



Gwen Westerlund, LPC, MAC, MATS
6270 Lehman Dr., Suite 280, Colorado Springs, CO 80919
Phone:719-337-8396 Email:gwen.westerlund@gmail.com

It is such an honor to be chosen to walk with you through this process of premarital counseling. This is an exciting time as you move toward your wedding day. It is also a time of challenge, growth, and adjustment as you work at combining your two lives. Yes, there are certainly a lot of challenges that come with building a happy, successful, and fulfilling marriage. Seeing the importance of establishing a good and strong foundation through premarital counseling is an important and courageous first step towards achieving that!

My standard policy for premarital counseling is to spend six sessions together before the wedding and an additional session scheduled for three to six months after the wedding. Most couples find this to be very beneficial as they prepare for their lives together and then get a chance to talk about and assess how they are adjusting and progressing in life as a married couple.

Before you come for our first session together, please fill out the following paperwork, which includes two sets of client information forms (one set for each of you), a disclosure statement, and a statement of my counseling practices. Please be assured that this information will be held in complete confidentiality. All the information requested is relevant and helpful in considering how each of your individual stories may impact your relationship. The more open and honest you are in answering the questions, the more helpful I will be to you in this process. If you feel that any of the questions are irrelevant or too intrusive, you may decline to answer. I will be happy to discuss any concerns with you.

Please bring the paperwork with you to the first session, fully completed.

Please feel free to contact me if you have any questions before our first appointment—otherwise, I look forward to seeing you then.

Sincerely,
Gwen

CLIENT INFORMATION

Date _____

General Contact Information

Full Name _____ Preferred Name _____

Birthdate _____ Age _____

Street Address _____ Apartment # _____

City _____ State _____ Zip Code _____

Home Phone _____ May I leave a message at this number? Yes No

Cell Phone _____ May I leave a message at this number? Yes No

Work Phone _____ May I leave a message at this number? Yes No

Email _____ May I send email to this address? Yes No

Emergency Contact

Name _____ Relationship _____

Home Phone _____ Cell Phone _____

Referral Information

How did you hear about me? _____

May I contact this person to thank them? Yes No If yes, please initial here _____

Education & Employment Information

Employer _____ Length of employment _____

Occupation _____ Average hours/week _____

Last year of school completed 9 10 11 12 GED College: 1 2 3 4 Trade School Graduate level+

Are you currently in school? Yes No If yes, what level? _____

Relational Information

Current relational status: Single Dating Engaged Married Separated Divorced Widowed

Are you content with your current status? Yes No If no, briefly explain _____

If married, separated, divorced or widowed, how long? _____ Number of previous marriages for you _____

Partner's name _____ Age _____ Previous marriages _____

Partner's occupation _____ Average hours/week _____

How would you describe your partner? _____

Is your partner supportive of you seeking counseling? Yes No Uncertain Partner doesn't know

With whom do you currently live? Please check all that apply:

Alone Spouse Partner Child/ren Parent(s) Sibling(s) Grandparent(s)

Boyfriend Girlfriend Roommate(s) Other _____

Children – please list your children, living and deceased

Name	Sex	Age	Relationship to you (natural, adopted, step)	Living with you?	Describe him/her

Have you ever placed a child for adoption? Yes No If yes, when? _____

Have you ever had a miscarriage Yes No If yes, when? _____

Have you ever had a medical/surgical abortion? Yes No If yes, when? _____

Family of Origin – list parents, siblings, step-family and any family members who impacted your life.

Name	Sex	Age	Relationship to you (Mom, Dad, sibling, etc.)	Occupation	Describe him/her

How would you describe the general atmosphere of your home when you were growing up? _____

Were you adopted? Yes No If yes, what was your age at the time of adoption? _____

If adopted, do you have any relationship with your biological parents? Yes No If yes, please describe: _____

With whom did you live until the age of 18? _____

Did your parents ever divorce? Yes No If yes, what was your age at the time of divorce? _____

Did your parents remarry? Yes No If yes, what was your age at the time of remarriage? _____

Were you ever in foster or residential care? Yes No If yes, please indicate age and living situation: _____

Have you ever experienced the death of a family member or close friend? Yes No If yes, please indicate the relationship and your age at the time of their death: _____

Medical Information

Primary Physician _____ Phone _____

Are you currently receiving medical treatment? Yes No If yes, please specify _____

Please indicate any health issues that you are experiencing now, or have in the past, by checking all that apply in the table below:
Why am I asking this? Because as holistic beings, our physical condition can greatly affect our emotional and psychological condition.

