**_Faith Winters, LPC, ACS_**
Licensed Professional Counselor
Approved Clinical Supervisor

503 267-3149 Website www.faithwinters.com

# Welcome for New Clients

You have made an important decision to seek counseling. I know that can be hard. I want to help you find the relief, healing or insight you seek.

Here are some things you need know before your first visit:

Please print these 3 pages of forms, fill them out and bring to your first visit.

My counseling office is conveniently located in the UGM Life Change Center building at the corner of 103rd Ave and Walker Road, Beaverton Oregon, 97005. I am in Suite #359 in that big, tan office/residential building. Google search or GPS might NOT get you here. There is no name, no address and no sign on this building; it is next door to the Cornerstone Church.

The easiest way to get to my office is: drive east on Walker Road, past 103rd Ave, turn right into the third driveway past the corner. Again, there are no address numbers, nor sign there. Park by the blue topped 4plex building; but walk up the ramp that leads to the back of the big tan building with the brown stripe around the top.

This is a back door and therefore locked; text or call me and I will come let you in. My office is just inside this back door.

I look forward to seeing you in my office.

*Faith Winters*

Faith Winters, LPC, ACS

*Belief, trust, and loyalty endure through the difficult seasons of life.*

# *Faith Winters, LPC*

## Consent for Professional Services

Office Policies & General Information Agreement for Talk Therapy/Counseling Services

This form provides you, the client, with information that is additional to that detailed in the Notice of Privacy Practices and it is subject to HIPAA preemptive analysis. Further information is detailed in Counseling Office Policies and HIPAA Notice of Privacy Practices posted online at faithwinters.com and at the Counseling office. Your therapist would be happy to discuss any of those with you.

Please print your name on the top line, initial each box and sign at the X.

Name _____

I request that Faith Winters provide professional counseling, talk therapy services to me and/or to

_____ Relationship _____

☐ Psychotherapy/counseling services: ***$110 per 45-50 minute session,***
Preparation of reports, letters, and phone calls over 5 minutes will be pro-rated as a partial session.

☐ If coverage by Employee Assistance Program; write name of program, employer and Authorization Number here. _____

☐ I agree that payment for services is due at the time of service and that I am fully responsible for payment, even if insurance is billed. I understand that there is no guarantee of insurance coverage/reimbursement for fees.

☐ In order to avoid full charges for missed appointments; I understand that I must call at least 24 hours in advance if I am unable to keep the scheduled appointment. (Insurance is unlikely to cover the cost of any missed appointment fees)

☐ I understand that my therapist **will not** be available for 24 hour crisis intervention or emergencies and I have been informed where to call if I have an emergency 911 or the local Crisis Line 503.291.9111.

☐ I acknowledge that I have received notice that a copy of Professional Disclosure Statement and a Notice of Privacy Practices for Faith Winters, LPC is available online at www.faithwinters.com. I can ask for a paper copy if I want. I will review both documents and know that I am encouraged to discuss any further questions with my therapist at any point in my treatment.

I have read and understand the above information. I consent to therapy in full agreement with the terms stated above and the understanding that my therapist and I will clarify goals and objectives at any time.

X _____ _____
Signature of client (or person acting for client) Date

_____
Relationship to client (if necessary)

I, _____Therapist, have discussed the issues above with the client. My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Signature of Therapist Date .

# *Faith Winters, LPC*

## Confidential Intake Information – Counseling

Please fill out this form to help me know more about you so your counseling sessions can focus on what's most important to you. This information is confidential as outlined my Professional Disclosure Statement, the Counseling Office Policies and HIPAA Notice of Privacy Practices posted at www.faithwinters.com and outside my office. I would be happy to discuss those with you.

Name _____ Date _____

Phone # Cell Other

OK to leave messages at these phone numbers? Yes No OK to Text Yes No.
*Please note: regular texting/email is not considered confidential communication, see Office Policies for details.

Date and Place of Birth: Age: Gender: F M

Address _____

_____

Current Employment _____ Highest grade of education _____

Do you enjoy your work? Yes No Are finances a major stressor for you? Yes No

Person and phone number of whom to call in emergency and relationship to you (Spouse, Parent, Child, Friend, etc.)

