CLIENT INFORMATION

Date _____

General Contact Information

Full Name _____ Preferred Name _____

Birthdate _____ Age _____

Street Address _____ Apartment # _____

City _____ State _____ Zip Code _____

Cell 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 _____
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 play 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*)

1 2 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 important and 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 it started, and will be charged the full usual fee. In the event that I miss a scheduled appointment, or have to reschedule 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.

FEE INFORMATION

The standard 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 and North Dakota 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.

Colorado - El Paso County	888-557-4441	24-hour crisis line
North Dakota Crisis Line	Dial 211	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 eclectic and 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.
- **EMDR (Eye Movement Desensitization & Reprocessing)** is a highly effective, evidence-based therapy that addresses traumas such as war, PTSD, accidents, assaults, disaster, and childhood abuse or neglect.
- **Experiential Techniques** such as creative, artistic, body-mind practices engage the deeper emotions and help to circumnavigate too much cognitive involvement when one is "overthinking" an issue.
- **Solution-Focused, Brief Therapy** techniques help diminish symptoms in order to enable the client to reengage as quickly as possible with life in a healthy and effective manner without the emotional disturbances that have caused discomfort.

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

_____

Client Signature Date

_____

Client Signature Date

Disclosure Statement

Information

Gwen Westerlund
321 South 1st St., Bismarck, ND 58504
Phone: 719-337-8396 Email: gwen.westerlund@gmail.com

Credentials

I am a Licensed Professional Counselor in the State of Colorado—LPC0013009—licensed by the Department of Regulatory Agencies (DORA) and in the State of North Dakota—#1104-1-1-21—licensed by the ND Board of Counselor Examiners. 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 EMDR trained (EMDRIA accredited), a certified Splankna practitioner and a certified Prepare/Enrich facilitator.

Regulation of Psychotherapists

For the State of Colorado: 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.
For the State of North Dakota: The practice of licensed or registered persons in the field of psychotherapy is regulated by the North Dakota Board of Counselor Examiners. The Board can be reached at 2112 10th Ave. SE., Mandan, ND 58554, (701) 667-5969. The regulatory requirements for mental health professionals provide that a Licensed Professional Counselor must hold a master's degree in their profession and have 100 hours of post-master's direct supervision and 400 hours of direct client contact hours.

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 to law enforcement;
    - I am required to report any threat of imminent physical harm by a client towards another person(s) 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 regarding 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. 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

_____

If signed by parent or guardian, please state relationship to client and authority to consent.

_____

Gwen Westerlund Date
Colorado - LPC0013009
North Dakota - #1104-1-1-21