	Now	Past		Now	Past		Now	Past
Asthma			Allergies			Headaches/Migraines		
Brain Injury			Epilepsy			Seizures		
Digestive/Eating Disorder			Cancer			Diabetes		
Breathing Problems			Immune System Issues			Heart Disease		
High Blood Pressure			Vision Problems			Hearing Problems		
Arthritis			Urinary Disorders			Tuberculosis		
Thyroid Disorder			Multiple Sclerosis			Chronic Fatigue Syndrome		
Fibromyalgia			Pregnancy (how many)			Miscarriage (how many)		
Abortion (how many)			Sexually Trans. Disease			Sleep Disorder		
Serious Accident			Surgery			Other		

Are there any other relevant medical conditions, illnesses, surgeries, traumas, or related treatments you have had: _____

List all medications you are currently taking (*use extra paper if necessary*):

Medication _____ Purpose _____
 Medication _____ Purpose _____
 Medication _____ Purpose _____
 Medication _____ Purpose _____

Are you taking these medications according to your doctor's recommendations? Yes No If no, briefly explain: _____

Please indicate any other substances you are using or have used consistently in the past:

Substance	Current	Amount	Frequency	Past	Age	Length Used
Caffeine						
Alcohol						
Tobacco						
Marijuana						
Ecstasy						
Cocaine/Crack						
Heroin						
Methamphetamines						
PCP/LSD/Mushrooms						
Pain Killers						
Steroids						
Tranquilizers						
Sleeping Pills						
Diet Pills						

In what ways have the medical/health or substance use/abuse issues of yourself or family members impacted your life? _____

Legal Information

Have you ever been the victim of a crime? Yes No If yes, please indicate date and briefly describe: _____

Are you currently involved in divorce or child custody proceedings? Yes No If yes, please explain: _____

Have you ever been convicted of a crime? Yes No If yes, please explain: _____

Have you ever been incarcerated? Yes No If yes, please explain: _____

Religious/Spiritual Background

What are your current spiritual beliefs? _____

Briefly describe the religious/spiritual atmosphere in your home as you were growing up: _____

Do you attend a place of worship regularly? Yes No If so, where? _____

Do you have a personal support system? Yes No If so, who? _____

How would you describe yourself? _____

How do you think God would describe you? _____

Mental Health History

Have you ever received a mental health diagnosis? Yes No If yes, please give diagnosis and dates: _____

Please list any previous counseling, psychiatric treatment, or residential/in-patient care you have received in the past. Please provide dates and the reason for treatment: _____

Did you feel that the counseling/treatment was beneficial or successful? Yes No Why or why not? _____

What was the *most helpful* or beneficial about any previous counseling or treatment? _____

What was the least helpful or even traumatic about any previous counseling or treatment? _____

Are you currently under the care of a psychiatrist? Yes No If yes, Name: _____

Are you currently taking any medications specifically for mental health diagnoses not previously listed? Yes No If yes, please list: _____

Level of Distress

Indicate how distressed you are **at this time** but circling a number on the scale below. (1=*very little distress*; 10=*extreme distress*)

12 3 4 5 6 7 8 9 10

Are you currently experiencing any suicidal thoughts? Yes No Have you experienced them in the past? Yes No

Have you ever attempted suicide? Yes No If yes, when and how? _____

Have any of your close friends or family members ever completed or attempted suicide? Yes No If yes, when and how? _____

Presenting Issues & Goals

Please describe why you are coming to counseling. What are the issues or problems that you are facing? _____

How long have you been dealing with these issues? _____

What made you decide to seek counseling at this time? _____

What do you hope to gain or change by coming to counseling? _____

How long do you believe counseling should last? _____

How will we know when we have accomplished your counseling goals? _____

Is there any other information that you want to share that you feel would be beneficial for your therapist to know? _____

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High Blood Pressure			Vision Problems			Hearing Problems		
Arthritis			Urinary Disorders			Tuberculosis		
Thyroid Disorder			Multiple Sclerosis			Chronic Fatigue Syndrome		
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In what ways have the medical/health or substance use/abuse issues of yourself or family members impacted your life? _____

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What made you decide to seek counseling at this time? _____

What do you hope to gain or change by coming to counseling? _____

How long do you believe counseling should last? _____

How will we know when we have accomplished your counseling goals? _____

Is there any other information that you want to share that you feel would be beneficial for your therapist to know? _____

COUNSELING POLICIES

APPOINTMENTS

Appointments are scheduled directly with me. In general, appointments are scheduled weekly or bi-weekly, but are also offered on an “as-needed” basis.

