Personal Information Questionnaire

Legacy Life Care Programs

Identification Information

Name: ______________________________ Age ________ DOB _____ SS# ___________

Address: ________________________________ Telephone: __________

Email: ____________City:___________________ State_______________ Zip: _____________

It is okay to contact you at this number?

PRESENT PSYCHOLOGICAL STATUS

Present Psychological Status:

Please describe your Reason for seeking help		
O Yes O No	Have you ever seen a counselor or mental health worker before?	
	← Why were you seeking help?	
O Yes O No	← Was the counseling beneficial?	
	← Who was the counselor?	
O Yes O No	Does anyone in your family have psychological or emotional difficulties or been hospitalized?	
O Yes O No	Have you ever experienced what some people refer to as a "nervous breakdown"?	
O Yes O No	Is there anything currently bothering you or causing you to worry?	
O Yes O No	Are you having disturbing or difficulty with your sleep?	
O Yes O No	Have you experienced any changes in appetite lately?	
O Yes O No	Have there been any sudden changes with your weight?	
O Yes O No	Do you have any health problems (diabetes, heart problems, etc?)	
O Yes O No	Have you experienced your heart racing and you become short of breath?	
O Yes O No	Are you having headaches or migraines?	
O Yes O No	Are you experiencing any stomach problems?	
O Yes O No	Do you have any problems with depression?	
O Yes O No	Any suicidal thoughts or attempts (past or current)?	
O Yes O No	Do you have any unwanted thoughts you cannot seem to get rid of?	

O Yes O No	Any problems related to thinking, concentrating, or memory?	
• Short • Medium (circle one) • Long	How would you rate your temper (fuse)?	
Spouse/Significant Other	Name:_____________________	Age: _______ DOB: ____________
(If married Souse's age at marriage)	Age:_______	Occupation: _________________
O Yes O No	Has your partner been married previously?	
O Yes O No	Is your spouse's occupation a source of your conflict in your marriage?	
O Yes O No	Do you have any children?	
Names: ___________ __________________ __________________ __________________	Ages: ____________________ ____________________ _____________________ _____________________	
O good O fair O Poor	What kind of relationship do you have with your children?	
O good O fair O Poor	What kind of relationship do your children have with each other?	
O Yes O No	Have you been married previously?	
O goof O fair O Poor	How would you describe your current marriage?	
O Yes O No	Do you have family members that live in the immediate area?	
Mother O Father O	O Siblings O Grandparents O In-laws?	
O good O fair O Poor	How do you like your living arrangements?	
O Yes O No	Are you able to keep up with your normal chores and responsibilities?	
O Yes O No	Do you find it difficult to remain focused or attentive with tasks?	
	← What is your occupation?	
O good O fair O Poor	Are you satisfied with your current career/employment?	
O Yes O No	Is your occupation employment a source of conflict with your partner?	
	← Do you have any hobbies or other interests? What type?	
O Yes O No	Lately have you seemed to lose intersest in things that normally bring you pleasure?	
O Yes O No	Do you have an individual whom you can share	

	problems or worries (confide)?	
O Yes O No	Do you have any pets?	
Years:	If married, how many years have you been married?	
	← What kind of pets?	
O Yes O No	Do you have enough money to pay your bills?	
O Yes O No	Do you own or have access to your car?	
CURRENT HEALTH		
	← Who is your family physician?	
Year/Month:	When was the last time you say a physician (approximately)?	
List of Medications:	Are you currently taking any medications? Please list them ←	
1. ___________ 2. ___________ 3. ___________ 4. ___________ 5. __________		
O Yes O No	Have you prescribed medications to help you sleep?	
O Yes O No	Have you ever been given medication for depression?	
O Yes O No	Are you allegric to any medication?	
O Yes O No	Do you drink (alcohol) on a regular basis?	
O Yes O No	Do you smoke?	
O Yes O No	Have you ever taken/used any illegal drugs? (If yes, please indicate)	
2. Cocaine/C-track O	3. Ampheramines (speed) O	4. PCP (Angel dust) O
5. Marijuana O	6. O Hallucinogens (LSD, Peyote, “magic mushrooms” (circle one)	7. O Inhalants (gas, glues, thinners) (circle one)
8. Heroin (morphine) O		
O Yes O No	Do you have any sexual concerns?	
10, 9, 8, 7, 6, 5, 4, 3, 2, 1	How would you overall rate your current health? (please circle)	
Spiritual Inventory		
____	What relationships have the greatest influence in your life right now?	
1. ___________ Yes 2. ____________ Yes 3. _____________ No 4. _____________ No	← Are there any persons from your past that have played a significant part in shaping your view of life? (If yes, please list each one	
Yes O No O (check one)		

