PATHWAY COUNSELING SERVICES

PATIENT RIGHTS

As a patient at Pathway Counseling Services you have specific rights that are enumerated in Texas Statutes 404.154 and the Texas Administrative Code.

AS A PATIENT YOU HAVE THE RIGHT TO:

1. Be informed of your rights verbally and in writing;
2. Give informed consent acknowledging your permission to receive treatment;
3. Receive prompt and adequate treatment;
4. Refuse treatment that you do not desire;
5. Be free from unnecessary or excessive medication;
6. Receive clear information regarding medication, including its possible benefits, side effects and alternatives;
7. Be free from drastic treatment procedures, unless you give informed consent;
8. Be free from experimental research, unless you give informed consent;
9. Be free from unreasonable or arbitrary decisions pertaining to your treatment;
10. Be free from audio and video recording without informed consent;
11. Have the confidentiality of your treatment and treatment records protected;
12. Have access to information in your treatment records. You may also have your treatment records forwarded to a new therapist following your treatment at Pathway Counseling Services. You may also challenge the accuracy of the information in your record and have the right to have factual errors corrected.
13. File a grievance regarding this clinic if you feel your rights have been denied or limited;
14. Ask for and obtain a copy of the grievance procedure for this clinic.

INFORMED CONSENT POLICY:

It is the policy of Pathway Counseling Services that each patient, or individual acting on behalf of the patient, will receive specific, complete and accurate information regarding the psychotherapy or other treatment they receive at this clinic. It is this clinic's policy to offer information in both verbal and written form.

All patients will be provided with and should take the time to review this Informed Consent Policy prior to the onset of their treatment. You may request another copy of this policy at any time. You may also ask for additional information from the therapist regarding any particular treatment at any time.

Complete and accurate information will be provided at your request in regard to each of the following areas:

1. The benefits of the proposed treatment;
2. The way treatment will be administered;
3. Expected side effects from the treatment and/or risks of side effects from medications;
4. Alternative treatment modes;
5. The probable consequences of not receiving treatment;
6. The time period for which the informed consent is effective;
7. The patient's right to withdraw the informed consent in writing at any time.

My signature indicates that I have read and understand the policies and procedures pertaining to my Patient Rights and to my granting of Informed Consent for the treatment which I choose to receive. I have been presented with necessary and appropriate information either verbally or in writing and, having adequate time to consider the information, do hereby give my informed consent to participate in the recommended treatment. I have also received a copy of this document.

PATIENT SIGNATURE _____ DATE _____

LEGAL GUARDIAN SIGNATURE _____ DATE _____

NOTICE OF PRIVACY PRACTICES

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. This form Notice of Privacy Practices requires customization to match the particular privacy practices of the various services we offer, as well as the various relationships we have with others.

Instructions: Consult our Privacy Official and legal counsel to ensure that the Notice of Privacy Practices we intend to use accurately reflects our privacy practices. This Notice reflects the greater privacy protections and rights afforded by the Texas patient confidentiality statute. We much check other applicable state privacy law to determine if it provides greater privacy protections or rights than federal law. If so, our Notice must reflect those greater protections or rights. Our Privacy Official must approve each Notice of Privacy Practices to ensure that the Notice sufficiently complies with applicable federal and state laws before we distribute the Notice.

We must distribute this Notice to each individual no later than the date of our first service delivery, including service delivered electronically after the April 14, 2003. We must also have the Notice available at the service delivery site for individuals to request to take with them. We must post the Notice at each of our physical service delivery sites in a clear and prominent location where it is reasonable to expect any individuals seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your medical information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your medical information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all medical information that we maintain, including medical information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Medical Information

We use and disclose medical information about you for treatment, payment, and health care operations. For example:
Treatment: We may use or disclose your medical information to a physician or other health care provider in order to provide treatment to you.

Payment: We may use and disclose your medical information to obtain payment for services we provide to you. We may disclose your medical information to another health care provider or entity subject to the federal Privacy Rules so they can obtain payment. We may need your written permission to disclose information taken from your mental health treatment records for payment purposes.

Health Care Operations: We may use and disclose your medical information in connection with our health care operations. Health care operations include:
- quality assessment and improvement activities;
- reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities;
- medical review, legal services, and auditing, including fraud and abuse detection and compliance;
- business planning and development; and
- business management and general administrative activities, including management activities relating to privacy, customer service, resolution of internal grievances, an creating de-identified medical information or a limited data set.

