KATHLEEN JONES

therapy

# ADULT PERSONAL DATA

Name:_____ Date:_____

Home Phone:_____ Work Phone:_____ Cell: _____

Street Address:_____ City:_____ Zip: _____

Age: _____ Birthdate: _____ email: _____

Married_____ Partnered_____ Single_____ Separated_____ Divorced_____ Widowed_____

How long (to all that apply above): _____

Ethnicity:_____ Religion:_____

Referred by:_____

Name of Emergency contact:_____ Phone #:_____

Relationship to client:_____

Are You Currently in Other Counseling? [ ] Yes [ ] No

If So, Name and Address:_____

Prior Counseling, Name(s) & Date(s):_____

_____

Current Medications/Dosages (Include Over the Counter):_____

_____

Have You Had Any Problems with Medications?_____ If Yes, Details:_____

_____

**Type(s) Of Help Desired:**

[ ] Parenting Education [ ] Individual Counseling [ ] Group Counseling

[ ] Family Counseling [ ] Couples Counseling [ ] Substance Use/Abuse Treatment

[ ] Other _____

**Major Reason(s) For Seeking Help at This Time:**

**How long have you had these problems or symptoms?**

**How often do they occur?**

**Why did you seek help now?**

**What have you tried?**

**Do You Have Any Serious or Chronic Medical Conditions?**

**If Yes, Dates & Details:**

**Have You Had Any Serious Accidents/Head Injuries/Seizure Activity?**

**If Yes, Dates & Details:**

**Drug and Alcohol Use:**

Do you use alcohol?_____ How much per week?_____ Age started drinking:_____

Do you use other drugs?_____ What kind:_____ How much: _____

Do you feel you have a problem with alcohol?_____ Other drugs? _____

Any previous drug/alcohol treatment (inpatient/outpatient)? _____

If yes, dates and locations: _____

Has your drinking/drug use caused problems with family or relationships?_____

Has your drinking/drug use caused problems with your job?_____

Is it difficult for you to stop or control the amount you take?_____

Have you been arrested for driving under the influence or other drug related offense?_____

If yes, dates:_____

Have you ever used tobacco products?_____ What kind?_____ How much?_____

How many cups of caffeinated beverages do you drink per day (coffee, tea, soda, chocolate)?____

_____

Have you had any legal problems or previous imprisonment?_____

If yes, explain:_____

**Family Data:**

Spouse/Partner Name:_____ DOB:_____ Age:_____ M/F:_____

Lives with you?_____ Ethnicity:_____ Spirituality: _____

Child:_____ DOB:_____ Age:_____ M/F:_____

Lives with you?_____ Ethnicity:_____ Spirituality: _____

Child:_____ DOB:_____ Age:_____ M/F:_____

Lives with you?_____ Ethnicity:_____ Spirituality: _____

# THE AMEN CLINIC QUESTIONNAIRE

0 = Never 1 = Rarely 2 = Occasionally 3 = Frequently 4 = Very Frequently

_____1. Frequent feelings of nervousness or anxiety
_____2. Panic attacks
_____3. Avoidance of places due to fear of having an anxiety attack
_____4. Symptoms of heightened muscle tension (sore muscles, headaches)
_____5. Periods of heart pounding, nausea, or dizziness (not w/ exercise)
_____6. Tendency to predict the worst
_____7. Multiple, persistent fears or phobias (dying, doing something crazy)
_____8. Conflict Avoidance
_____9. Excessive fear of being judged or scrutinized by others
_____10. Easily startled or tendency to freeze in intense situations
_____11. Seemingly shy, timid, and easily embarrassed
_____12. Bites fingernails or picks skin
_____**Total number of questions with a score of 3 or 4 for questions 1- 12**

