

# Jodi G. Dunphy, M.A., LPC, LLC

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## **CONFIDENTIAL - ASSESSMENT FOR COUNSELING INTENSIVE**

Name \_\_\_\_\_ Appointment Date \_\_\_\_\_

Age \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Mailing Address: \_\_\_\_\_  
Street City State Zip

Phone(h) \_\_\_\_\_ Phone(c) \_\_\_\_\_ Phone (w) \_\_\_\_\_

Email Address \_\_\_\_\_

For Confidentiality when and where do you prefer to be reached? \_\_\_\_\_

How did you hear about this counseling office? \_\_\_\_\_

Current Marital Status: Single \_\_\_\_\_ Engaged \_\_\_\_\_ Married \_\_\_\_\_ Separated \_\_\_\_\_

Divorced \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

Number of Children and ages: \_\_\_\_\_

Presently living with: Parents \_\_\_\_\_ Spouse \_\_\_\_\_ Roommate \_\_\_\_\_ Alone \_\_\_\_\_ Other \_\_\_\_\_

Emergency Contact: Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relation to you: \_\_\_\_\_

## **REASONS FOR SEEKING HELP**

What concerns have led you to pursue a potential counseling intensive? \_\_\_\_\_

Where are your concerns causing the most problems for you?

Check all that apply: \_\_\_ Home \_\_\_ Work \_\_\_ Marriage \_\_\_ God \_\_\_ Other Relationships

When did your present concern begin to be a problem for you? \_\_\_\_\_

Please rate the severity of your present concerns on the following scale.

Check one: \_\_\_ Mild \_\_\_ Moderate \_\_\_ Severe

What do you hope to gain from counseling \_\_\_\_\_

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## MEDICAL/HEALTH INFORMATION

Overall Health \_\_\_ Good \_\_\_ Fair \_\_\_ Poor      Date of last physical exam: \_\_\_\_\_

Do you have a physician, if so provide the name: \_\_\_\_\_

Are you currently experiencing any physical problems? (e.g. headaches, body aches, stomach problems): \_\_\_ Yes \_\_\_ No If yes, please explain: \_\_\_\_\_

Medications (Over-the-Counter or Prescription)	Dosage	Reason for Medication

Have you ever had surgery? If yes, for what reason \_\_\_\_\_

Have you ever been hospitalized for mental illness or substance abuse? \_\_\_ Yes \_\_\_ No

If yes, for what specific reason? \_\_\_\_\_

Have you ever participated in counseling before? \_\_\_ Yes \_\_\_ No

If so, when and why? \_\_\_\_\_

\_\_\_\_\_

## OCCUPATIONAL/EDUCATIONAL INFORMATION

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

If Currently a Student: Field of Study \_\_\_\_\_

\_\_\_ Part-Time \_\_\_ Full Time

Circle last year of school completed: 9 10 11 12 GED College: 1 2 3 4

Other: \_\_\_\_\_

Military Service (including dates):

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**RELIGIOUS BACKGROUND**

Religious Affiliation: \_\_\_\_\_ Active. \_\_\_ Inactive

How significant is your religion to your everyday life? \_\_\_\_\_

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**Please indicate which of the following areas are currently problems for you.  
Check all that apply:**

