A thorough assessment is important because it can provide your counselor with helpful information about your background that could assist in your treatment. In an effort to ensure your counselor can spend in-session time on what is most important to you instead of collecting this information, we ask that you complete this packet in its entirety and bring it with you to your first appointment. ***You will not be able to be seen without completion of this paperwork***. Please ***read carefully*** as there is important legal information about policies, your rights, and consent to treatment.

A. Personal Information

Client Name: ______________________________ Today's Date:____________

DOB: _____/_____/_____ Age: __________ Gender:______________ Sexual Orientation:______________

Race/Ethnicity:______________________ Place of Birth: ______________________

Street Address: ______________________ City:______________State:________Zip:__________

Phone Number: ______________________Email:______________________

May I…

Leave messages at the above phone numbers? Y N

Send appointment reminders via text message to your cell phone? Y N

Send appointment reminders to your email address? Y N

Contact you via email if you can't be reached by phone? Y N

B. Emergency Contact

Name:______________________ Phone:______________ Relationship:______________

C. Employment

Occupation:____

How many hours a week do you typically work?______________________________

How would you describe your stress level at work? Low Moderate High

Therapist's Notes:____

____

____

D. Education

What is your highest level of education completed? High School/GED Some College

Associates Degree in______________________ Bachelor's Degree in______________________

Master's Degree in______________________ Doctorate Degree in______________________

Are you currently enrolled in school? Y N

Therapist's Notes:____

E. Religious Affiliations

Christian Catholic Jewish Islamic Buddhist Other:____________ None

Level of Involvement: None Some/Irregular Active

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How important are spiritual concerns in your life? Very Somewhat Not Really

Therapist's Notes:____________________

F. Referral Source

How did you find me? ____________________

If you found me online what words did you use to search?____________________

G. Medical/Physical Health History

Do you have any chronic medical and/or physical conditions? If so, please list:____________________

Do you experience any chronic pain? Y N

Are you currently under medical care? Y N If so, what for?____________________

Do you have a primary care physician (PCP)? Y N

Are you currently taking any prescription medications? If so, please list medication(s) and dosage if possible:____________________

When was your last physical exam?____________________

If you enter mental health treatment with me, may I inform your PCP so that we may coordinate your treatment? If so, please provide name and phone number of your PCP:____________________

Therapist's Notes:____________________

H. Mental Health History

Have you ever been diagnosed with a mental health condition? Y N

If so, please check all that apply: Depression Bipolar Anxiety Social Anxiety OCD PTSD Borderline Personality Disorder ADHD/ADD Other (specify)____________________

Do you have a history of self-harming behaviors (*i.e. cutting, burning, putting yourself in risky situations where you know you could be harmed*)? If so, please explain:____________________

Are you currently taking any psychiatric medications? If so, please list medication(s) and dosage if possible:__________

Have you ever been hospitalized for any mental health reasons? Y N

If so, where, what year, for how long were you hospitalized, & what were the outcomes?____________________

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Has anyone in your family ever been diagnosed with a mental health condition? If so, please list who & what their diagnosis was if known:____

Have you ever *thought*, or are you currently *thinking,* of ending your life? If so, please explain:____________________

Have you ever *planned*, or are you currently *planning,* to end your life? Do you have the *means* to end your life? If so, please explain:____

Are you currently *thinking* of or *planning* to seriously harm anyone? If so, please explain:________________________

Do you currently own or have access to weapons in your home? Y N
If yes, who has access to them & what are the safety protocols around them?________________________________

Therapist's Notes:____

I. Substance Use History

Are you currently using or have used in the past any of the following (*please check all that apply):*

Alcohol   Marijuana   Spice   Cocaine   Ecstasy   Opioids   Other (*specify*):________________________

When was the last time you used?____

How often are you drinking and/or using a substance(s)?   Daily   Weekly   Monthly   Occasionally/Recreationally

What age did you start drinking and/or using?____

Have you ever tried to stop using but couldn't? Y N

Have you ever been charged with DUI? If so, when and what was the outcome?____________________________

Does anyone in your family have a substance abuse issue? Y N

Have you ever felt your substance use was problematic? Y N

Is the reason you're seeking counseling now related in any way to substance use? Y N

Therapist's Notes:____

J. Trauma History

Have you ever experienced any of the following abuse (*please check all that apply*):

Physical   Psychological/Mental   Verbal   Emotional   Sexual

What age were you when the abuse occurred?____

Who was the perpetrator?   Family Member   Friend of Family   Significant Other   Stranger

