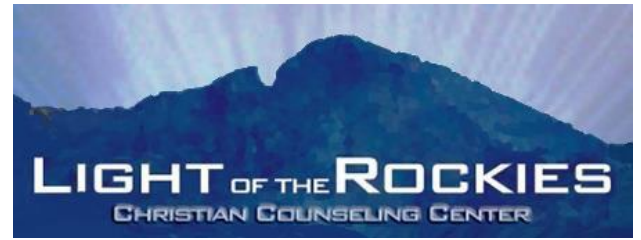


## **Chris Bassett, MA, LMFT**

### **Consent for Counseling and Mandatory Disclosure Statement**



#### **Degrees and credentials:**

- Colorado Licensed Marriage and Family Therapist (LMFT.698)
- MA, Marriage and Family Therapy, 1999, George Fox University
- BA, Interdisciplinary Child Development, Western WA University

I received a Master's degree in Marriage & Family Therapy from George Fox University, in Oregon, and then became a Licensed Marriage & Family Therapist. Prior to that I received a Bachelor's degree from Western Washington University in Interdisciplinary Child Development. I have worked as a therapist since 1999, working with couples, children, teens, women, men and groups, working in private practice and agency settings. I am the Executive Director at Light of the Rockies Christian Counseling Center, and I also supervise interns and staff who are working toward licensure.

Because you are receiving counseling from Light of the Rockies Christian Counseling Center, you are entitled to know that each of the therapists practice counseling from a Christian perspective. Please feel free to ask questions or discuss this information at any time.

The Colorado Department of Regulatory Agencies has the general responsibility of regulating the practice of licensed and unlicensed counselors and marriage and family therapists. The agency with this responsibility is the State Grievance Board, 1560 Broadway, Suite 1350, Denver, CO, 80202, 303-894-7766. The regulatory requirements for mental health professionals provide that a Licensed Clinical Social Worker, a Licensed Marriage and Family Therapist, and a Licensed Professional Counselor must hold a master's degree in their profession and have two years of post-master's supervision. A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision. A Licensed Social Worker must hold a master's degree in social work. A Psychologist Candidate, a Marriage and Family Therapist Candidate, and a Licensed Professional Counselor Candidate must hold the necessary licensing degree and be in the process of completing the required supervision for licensure. A Certified Addiction Counselor I (CAC I) must be a high school graduate, and complete required training hours and 1,000 hours of supervised experience. A CAC II must complete additional required training hours and 2,000 hours of supervised experience. A CAC III must have a bachelor's degree in behavioral health, and complete additional required training hours and 2,000 hours of supervised experience. A Licensed Addiction Counselor must have a clinical master's degree and meet the CAC III requirements. A Registered Psychotherapist is registered/listed with the State Board of Registered Psychotherapists, but is not licensed or certified by the state, and no degree, testing, training or experience is required to obtain registration from the state. You are entitled to receive information from your therapist about the methods of therapy, the techniques used, fee structure and the duration of your therapy (if known). You may ask questions about your therapy at any time. You may discontinue therapy services at any time and for any reason. You are entitled to receive a second opinion from another therapist. If necessary, referrals to other counselors or marital and family therapists will be made available. In a professional therapeutic relationship sexual contact of any kind between a therapist and a client is never appropriate. If sexual intimacy between a client and therapist occurs, it should be reported to the State Grievance Board.

#### **Confidentiality:**

Both professional ethics and the Colorado State Mental Health Code-CRS 112.43.214 (1) (d) require that your privacy be carefully protected. Generally speaking, information provided by and to a client in therapy is legally confidential and will not be released to anyone without your written permission. Confidentiality can be broken by your therapist in certain circumstances as required by Colorado law (listed in section 12-43-218 of the Colorado Revised Statutes and the Notice of Privacy Rights you were provided) These circumstances are summarized below:

- (1) if you sign a release of information form that allows me to disclose information to individuals or institutions specified by you;
- (2) if you are using insurance benefits, I may disclose relevant information regarding diagnosis and treatment if requested by your insurance company;
- (3) if you are in danger of causing immediate harm to yourself or another person, I am required by law to report this to appropriate authorities;
- (4) if I am ordered by a court of law to disclose information about you (e.g., if I am served with a legitimate subpoena), I am required in some cases to respond to that order;
- (5) if you reveal information concerning neglect, physical or sexual abuse of a child or an elder, I am required by law to report this knowledge to the appropriate authorities;
- (6) if you are in therapy by order of a court of law;
- (7) if you are involved in a criminal or delinquency proceeding;
- (8) if I need to provide another therapist with pertinent information when that therapist is on-call for my practice in my absence, or if I consult with another colleague about your treatment. Supervision and case consultation of cases will occur with staff members of Light of the Rockies Christian Counseling Center. Any objections to this supervision or known affiliations with these parties should be shared with your therapist immediately.

Couples attending therapy together are informed that information shared with the therapist by one individual may be disclosed to the other party at the therapist's discretion. Other than these exceptions noted above, information shared in therapy is privileged communication and cannot be disclosed in any court of competent jurisdiction in the state of Colorado without your consent. Information shared in couple's therapy when both parties are present cannot be disclosed to other parties without the written consent of both parties attending the couples' sessions.

**Payments/Cancellations:**

The fee for therapy has been agreed upon by those signed below. The fee has been set at: \$\_\_\_\_\_per session (50 minutes). Payment of this fee is expected at the beginning of each session. A pro-rated fee will be charged for phone consultations greater than 5 minutes in duration and any written correspondence. If a court appearance/deposition is required, please ask for the separate consent form. The full session fee is charged for appointments at which you do not show or cancel with less than 24-hour notice of the reserved appointment time. Two-hour sessions must be cancelled one week in advance. A \$20 fee will be charged for all checks returned for insufficient funds.

**Emergencies:**

As is the case with most outpatient therapists, I am not available at all times. I encourage clients to develop additional support systems and to have access to other individuals and/or agencies in case of emergencies. Listed below are local emergency telephone numbers should you need them:

Colorado Crisis Support, 494-4200; Walk-in crisis center: 1217 Riverside Dr., Fort Collins

Crisis Assessment Center at Poudre Valley Hospital, 495-8090;

Or, call 911 or go to the nearest hospital emergency room.

**Treatment Agreement:**

If applicable, those signed below give permission for minor/children (\_\_\_\_\_) to be seen in individual or family counseling and affirm the right and authority to give such consent.

Those signed below have read and understood the above including the Mandatory Disclosure Statement and give consent for marital and family therapy provided by Chris Bassett, M.A., LMFT. The therapy has been explained verbally and any questions have been answered.

My signature below indicates my understanding and agreement to these policies and procedures. I understand my rights as a client or as the client's responsible party.

**Print Client Name** \_\_\_\_\_

**Client or Responsible Party's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Counselor's signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**If signed by Responsible Party, state relationship to client and authority to consent:** \_\_\_\_\_

\_\_\_\_\_

**Light of the Rockies Christian Counseling Center**  
**5236 Strauss Cabin Rd**  
**Ft Collins, CO 80528**

**Notice of Privacy Practices**

**Acknowledgment of Receipt of HIPAA Notice**

Patient/Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_

I hereby acknowledge that I have received and have been given an opportunity to read a copy of the Light of the Rockies Christian Counseling Center's Notice of Privacy Rights. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Susan Witter, Office Manager at Light of the Rockies Christian Counseling Center at 5236 Strauss Cabin Rd, Ft Collins, CO 80528, 970-484-1735.

Client's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If not the client, please print and state legal authority to sign for client: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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**For Light of the Rockies' Use Only**

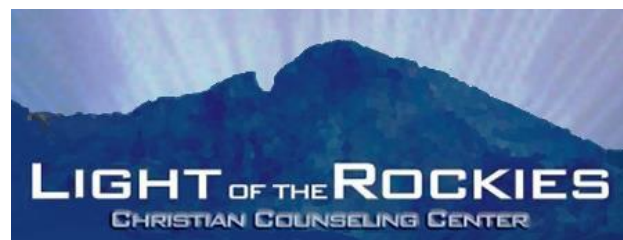
Notice of Privacy Rights was presented to the client or legal guardian today, but the client or legal guardian did not sign this acknowledgement because:

