Emotional Inner-Change Counseling

5959 West South Loop, Suite 367
Bellaire Texas 77401

Office: 832-827-3282/ website: emotionalichange.com

Date _____
Appointment Date _____
First Name _____ MI_____ Last Name_____ Maiden Name _____
Age _____ Date of Birth_____ Gender : □ Male □ Female

Ethnicity □ African American/Black □ American Indian □ Asian /Pacific Islander □ Caucasian/White □ Hispanic □Other _____	Relationship Status □ Single □ Engaged □ Married □ Separated □ Divorced □ Widowed

Address:	City	State	Zip
Home phone:	□√ if we may leave a message	Cell phone :	□√ if we may leave a message

Email Address:	□√ if we may leave a message

Please indicate how you referred			List Website/List Serve
□ self	□ family	□ EAP	
□ friend	□ employer/school	□Healthcare Provider	

Religious Affiliation	□ Jewish	□ None, but I believe in God
	□ Catholic	□ Atheist or agnostic
	□ Protestant (i.e., Baptist & etc.)	□ Other

Please read the following questions and mark those to which you would respond "yes."

□ Have you previously been involved in counseling > Year? _____ How long? _____ Where? _____ Who? _____

□ Do you currently use alcohol or other nonprescription drugs?	□ Is there a history of alcohol or drug problems in your family?
□ Is there a history of mental health problems in your family?	□ Have you ever been in legal trouble
□ Have you ever been physically abused?	□ Have you ever been sexually abused or assaulted?
□ Have you ever been emotionally abuse?	□ Are you currently taking prescription medications
□ Are you concerns interfering with your productivity?	□ Are your concerns interfering with you staying in school or employed?
□ Have you ever attempted suicide	□ Have you ever been hospitalized for mental health?

Please describe the concerns that you would like to discuss with a counselor:

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Family Makeup History (if married/cohabitating) Mate's name _____ Children Name(s) age _____ _____ _____ _____ _____ _____ _____ _____	Mother's Age ____ if deceased, how old were you when she died? _____ Father's Age ____ if deceased, how old were you when he died? _____ If you parents are separated, how old were you when they separated? _____ Number of brother(s) _____ What are their ages? _____, _____, _____, _____ Number of sister(s) _____ What are their ages? _____, _____, _____, _____

If you were adopted or raised with parents other than your natural parents explained:	
Briefly describe your mother's personality:	Brief describe father's personality:
Brief describe your stepparent(s) personality:	

Briefly describe your past and current relationships with your:

Mother	Father
Stepmother	Stepfather

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Please mark all the following that apply

Feelings		Thoughts	
□ Helpless	□ Anxious	□ Confused	□Racing
□ Depressed	□ Out of control	□ Unintelligent	□Obsessive
□ Shameful	□ Afraid	□ Worthless	□Distracted
□ Angry	□ Numb	□Unmotivated	□Disorganized
□ Guilty	□ Relaxed	□Unattractive	□Paranoid
□ Hopeless	□ Excited	□Unlovable	□Suicidal
□ Lonely	□ Hopeful	□ Confident	□Sensitive
□ Stressed	□ Inferiority Feeling	□ Worthwhile	□ Honest
□ Happy	□ Mood Shifts	□ Homicidal	

Symptoms/Behaviors for the last year ***(mark all that apply)***

	Eating less		Acting Out Sexually		Socializing
	Procrastinating		Acting aggressively		Martial Relationships
	Attempting suicide		Disorganization		Parental /Child conflicts
	Poor concentration		Impulsivity		Lack of ambitions/ goals
	Crying		Recklessness		Poor Peer Relationships
	Withdrawing		Irritability		Nightmare
	Skipping Classes / work		Passivity		Worries about body image
	Binge drinking		Drug Use		Spiritual Problems
	Injury self		Alcohol use		Dating concerns
	Compulsivity		Being good to yourself		Finances
	Career/Major Choice		Sexual Problems		Other :_____

Physical Symptoms		Please describe any medical conditions you have:
□ Insomnia	□Rapid	
□Tired	□Dry mouth	
□Weight gain or loss	□Excessive sleep	
□Pain	□Loss of memory	
□Headaches	□ Eating problems	
□Tightness in chest	□Other	
□Dizziness / light headedness	_____	
□Numbing/Tingling		
□ Vomiting		

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What to expect

The purpose of counseling/psychotherapy is to assist you in the development of your mind, body, and spirit. A wide variety of concerns can be discussed including but not limited to communication, relationship difficulties, depression, anxiety, and sexual abuse. You can expect to be treated with the utmost respect and professionalism. Most scheduled are approximately 50 minutes in length. You will work with your counselor to determine how often sessions should be scheduled.

How therapy works

Counseling/psychotherapy provides an opportunity to talk with someone about issues or problems you may be experiencing. Therapist utilize various skills to build relationships, assess personnel problems, and provide assistance by giving feedback, support, education, or other helpful resources as appropriate. Counselors rarely give advice or offer direct suggestions about how to solve problems. Instead, you may expect your counselor to be empathic and warn as he, or she helps YOU process various issues and come to deeper understandings**.** Other resources may include the consultations psychiatrist, physicians, or mental health professionals.

The benefits and risks

Research shows that counseling/psychotherapy is effective in helping many people deal with mental, emotional, relational, and developmental issues in their lives. However, because benefits and particular outcomes cannot be guaranteed, there are some risks involved. Counseling provides an environment to talk about unpleasant issues, both past and present that may cause negative feelings. Relationships may also become strained as you make changes that impact the lives of others.

Client Rights

You have the right to:

- Be treated with dignity and respect.
- Know the qualifications and professional experience of your therapist and your therapist's supervisor were applicable.
- Ask questions regarding your treatment.
- Know information concerning diagnosis, treatment philosophy, method, progress, and prognosis
- Participate in decisions related to your treatment.
- Refuse methods of treatment.
- Know your assessment results (if applicable) and have them explained to you in manner that you understand.
- Request a second opinion and/or referral to another therapist or agency.
- End treatment at any time (please discuss your reasons for wanting to stop therapy with your counselor).
- Privacy and confidentiality.

Privacy and Confidentiality

Many precautions are taken by the staff of this office to protect any information that you disclose. Your information is considered confidential except for limitations mandated by state law. Your counselor may be required by law to release information:

1. To protect you or others from imminent harm, serious harm.
2. To protect children, disabled, or the elderly from abuse.
3. To parent/ guardians of minors (clients under age of 18).
4. By court order.
5. For the purpose of accessing treatment.

Please note that we utilize an electronic means of data storage and record keeping. Many appropriate precautions have been taken to protect your confidential information including encryptions; however limited access by technical administrators may be necessary at times.

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Clients Responsibilities
You have the reasonability to:

- Take an active role in the counseling process (i.e. honestly sharing thought, feelings, or concerns).
- Follow through on assignments mutually agreed upon with your counselor.
- Reflect on new ideas that may arise during your therapy.
- Provide accurate information regarding past and present physical and psychological problems (hospitalization, medication and/or previous treatment that may impact your current treatment).
- Keep scheduled appointment. If you are not able to keep your appointment, call 24 hours in advance to cancel and /or reschedule. ***Appointments missed without notifications will result in standard office fee payment.***

Emergencies :
If emergencies arise after hours or during a time when the office is closed, call 911 or proceed directly to the nearest emergency room.

Signature Page:

You may discuss any of the aforementioned sections with a counselor before signing:

I have completed this form truthfully and understand that I am entering into counseling voluntarily. I have read and understood the above information, and I am fully aware of my rights, the benefits, and risks that counseling may present.

_____ _____

Signature *Date*