We may disclose your medical information to another entity which has a relationship with you and is subject to the federal Privacy Rules, for their health care operations relating to quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, or detecting or preventing health care fraud and abuse.

We may need your written permission to disclose medical information or information taken from your mental health treatment records for health care operations.

On Your Authorization: You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your medical information for any reason except those described in this notice.

To Your Family and Friends: With your written permission, we may disclose your medical information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care.

We may use or disclose your name and location (and, with your written permission, general condition or death) to notify, or assist in the notification of (including identifying or locating), a person involved in your care. If you have not previously given us written permission for such uses or disclosures, we will provide you with an opportunity to object to such uses or disclosures. If you are not present, or in the event of your incapacity or an emergency, we will disclose your name and location based on our professional judgment of whether the disclosure would be in your best interest.

We will also use our professional judgment and our experience with common practice in your care. We may not disclose confidential medical information or any information taken from mental health treatment records in these circumstances without your written permission.

Health Related Services: We may use your medical information to contact you with information about health-related benefits and services or about treatment alternatives that may be of interest to you. With your written permission, we may disclose your medical information or a business associate to assist us in these activities.

Public Benefit: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- as required by law;
- for public health activities, including disease and vital statistic reporting, child abuse reporting, and FDA oversight;
- to report adult abuse or neglect;
- to health oversight agencies;
- in response to court and, in some circumstances, administrative orders and other lawful processes;
- to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes or identifying or locating a suspect or other person;
- to coroners and medical examiners;
- to organ procurement organizations;
- to avert a serious and imminent threat to health and safety;
- in connection with certain research activities;
- to the military and federal officials for lawful intelligence, counterintelligence, and national security activities;
- to correctional institutions regarding inmates; and
- as authorized by state worker's compensation laws.

You may be able to opt out of use or disclosure of your medical information for (a) research purposes or (b) pursuant to a written request from a government agency, unless the disclosure is required by law.

We may not disclose certain confidential medical information or mental health treatment records for certain purposes without your written permission, unless required by law.

Disaster Relief: We may use or disclose your name and location to a public or private entity authorized by law or by its charter to assist in disaster relief efforts. We may not disclose confidential medical information (except in response to a written request from a government agency) or any information taken from mental health treatment records in these circumstances without your written permission.

Individual Rights

Access: You have the right to look at or get copies of your medical information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. {You must make a request in writing to obtain access to your medical information. You may obtain a form to request access by using the contact information listed at the end of this notice. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you $.25 for each page and $100.00 per hour for staff time to copy your medical information, and postage if you want copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your medical information in that format. If you prefer, we will prepare a summary or an explanation of your medical information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.}

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your medical information for purposes, other than treatment, payment, health care operations for which we have written permission, and certain other activities, since April 14, 2003. We will provide you with the data on which we made the disclosure, the name of the person or entity to whom we disclosed your medical information, a description of the medical information we disclosed, the reason for the disclosure, and curtain other information. If you request a disclosure accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). {Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.}

Confidential Communication: You have the right to request that we communicate with you about your medical information by alternative means or to alternative locations. {Your request must be in writing, and it must state that the information could endanger you if it is not communicated by the alternative means or to the alternative location you want.} We must accommodate your request if it is reasonable, specifies that alternative means or location, and provides satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your medical information. {Your request must be in writing, and it must explain why the information should be amended.} We may deny your request if we did not create the information you want amended and the originator remains available or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information or in response to a request you made to amend or restrict the use or disclosure of your medical information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Office:
Pathway Counseling Services
22601 Lutheran Church Road
Tomball, TX 77377
281-205-1355

PATHWAY COUNSELING SERVICES

NOTICE OF ACKNOWLEDGEMENT

Purpose: This form is used to document (a) an individual's acknowledgement of receipt of our Privacy Practices Notice (HIPPA) or (b) when we have not obtained this acknowledgement, our good faith effort to obtain the acknowledgement.

SECTION A: Individual receiving Privacy Practices Notice.

Name: _____

Address: _____

Telephone: _____ Social Security Number: _____

SECTION B: Acknowledgement of receipt of Privacy Practices Notice.