- ☐ The client refused to sign.
- ☐ The legal guardian refused to sign.
- ☐ Other: \_\_\_\_\_

LOTR Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **Light of The Rockies**

### **Financial Policies**



#### **CANCELLATIONS**

- Light of the Rockies Christian Counseling Center requires **24-hour notice** for a cancellation of an appointment unless there is a true emergency. Examples of true emergencies would include sudden onset of fever or stomach flu. If you need to cancel your appointment, we prefer as much advance notice as you can give us so that we can potentially make the appointment available for another client. We need 1-week cancellation notice for 2-hour appointments.
- Under certain circumstances (example: a sick child or a snow day) you may be able to have your appointment with your therapist via phone. Please contact our office manager if you wish to have a phone appointment.
- An appointment cancelled with less than 24 hours' notice will be **charged at your regular rate**. Insurance cannot be billed for cancelled appointments, and clients will be responsible for paying the full fee for their missed session.

#### **PAYMENTS**

- Payment for your session is due at the time of service.
- Our counseling center prefers to take checks or cash. If necessary, we can also take credit cards (VISA and MasterCard, Discover, we cannot take American Express). We can also receive your benefit credit card (HSA, FSA), so that you can pay for counseling services pre-tax through a plan provided by your employer.
- If you have made other payments arrangements with the Office Manager, we require that all bills be brought up to date by the last business day of the month.

#### **INSURANCE**

- Some of our therapists take insurance. If you are hoping to bill insurance for your session, please call the office and we can help you determine if your therapist participates with your insurance and what your options may be.
- It is your responsibility to know and understand what your insurance will cover. If you wish to use your insurance for counseling, it is also important that you contact your insurance company to determine your mental health benefits.
- We will require a credit card to be on file for any insurance company that we submit claims for.
- Your insurance policy is an agreement between you and your insurance company. Our relationship is with you, not your insurance company. Therefore, all charges are ultimately your responsibility, regardless of your insurance status. You are responsible for getting proper referral and pre-authorization information prior to your counseling sessions.
- At the time of your first appointment, if we are submitting claims for you, please make sure that we have a copy of both sides of your insurance card (which we can make at that first appointment), date of birth (both client and primary on the insurance), and a phone number to contact you.

#### **CLOSING**

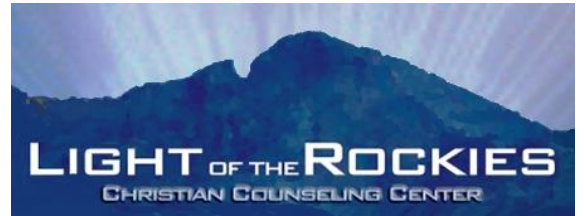
- For record keeping purposes, if you have not been seen for a counseling session within a two-month period, we will consider your file closed.
- You are always welcome to return to counseling at any time, and we will re-open your file at that time.

I have read and understand the financial policies of Light of the Rockies Christian Counseling Center.

|           |       |      |       |
|-----------|-------|------|-------|
| Signature | _____ | Date | _____ |
| Signature | _____ | Date | _____ |
| Therapist | _____ | Date | _____ |

# Light of The Rockies

## Client Contact & Referral Information



Today's Date: \_\_\_\_\_ Sex: \_\_\_\_\_

Client Name(s): \_\_\_\_\_ DOB: \_\_\_\_\_

DOB: \_\_\_\_\_ Counselor you are scheduled with: \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

( \_\_\_\_\_ ) ( \_\_\_\_\_ )

☐ Home Phone ☐ Mobile

☐ Work ☐ Mobile

Email Address \_\_\_\_\_ Emergency Contact Name \_\_\_\_\_ Phone \_\_\_\_\_

Parent or Guardian Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Primary Care Doctor: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**How did you hear about your therapist or Light of the Rockies?**

☐ Professional referral: Name \_\_\_\_\_

☐ Personal referral: Name \_\_\_\_\_

☐ My pastor / church: Name \_\_\_\_\_

☐ The Yellow Pages / Christian Business Directory Ad / Website / Facebook Page/Find a Christian Counselor (circle one)

☐ Google/Web search

☐ Other: \_\_\_\_\_

**Do we have your permission to send a thank you note to the party who referred you?**

☐ YES, please initial: \_\_\_\_\_ ☐ I prefer you not do so.