If you must cancel an appointment, please do so at least a full 24 hours in advance of the session. Missed appointments or appointments cancelled with less than 24-hour notice will be charged at the usual fee (except in infrequent instances of illness, emergencies, or dangerous weather/driving conditions). You are asked to arrive promptly for your appointment. If you are late, the session will end at the scheduled time regardless of when they started, and will be charged the full usual fee. In the event that I miss a scheduled appointment without 24-hour prior notice to you (with the above noted exceptions) you will be provided with one free session.

CONTACTING ME

If you need to speak with me between your regularly scheduled appointments, please feel free to text, call, or leave a message on my confidential voicemail at 719.337.8396 or email be at gwen.westerlund@gmail.com. I will return texts, calls, or emails as soon as possible and certainly within 24 hours. My policy is not to engage in therapeutic counseling over the phone or via email, so please utilize these methods of contact for rescheduling appointments or passing on important and relevant information.

In order to protect your privacy, in the event that we meet inadvertently in public, I will not approach you or speak to you. If you wish to acknowledge our acquaintance and speak to me, it is your choice to do so.

It is my policy not to engage in social activities with, nor accept gifts from, my clients.

FEE INFORMATION

The basic fee for therapy is \$75 per 50-minute session. These fees for counseling are based on customary and reasonable fee profiles for this area.

Payment is expected at the time of service. I accept cash, check, and credit cards. Please make checks payable to *RCIS* or *Rosmarinus Counseling*. There is a standard \$25 fee for all checks returned for insufficient funds. If you should encounter financial difficulties during counseling, please discuss this with me promptly.

I do not accept private insurance assignments. However, if you will to file for reimbursement with your insurance provider, I will be happy to furnish you with a medical provider receipt for each session.

HIPAA PRIVACY ACT

Because I do not accept insurance, nor conduct any financial or administrative transactions electronically, I am not required to comply with the Health Insurance Portability Accountability Act (HIPAA) standards. However, in regard to client rights of confidentiality in counseling, the protections of the mental health statutes in Colorado exceed those of HIPAA. I am in compliance with the requirements of the mental health statutes and therefore also with the requirements of HIPAA.

FAITH, SPIRITUALITY & PRAYER

As holistic beings, all aspects—physical, mental, emotional, and spiritual—contribute to our overall experience of wholeness and wellness. With your permission, aspects of faith, spirituality, and prayer may be incorporated as part of the counseling process.

EMERGENCIES

I do not provide 24-hour emergency care or phone coverage. In case of emergency, call 911, contact the community health center for your county, or go to the nearest hospital emergency room.

El Paso County	888-557-4441	24-hour crisis line
Pikes Peak Mental Health	719-635-7000	24-hour crisis line

REFERRALS

The work I do is highly based on word of mouth referrals. I am always thankful for and appreciative of all referrals from my clients. Please ask for business cards if you know of someone that you believe could benefit from my services.

If you decide at any time that my therapeutic techniques and style are not providing you with the desired benefit, please let me know and I will be happy to provide you with referrals to three other therapists as is the accepted and customary practice.

THEORETICAL ORIENTATION

My counseling orientation and the approach used is integrative, which enables me, as your therapist, to tailor therapeutic interventions to your particular needs. These may include:

- **Cognitive Behavioral Therapy (CBT)** interventions provide realistic procedures and methods to practice on a daily basis that help eliminate and prevent troublesome behaviors.
- **Experiential Techniques** engage the deeper emotions and help to circumnavigate too much cognitive involvement when one is “overthinking” an issue.
- **Solution-Focused, Brief Therapy** techniques help the client reengage as quickly as possible with life in a healthy and effective manner without the emotional disturbances that have caused discomfort.
- **Splankna Therapy**, a biblically-based protocol for Energy Psychology/Mind-Body work, is designed to help get to the origin of an emotional issue with the goal of rapidly desensitizing the emotional stress connected to a past event. It incorporates elements from several newly-emerging energy psychotherapy, coaching, and self-help techniques, specifically Neuro-Emotional Techniques (NET), Thought Field Therapy (TFT) and Eye Movement Desensitization and Reprocessing (EMDR). Basic biblical principles such as prayer, following the leading of the Holy Spirit, confession, repentance, and forgiveness are incorporated. The application of Splankna Therapy includes minor touch on the back of the wrist by the therapist. Although Energy Techniques like Splankna Therapy appear to have promising emotional, spiritual, and physical health benefits, they have yet to be fully researched by the Western academic, medical, and psychological communities, and therefore may be considered experimental. Because Energy Techniques are relatively new healing approaches, the extent of their effectiveness, as well as their risks and benefits are not fully known. If you ever have questions or concerns about the nature of the theories, methods, approaches, and/or techniques, please feel free to ask for further resources or references.

I acknowledge and agree to the policies of Romarinus Counseling Services.