I, _____, acknowledge that I have received a Privacy Practices Notice from Pathway Counseling Services.

Signature: _____ Date: _____

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____ Relationship to patient: _____

SECTION C: Good faith effort to obtain acknowledgement of receipt.

• Individual refused or was unable to sign this form. Describe your good faith effort to obtain the individual's signature on this form:

_____

_____

• Describe the reason why the individual would not sign this form:

_____

_____

SIGNATURE.

I attest that the above information is correct.

Therapist Signature: _____ Date: _____

Print Name: _____ Title: _____

PATHWAY COUNSELING SERVICES

LIMITS OF CONFIDENTIALITY

All information both, verbal and written, from therapy sessions in held in confidence and will not be discussed with any other party unless you as the patient or guardian have given written consent. The few exceptions (legally and ethically) are listed below:

1. **Duty to Warn and Protect** - If a client discloses the intent and/or plan to harm him or herself or another individual, Pathway Counseling Services is both legally and ethically required to disclose this information to legal authorities and make reasonable attempts to notify the family of the client for protection purposes.

2. **Abuse or Neglect of a Child or Vulnerable Adult** - If a client discloses that he or she is or has abused a child or vulnerable adult or if a child or vulnerable adult is in danger of being abused, Pathway Counseling Services is required legally and ethically to report this information to the appropriate social services agency and/or legal authorities.

3. **Minors/Guardianship** - The parents or legal guardians of minor clients have the right to access the client's records. This request will be discussed at length with the therapist as to the reasoning and possible ramifications.

4. **Insurance Providers (when applicable)** - Pathway Counseling Services currently does not contract with any insurance providers. If a client chooses to submit each session as claims to their own insurance provider they are welcome to do that. If a patient chooses to do this, it is understood that insurance companies and other third party providers generally require detailed information from the therapist such as but not limited to: dates and times of services, diagnosis, treatment plans and progress notes, type of services given, progress of treatment and summaries.

5. **Court Subpoena** - If subpoenaed by Court, the requested patient information has to be disclosed.

6. **Valid Collection of Debt** - If a client's account goes into collections with a collections agency, identifying patient information will be disclosed to settle the account.

7. **Peer Consultation** - There may be a times your therapist may consult with other therapists and other treatment providers to provide the best possible care. Personal identifiable information will be withheld and all therapists and treatment providers are held to confidentiality rules.

My signature indicates that I have read and understand the legal and ethical Limits of Confidentiality Policy as stated above.

PATIENT OR GUARDIAN SIGNATURE _____ DATE _____

PHONE MESSAGES

From time to time, there may be a need to leave a message for you as the client. Messages are usually appointment related information or other agreed upon information. May Pathway Counseling Services leave messages on your phone? If so, please indicate below which numbers are ok. Please provide numbers for our records.

Home: ❑ Yes ❑ No #_____

Work: ❑ Yes ❑ No #_____

Cell: ❑ Yes ❑ No #_____

Cell only: ❑ Yes ❑ No

PATIENT OR GUARDIAN SIGNATURE _____ DATE _____

THERAPIST REVIEW _____ DATE _____

CONSENT TO USE UNENCRYPTED E-MAIL AND TEXT

It is important that you understand the use of unencrypted e-mail, text and e-fax are relatively easy to access by unauthorized people and can thus compromise the privacy and confidentiality of such communication. This puts the confidentiality of your personal health information at risk.

Due to this risk, Pathway Counseling Services will not get into an electronic exchange of private information without your consent. E-mail and text should be used in a limited manner such as matters of appointment scheduling. Please take into consideration your environment such as work, school, home when using these forms of communication. Text, e-mail, voice mail or faxes should NOT be used for emergencies.

Please notify Pathway Counseling Services if you decide to avoid or limit, in any way, the use of e-mail, texts, cell phone calls, phone messages or e-faxes. If you communicate confidential or private information via unencrypted e-mail, texts or e-fax or phone messages, it will be assumed that you have evaluated the risks and made an informed decision. Pathway Counseling Services will view this communication as your agreement to take the risk that such communication may be intercepted, and your desire to communicate on such matters will be honored.