**May we use your name in the thank you note?** ☐ YES, please initial: \_\_\_\_\_ ☐ I prefer you not do so.

**Do you attend a church?** ☐ No ☐ Yes Church Name: \_\_\_\_\_

**May we have your permission to send:**

- An anonymous note to your church stating that one of their members recently sought counseling with Light of the Rockies?  
If ☐ YES, please initial: \_\_\_\_\_ ☐ I prefer you not do so. (If we can use your name, please initial here: \_\_\_\_\_)
- Do we have your permission to send or email you a 6-month follow up questionnaire once you have completed your counseling? ☐ No ☐ Yes
- Do we have your permission to send or email you occasional mailings in the future concerning Light of the Rockies Christian Counseling Center? ☐ No ☐ Yes

**Financial Information:** ☐ I want to use insurance. Primary Insured \_\_\_\_\_ DOB: \_\_\_\_\_

☐ If you want to use the sliding fee scale, fill out below:

**What is your annual gross (pre-tax) income for your entire household? (There will be an application to complete.)**

☐ Less than \$29,999 ☐ \$30,000 – \$49,999 ☐ \$50,000 – \$59,999 ☐ \$60,000 – 79,999

☐ \$80,000 – \$89,999 ☐ \$90,000 – \$99,999 ☐ \$100,000 – \$119,999 ☐ Above \$120,000

## INITIAL INTAKE FORM - ADULT

**Today's Date:** \_\_\_\_\_

All questions contained in this questionnaire are confidential and will become part of your clinical record.

|                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                       |                                                                            |  |             |  |
|----------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|----------------------------------------------------------------------------|--|-------------|--|
| <b>Name</b> <i>(Last, First, M.I.):</i>                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | <input type="checkbox"/> M <input type="checkbox"/> F | <b>DOB:</b>                                                                |  | <b>Age:</b> |  |
| <b>Why are you here today?</b>                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                       |                                                                            |  |             |  |
| <b>PRESENTING PICTURE</b>                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                       |                                                                            |  |             |  |
| <b>My main symptoms are related to:</b>                                                      | <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Obsessive Worries <input type="checkbox"/> Panic Attacks <input type="checkbox"/> Confusion <input type="checkbox"/> Drug Use <input type="checkbox"/> Focus/Inattention<br><input type="checkbox"/> Hyperactivity <input type="checkbox"/> Mood Swings <input type="checkbox"/> Self Worth <input type="checkbox"/> Spiritual Issues <input type="checkbox"/> Relationships <input type="checkbox"/> Sex Life <input type="checkbox"/> Memory Issues<br><input type="checkbox"/> Anger <input type="checkbox"/> Compulsive Behavior <input type="checkbox"/> Work/Professional <input type="checkbox"/> Other: |                                                       |                                                                            |  |             |  |
| <b>The major stressor (s) that precipitated my symptom (s): (Please include start dates)</b> | <input type="checkbox"/> Marital Issues                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                       | <input type="checkbox"/> Parent/Child Issues                               |  |             |  |
|                                                                                              | <input type="checkbox"/> Job Stress                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                       | <input type="checkbox"/> Past Issues <i>Abuse, Guilt, Family of Origin</i> |  |             |  |
|                                                                                              | <input type="checkbox"/> Health Issues                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                       | <input type="checkbox"/> Other:                                            |  |             |  |
| <b>My three biggest issues at present are:</b>                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                       |                                                                            |  |             |  |
| 1.                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                       |                                                                            |  |             |  |
| 2.                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                       |                                                                            |  |             |  |
| 3.                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                       |                                                                            |  |             |  |