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Did you ever tell anyone? If so, who and what was the outcome?____

Was the perpetrator ever prosecuted? Y N
Did you ever receive help for the abuse? Y N
Have you ever experienced nightmares or flashbacks, or do you avoid anything that causes emotional discomfort? If so, please explain:____

How do you think the abuse has affected you in your life? Please explain:____

Have you ever witnessed someone being abused or harmed in any way? If so, please explain:___________________

Have you ever been through any *other* type of traumatic experiences not listed above (*i.e. major car accident, witnessing someone get seriously hurt, etc.*)? If so, please explain:____

Therapist's Notes:____

K. Legal

Are you currently involved in any legal matters? If so, please explain:____

Are you currently court ordered to attend therapy? Y N
If yes, please explain:____
Therapist's Notes:____

L. Military Information

Are you currently active duty? Y N
Are you retired? Y N
Branch of Service:_______________________ Entrance Date:__________________ Exit Date:____________________
Were you ever deployed? If so, where, when, & for how long?____

Were you ever in combat? Y N
Were you ever injured in the military? Y N
Do you receive service connected and/or non-service connected pension? *(*if you have served during war time and had at least one day in combat you may qualify for VA benefits; please inquire*): Y N

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M. Relationship History

Marital Status: Single Married Separated Divorced Widowed Actively Dating In Relationship

How satisfied are you with your relationship status? Satisfied Moderately Satisfied Unsatisfied

Have you ever experienced domestic violence in any of your relationships? If so, please explain:____________________

Is the reason you're seeking counseling related to your current relationship? Y N

If yes, please check all that apply to your current concerns: Communication Physical Intimacy Lack of Trust Emotional Intimacy Lack of Support Power/Control Feeling Disconnected Other (specify):______________

How would you describe your communication style?____________________

How would you describe the communication style of your partner?____________________

If you are in a relationship answer the following regarding your relationship:

1. Likes ____________________
2. Dislikes ____________________
3. Not enough of ____________________
4. Too much of ____________________
5. Words to describe your ideal relationship:____________________

Do you have any children? If so, what age?____________________

Therapist's Notes:____________________

N. Client's Main Concerns

What are your main concerns that led you to seek counseling? How long have each been going on? Put them in order of importance:

1. ____________________
2. ____________________
3. ____________________
4. ____________________

What do you think those that care about you would say their concern(s) is/are in regard to you?

What solutions (helpful or unhelpful) have you tried to resolve the above concerns?____________________

Have you ever been to therapy before? If so, please circle type of therapist (licensed mental health counselor, psychologist, psychiatrist)? What reason(s) did you attend therapy for? Did you find it helpful/unhelpful? What did you like/dislike?____________________

Therapist's Notes:____________________

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O. Client's Expectations

Do you have any expectations for therapy? Do you have any expectations of the therapist? If you have seen a therapist in the past, what do you wish you had received but didn't?____

Looking into the future, how will you know that our work and time together has been worth it? List concrete changes you would like to see:____

What other things would you like to see improve in your life (*family, career, health, relationships, work-life balance, self-care, stress management, etc.*)?____

Do you foresee there being anything that would get in the way of you achieving your therapy goals?________________

How long are you willing to commit to the therapy process? Please write down a target time frame:________________

List 5 strengths about yourself or strengths others would say you have:

1. ____
2. ____
3. ____
4. ____
5. ____

Is there anyone that you would like to be a part of your sessions either now or in the future because you think he/she can provide important insight into some of your concerns?____

Therapist's Notes:____

P. Lifestyle Information

What do you currently do to take care of yourself? (*i.e. diet, exercise, limits on TV/electronics/work, holistic/alternative practices, family time, leisure, etc.*)?____

On average, how many hours of sleep do you get each night?________________________________

How would you rate the quality of your sleep? Excellent Good Fair Poor

Do you feel like your life is balanced or unbalanced? If unbalanced, what do you think would help you create more balance in your life?____

Do you have any allergies (*food, environmental, medicinal, animal, etc.*)?:________________________________

Over the past year, have you experienced any major changes in your life? (*i.e. moves, changes in appetite, sleep, health, divorce, death of family or friend, or changes in overall functioning*)?________________________________

List any over-the-counter medications, vitamin or herbal supplements you're taking on a regular basis, and what alternative treatments (*acupuncture, chiropractic, etc.*) you are currently receiving, if any:____________________________

____

____

Do you make time for leisure? Y N If no, why not?____

Q. Understanding Your Family & Childhood Influences

Parent's marital status: Married Divorced Never Married Separated Domestic Partners Widowed

List three words to describe your Mother:____

List three words to describe your Father:____

List three words to describe your home environment growing up: ____

____

List some words to describe your parent's relationship with each other:_______________________________________

____

List some words to describe your relationship with your mother:____

____

List some words to describe your relationship with your father:____

____

List some words to describe your relationships with your sibling(s) if applicable:________________________________

____

Who lives with you currently?____

____

Is there anything else you think I should know about your upbringing that would help me understand you better?