____	← Has there been an event in your life (either positive or negative) which was so intense that it permanently affected your outlook on life? (If yes, please describe briefly	
	What beliefs or values have been important in guiding your life?	
	What findings or emotions do you have where you think of God, is there any particular image that comes to mind?	
Yes, a lot O **Somewhat O** **Not at all O (check one)**	**Is your faith/spirituality helpful to you?**	
What do you do?________________________	**Is there anything you do to help nurture or maintain your faith/spirituality?**	
1. Consistent 2. Somewhat 3. Almost never (circle one)	**How successful are you in regularly maintaining these practices?**	
1. YES 2. NO (CIRCLE ONE)	**Are there any conflicts between your beliefs and your partner's beliefs and anything you are presently doing?**	
1. YES 2. NO (CIRCEL ONE)	**Do you believe you have committed an unpardonable sin?**	
CURRENT STATUS		
PLEASE ANSWER THE FOLLOWING QUESTIONS SO THT WE MIGHT HAVE A BETTER UNDERSTANDING OR BETTER IDEA OF HOW YOU ARE DOING (CIRCLE THE CORRECT NUMBER		

	NOT AT ALL			SOME		A LOT
During the week how concerned or worried have you been about your health?	1	2	3	4	5	6-7
	NOT AT ALL			SOME		A LOT
During the past week how anxious nervous or tense have you been	1	2	3	4	5	6-7
During the past week how much have you been bothered by guilt feelings	1	2	3	4	5	6-7

During the past week have you felt super-efficient or like you have unlimited energy, special talents or powers?	1	2	3	4	5	6-7

During the past week how depressed have you been ?	1	2	3	4	5	6-7

During the past week how irritable or angry have you been	1	2	3	4	5	6-7
During the past week how much distrust of others have you felt (or how much did it seem like others were out to hurt you?	1	2	3	4	5	6-7
During the past week did you hear or see things around you that others did not see?	1	2	3	4	5	6-7
During the past week how much difficulty have you had with your thinking?	1	2	3	4	5	6-7

CHILDHOOD AND FAMILY OF ORIGINS				
O YES O NO	**Do you have any brothers of sisters?**			
NAMES: AGE:	**NAME: AGE:**	**NAMES: AGE**	**NAMES: AGE:**	**NAMES: AGE:**
1.	**2.**	**3.**	**4.**	**5.**

O good O fair O Poor	As a child how well did you get along with your brothers or sisters?	(circle one)		
O good O fair O Poor	As a parent how well did you get along with your brothers/sisters	(circle one)		
What was your father like?				
___________	(fill in your answer)			
O good O fair O Poor	What kind of a relationship did you have with your mother?			
O good O fair O Poor	What was your mother like?			
O good O fair O Poor	What kind of relationship did you have with your father?			
O good O fair O Poor	What kind of relationship did your parents have with each other?			
___________	As a child how did you know your parents loved you?			
___________	As a child how did you know your parents loved each other?			
O YES O NO	Are your parents divorced?			
Age:	How old were you when they divorced?			
O YES O NO	Were you ever abused as a child?			
O good O fair O Poor	How would you describe your health during childhood?			
1 Nail-biting 2 Bedwetting 3 Temper tantrums	4 Fears 5 Thumbsucking 6 Running away 7 Nightmares Did you get into trouble as a child?	O Other:	Any childhood habits?	
O YES O NO				
10, 9, 8, 7, 6, 5, 4, 3, 2, 1 Fair O Good O Poor O	How would you characterize your overall childhood?			
EDUCATION AND WORK HISTORY				
___________	Which best describes your educational experience?			
O YES O NO	Are you currently in school?			
___________	If yes, where are you enrolled?			
O YES O NO 1 Sports, 2 Band 3 clubs 4 Other (circle what applies)	Were you involved in any extra-curricular activities?			
O YES O NO	Do you have any learning problems or complications?			
O Above Average O Average O Below Average	What kind of grades did you receive in school?			
O Good O Fair O Poor	How well did you get along with your class mates?			