- |                                                                                         |                                                                     |
|-----------------------------------------------------------------------------------------|---------------------------------------------------------------------|
| <input type="checkbox"/> Under too much pressure/feeling stressed                       | <input type="checkbox"/> Excessive anxiety or worry                 |
| <input type="checkbox"/> Feeling lonely                                                 | <input type="checkbox"/> Angry feelings                             |
| <input type="checkbox"/> Concerns about finances                                        | <input type="checkbox"/> Feeling “numb” or cut off from emotions    |
| <input type="checkbox"/> Angry outbursts                                                | <input type="checkbox"/> Excessive fear of specific places/objects  |
| <input type="checkbox"/> Difficulty making friends                                      | <input type="checkbox"/> Feeling as if you’d be better off dead ___ |
| <input type="checkbox"/> Feeling that people are “out to get you”                       | <input type="checkbox"/> Difficulty making decisions                |
| <input type="checkbox"/> Feeling manipulated or controlled by others                    | <input type="checkbox"/> Lacking self confidence                    |
| <input type="checkbox"/> Loss of interest in sexual relationship                        | <input type="checkbox"/> Concerns about physical health             |
| <input type="checkbox"/> Feeling sexually attracted to members of your own sex          | <input type="checkbox"/> Loss of appetite/increased appetite        |
| <input type="checkbox"/> Recent significant weight gain/loss                            | <input type="checkbox"/> Use of alcohol                             |
| <input type="checkbox"/> Use of non prescription/prescription drugs                     | <input type="checkbox"/> Feeling distant from God                   |
| <input type="checkbox"/> Hallucinations                                                 | <input type="checkbox"/> Crying spells                              |
| <input type="checkbox"/> Inability to concentrate while at school/work                  | <input type="checkbox"/> Nightmares                                 |
| <input type="checkbox"/> Loss of interest in usual activities/lack of motivation        | <input type="checkbox"/> Inability to control thoughts              |
| <input type="checkbox"/> Feeling trapped in rooms/buildings                             | <input type="checkbox"/> Hearing voices                             |
| <input type="checkbox"/> Blackouts or temporary loss of memory                          | <input type="checkbox"/> Sleeping too much or too little            |
| <input type="checkbox"/> Obsessions or compulsions with specific activities or thoughts |                                                                     |
| <input type="checkbox"/> Feeling driven                                                 |                                                                     |

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**Any other information that you feel is important to share that is not covered above: (use the back of this page if needed)**

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## **DISCLOSURE STATEMENT**

Please be aware that the assessments provided by Jodi G. Dunphy, LPC LLC are designed for informational, educational, or evaluative purposes only. These assessments are not intended to diagnose, treat, or provide therapeutic interventions for any mental health conditions. The assessments are not a substitute for therapy but rather are to gather the necessary information to establish a plan regarding a future in state counseling intensive. As an out-of-state service provider, I am not licensed to offer therapeutic services in your state. If you require mental health treatment, I recommend seeking services from a licensed therapist or counselor in your area. If you have any questions about the nature of the assessment or require further clarification, please feel free to contact me.

## **FINANCIAL POLICY AND INFORMATION**

Initial Evaluation fee is \$300 for 90 minutes or \$250 for 60 minutes. The fee for a 60-minute session is \$200. The fee for a 90-minute session is \$300. Payment is due at the beginning or the end of each session and accounts must be kept current in order to continue counseling. Cash, checks, and credit cards are accepted forms of payment (there is a \$30 charge on all returned checks.).

Fees for any court related requests are my standard hourly rates which will include any written correspondence, phone calls, travel time and/or court related appearances.

Jodi G. Dunphy, MA LPC LLC is not in network with any insurance providers. If you would like to file out of network, a form will be provided to you at the end of each session. Payment is due at time of service.

## **CONFIDENTIALITY**

Generally speaking, information provided by and to a client in a professional relationship with a counselor is legally confidential. By law, information can only be released with the written consent of the client and only to parties specified by the client. There are specific exceptions to your right to confidentiality which include: 1) Any suspected incident of child abuse or neglect; and 2) Imminent danger to self or others. When consulting with parents regarding minor children, specific content of therapy sessions with children or adolescents will be held in confidence unless their welfare requires that the parent(s) have access to such information. In most cases, joint meetings between children and/or adolescents, their parents and the therapist will be arranged as a part of the therapy process.

## **CANCELLATION POLICY**

I request that you notify at least 24 hours before your scheduled appointment time if you need to cancel a session. Failure to do so will result in charges for the missed appointment. This charge should be paid before or at the time of your next appointment to continue in the counseling relationship. Exceptions are for sudden illnesses and emergencies only. The charge for the missed appointment is \$100.

**CONTACTING JODI DUNPHY** For scheduling and canceling your appointments, you must contact my office directly. For emergencies after hours, please contact 911 or go to your nearest emergency room. I am available for very limited contact during non scheduled times. I do not have regular office hours and have limited availability to communicate via phone, email or text.

If these guidelines are acceptable to you, please sign below:

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Client/Guardian Signature

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Date

*Jodi G. Dunphy, M.A., LPC*

## Disclosure Statement – Client Copy

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