PATIENT OR GUARDIAN SIGNATURE _____ DATE _____

E-MAIL ADDRESS _____

PATHWAY COUNSELING SERVICES

FINANCIAL AGREEMENT

Pathway Counseling Services does not contract with insurance companies for services. Each session is considered self-pay by the client. Rates for therapy are as follows: 50-60 minute initial assessment at a rate of $140. Each 45-50 minute psychotherapy session at a rate of $125. Pathway Counseling Services accepts cash, checks & major credit cards. If you choose to use a credit card, there will be a $5 added processing fee.

Full payment for treatment is expected at time of session. Any balance, ie: late cancellations, no shows, etc., carried by the client is expected to be paid at time of next session. Pathway Counseling Services reserves the right to suspend treatment if proper payment is not made as agreed upon with the clinic. If necessary a collections agency will be retained by Pathway Counseling Services to recoup delinquent accounts not able to be collected by the clinic.

Even though Pathway Counseling Services is not contracted with insurance companies, patients still could be eligible for "out of network" benefits through most insurance companies. Clients are welcome to submit session claims to their own insurance companies for reimbursement. If requested, you will be given a receipt for submission. Please be aware that by submitting claims, insurance companies will request confidential treatment information such as, but not limited to, dates and times of services, diagnosis, treatment plans and progress notes, type of services given, progress of treatment and summaries.

CANCELLATION AND NO SHOW POLICY

It is the policy of Pathway Counseling Services that if a client cancels a session with less than 24 hours notice (unless due to illness or an emergency as determined by the therapist) or no shows, the session will be billed at the full rate of $125. This fee is not reimbursable by insurance companies. This will be billed directly to the patient or guardian.

OUTSIDE OF SESSION CONTACT POLICY

Phone conversations outside of session, other than making/changing appointments or as agreed upon with therapist, will be billed in 15 minute increments at $31.25 (based on session rate of $125). A contact log will be recorded in the patient record.

My signature indicates that I have read and understand the Financial Agreement as stated above and agree to the terms stated above in entering into treatment with Pathway Counseling Services.

PATIENT OR GUARDIAN SIGNATURE _____ DATE _____

WITNESS (PATHWAY COUNSELING SERVICES) _____ DATE _____

TO BE FILLED OUT BY OFFICE ONLY:

Additional agreements: _____

_____

_____

_____

_____

THERAPIST SIGNATURE _____ DATE _____

PATHWAY COUNSELING SERVICES

CHILD INTAKE EVALUATION

TO THE PARENT / GUARDIAN

Your responses to the following questions will help me, as the therapist, better understand your child's situation in order to provide the best possible treatment. Please answer all questions as completely as possible.

IDENTIFYING INFORMATION ABOUT THE CHILD

Child's Name: _____ DOB: ____/____/____ Age: _____ Sex: ❑ F ❑ M
(Last, First, MI)

Address : _____
(No PO Box) (City) (State) (Zip)

Height: _____ Weight: _____ Eye Color: _____ Hair Color: _____

Grade: _____ Race: _____ Religion: _____

Referral Source: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

If you feel I, as the therapist, should be aware of any special treatment considerations due to gender, age, sexual orientation or cultural, religious, national, racial or ethnic identity, please explain here: _____

_____

PRESENTING PROBLEM

1. Please check the main problem(s) for which you are seeking help for your child:

❑ Behavior at home	❑ Behavior at school	❑ Eating disorder	Other: _____
❑ Family problems	❑ Lack of confidence	❑ Physical	_____
❑ Loneliness	❑ Hyperactivity	❑ Legal	_____
❑ Moodiness	❑ Anxiety	❑ Thoughts/attempts to hurt himself/herself	_____
❑ Depression	❑ Drugs and/or Alcohol	❑ Thoughts/attempts to hurt others	_____

2. Describe the problem(s) in your own words: _____

_____

_____

_____

3. When did the problem(s) begin? _____

4. How has it changed over time? _____

_____

_____

_____

5. Has the child ever received treatment for this or other problems? ❑ Yes ❑ No

If yes, when, where and with whom: _____

_____

_____

FAMILY HISTORY

1. Who has been involved in rearing the child? (Check all that apply):

- ❑ Both parents
- ❑ Father alone
- ❑ Mother alone
- ❑ Adoptive parents
- ❑ Relatives
- ❑ Foster parents
- ❑ Other
- ❑ Father with significant other — Who? _____
- ❑ Mother with significant other — Who? _____