### HISTORY ( Past issues that may be relevant now )

|                                                                                                                                                             |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
| A. Have you had similar and significant symptoms in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No. If yes, when:                       |
| Did they recently increase? <input type="checkbox"/> Yes <input type="checkbox"/> No. If yes, when & what caused it?:                                       |
|                                                                                                                                                             |
| B. Have you had any other significant life events that you might want to talk about? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what? |
|                                                                                                                                                             |
| C. Prior Psychiatric Hospitalizations? <input type="checkbox"/> Yes <input type="checkbox"/> No. If yes, when:                                              |
| Reason for hospitalization:                                                                                                                                 |
|                                                                                                                                                             |
| D. Past Counseling History? <input type="checkbox"/> Yes <input type="checkbox"/> No.                                                                       |
| If yes, please list therapist and reason, in last year:                                                                                                     |
| Therapists and reasons in last 5 years:                                                                                                                     |
|                                                                                                                                                             |
| E. Substance Abuse History? <input type="checkbox"/> Yes <input type="checkbox"/> No. If yes, when started:                                                 |
| Substances:                                                                                                                                                 |
| Treatment Location and Dates:                                                                                                                               |
|                                                                                                                                                             |
| F. Have you experienced any physical, sexual, verbal, or emotional abuse? <input type="checkbox"/> Yes <input type="checkbox"/> No. If yes, please list:    |
|                                                                                                                                                             |
| G. Any Head/Brain Trauma (concussion, asphyxia, other injury?) <input type="checkbox"/> Yes <input type="checkbox"/> No. If yes, please list:               |
|                                                                                                                                                             |
| H. Have you ever attempted suicide? <input type="checkbox"/> Yes <input type="checkbox"/> No. If yes, please explain:                                       |
| Have you been hospitalized for attempted suicide? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                  |

| PRESCRIBED MEDICATIONS (Current) |               |                         |                  |
|----------------------------------|---------------|-------------------------|------------------|
| Medication & Dosage              | Reason Taken? | Reactions/Side Effects? | Date Prescribed? |
|                                  |               |                         |                  |
|                                  |               |                         |                  |
|                                  |               |                         |                  |
|                                  |               |                         |                  |

I am currently taking the following over the counter medications:

Supplements:

Significant Allergies:

| EMPLOYMENT HISTORY (Last 3 Employers) |                |                     |       |
|---------------------------------------|----------------|---------------------|-------|
| Employer                              | Dates Employed | Reason for leaving? | Notes |
|                                       |                |                     |       |
|                                       |                |                     |       |

|                 |
|-----------------|
| PERSONAL HABITS |
|-----------------|

|                                                                                                    |
|----------------------------------------------------------------------------------------------------|
| ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL. |
|----------------------------------------------------------------------------------------------------|

