The Gathering Counseling
Client Information Form

SCREENING INFORMATION

Please Print Clearly **THIS SHEET MUST BE FILLED IN COMPLETELY**

Date_____ Client's Social Security #_____

Client's First Name_____ Last Name_____ MI_____

Address_____ City_____ State_____ Zip_____

Telephone (Home)_____ (Cell)_____ (Work)_____

Birthdate ____/____/____ Age_____ Gender __F __M Race_____

Name of Spouse/Guardian_____ Phone_____

Address_____ City_____ State_____ Zip_____

Person Responsible for Payment _____ Soc. Sec. #_____

Signature of Person Responsible for Payment **X**_____ (Must be signed for services to begin)

Emergency Information

In case of emergency, contact:

Name _____ Relationship_____ Phone_____

Physician_____ Phone_____

Psychiatrist_____ Phone_____

Other Physicians_____ Phone_____

Current Medications_____

Allergies_____

Employment Information (If client is a child, use parent's employment)

Client/Guardian: Place_____ Phone_____

Spouse: Place_____ Phone_____

Insurance Information

Primary Insurance_____

Phone_____

Contract/ID#_____

Group/Acct#_____

Subscriber_____

Subscriber Date of Birth _____

Client's relationship to Subscriber

__Self __Spouse __Child __Other_____

Secondary Insurance_____

Phone_____

Contract/ID#_____

Group/Acct#_____

Subscriber_____

Subscriber Date of Birth_____

Client's relationship to Subscriber

__Self __Spouse __Child __Other_____

Referral Source

How did you hear of The Gathering Counseling?_____

The Gathering Counseling
Personal History—Adult (18+)

Client's name: _____ Date: _____

Gender: ___ F ___ M Date of birth: _____ Age: _____

Form completed by (if someone other than client): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (home): _____ (work): _____ ext: _____

If you need any more space for any of the questions please use the back of the sheet.

Primary reason(s) for seeking services:

___ Anger management ____ Anxiety ____ Coping ____ Depression

___ Eating disorder ____ Fear/phobias ____ Mental confusion ____ Sexual concerns

___ Sleeping problems ____ Addictive behaviors ____ Alcohol/drugs

___ Other mental health concerns (specify): _____

Family Information

___

			Living		Living with you	
Relationship	Name	Age	Yes	No	Yes	No
Mother			___	___	___	___
Father			___	___	___	___
Spouse			___	___	___	___
Children			___	___	___	___
			___	___	___	___
			___	___	___	

Significant others (e.g., brothers, sisters, grandparents, step-relatives, half-relatives. Please specify relationship.)

			Living		Living with you	
Relationship	Name	Age	Yes	No	Yes	No
			___	___	___	___
			___	___	___	___
			___	___	___	___
			___	___	___	___
			___	___	___	___
			___	___	___	___

Marital Status (more than one answer may apply)

__ Single ___ Divorce in process ____ Unmarried, living together

Length of time: _____ Length of time: _____

__ Legally married ___ Separated ____ Divorced

Length of time: _____ Length of time: _____ Length of time: _____

__ Widowed ___ Annulment

Length of time: _____ Length of time: _____ Total number of marriages: __

Assessment of current relationship (if applicable): ___ Good ___ Fair ___ Poor

Parental Information

__ Parents legally married ____ Mother remarried: Number of times: _____

__ Parents have ever been separated ____ Father remarried: Number of times: _____

__ Parents ever divorced

Special circumstances (e.g., raised by person other than parents, information about spouse/children not living with you, etc.): _____

Development

Are there special, unusual, or traumatic circumstances that affected your development? __ Yes ___ No

If Yes, please describe: _____

Has there been history of child abuse? ____ Yes ____ No

If Yes, which type(s)? ____ Sexual ____ Physical ____Verbal

If Yes, the abuse was as a: ____ Victim ____ Perpetrator

Other childhood issues: ____ Neglect ____ Inadequate nutrition ____ Other (please specify): _____

Comments re: childhood development: _____

Social Relationships

Check how you generally get along with other people: (check all that apply)