O Good O Fair O Poor	How well did you relate with your teachers?			
O YES O NO	Were you ever in the military?			
O National Guard O Marines O Air Force/Air Space Other:	If so, which branch?			
Specialty/Job	What was your military specialty/job?			
Years of Service:	How long did you serve?			
O YES O NO	Are you currently employed?			
	Do you have any special job skills or training?			
O ENJOY O LIKE IT O DISLIKE IT	Do you like your present work experience?			
O Good O Fair O Poor	How well do you get along with your boss/supervisor?			
O Good O Fair O Poor	How well do you get along with your coworkers?			
O YES O NO	Do you have any problems with being late or absent to work?			
O YES O NO	Have you experienced any accidents or losses while working?			
O YES O NO	Have you ever been fired from a job before?			
1. 2.	Previous jobs you have held?			

SYMPTOM CHECKLIST

Please Mark Those That Apply to the Patient

1. Depressed Mood	27. Shortness of breath, dizziness, sweating
2. Lost interest in most activities	28. Recurrent undesirable thoughts
3. Increased appetite	29. Repetitive behaviors (handwashing, checking) or mental acts (counting, etc.)
4. Decreased appetite	30. Nausea or abdominal stress
5. Weight gain	31. Fear of losing control
6. Weight loss	32. Fear of dying
7. Difficulty going to sleep	33. Recurrent intrusive memories
8. Difficulty staying asleep	34. Flashbacks
9. Fatigue, loss of energy	35. Efforts to avoid memories
10. Feelings of worthlessness	36. Fear of social situations
11. Inappropriate guilt	37. Alcohol problems
12. Difficulty concentrating	38. Drug use problems
13. Preoccupation with death	39. Compulsive dieting
14. Suicidal thoughts	40. Vomiting, use of laxatives
15. Excessive or uncontrollable worry	41. Marital problems
16. Restlessness	42. Sexual problems
17. Irritable	43. Impulsive
18. Decreased need for sleep	44. Overwhelmed
19. Increased talking	46. Angry
20. Racing thoughts	47. Easily upset, on edge
21. Distractible	48. Careless, forgetful, easily distracted, difficulty organizing loses things
22. Elevated mood	
23. Engaging in risky, pleasurable activities	
24. Mood swings	
25. Feelings of panic	
26. Pounding heart, chest pain, shaking	

Legacy Life Care Programs

Linda Smith, MMFT

Practice Policies

This practice exists for the purpose of reaching out to meet the needs of those who are experiencing serious life issues. Specific areas of counseling focus may be related to anything of a serious life nature. This policy statement exists in order to answer questions that are frequently asked by clients regarding fees, confidentiality, services, etc.

Counselor Information

Counselor Name: Ms. Linda R Smith

Contact: 931-215-2182 or legacyoflife16@yahoo.com
Credentials: Master of Marriage and Family Therapy

Ethical Oversight

This agency adheres to the professional standards of the ACA, AAMFT, and the AACC. Client may obtain a copy of these ethical guidelines from the following locations: www.aamft.org., www.adce.net.

Professional Services

Appointments for counseling are available at select times throughout the week. This includes some evening late sessions. In case of an emergency, please contact one of the following: Dial 911 or go to your local hospital emergency room; call the Crisis Help Line at 615.244.7444, call the YW Domestic Violence Center at 615.242.1199. To schedule a session, please contact me at the number or email listed on my business card.