|                                           |                                                                                                                 |                                 |                              |                               |                                                 |                              |                             |                                       |                             |                              |                             |
|-------------------------------------------|-----------------------------------------------------------------------------------------------------------------|---------------------------------|------------------------------|-------------------------------|-------------------------------------------------|------------------------------|-----------------------------|---------------------------------------|-----------------------------|------------------------------|-----------------------------|
| <b>Exercise</b>                           | <input type="checkbox"/> Sedentary (No exercise)                                                                |                                 |                              |                               |                                                 |                              |                             |                                       |                             |                              |                             |
|                                           | <input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)                                |                                 |                              |                               |                                                 |                              |                             |                                       |                             |                              |                             |
|                                           | <input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.) |                                 |                              |                               |                                                 |                              |                             |                                       |                             |                              |                             |
|                                           | <input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4-5x/week for 30-50 minutes)       |                                 |                              |                               |                                                 |                              |                             |                                       |                             |                              |                             |
|                                           | <input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 5-7x/week for 50+ minutes)         |                                 |                              |                               |                                                 |                              |                             |                                       |                             |                              |                             |
| <b>Sleep</b>                              | <input type="checkbox"/> Insomnia (no consistent or sound sleep)                                                |                                 |                              |                               |                                                 |                              |                             |                                       |                             |                              |                             |
|                                           | <input type="checkbox"/> Little Sleep (i.e., 2-4 hours per day)                                                 |                                 |                              |                               |                                                 |                              |                             |                                       |                             |                              |                             |
|                                           | <input type="checkbox"/> Limited Sleep (i.e., 4-6 hours per day.)                                               |                                 |                              |                               |                                                 |                              |                             |                                       |                             |                              |                             |
|                                           | <input type="checkbox"/> Regular Sleep (7 hours or more per day on average)                                     |                                 |                              |                               |                                                 |                              |                             |                                       |                             |                              |                             |
| <b>Diet</b>                               | Are you dieting?                                                                                                |                                 |                              |                               |                                                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of meals you eat in an average day? |                             |                              |                             |
|                                           | Do you have concerns about your eating patterns or habits?                                                      |                                 |                              |                               |                                                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes: Height/Weight:                |                             |                              |                             |
| <b>Caffeine</b>                           | <input type="checkbox"/> None                                                                                   | <input type="checkbox"/> Coffee | <input type="checkbox"/> Tea | <input type="checkbox"/> Cola | <input type="checkbox"/> Energy Drinks          | # of cups/cans per day?      |                             |                                       |                             |                              |                             |
| <b>Alcohol</b>                            | Do you drink alcohol?                                                                                           |                                 |                              |                               |                                                 |                              |                             |                                       |                             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|                                           | If yes, what kind?                                                                                              |                                 |                              |                               |                                                 |                              |                             |                                       |                             |                              |                             |
|                                           | How many drinks per week?                                                                                       |                                 |                              |                               |                                                 |                              |                             |                                       |                             |                              |                             |
|                                           | Are you concerned about the amount you drink?                                                                   |                                 |                              |                               |                                                 |                              |                             |                                       |                             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|                                           | Have you ever "passed out" or experienced blackouts?                                                            |                                 |                              |                               |                                                 |                              |                             |                                       |                             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|                                           | Do you occasionally "binge" drink?                                                                              |                                 |                              |                               |                                                 |                              |                             |                                       |                             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|                                           | Have you driven after drinking?                                                                                 |                                 |                              |                               |                                                 |                              |                             |                                       |                             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>Nicotine</b>                           | Do you use any Nicotine? (This includes patches, gum, vaping, etc.)                                             |                                 |                              |                               |                                                 |                              |                             |                                       |                             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|                                           | If yes, what kind? How many times per week?                                                                     |                                 |                              |                               |                                                 |                              |                             |                                       |                             |                              |                             |
| <b>Sex</b>                                | Are you sexually active?                                                                                        |                                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No   | Any discomfort or dysfunction with intercourse? |                              |                             | <input type="checkbox"/> Yes          | <input type="checkbox"/> No |                              |                             |
|                                           | Frequency?                                                                                                      |                                 | Concerns?                    |                               |                                                 |                              |                             |                                       |                             |                              |                             |
|                                           | Anything you want me to know about your sexuality?                                                              |                                 |                              |                               |                                                 |                              |                             |                                       |                             |                              |                             |
| <b>Anything Else You Want me to Know?</b> |                                                                                                                 |                                 |                              |                               |                                                 |                              |                             |                                       |                             |                              |                             |

|                     |                                                                                                    |  |                              |                             |
|---------------------|----------------------------------------------------------------------------------------------------|--|------------------------------|-----------------------------|
| <b>Spirituality</b> | How do you identify spiritually/religiously? (i.e., Christian, atheist, Hindu, etc....):           |  |                              |                             |
|                     | Would you say you have a personal relationship with Jesus Christ?                                  |  | Yes                          | No If so, how long?         |
|                     | Do you attend a church (name...)?                                                                  |  | Yes                          | No If so, how often?        |
|                     | Do you pray and/or meditate?                                                                       |  | Yes                          | No If so, how often?        |
|                     | Do you read/study the Bible?                                                                       |  | Yes                          | No If so, how often?        |
|                     | Do you have personal concerns or questions related to God, the Christian faith, and/or the church? |  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|                     | Are you open to discussing relevant matters of faith with your therapist?                          |  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