_____

Referral source or how you came here: _____

Past/Present Medical Issues (Brief summary of major medical problems, surgeries, accidents, falls, illness, etc.):

_____

Medication you are presently taking and for what. (Brief summary):

_____

Have you or your family been affected by alcohol or drug use?. (Brief summary):

_____

Any suicide attempt/s or violent behavior (describe: ages, reasons, circumstances, how, etc.)

_____

Have you or any of your family had concerns with depression, anxiety, suicide attempts, mental illness?
No Yes If "Yes," please explain briefly.

_____

Are you involved in any current or pending civil or criminal litigation/s, lawsuit/s or divorce or custody dispute/s?
No Yes If "Yes," please explain briefly.

_____

Your current marital status: Never Married Married Partnered Separated Widowed Divorced
Past and present significant relationships:_____

_____

What other family do you have? _____

Among your friends and family, who do you count on for support?

_____

Have you ever been diagnosed with a mental disorder? □ No □ Yes If "Yes," please explain

_____

Have you experienced counseling before? □ Yes □ No • Was it helpful? □ Yes □ No □ Somewhat
With Whom? _____ When _____

Reasons for prior therapy _____ # of sessions _____

How would you rate your daily:

| | | | | | |
|---|---|---|---|---|---|
| Peace vs worry level? | Very Good | Good | Satisfactory | Unsatisfactory | Poor |
| Calmness vs tension level? | Very Good | Good | Satisfactory | Unsatisfactory | Poor |
| Current physical health? | Very Good | Good | Satisfactory | Unsatisfactory | Poor |
| Your eating habits? | Very Good | Good | Satisfactory | Unsatisfactory | Poor |
| Your exercise habits? | Very Good | Good | Satisfactory | Unsatisfactory | Poor |
| Your sleeping habits? | Very Good | Good | Satisfactory | Unsatisfactory | Poor |

List any specific sleeping concerns.

Please describe yourself spiritually

What gives you the most joy or pleasure in your life?

What are your main worries and fears?

What are your most important hopes or dreams?

Please describe what you want to work on in therapy; what do you want to be different in your life?

As specifically as possible, what are your expectations of counseling?

Do you have any concerns about the counseling process?

How long has this been troubling you? _____ yrs. How bad is it? ☐ Mild ☐ Moderate ☐ Serious ☐ Severe

What else is related to this problem?

__ Abuse: Physical, Sexual, Emotional, Spiritual
__ Adjustment Difficulties
__ Alcohol, Drug Use
__ Anger, Hostility, Arguing, Irritability
__ Anxiety, Worry
__ Appetite, Weight Control, Diet Issues
__ Childhood Issues (Your Childhood)
__ Children, Childcare, Parenting
__ Communication Concerns
__ Concentration, Motivation
__ Conflicts: Relational, Personality
__ Decision Making Difficulties
__ Depressed Mood, Sadness, Crying
__ Divorce, Separation
__ Emotions, Mood Swings
__ Family Difficulties
__ Fatigue, Tiredness, No Energy
__ Fears Or Panic
__ Feeling Unworthy
__ Financial, Money, Spending Concerns
__ Forgiveness Issues
__ Grief, Loss, Mourning
__ Guilt, Shame
__ Hopelessness
__ Isolation, Loneliness, Shyness
__ Marriage: Conflict, Coldness, Infidelity
__ Molested as a Child
__ Nervousness, Tension
__ Obsessions, Compulsions
__ Personal Growth
__ Physical Health, Pain
__ Pregnancy, Abortion, Miscarriage
__ Recurring Thoughts
__ Raped (as a child or adolescent)
__ Raped (as an adult)
__ Self-Esteem
__ Sexual Concerns
__ Sleep Problems
__ Spiritual/Faith Concerns
__ Suicidal Thoughts, Feelings
__ Unable To Have Fun
__ Unwanted Sexual Contact (as a child or adolescent)
__ Unwanted Sexual Contact (as an adult)
__ Work, Career Concerns, Goals, Choices.
__ Other _____
__ _____
__ _____

*Thank you for taking the time to fill this out.*