__ Affectionate ____ Aggressive ____ Avoidant ____ Fight/argue often ____ Follower

____ Friendly ____ Leader ____ Outgoing ____ Shy/withdrawn ____ Submissive

____ Other (specify): _____

Sexual orientation: _____ Comments: _____

Sexual dysfunctions? _____ Yes ____ No

If Yes, describe: _____

Any current or history of being as sexual perpetrator? ____ Yes ____ No

If Yes, describe: _____

Cultural/Ethnic

To which cultural or ethnic group, if any, do you belong? _____

Are you experiencing any problems due to cultural or ethnic issues? ____ Yes ____ No

If Yes, describe: _____

Other cultural/ethnic information: _____

Spiritual/Religious

How important to you are spiritual matters? ___ Not ___ Little ___ Moderate ___ Much

Are you affiliated with a spiritual or religious group? ___ Yes ___ No

If Yes, describe: _____

Were you raised within a spiritual or religious group? ___ Yes ___ No

If Yes, describe: _____

Would you like your spiritual/religious beliefs incorporated into the counseling? ___ Yes ___ No

If Yes, describe: _____

Legal

Current Status

Are you involved in any active cases (traffic, civil, criminal)? ___ Yes ___ No

If Yes, please describe and indicate the court and hearing/trial dates and charges: _____

_____

Are you presently on probation or parole? ___ Yes ___ No

If Yes, please describe: _____

Past History

Traffic violations: ___ Yes ___ No DWI, DUI, etc.: ___ Yes ___ No

Criminal involvement: ___ Yes ___ No Civil involvement: ___ Yes ___ No

If you responded Yes to any of the above, please fill in the following information.

Charges	Date	Where (city)	Results

Education

Fill in all that apply: Years of education: _____ Currently enrolled in school? ___ Yes ___ No

__ High school grad/GED

__ Vocational: Number of years: ___ Graduated: ___ Yes ___ No Major: _____

__ College: Number of years: ___ Graduated: ___ Yes ___ No Major: _____

__ Graduate: Number of years: ___ Graduated: ___ Yes ___ No Major: _____

Other training: _____

Special circumstances (e.g., learning disabilities, gifted): _____

Employment

Begin with most recent job, list job history:

Employer	Dates	Title	Reason left the job	How often miss work?

___

Currently: ___ FT ___ PT ___ Temp __ Laid-off ___ Disabled ___ Retired

___ Social Security ___ Student ___ Other (describe): _____

Military

Military experience? ___ Yes ___ No Combat experience? ___ Yes ___ No

Where: _____

Branch: _____ Discharge date: _____

Date drafted: _____ Type of discharge: _____

Date enlisted: _____ Rank at discharge: _____

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

Activity	How often now?	How often in the past?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical/Physical Health

___ AIDS
___ Alcoholism
___ Abdominal pain
___ Abortion
___ Allergies
___ Anemia
___ Appendicitis
___ Arthritis
___ Asthma
___ Bronchitis
___ Bed wetting
___ Cancer
___ Chest pain
___ Chronic pain
___ Colds/Coughs
___ Constipation
___ Chicken Pox
___ Dental problems
___ Diabetes
___ Diarrhea
___ Dizziness
___ Drug abuse
___ Epilepsy
___ Ear infections
___ Eating problems
___ Fainting
___ Fatigue
___ Frequent urination
___ Headaches
___ Hearing problems
___ Hepatitis
___ High blood pressure
___ Kidney problems
___ Measles
___ Mononucleosis
___ Mumps
___ Menstrual pain
___ Miscarriages
___ Neurological disorders
___ Nausea
___ Nose bleeds
___ Pneumonia
___ Rheumatic Fever
___ Sexually transmitted diseases
___ Sleeping disorders
___ Sore throat
___ Scarlet Fever
___ Sinusitis
___ Smallpox
___ Stroke
___ Sexual problems
___ Tonsillitis
___ Tuberculosis
___ Toothache
___ Thyroid problems
___ Vision problems
___ Vomiting
___ Whooping cough
___ Other (describe): _____
_____

List any current health concerns: _____

List any recent health or physical changes: _____

_____

Nutrition

Meal	How often (times per week)	Typical foods eaten	Typical amount eaten
Breakfast	____ / week	_____	___ No __ Low ___ Med ___ High
Lunch	____ / week	_____	___ No __ Low ___ Med ___ High
Dinner	____ / week	_____	___ No __ Low ___ Med ___ High
Snacks	____ / week	_____	___ No __ Low ___ Med ___ High