Who? _____

Who? _____

2. Please provide the following information about the child's parents / caretakers as applicable:

Father's Name: _____ Phone: _____
Address: _____
DOB: _____ Occupation: _____ Education: _____

Mother's Name: _____ Phone: _____
Address: _____
DOB: _____ Occupation: _____ Education: _____

Stepfather's Name: _____ Phone: _____
Address: _____
DOB: _____ Occupation: _____ Education: _____

Stepmother's Name: _____ Phone: _____
Address: _____
DOB: _____ Occupation: _____ Education: _____

Foster Father's Name: _____ Phone: _____
Address: _____
DOB: _____ Occupation: _____ Education: _____

Foster Mother's Name: _____ Phone: _____
Address: _____
DOB: _____ Occupation: _____ Education: _____

Guardian's / Other's Name: _____ Phone: _____
Address: _____
DOB: _____ Occupation: _____ Education: _____

NAMES OF SIBLINGS	AGE	RELATIONSHIP (Full, Half, Step, Foster Sibling)	LIVES WITH CHILD?	IF NO, LIVES WHERE?
			❑ Yes ❑ No	
			❑ Yes ❑ No	
			❑ Yes ❑ No	
			❑ Yes ❑ No	
			❑ Yes ❑ No	
			❑ Yes ❑ No	
			❑ Yes ❑ No	

7. If you can recall, record the age when your child reached the following developmental milestones:

DEVELOPMENTAL MILESTONES	AGE	EARLY	NORMAL AGE	LATE	DON'T KNOW
Slept through the night					
Sat alone					
Stood alone					
Walked without help					
Said first words					
Spoke in simple phrases					
Toilet trained - Day					
Toilet trained - Night					

MEDICAL HISTORY

1. Please check the appropriate box if your child currently has or has had any of these problems:

- ❑ Eye disease, injury, poor vision
- ❑ Ear disease, injury, poor hearing
- ❑ Nose, sinus, mouth, throat problems
- ❑ Head injury
- ❑ Frequent or severe headaches
- ❑ Memory problems
- ❑ Loss of consciousness
- ❑ Convulsions or seizures
- ❑ Neck stiffness, pain, swelling
- ❑ Chest pain or angina pectoris
- ❑ Back, arm, leg or joint problems
- ❑ Blood disease
- ❑ PMS/Premenstrual Syndrome
- ❑ Stomach trouble
- ❑ Bowel problems
- ❑ Hemorrhoids, rectal bleeding
- ❑ Skin disease
- ❑ Sleep disturbances
- ❑ Extreme tiredness or weakness
- ❑ Marked weight changes
- ❑ Thyriod disease or goiter
- ❑ Circulatory problems
- ❑ Heart disease
- ❑ Diabetes
- ❑ Allergies / Asthma
- ❑ Other: _____

Please explain anything checked above: _____

2. Past or present illnesses (Check all that apply):

❑ Meningitis	Age: _____	Complications: _____
❑ Encephalitis	Age: _____	Complications: _____
❑ Venereal Disease	Age: _____	Complications: _____
❑ HIV / AIDS	Age: _____	Complications: _____
❑ Hepatitis	Age: _____	Complications: _____
❑ Tuberculosis (TB)	Age: _____	Complications: _____
❑ Other: _____	Age: _____	Complications: _____

3. Please list all psychiatric and medical hospitalizations, operations and injuries (including broken bones):

WHERE	REASON	WHEN	LENGTH OF STAY	DOCTOR

4. Does the child have a history of drug and/or alcohol problems? ❑ Yes ❑ No
If yes, please describe the circumstances and any treatment received? _____

_____

_____

_____

5. Does anyone in the child's immediate family have a drug and/or alcohol problem? ❑ Yes ❑ No
If yes, who, what type of problem, when did it occur and was any treatment received? _____

_____

_____

_____

6. Has the child experienced any type of emotional, physical or sexual abuse? ❑ Yes ❑ No
If yes, please describe the circumstances: _____

_____

_____

_____

7. Has there been any type of domestic, emotional, physical and/or sexual abuse in the child's family? ❑ Yes ❑ No
If yes, please describe the circumstances: _____

_____

_____

_____

DEVELOPMENTAL HISTORY

1. Was the pregnancy normal? ❑ Yes ❑ No ❑ I Don't Know
If no, was pregnancy complicated by:

a. Bleeding ❑ Yes ❑ No
b. Toxemia ❑ Yes ❑ No
c. Other ❑ Yes ❑ No Please describe: _____