| FAMILY DETAIL                                                                                                                                                                                                                              |                                                                |  |                                   |                       |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|--|-----------------------------------|-----------------------|
| <b>Your Current Marital Status:</b> <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Other: |                                                                |  |                                   |                       |
|                                                                                                                                                                                                                                            | <b>DOB &amp; AGE</b>                                           |  | <b>NAME</b>                       | <b>RELEVANT NOTES</b> |
| <b>Spouse</b>                                                                                                                                                                                                                              |                                                                |  |                                   |                       |
| <b>Children</b>                                                                                                                                                                                                                            | <input type="checkbox"/><br>M<br><input type="checkbox"/><br>F |  |                                   |                       |
|                                                                                                                                                                                                                                            | <input type="checkbox"/><br>M<br><input type="checkbox"/><br>F |  |                                   |                       |
|                                                                                                                                                                                                                                            | <input type="checkbox"/><br>M<br><input type="checkbox"/><br>F |  |                                   |                       |
|                                                                                                                                                                                                                                            | <input type="checkbox"/><br>M<br><input type="checkbox"/><br>F |  |                                   |                       |
| <b>Were your Parents Divorced?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No. If yes, when: <b>Parents Remarried?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No.                                             |                                                                |  |                                   |                       |
| <b>Previous Spouse (s)</b><br>(or cohabitant)                                                                                                                                                                                              |                                                                |  | Reason for ending relationship... |                       |

| COUPLES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                |                  |                 |                   |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|------------------|-----------------|-------------------|
| <input type="checkbox"/> Communication <input type="checkbox"/> Anger management <input type="checkbox"/> Guilt <input type="checkbox"/> Time management <input type="checkbox"/> Parenting Conflicts <input type="checkbox"/> Dishonesty<br><input type="checkbox"/> Sexual Connection <input type="checkbox"/> Flirting <input type="checkbox"/> Emotional Infidelity <input type="checkbox"/> Physical Infidelity <input type="checkbox"/> Spiritual <input type="checkbox"/> Leadership<br><input type="checkbox"/> Structural (family relationships) <input type="checkbox"/> Structural (definition of marriage) <input type="checkbox"/> Finances <input type="checkbox"/> Other: |                |                  |                 |                   |
| <b>What have been the recent events leading up to seeking couple's counseling now?</b><br>1.<br>2.<br>3.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                |                  |                 |                   |
| <b>Our three primary goals for marriage counseling are (in order):</b><br>1.<br>2.<br>3.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                |                  |                 |                   |
| <b>When did you first think your problems were serious enough for couple's counseling...? Date:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                |                  |                 |                   |
| <b>Date met current spouse:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | <b>Dating?</b> | <b>Engaged?:</b> | <b>Married?</b> | <b>Separated?</b> |
| <b>Premarital Counseling (date)?</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                |                  |                 |                   |
| <b>Previous Marriage Counseling?</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                |                  |                 |                   |
| <b>Other Relevant Notes:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                |                  |                 |                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                |                  |                 |                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                |                  |                 |                   |

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: ☐ Male ☐ Female Date: \_\_\_\_\_

If this questionnaire is completed by an informant, what is your relationship with the individual? \_\_\_\_\_  
 In a typical week, approximately how much time do you spend with the individual? \_\_\_\_\_ hours/week