_____13. Persistent sad or empty mood
_____14. Loss of interest or pleasure from activities that are normally fun
_____15. Restlessness, irritability, or excessive crying
_____16. Feelings of guilt, worthlessness, helplessness, hopelessness
_____17. Sleeping too much or too little, or early morning waking
_____18. Appetite changes/ weight loss or weight gain through overeating
_____19. Decreased energy, fatigue, feeling “slowed down”
_____20. Thoughts of death or suicide, or suicide attempts
_____21. Difficulty concentrating, remembering, making decisions
_____22. Physical symptoms; headaches, chronic pain, digestive problems
_____23. Persistent negativity or low self esteem
_____24. Persistent feeling of dissatisfaction or boredom
_____**Total number of questions with a score of 3 or 4 for questions 13-24**

_____25. Excessive or senseless worrying
_____26. Upset when things are out of place or don’t go according to plan
_____27. Tendency to be oppositional or argumentative
_____28. Tendency to have repetitive negative or anxious thoughts
_____29. Tendency toward compulsive behaviors
_____30. Intense dislike of change
_____31. Tendency to hold grudges
_____32. Difficulty seeing options in situations
_____33. Tendency to hold on to own opinion and not listen to others
_____34. Needing to have things done a certain way or you become upset
_____35. Others complain you worry too much
_____36. Tendency to say no without first thinking about the question
_____**Total number of questions with a score of 3 or 4 for questions 25-36**

_____37. Periods of abnormally happy, depressed or anxious mood
_____38. Periods of decreased need for sleep, energetic on much less sleep
_____39. Periods of grandiose thoughts and ideas (feeling very powerful)
_____40. Periods of increased talking or pressured speech
_____41. Periods of too many thoughts racing through your mind
_____42. Periods of increased energy level
_____43. Periods of poor judgment that leads to risk-taking behaviors
_____44. Periods of inappropriate social behavior
_____45. Periods of irritability or aggression
_____46. Periods of delusional or psychotic thinking
_____**Total number of questions with a score of 3 or 4 for questions 37 – 46**

_____47. Short fuse or periods of extreme irritability
_____48. Periods of rage without being provoked
_____49. Often misinterprets comments as negative when they are not
_____50. Periods of spaciness or confusion
_____51. Periods of panic or fear for no specific reason
_____52. Visual or auditory changes (seeing shadows or hearing sounds)
_____53. Frequent periods of déjà vu (feeling you've been somewhere you have never been)
_____54. Sensitivity or mild paranoia
_____55. Headaches or abdominal pain of uncertain origin
_____56. History of head injury or family history of violence/ explosiveness
_____57. Dark thoughts, may be homicidal or suicidal
_____58. Periods of forgetfulness or memory problems
_____**Total number of questions with a score of 3 or 4 for questions 47- 58**

_____59. Trouble staying focused
_____60. Spaciness or feeling like you're in a fog
_____61. Overwhelmed by tasks of daily living
_____62. Feels tired, sluggish, or slow moving
_____63. Procrastination, failure to finish things
_____64. Chronic boredom
_____65. Loses things
_____66. Easily distracted
_____67. Forgetful
_____68. Poor planning skills
_____69. Difficulty expressing feelings
_____70. Difficulty expressing empathy for others
_____**Total number of questions with a score of 3 or 4 for questions 59-70**

KATHLEEN JONES
therapy

# CREDIT CARD AGREEMENT

---

**Please note:** New clients are required to keep a valid credit card number on file. Please complete the following information and provide your credit card at your initial session.

CC Type: MC Visa Amex Other _____

Name as shown on card _____

CC Number _____

3-digit security code on back of the card _____

Billing zip code associated with the card _____

Expiration Date _____

**This card may be charged for:**

_____ Regular session fees (at your request, as a convenience to you)

_____ Fees for cancellation without 24 hours' notice (according to Policy)

_____ Delinquent session fees (fees more than 30 days overdue)

**Agreement:**

"I_____(print name) have read and understand the terms of providing my credit card to Kathleen Jones, LMFT. I understand that my credit card may be charged for the reasons indicated above. Any questions I have about this practice have been answered."

