ Maybe

Have you ever been emotionally abused? □ Yes □ No □ Maybe

Have you ever been sexually abused? □ Yes □ No □ Maybe

**RELIGIOUS/SPIRITUAL INFORMATION**

Is Faith, Religion or Spirituality important to you? □ Yes □ No □ Maybe. If yes or maybe, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Would you like to include prayer as part of your counseling experience? □ Yes □ No

Whatever fee you choose is paid at the time of service. If you fail to show for a scheduled appointment or do not call to cancel 24 hours before a scheduled appointment, we ask that you pay the full amount of the agreed upon fee.

The standard fixed rate for assessments for any third party (Court System, Lawyers, etc.) will be $80 per hour.

The Rate I Choose \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
  
Initial: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TERMS OF SERVICE***I understand that it is customary to pay for professional services when rendered. I accept full responsibility for payment of any balance incurred for services. I further understand that without 24-hour notice of cancellation, I will be charged the full fee for professional service.*

**PAYMENT**

*All accounts are requested to have a credit card on file to reserve appointments. This information will be kept confidential and will only be used to process payments at your request or to bill for late cancellations and missed appointments.*

Credit Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exp Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Type of Card: □ AMEX □ VISA □ MC Code on the back of card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name on card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing Address: (Same as above □ Yes)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Therapist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CLIENT RIGHTS AND RESPONSIBILITIES**

Ormond-by-the-Sea Counseling is committed to providing service to you, the client, without regard to race, sex, color, religion, handicapping condition, or national origin.

**AS A CLIENT YOU HAVE THE RIGHT TO:**

*INDIVIDUAL DIGNITY*, to be treated in a respectful and confidential manner.

*QUALITY SERVICES*, suited to your needs, administered skillfully, safely, humanely, with full respect for your dignity and personal integrity, and in accordance with all statutory and regulatory requirements.

*WITHDRAW YOUR CONSENT* for any specific activity.

*CONFIDENTIALITY OF CLIENT RECORDS*, Ormond-by-the-Sea Counseling has the obligation to obtain your written consent prior to any exchange of confidential information. There are a few exceptions to confidentiality listed below: If you present a danger to yourself or others, we are legally, ethically and morally required to protect the safety of threatened persons. If abuse or neglect of a child, elder or disabled person is known or suspected, we are required by law to report it to the Florida Abuse Hotline. If we receive a court order for client records, deposition or court testimony, we are required to comply. We are also required to report attendance compliance by court ordered clients. In the event that group or family services are provided, it is acknowledged that Ormond-by-the-Sea Counseling or its counselors/therapists cannot be held responsible for a breach of confidentiality on the part of a family member.

**AS A CLIENT YOUR RESPONSIBILITIES INCLUDE:**

*APPOINTMENTS*: Regular attendance is very important to ensure progress with the concerns and issues that have been presented. If there is an emergency and you need to cancel or reschedule an appointment, please call as soon as you know.   
*PARTICIPATION:* Your honest and accurate reporting of dilemmas and concerns is vital to your progress. To the best of your ability you must be open and honest in your sessions.

*SAFETY*: It is important that you and your children exercise appropriate caution, control and safe behavior on the premises. *TERMINATION:* Services may be discontinued for repeatedly missed appointments, if you come to appointments intoxicated and/or under the influence of substances, or if you show evidence of inappropriate behavior.

*TRANSFER PLAN*: Files/Records are the responsibility of your therapist as long as they work at Ormond-by-the-Sea Counseling.

**THERAPY INFORMED CONSENT**

*SERVICES*: We provide many different types of therapy and counseling. Counseling services can vary in length depending on the collaborative effort between therapist and client. The goals for counseling are developed with the therapist and are based on the client’s needs and concerns, and are reviewed on a regular basis to monitor progress. Our counseling services are voluntary. If the client has court documentation for counseling a copy of this documentation must be provided by the next counseling session. When bringing children for counseling services, the adult providing transportation is required to stay on the premises during the session.

*STAFF:* Counselors providing services are Licensed or Registered Clinical Social Workers, Marriage and Family Therapists, Mental Health Counselors, or they are Master Degree Student Interns in these fields supervised by Licensed Therapists.

*FEES*: Counseling session fees are based on the client’s agreed upon rate, set at the first counseling session. All fees are due at the end of each session.

*AUDIO/VIDEO TAPES*: Videotapes are used to assist with supervision, consultation and training of counselors working with their clients. These tapes are not considered part of client files and will be used only to assist the progress of the client’s case. The tapes are the destroyed on a regular basis.

*TERMINATION:* The client is expected to inform the therapist if the client plans to discontinue counseling for any reason. If a client fails to show up or cancel two appointments, their file will be closed. Counselors may have to discontinue therapy if the client is currently involved in domestic violence, substance abuse, or has shown violent or threatening behavior. The client may be given a referral to other more appropriate services for issues of substance abuse, violence, or severe mental health issues.

*BENEFITS/RISKS*: The majority of individuals and families that obtain counseling, benefit from the process. Self exploration, gaining insight, exploring options, for dealing with problem behavior, learning new skills, or venting difficult feelings and experiences are generally quite useful. But, some risks do exist. As counseling is begun some individuals experience unwanted feelings. Examining ones’ life can produce unhappiness, anger, guilt or frustration. These unwanted feelings are a natural part of the psychotherapeutic process and often provide the basis for change. Also, sometimes a decision that is positive for one family member will be viewed quite negatively by another.

*QUESTIONS*: Do not hesitate to discuss counseling goals, procedures, concerns, or your impression of services provided. If there is something you do not understand, please ask for a clarification.

**I have read and understand the nature and limits of therapeutic services provided by Ormond-by-the-Sea Counseling.**   
  
Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
  
Counselor/Therapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_