Comments: _____

Current prescribed medications	Dose	Dates	Purpose	Side effects

Current over-the-counter meds	Dose	Dates	Purpose	Side effects

Are you allergic to any medications or drugs? ___ Yes ___ No

If Yes, describe: _____

	Date	Reason	Results
Last physical exam			
Last doctor's visit			
Last dental exam			
Most recent surgery			
Other surgery			
Upcoming surgery			

Family history of medical problems: _____

Please check if there have been any recent changes in the following:

__ Sleep patterns ___ Eating patterns ___ Behavior ___ Energy level

__ Physical activity level ___ General disposition ___ Weight ___ Nervousness/tension

Describe changes in areas in which you checked above: _____

Chemical Use History

	Method of use and amount	Frequency of use	Age of first use	Age of last use	Used in last 48 hours		Used in last 30 days	
					Yes	No	Yes	No
Alcohol								
Barbiturates								
Valium/Librium								
Cocaine/Crack								
Heroin/Opiates								
Marijuana								
PCP/LSD/Mescaline								
Inhalants								
Caffeine								
Nicotine								
Over the counter								
Prescription drugs								
Other drugs								

Substance of preference

1. _____ 3. _____
2. _____ 4. _____

Substance Abuse Questions

Describe when and where you typically use substances: _____

Describe any changes in your use patterns: _____

Describe how your use has affected your family or friends (include their perceptions of your use): ____

Reason(s) for use:

___ Addicted ____ Build confidence ____ Escape ____ Self-medication

___ Socialization ____ Taste ____ Other (specify): _____

How do you believe your substance use affects your life? _____

Who or what has helped you in stopping or limiting your use? _____

Does/Has someone in your family present/past have/had a problem with drugs or alcohol?

___ Yes ____ No If Yes, describe: _____

Have you had withdrawal symptoms when trying to stop using drugs or alcohol? ____ Yes ____ No

If Yes, describe: _____

Have you had adverse reactions or overdose to drugs or alcohol? (describe):_____

Does your body temperature change when you drink? ____ Yes ____ No

If Yes, describe: _____

Have drugs or alcohol created a problem for your job? ____ Yes ____ No

If Yes, describe: _____

Counseling/Prior Treatment History

Information about client (past and present):

	Yes	No	When	Where	Your reaction to overall experience
Counseling/Psychiatric treatment	____	____	_____	_____	_____
Suicidal thoughts/attempts	____	____	_____	_____	_____
Drug/alcohol treatment	____	____	_____	_____	_____
Hospitalizations	____	____	_____	_____	_____
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	____	____	_____	_____	_____

Information about family/significant others (past and present):

	Yes	No	When	Where	Your reaction to overall experience
Counseling/Psychiatric treatment	____	____	_____	_____	_____
Suicidal thoughts/attempts	____	____	_____	_____	_____
Drug/alcohol treatment	____	____	_____	_____	_____
Hospitalizations	____	____	_____	_____	_____
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	____	____	_____	_____	_____

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

___ Aggression
___ Alcohol dependence
___ Anger
___ Antisocial behavior
___ Anxiety
___ Avoiding people
___ Chest pain
___ Cyber addiction
___ Depression
___ Disorientation
___ Distractibility
___ Dizziness
___ Drug dependence
___ Eating disorder
___ Elevated mood
___ Fatigue
___ Gambling
___ Hallucinations
___ Heart palpitations
___ High blood pressure
___ Hopelessness
___ Impulsivity
___ Irritability
___ Judgment errors
___ Loneliness
___ Memory impairment
___ Mood shifts
___ Panic attacks
___ Phobias/fears
___ Recurring thoughts
___ Sexual addiction
___ Sexual difficulties
___ Sick often
___ Sleeping problems
___ Speech problems
___ Suicidal thoughts
___ Thoughts disorganized
___ Trembling
___ Withdrawing
___ Worrying
___ Other (specify): _____

Briefly discuss how the above symptoms impair your ability to function effectively: _____

Any additional information that would assist us in understanding your concerns or problems: _____

What are your goals for therapy? _____

Do you feel suicidal at this time? ___ Yes ___ No

If Yes, explain: _____

For Staff Use

Therapist's signature/credentials: _____ Date: ____/____/_____

Supervisor's comments: _____

___ Physical exam: _____ Required _____ Not required

Supervisor's signature/credentials: _____ Date: ____/____/_____

(Certifies case assignment, level of care and need for exam)

Ronald Koval, MA, LPC

913-A E. Judge Perez Dr.
Chalmette, LA 70043
504-301-4497

DECLARATION OF PRACTICES AND PROCEDURES

Qualifications: I earned an MA degree from The Ohio State University in 1990 and completed the Clinical Counseling track at the University of Dayton in 2001. I am licensed as a Professional Counselor #4005 with the LPC Board of Examiners which is located at 8631 Summa Avenue, Baton Rouge, LA 70809 (phone 225/765-2515).