Client Signature _____ Date _____

Client Signature _____ Date _____

Disclosure Statement

Information

Gwen Westerlund
6270 Lehman Dr., Suite 280, Colorado Springs, CO 80918
Phone: 719-337-8396 Email: gwen.westerlund@gmail.com

Credentials

I am a Licensed Professional Counselor—LPC0013009—in the State of Colorado, licensed by the Department of Regulatory Agencies (DORA). I received a Master of Arts in Counseling from Denver Seminary, a counseling program which is accredited by the Council for Accreditation of Counseling and Related Programs (CACREP) and focuses on general practice psychotherapy from a Christian perspective. I am a certified Splanckna practitioner and a certified Prepare/Enrich facilitator.

Regulation of Psychotherapists

The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Registrations. The regulatory boards can be reached at 1560 Broadway, Suite 1350, Denver CO, 80202, (303) 894-7800. The regulatory requirements for mental health professionals provide that a Licensed Clinical Social Worker, a Licensed Marriage and Family therapist, and a Licensed Professional Counselor must hold a master's degree in their profession and have two years of post-masters supervision. A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision. A Licensed Social Worker must hold a master's degree in social work. A Psychologist Candidate, a Marriage and Family Therapist Candidate, and a Licensed Professional Counselor Candidate must hold the necessary licensing degree and be in the process of completing the required supervision for licensure. A Certified Addiction Counselor I (CAC I) must be a high school graduate, and completed required training hours and 1000 hours of supervised experience. A CAC II must complete additional required training hours and 2000 hours of supervised experience. A CAC III must have a bachelor's degree in behavioral health, and complete additional required training hours and 2000 hours of supervised experience. A Licensed Addiction Counselor must have a clinical master's degree and meet the CAC III requirements. A Registered Psychotherapist is listed in the State's Database and is authorized by law to practice psychotherapy in Colorado, but is not licensed by the state and is not required to satisfy any standardized educational or testing requirements to obtain registration from the state.

Client Rights and Important Information

- You are entitled to receive information from me about my methods of therapy, the techniques I use, and the duration of your therapy, and my fee. Please ask if you would like to receive this information.
- You can seek a second opinion from another therapist or terminate therapy at any time.
- In a professional relationship (such as ours), sexual intimacy between a therapist and a client is never appropriate. If sexual intimacy occurs, it should be reported to the Board that licenses, certifies, or registers the therapist.
- Generally speaking, information provided by and to a client in a professional relationship with a psychotherapist is legally confidential, and the therapist cannot disclose the information without the client's consent. There are several exceptions to confidentiality which include:
 - I am required to report any suspected incident of child abuse or neglect, elder abuse, or abuse of disabled persons to law enforcement;
 - I am required to report any threat of imminent physical harm by a client to law enforcement and to the person(s) threatened;
 - I am required to initiate a mental health evaluation of a client who is imminently dangerous to self or to others, or who is gravely disabled, as a result of a mental disorder;
 - I am required to report any suspected threat to national security to federal officials
 - I may be required by Court Order to disclose treatment information.
- When I am concerned about a client's safety, it is my policy to request a Welfare Check through local law enforcement. In doing so, I may disclose to law enforcement officers information concerning my concerns. By

signing this Disclosure Statement, and agreeing to treatment with me, you consent to this practice, if it should become necessary.

- Under Colorado law, CRS 14-10-123.8, parents have the right to access mental health treatment information concerning their minor children, unless the court has restricted access to such information. If you request treatment information from me, I may provide you with a treatment summary, in compliance with Colorado law and HIPAA Standards.
- I agree not to record our sessions without your written consent; and you agree not to record a session or conversation with me without my written consent.

Disclosure Regarding Divorce and Custody Litigation

If you are involved in divorce or custody litigation, my role as a therapist is not to make recommendations to the court concerning custody or parenting issues. By signing this Disclosure Statement, you agree not to subpoena me to court for testimony or for disclosure of treatment information in such litigation; and you agree not to request that I write any reports to the court or to your attorney, making recommendations concerning custody. The court can appoint professionals, who have no prior relationship with family members, to conduct an investigation or evaluation and to make recommendations to the court concerning parental responsibilities or parenting time in the best interests of the family’s children.

I understand that I am not receiving medical diagnosis, medical treatment, or prescriptions as part of psychotherapy interventions. I hereby release Gwen Westerlund, Rosmarinus Counseling Services, Inc., and Mercy’s Gate from any liability resulting in any possible damages or loss incurred in our association.

I have read the preceding information, and it has been presented to me verbally. I understand the disclosures that have been made to me and my rights as a client. I also acknowledge that I have received a copy of this disclosure statement.

Print Client Name	Signature	Date
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Gwen Westerlund – LPC0013009