____

____

Therapist's Notes:____

____

R. Therapy Goals

Please list three *outcomes*, in order of importance, that you'd like to achieve while in therapy that will be the focus of our work together:

1.____

2.____

3.____

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Checklist of Concerns

- ☐ Abuse: physical, sexual, emotional, verbal (*please circle all that apply*)
- ☐ Neglect of children, elderly, or person with disability
- ☐ Aggression, violence
- ☐ Alcohol abuse
- ☐ Anger, hostility, arguing, irritability
- ☐ Anxiety, nervousness
- ☐ Attention, concentration, distractibility
- ☐ Bullying
- ☐ Career concerns, goals, & choices
- ☐ Childhood issues (your own)
- ☐ Co-dependency
- ☐ Confusion
- ☐ Compulsions
- ☐ Custody of children
- ☐ Decision-making, indecision, mixed feelings, avoiding decisions
- ☐ Delusions (false ideas)
- ☐ Dependence
- ☐ Depression, low mood, sadness, uncontrollable crying spells
- ☐ Divorce, separation
- ☐ Drug abuse
- ☐ Eating problems (overeating, under-eating, appetite issues)
- ☐ Emptiness
- ☐ Failure
- ☐ Fatigue, tiredness, low energy
- ☐ Fears, phobias
- ☐ Financial troubles, debt, impulsive spending, low income
- ☐ Friendships
- ☐ Gambling
- ☐ Grief, mourning, loss of loved one
- ☐ Guilt
- ☐ Headaches, migraines
- ☐ Health, illness, medical concerns, physical problems
- ☐ Housework/chores, sharing household duties
- ☐ Inferiority feelings
- ☐ Interpersonal conflicts
- ☐ Impulsiveness, loss of control, outbursts
- ☐ Irresponsibility
- ☐ Infidelity
- ☐ Judgment problems, risk taking
- ☐ Legal troubles, charges, lawsuits
- ☐ Loneliness
- ☐ Marital problems
- ☐ Memory problems
- ☐ Menstrual Problems, PMS
- ☐ Menopause
- ☐ Mood swings
- ☐ Motivation (lack of)
- ☐ Nervousness, tension
- ☐ Obsessions, compulsions
- ☐ Oversensitivity to rejection
- ☐ Panic or anxiety attacks
- ☐ Parenting, child management
- ☐ Perfectionism
- ☐ Pessimism
- ☐ Procrastination
- ☐ Relationship problems
- ☐ School problems
- ☐ Self-centeredness
- ☐ Self-esteem
- ☐ Self-worth
- ☐ Self-neglect, poor self-care
- ☐ Sexual issues, dysfunction
- ☐ Shyness, sensitivity to criticism
- ☐ Smoking, tobacco use
- ☐ Spiritual, religious, moral, ethical
- ☐ Stress management, tension
- ☐ Suspiciousness
- ☐ Suicidal thoughts/plans
- ☐ Temper problems, no self-control
- ☐ Thought disorganization
- ☐ Threats, violence
- ☐ Weight management problems
- ☐ Withdrawal, isolation
- ☐ Work problems, lack of ambition
- ☐ Worrying about everything
- ☐ Other:____________________________

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Policies and Consent to Treatment

PLEASE INITIAL TO INDICATE YOU HAVE READ OF UNDERSTAND EACH POLICY

_____**Financial Policy**: Full payment is due at time of service (unless prior arrangements have been made). Please note that your Brandy Torretta ***does not*** accept insurance at this time and you are solely responsible for making payments in a timely manner. You will be charged a ***$35 fee for any declined payments in addition to your full session payment***. Unpaid balances may be turned over for collection or reported to the state's attorney's office. Understanding this policy is important to our relationship. Please feel free to ask if you have any questions about this policy.