Counseling Relationship: I see counseling as a process in which you, the client, and I, the counselor, having come to understand and trust one another, work as a team to explore and define present problem situations, develop future goals for an improved life and work in a systematic fashion toward realizing those goals.

Areas of Expertise: I have a general practice, but focus on Career Counseling, Child and Adolescent Counseling, Psychoeducational Counseling, counseling children with educational disabilities, Personal and Social Counseling, Marriage Counseling, Family Counseling, Mental Health Counseling, Chemical Dependency Counseling, Addictions Counseling, Diagnosis and Treatment of Mental and Emotional Disorders, and treatment of Personality Disorders. I supervise practicum and internship students from Loyola University and New Orleans Baptist Theological Seminary. I hold Ohio Counselor certification as a Licensed Professional Clinical Counselor, #E0007494.

Fee Scales: The fee for my services is $75.00 per session. Payment is due at the time of service. Clients are seen by appointment only. Clients will be charged for appointments that are broken or canceled without 24-hour notice. Payment is accepted from insurance companies and a sliding fee scale is also available.

Services Offered and Clients Served: I approach counseling from a cognitive-behavioral, emotion-focused, systems perspective in that patterns of thoughts, feelings, and actions are explored in order to better understand the clients' problems and to develop solutions within the systems of his/her life. I work with a variety of formats, including individually, as couples and as families. I also conduct group therapy. I see clients of all ages and backgrounds with the exception that I do not work individually with children under seven years of age.

Code of Conduct: As a Counselor, I am required by state law to adhere to the Code of Conduct for practice that has been adopted by my licensing Board. A copy of this Code of Conduct is available upon request.

Privileged Communications: Materials revealed in counseling will remain strictly confidential except for the following circumstances in accordance with state law:

1.) The client signs a written release of information indicating informed consent of such release.

2.) The client expresses intent to harm him/herself or someone else.

3.) There is a reasonable suspicion of abuse/neglect against a minor child, elderly person (65 or older), or a dependant adult.

4.) A court order is received directing the disclosure of information.

It is my policy to assert privileged communication on behalf of the client and the right to consult with the client if at all possible, except during an emergency, before mandated disclosure. I will endeavor to appraise clients of all mandated disclosures as conceivable. In the event of marriage or family counseling, material obtained from an adult client individually may be shared with the client's spouse or other family members only with the client's permission. Any material obtained from a minor client may be shared with that client's parents or guardian.

Emergency Situations: If an emergency situation should arise, you may seek help through hospital emergency room facilities or by calling 911.

Client Responsibilities: You, the client, are a full partner in counseling. Your honesty and effort is essential to success. If as we work together you have suggestions or concerns about your counseling, I expect you to share these with me so that we can make the necessary adjustments. If it develops that you would be better served by another mental health provider, I will help you with the referral process. If you are currently receiving services from another mental health professional, I expect you to inform me of this and grant me permission to share information with this professional so that we may coordinate our services to you.

Physical Health: Physical health can be an important factor in the emotional well being of an individual. If you have not had a physical examination in the last year, it is recommended that you do so. Also, please provide me with a list of the medicines you are currently taking.

Potential Counseling Risk: The client should be aware that counseling poses potential risks. In the course of working together additional problems may surface of which the client was not initially aware. If this occurs, the client should feel free to share these new concerns with me.

I have read and understand the above information.

Client Signature _____ Date _____

Counselor Signature _____ Date _____

FOR MINOR CLIENTS

I (*signature of parent or guardian*) _____, give permission for

Ronald Koval, MA, LPC to conduct counseling with my **son/daughter**.

(*name of minor*) _____ Date _____

The Gathering Counseling - Privacy of Information Policies

This form describes the confidentiality of your medical records, how the information is used, your rights, and how you may obtain this information. Effective 4-14-03

Our Legal Duties
State and Federal laws require that we keep your medical records private. Such laws require that we provide you with this notice informing you of our privacy of information policies, your rights, and our duties. We are required to abide these policies until replaced or revised. We have the right to revise our privacy policies for all medical records, including records kept before policy changes were made. Any changes in this notice will be made available upon request before changes take place.