Fee Policy

I am committed to offering the highest quality, professional counseling services. Fees are 80.00-120.00 per clinical hour (45-50 minutes). I charge 120.00 per clinical hour for Pre-Marital Counseling. You can apply for a sliding scale fee, and that fee is based on client {s) gross annual household income. With approval for financial assistance, my fee scale ranges from $80.00 per session to $120.00 per session. In order to apply, I will need a tax return at the first appointment to verify your income. Once I have that information, I will work on a financial agreement as part of the intake process and determine your sliding scale fee. With this system, no one is excluded based on income and quality therapeutic services can be afforded by all.

The fee for working with a licensed therapist is $150.00 per session and is based on gross household income. All sessions will be held at Columbia Legacy Life Care Programs, or at Therapeutic Wellness Centre under the direction of site supervisor, Tina Waymire Collier. Virtual Therapy is available at similar rates and session times via software at 3CNow, and intake is the same as person to therapist sessions would be at paying in advance prior to starting the

sessions. All sessions are viable and recognized and By initialing you are stating that you understand and freely grant permission for this type of session with a therapist or their site supervision to occur________.

A session is typically based on a 45-50-minute hour. However, when working with couples or families the session may exceed this time. Unless this time is excessive, the rate will still be based on the regular hourly fee. There are back to back sessions, however, there is a opportunity to request a 10-minute break between sessions, I request that cancellations be made 24 hours in advance; ***otherwise, you will be billed for a full session*** (cancellations for emergency reasons may not be the full fee). Initial you understand this cancellation for emergency reasons and may not be the full fee:_____. Other services such as school appearances, participation in IEP meetings, etc. are based on the same sliding scale fee you would pay for an in-office or during a virtual live c3Now therapy session and conjoined session or other personal on site/virtual site visit is held, in addition to transportation expenses may be billed.

Cancellations should be made 24 hours in advance, without the requested notice, you are responsible for one-half of the set fee. **If no notice is given (no-show), the full session fee will be due. Should you cancel under 24 hours, the fee is ½ your determined session fee. Also, please note, there will be a $25.00 fee on all returned checks.**

At this time, I do not accept insurance. I will however, provide you an invoice if requested to turn into your own insurance.

I am not a certified Custody Evaluator or an Expert Witness, as defined by the legal system. As a marriage and family therapist, I am not permitted to make any judgments on custody. In the case that I would be subpoenaed to court or involved in any legal matter, the client will be charged $300 an hour (this includes note taking, phone calls, writing case summaries, time in court, etc). Initial that you acknowledge this Expert Witness or Custody Evaluator:________.

For parent intake sessions, I may allow 60 minutes and the session cost will be the same as for a 50-minute hour. This arrangement is based on need and is arranged prior to the first intake appointment. When working with children, I will spend the first ten minutes of the session with the parent to collect payment, schedule the next appointment and touch base about the program of therapy. At the end of the session, I will direct your child to go to the lobby without me (unless they are under the age of 7, in that case I will walk them out). I have found that it is best for the therapist and parent not to see each other at the end of a child's session (this gives the child the advantage to give the child assurance of confidentiality. If you would like to discuss a concern regarding your child, please schedule an appointment with the outside scheduling of your child's appointment time.

Dual Relationships

For the purposes of professionalism and relational clarity, it is the policy of this practice to not accept gifts of any kind from the client directly to the therapist or anyone working for the

company. Legacy Life Care Programs is a 501 c 3 domestic faith-based nonprofit, and as such, any donations or gifts in kind are strictly adhering to the state's definition of this opportunity for giving through donations. If you are inclined to want to give, you may do so at our website navigator system at https://www.legacylifecareprograms.com/giving. You will receive a gift of donation letter back should you determine a value be placed on the gift for tax benefits as indicated. This policy is extended to include all office staff as well. As a matter of policy, if counselor and client see each other in a public setting, counselor will not acknowledge client unless client first does so. Client is solely responsible for all public interactions with the counselor and others in the public setting.