_____**Cancellation Policy**: Please help me serve you and others better by keeping your scheduled appointments. If you need to reschedule or cancel an appointment, please do so 24 hours in advance to avoid being charged your full session fee. ***You will be charged your full session fee for any missed appointments and cancellations made after 24 hours.*** The 24-hour cancelation policy allows me to offer the appointment to another client who may need to be seen. Brandy Torretta reserves the right to require prepayment in order to schedule subsequent appointments.

_____**Confidentiality**: Federal and State laws protect your confidentiality (see 42 U.S.C 290dd-3 and 290ee-3 for Federal laws and 42 CFR Part 2, 491.0147 FL). Brandy Torretta will not share information with any person outside of Inspire Counseling, LLC without your written permission, except as required by law. Information obtained from minors is not generally shared with parents without permission. HIPPA (Health Insurance Portability and Accountability Act) laws allow you to access your file and protect the electronic transfer of information.

_____**Limits to Confidentiality**: Federal regulations do not protect from disclosure of information related to clients' involvement in a crime against property or person(s). Brandy Torretta is required under Florida state law to report suspected abuse of a child, elderly person, or an individual(s) with a disability. Brandy Torretta may share limited information in the event of a medical emergency or in the event of a specialized court order signed by a judge. Brandy Torretta has the option of breeching confidentiality if you report a specific plan or intent to cause life threatening bodily harm to yourself or another person(s).

_____**Consent to Treatment**: I am voluntarily seeking outpatient counseling from Brandy Torretta at Inspire Counseling, LLC. I understand that I have rights and responsibilities regarding my participation in treatment, including the right to discontinue therapy at any time. I am strongly encouraged to discuss my treatment plan and progress in treatment with Brandy Torretta. Brandy Torretta will also discuss alternative treatments as well as the benefits and risks associated with therapy. ***With my signature below, I acknowledge that I have read, understand, and agree to all of the information above and consent to treatment from Brandy Torretta at Inspire Counseling, LLC.*** I also acknowledge that I have been given a copy of HIPPA/Privacy Practices implemented at Inspire Counseling, LLC. Please note that individual counseling sessions are 50 minutes in length. Please note that Brandy Torretta does not provide emergency services and you are to call 911 for medical or mental health crisis/emergencies.

Notice of Privacy Practices

As a licensed mental health provider, I am required by federal and state laws to protect your privacy. The **Health Information Portability & Accountability Act (HIPPA)** establishes limits on how our health information may be used and shared and how it must be protected. When Florida laws protecting your health records are more restrictive than federal laws, I must abide by the Florida laws. The following *Notice of Privacy Practices* will tell you about the ways I may use and share mental health information about you. It will also describe your rights and my obligations regarding the use and disclosure of your mental health information.

My Pledge to You Regarding Your Mental Health Information
The privacy of your mental health information is important to me. I create a record of the treatment you receive from me to provide you with quality treatment and to comply with certain legal requirements. I understand this information is personal and I am committed to protecting it.

This Notice of My Privacy Practices Describes:

- How and to what extent the privacy of your Protected Health Information is guaranteed.
- How your Protected Health Information may be used and disclosed.
- How you may access portions of your Protected Health Information and the procedure for doing so.

Your Protected Health Information (PHI)
Your PHI includes any *individually identifiable information* created or received about you. Specifically, it includes identification of symptoms, diagnosis, medications, treatment, appointment dates and times, session summaries, and payment history.

Use and Disclosure of Your Protected Health Information (PHI)

- I will not share with your managed care company (insurance) or Employee Assistance Program (EAP) the PHI required to obtain authorization to treat you and to bill for your treatment services.
- I will not share your PHI with another therapist or treatment facility.
- I will not share your PHI with any other individual, including family members, except in the case of minor children.
- I am required by law to report abuse and/or neglect of children, elderly, and persons with disabilities to the proper authorities. This report may, of necessity, include your PHI.
- I am required by law to take immediate action, including the release of your PHI, if I believe that you or someone else is at imminent risk of harm.
- I may share your PHI with my Clinical Supervisor, Misty Lee Fenton, LMHC whom has agreed to abide by the terms of my Notice of Privacy Practices.
- I may disclose your PHI in response to a court order, subpoena, warrant, summons, or similar legal process.
- I may disclose your PHI as required by federal, state, or local law.

Your Privacy Rights

- With the exception of the purposes listed above, you have the **right to decide** if your PHI is given out to a third party and to specify what information is given. You do this by completing and signed the **Authorization for Release of Confidential Information** form provided by your counselor upon request. You may revoke this consent at any time.
- You have the **right to review** and get copies of your PHI with certain exceptions. This request must be in writing and there may be charges for copies and postage.