_____ (Signature) _____(Date)

# INFORMED CONSENT AGREEMENT

Therapy involves both benefits and risks. Risks include the possibility of experiencing uncomfortable levels of feelings like sadness, guilt, anxiety, anger, loneliness and helplessness. Therapy often requires recalling experiences, some of which may be unpleasant. Therapy may involve making changes that can feel uncomfortable to you and those close to you. Should you notice any negative effects, please tell me.
I will make every effort to remedy the situation or provide you with names of other therapists should you prefer a referral. Psychotherapy has been shown to have benefits for those who undertake it. It often leads to reduction of feelings of distress, and to better relationships and resolution of specific problems. The objective is to find more peace, joy, and healthier relationships.

**CONFIDENTIALITY:**

As part of the counseling process, I am bound by ethical responsibilities to keep confidential the information shared during the sessions and I will not release any information without your written permission. There are important **exceptions to the confidentiality** of the counseling relationship. I am required by law to reveal certain information under the following circumstances:

a) **Disclosure of serious intent to do harm to self or others**
b) **Disclosure of child abuse or my suspicion of child abuse, elder abuse, or dependent adult abuse**
c) **If a court of law orders the release of specific information**

**APPOINTMENTS:**

The length of a usual appointment is 80 – 90 minutes. Appointments are usually scheduled weekly and on a regular basis until you have accomplished the majority of your goals and other arrangements are made.

**CANCELLATIONS AND MISSED APPOINTMENTS:**

Cancellation of appointments must be made at least **24 hours in advance**. A credit card number will be taken at the onset of your counseling. Late cancellations will be charged at the regular hourly fee to your credit card. If you have a true emergency your credit card will not be charged.

**PAYMENT:**

Payment is expected at each session unless other arrangements have been made in advance. I am a licensed therapists with specialized training in individual, couples, family, and trauma therapy. You are responsible for payment for all services rendered either by debit card, credit card, check or cash. All checks and credit cards will be paid to Kathleen Jones, LMFT.

**CHECKS/OVERDUE ACCOUNTS:**

There is a fifteen-dollar ($15.00) service charge for all checks returned by the bank.

**THERAPEUTIC TOUCH:**

On occasion, and only with your permission, I will use therapeutic touch during trauma therapy sessions to help ground you if you are needing extra support and request this. The touch may involve placing my feet next to your feet for grounding, holding your hand(s) or a hug. It is understood that therapeutic touch and the client-therapist relationship is always non-sexual.

**TELEPHONE, TEXT AND EMAIL POLICY:**

Generally, I ask that clients reserve discussing problems that arise between sessions for the next scheduled appointment time. I encourage you to use resources you have and to reach out to your support system. Unless there is an emergency, my schedule does not permit me to talk on the phone, respond to lengthy texts or answer lengthy emails in between sessions. If you feel the need to text or email information beyond the routine scheduling of appointments, I will wait to discuss the content in our next scheduled session. If telephone calls are necessary for a client emergency, please schedule a time for a telephone consultation, which will be charged at my regular rates (In 15-minute segments). **Please do not text anything other than appointment times as confidentiality is not secure with texting.**

**INSURANCE:**

I am what is referred to as an "Out of Network Provider." I do not bill your insurance company and payment is due at each session. However, I will provide a "Super-bill" if you are eligible for reimbursement from your insurance company. Services may be covered in full or in part by your health insurance company or employee benefit plan.

**PHYSICAL EXAMINATION:**

I strongly recommend that each client obtain a thorough physical exam prior to commencing therapy. This is especially important if you are suffering symptoms of anxiety or depression, headaches, and/or weight gain/loss. Symptoms may be biologically caused or may be there for a protective reason.

**TRAINING:**

My training is extensive and I constantly seek more advanced training to be the best therapist for my clients. Your case may be discussed in a group or individual training format with a licensed supervisor present for feedback, education, and discussion. This is always done in a manner where the client, and any identifying information is kept confidential.

**EMERGENCIES:**

Counseling services are available only during scheduled office hours. In a crisis, you may utilize the Sacramento County Mental Health Crisis Service (phone: 916-875-1000)

**If you have any questions about my policies or about psychotherapy, please ask before signing below. Your signature indicates that you have read my policies and agree to enter therapy under these conditions. Further, it indicates your understanding that I may terminate therapy if you do not comply with the policies or if I feel you are not benefiting from treatment.**

Client signature _____ Date: _____