The contents of material disclosed to us in an evaluation, intake, or counseling session are covered by the law as private information. We respect the privacy of the information you provide us and we abide by ethical and legal requirements of confidentiality and privacy of records.

Use of Information
Information about you may be used by the personnel associated with this clinic for diagnosis, treatment planning, treatment, and continuity of care. We may disclose it to health care providers who provide you with treatment, such as doctors, nurses, mental health professionals, and mental health students and mental health professionals or business associates affiliated with this clinic such as billing, quality enhancement, training, audits, and accreditation.

Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian or personal representative. It is the policy of this clinic not to release any information about a client without a signed release of information except in certain emergency situations or exceptions in which client information can be disclosed to others without written consent. Some of these situations are noted below, and there may be other provisions provided by legal requirements.

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person or persons, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Public Safety
Health records may be released for the public interest and safety for public health activities, judicial and administrative proceedings, law enforcement purposes, serious threats to public safety, essential government functions, military, and when complying with worker's compensation laws.

Abuse
If a client states or suggests that he or she is abusing a child or vulnerable adult, or has recently abused a child or vulnerable adult, or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities. If a client is the victim of abuse, neglect, violence, or a crime victim, and their safety appears to be at risk, we may share this information with law enforcement officials to help prevent future occurrences and capture the perpetrator.

Prenatal Exposure to Controlled Substances
Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

In the Event of a Client's Death
In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records.

Professional Misconduct
Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

Judicial or Administrative Proceedings
Health care professionals are required to release records of clients when a court order has been placed.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

Other Provisions
When payment for services are the responsibility of the client, or a person who has agreed to providing payment, and payment has not been made in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, progress notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the client's credit report may state the amount owed, the time-frame, and the name of the clinic or collection source.

Insurance companies, managed care, and other third-party payers are given information that they request regarding services to the client. Information which may be requested includes type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, and summaries.

Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed. Some progress notes and reports are dictated/typed within the clinic or by outside sources specializing in (and held accountable for) such procedures.

In the event in which the clinic or mental health professional must telephone the client for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please notify us in writing where we may reach you by phone and how you would like us to identify ourselves. For example, you might request that when we phone you at home or work, we do not say the name of the clinic or the nature of the call, but rather the mental health professional's first name only. If this information is not provided to us (below), we will adhere to the following procedure when making phone calls: First we will ask to speak to the client (or guardian) without identifying the name of the clinic. If the person answering the phone asks for more identifying information we will say that it is a personal call. We will not identify the clinic (to protect confidentiality). If we reach an answering machine or voice mail we will follow the same guidelines.

Your Rights

You have the right to request to review or receive your medical files. The procedures for obtaining a copy of your medical information are as follows. You may request a copy of your records in writing with an original (not photocopied) signature. If your request is denied, you will receive a written explanation of the denial. Records for non-emancipated minors must be requested by their custodial parents or legal guardians. The charge for this service is $_____ per page, plus postage.

You have the right to cancel a release of information by providing us a written notice. If you desire to have your information sent to a location different than our address on file, you must provide this information in writing.

You have the right to restrict which information might be disclosed to others. However, if we do not agree with these restrictions, we are not bound to abide by them.

You have the right to request that information about you be communicated by other means or to another location. This request must be made to us in writing.

Your have the right to disagree with the medical records in our files. You may request that this information be changed. Although we might deny changing the record, you have the right to make a statement of disagreement, which will be placed in your file.

You have the right to know what information in your record has been provided to whom. Request this in writing.

If you desire a written copy of this notice you may obtain it by requesting it from the Clinic Director at this location.

Complaints

If you have any complaints or questions regarding these procedures, please contact the clinic. We will get back to you in a timely manner. You may also submit a complaint to the U.S. Dept. of Health and Human Services and/or the _____ (therapist's state licensing agency) _____. If you file a complaint we will not retaliate in any way.

Direct all correspondence to: _____

I understand the limits of confidentiality, privacy policies, my rights, and their meanings and ramifications.

Client's name (please print): _____

Signature: _____ Date: _____/_____/_____

Signed by: __client __guardian __personal representative