_____

_____

2. Did mother smoke during the pregnancy? ❑ Yes ❑ No ❑ I Don't Know
If yes, what was the average number of cigarettes smoked per day? _____

3. Did mother drink alcohol during the pregnancy? ❑ Yes ❑ No ❑ I Don't Know
If yes, please indicate the amount and frequency of alcohol consumption: _____

_____

_____

4. Did mother use illicit drugs during the pregnancy? ❑ Yes ❑ No ❑ I Don't Know
If yes, please indicate type(s) of drugs used and frequency of use: _____

_____

_____

5. Please list prescription medication(s) and over-the-counter medication(s) used during the pregnancy: _____

_____

_____

6. Were there any problems with the baby at birth? ❑ Yes ❑ No ❑ I Don't Know
If yes, please describe: _____

_____

_____

7. What prescription or over-the-counter medications does the child take?

MEDICATION	DOSAGE	FREQUENCY	SIDE EFFECTS / ALLERGIC REACTIONS

SCHOOL INFORMATION

1. What school does the child attend? _____

2. Current grade: _____ Special ed classes: _____

3. How does the child do academically in school? Check the closest answer:

❑ Very well (A's) ❑ Well (B's) ❑ Average (C's) ❑ Poorly (D's) ❑ Failing (F's)

4. Overall, how does the child do socially and behaviorally in school? Check the closest answer:

❑ Extremely well (model child) ❑ Very well (no problems) ❑ All right (nothing unusual)

❑ Fair (occasional problems) ❑ Poorly (frequent or serious problems)

SOCIAL RELATIONSHIPS / FRIENDS

1. How does the child get along with peers? _____

_____

_____

2. How does the child get along with adults? _____

_____

_____

3. Who does the child spends most time with?:

❑ Same age children ❑ Older children ❑ Younger children

❑ Adults ❑ Mostly alone

HOME BEHAVIOR

1. What problem behavior(s) does the child display at home? _____

_____

_____

2. Please describe what you see as the strengths in the child's current home. List all you believe are important: _____

_____

_____

3. What do you think the child's strengths are? List all you believe are important:_____

_____

_____

COUNSELING / THERAPY GOALS

1. What changes would you like to see as the result of the child receiving counseling / therapy? Please list up to five changes, beginning with the most important one to you:

(1) _____

_____

_____

_____

(2) _____

_____

_____

_____

(3) _____

_____

_____

_____

(4) _____

_____

_____

_____

(5) _____

_____

_____

_____

2. Please describe, from your point of view, how we will know when things are better with the child:

_____

_____

_____

_____

_____

_____

_____

_____

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____

THERAPIST'S REVIEW _____ DATE _____

PATHWAY COUNSELING SERVICES

SPIRITUALITY QUESTIONNAIRE

Read each statement and respond as directed. Please be honest with your answers as there will be NO judgments made. This information will be only read by me and discussed in treatment if that is your desire. I believe spirituality is very important in the healing process but will also respect if you do not desire for spirituality to be included in our work together. We will discuss this more when we meet. If you need more room to answer than provided, please use the back of this sheet.

1. Do you feel you are spiritual? In what way? _____

_____

2. Are you connected to a specific organized religion? If so, which one? _____

_____

3. What is the name of your home church? _____

_____

4. Were you reared in a religious home? _____ If so, in what ways was it religious? _____

_____

_____

5. Do you consider this to be positive or a negative? Why? _____

_____

6. What negative religious experiences, if any, did you have while growing up or as an adult? _____

_____

_____

7. What positive religious experiences, if any, did you have while growing up or as an adult? _____

_____

_____

8. How do you currently feel about God? _____

_____

9. When you think of God what words come to mind? _____

10. How do you think God feels about you? _____

_____

11. Do you feel God is active in your life? Why? _____

_____

12. What role does spirituality or God currently play in your life? _____

_____

13. Do you desire to include spirituality, faith and God into our work together? ❑ Yes ❑ No

14. Is there anything about spirituality or God that you want to share with me as your therapist? _____

_____

_____

_____

CLIENT'S SIGNATURE _____ DATE _____

THERAPIST'S REVIEW _____ DATE _____