**Instructions:** The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

|       | During the past <b>TWO (2) WEEKS</b> , how much (or how often) have you been bothered by the following problems?                                                                                                                                                                                                                                                                                                                                                | None<br>Not at<br>all | Slight<br>Rare, less<br>than a day<br>or two | Mild<br>Several<br>days | Moderate<br>More than<br>half the<br>days | Severe<br>Nearly<br>every<br>day | Highest<br>Domain<br>Score<br>(clinician) |
|-------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|----------------------------------------------|-------------------------|-------------------------------------------|----------------------------------|-------------------------------------------|
| I.    | 1. Little interest or pleasure in doing things?                                                                                                                                                                                                                                                                                                                                                                                                                 | 0                     | 1                                            | 2                       | 3                                         | 4                                |                                           |
|       | 2. Feeling down, depressed, or hopeless?                                                                                                                                                                                                                                                                                                                                                                                                                        | 0                     | 1                                            | 2                       | 3                                         | 4                                |                                           |
| II.   | 3. Feeling more irritated, grouchy, or angry than usual?                                                                                                                                                                                                                                                                                                                                                                                                        | 0                     | 1                                            | 2                       | 3                                         | 4                                |                                           |
| III.  | 4. Sleeping less than usual, but still have a lot of energy?                                                                                                                                                                                                                                                                                                                                                                                                    | 0                     | 1                                            | 2                       | 3                                         | 4                                |                                           |
|       | 5. Starting lots more projects than usual or doing more risky things than usual?                                                                                                                                                                                                                                                                                                                                                                                | 0                     | 1                                            | 2                       | 3                                         | 4                                |                                           |
| IV.   | 6. Feeling nervous, anxious, frightened, worried, or on edge?                                                                                                                                                                                                                                                                                                                                                                                                   | 0                     | 1                                            | 2                       | 3                                         | 4                                |                                           |
|       | 7. Feeling panic or being frightened?                                                                                                                                                                                                                                                                                                                                                                                                                           | 0                     | 1                                            | 2                       | 3                                         | 4                                |                                           |
|       | 8. Avoiding situations that make you anxious?                                                                                                                                                                                                                                                                                                                                                                                                                   | 0                     | 1                                            | 2                       | 3                                         | 4                                |                                           |
| V.    | 9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?                                                                                                                                                                                                                                                                                                                                                                                       | 0                     | 1                                            | 2                       | 3                                         | 4                                |                                           |
|       | 10. Feeling that your illnesses are not being taken seriously enough?                                                                                                                                                                                                                                                                                                                                                                                           | 0                     | 1                                            | 2                       | 3                                         | 4                                |                                           |
| VI.   | 11. Thoughts of actually hurting yourself?                                                                                                                                                                                                                                                                                                                                                                                                                      | 0                     | 1                                            | 2                       | 3                                         | 4                                |                                           |
| VII.  | 12. Hearing things other people couldn't hear, such as voices even when no one was around?                                                                                                                                                                                                                                                                                                                                                                      | 0                     | 1                                            | 2                       | 3                                         | 4                                |                                           |
|       | 13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?                                                                                                                                                                                                                                                                                                                                                     | 0                     | 1                                            | 2                       | 3                                         | 4                                |                                           |
| VIII. | 14. Problems with sleep that affected your sleep quality over all?                                                                                                                                                                                                                                                                                                                                                                                              | 0                     | 1                                            | 2                       | 3                                         | 4                                |                                           |
| IX.   | 15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?                                                                                                                                                                                                                                                                                                                                                       | 0                     | 1                                            | 2                       | 3                                         | 4                                |                                           |
| X.    | 16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?                                                                                                                                                                                                                                                                                                                                                                                      | 0                     | 1                                            | 2                       | 3                                         | 4                                |                                           |
|       | 17. Feeling driven to perform certain behaviors or mental acts over and over again?                                                                                                                                                                                                                                                                                                                                                                             | 0                     | 1                                            | 2                       | 3                                         | 4                                |                                           |
| XI.   | 18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?                                                                                                                                                                                                                                                                                                                                                         | 0                     | 1                                            | 2                       | 3                                         | 4                                |                                           |
| XII.  | 19. Not knowing who you really are or what you want out of life?                                                                                                                                                                                                                                                                                                                                                                                                | 0                     | 1                                            | 2                       | 3                                         | 4                                |                                           |
|       | 20. Not feeling close to other people or enjoying your relationships with them?                                                                                                                                                                                                                                                                                                                                                                                 | 0                     | 1                                            | 2                       | 3                                         | 4                                |                                           |
| XIII. | 21. Drinking at least 4 drinks of any kind of alcohol in a single day?                                                                                                                                                                                                                                                                                                                                                                                          | 0                     | 1                                            | 2                       | 3                                         | 4                                |                                           |
|       | 22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?                                                                                                                                                                                                                                                                                                                                                                                | 0                     | 1                                            | 2                       | 3                                         | 4                                |                                           |
|       | 23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]? | 0                     | 1                                            | 2                       | 3                                         | 4                                |                                           |

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