- You may **request that corrections or additions be made** to your PHI if you believe that there is an error or a significant omission.
- You may **request additional restrictions** on y use or disclosure of your PHI.
- You may **request that I use an alternative way to communicate with you in a confidential manner** or communicate with you at an alternative location about your PHI.
- You may **obtain a list of the times I have disclosed your health information** for purposes other than treatment, payment, healthcare operations, and other specified exceptions.
- You will **receive a paper copy of my Notice of Privacy Practices** for your records.
- You have the **right to file a written complaint** with the U.S. Department of Health and Human Services if you believe your privacy rights have been violated.

My Legal Duty

As a licensed mental health provider, I am required to abide by the terms of this notice. However, I reserve the right to change my privacy practices and the terms of this notice at any time provided the changes are permitted by law or meet any new requirement implemented by law for the benefit of your PHI. Before I make any important changes to my privacy practices, I will revise this notice and make the new notice available to you on your first visit following revisions. Any changes in my privacy practices and the new terms of this notice will be effective form the date of the revision forward for all mental health information I keep. You are entitled to receive a copy of the most current notice and may obtain it at any time by request.

I,____acknowledge that I have read the preceding information and have kept a copy of this notice for my personal records. I acknowledge that all questions regarding my privacy have been answered in an acceptable manner.

____ ______________

Client Signature **Date**

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Client Policies and Information

Client Expectations of the Counseling Process and Outcomes
Your goals and expectations are more likely to be met when you understand the nature and limitations of counseling. Generally, counseling is most useful in helping people improve their self-awareness to allow positive change in their life. Counseling provides a safe and confidential atmosphere to examine the way you choose to process information and to help you expand your ability to react to the world around you. Most people experience improvement or resolution of their concerns that brought them to counseling. However, there are no guarantees and there may be risks. For example, counseling could open up new level of awareness that could cause discomfort. We will work together as a team towards your personal counseling goals, but you determine the nature and amount of change you wish to make.

Office Visits
Hourly rates are based on a 50-minute session, which allows for necessary documentation time. At times, sessions may be slightly longer or shorter based on the therapist's judgement to maximize the quality of the session. After our initial session, we will determine together the frequency and availability of continued sessions. While the length of therapy varies from client to client, it is my aim to work together until resolution is found. It is your right as a client to terminate therapy at any time or to seek a second opinion from another therapist. Payments are to be made at the end of each session and accepted forms of payment include cash, check, or debit/credit card. When requested, documentation can be provided to assist you in seeking reimbursement from your insurance provider. **Please notify me of appointment cancelations at least 24 hours in advance of your appointment time to avoid a late cancelation/missed appointment fee. However, you will not be charged in cases of emergency situations.**

Methods of Contact
On occasion, there might be a need to have contact outside a normal session. To preserve your confidentiality, I request that email or text be used only to schedule or confirm appointment dates/times as I cannot assume responsibility for the security maintenance of electronic transmissions. In times of immediate crisis or emergency, I may be contacted by phone. If it is outside normal business hours of 9 AM to 7 PM, please leave a message ad I will return your call as soon as possible. **If you have a life-threatening emergency, please call 911 or the Tampa Bay Crisis Center at 211 for immediate assistance.**

Confidentiality
The notion of confidentiality is paramount in counseling. Everything disclosed between the therapist and client is confidential, unless authorized by the client or required by law. A client may authorize the release of confidential information by signing an *Authorization for Release of Confidential Information* form, which will be provided to you upon request. I will not release any confidential information without this written authorization, unless such release is otherwise authorized or required by law. **The law requires mandated release of confidential information in the case of child abuse or neglect, if the client has intent to harm himself/herself or others, or in the case of a court subpoena.** For additional details on how your information may be used and our rights to our health care information, please refer to the Notice of Privacy Practices that you received.

I,____have read the preceding information, understand my rights as a client and all general policies, and acknowledge I have kept a copy of this notice for my personal records.

____ ____________
Client Signature **Date**

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Payment Information

Your counselor requires a card to be kept on file for your session payments. Your card will also be automatically charged for any ***missed appointments*** *and* ***cancelations made less than 24 hours in advance***, and a ***$35 fee for any declined payments.*** By signing below, you consent to the policies above and authorize your card on file to be charged.

PLEASE WRITE CLEARLY

Name on Card:____ Card #:__________-__________-__________-__________

Exp. Date:_______/________ CVC Code:___________ Billing Zip Code:_______________

Signature:____

Best Email for Receipts:____

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