Colleague Consultation

In order to provide quality care, counselors often consult with other counseling professionals. When this occurs, every effort will be made to protect the identity of the client.

Confidentiality

Professional ethics and Tennessee State law indicate that confidential information is controlled by the client. This means that as a general rule, information shared in sessions with a counselor will be held in confidence. However, there are limits to confidentiality. They are as follows:

1. Confidentiality is waived when a client is a danger to self and others.
2. Confidentiality is waived when a client is engaging in or is aware of abuse or neglect of minors. Tennessee law requires that child abuse in any form be reported to the Department of Human Services or other authority such as a Juvenile Judge.
3. Confidentiality is waived if a lawsuit is brought against the counselor.
4. Confidentiality is waived when requested information is court ordered and signed by a judge.
5. Confidential information must be accessible to any Supervisor named on page one of this form.
6. Confidentiality is limited if counselor must engage collection agencies for the purpose of receiving payment for services rendered.
7. Confidentiality is limited for purposes of professional consultation between counselor and other practicing therapists.

If you are referred by a physician or other health care professional, it is a professional courtesy to maintain contact, as necessary, with this referral source. That may be done unless you request otherwise.

In cases where family members are being seen by multiple therapists for individual therapy, it is understood and agreed upon that Linda R Smith, MMFT will share necessary and pertinent information. This information will only be shared when it is necessary for individual and family health. This practice and policy is put in place to ensure that you and your family are getting the highest level of quality care and ensure that we are as an agency, are following the Family Systems Model.

When working with minors, I will not share the content of sessions with parents/guardians, unless the content must be shared for safety reasons or if my therapist judgment warrants sharing content for the welfare and health of the minor. Should this be the case between adult children, teens, or children over the age of 7 years, there will be a “Secrets Agreement” as part of this agreement that will help bridge any concerns as to confidentiality being shared, secrets being told, all discussions will discuss progress and treatment plan in general terms with parents/guardians. Parents are encouraged to be a very active part of the counseling process; be prepared to be in session with your child at times and to have “homework assignments” for your family.

_____By initial, client agrees that full disclosure has occurred regarding the limits of confidentiality, and agrees to the limits as listed.

Benefits and Risks of Counseling

Benefits: While there are no guarantees, this process should assist the client in emotional and mental growth, and general improvement of life challenges. While it is possible to improve personal issues without assistance, research has shown that individuals who participate in professional counseling sessions tend to improve more dramatically and for the long term.

Risks: Participation in therapy sessions may include the following risks; increased relational challenges, increased self-awareness that may be difficult or upsetting, or the general state of your life condition may decline in quality before it begins to improve. Risks related to most mainstream therapeutic methodologies are deemed to be minimal but may include an initial increase in anxiety and thought processes, as well as the potential of general life disorganization as the client works to address thought life changes or solving new life issues.

Persons contemplating counseling should realize that they may make significant changes in their lives. People often modify their emotions, attitudes, and behaviors. They may also make changes in their marriages or significant relationships, such as with parents, friends, children, relatives etc. they may change employment and begin to feel differently about themselves, and may change other aspects of their lives. While the therapist will assist the client in effecting change, they cannot guarantee a specific outcome. Clients are ultimately responsible for their own growth.

Do you have any questions about fees, confidentiality, or other matters? Yes____No _____

Do you agree with the conditions and provisions of these Practice Policies? Yes____No ___

Client’s Signature______________________________Date: ______________________________

Parent/Guardian’s Signature____________________________Date:_______________________
(If a minor)

I have discussed and explained the above information with the client.

Counselor’s Signature__________________________________ Date: ______________________

Legacy Life Care Programs

I,____have received a copy of the office's Notice of Privacy Practices and HIPPA

SIGNATURE: ____

PRINTED NAME: ____

DATE: ____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledge could not be obtained because:

1. Individual refused to sign
2. Communication barriers prohibited obtaining the acknowledgment
3. An emergency situation prohibited obtaining the acknowledgment

Other (please specify conditions): ___