Guidelines for Therapy

You may or may not have been to a therapist before. If this is your first experience with therapy, you may feel a bit nervous. **That's normal!** Therapy is a process that allows you the freedom and privacy to discuss issues that are often too painful or difficult to discuss with family or friends.

Below are a few suggestions to help make your counseling experience most effective:

1	Before your scheduled appointment, write down questions, topics or issues you would like to focus on in your session.
2	Communicate your expectations to me so that we are working together towards your goals.
3	Provide ongoing and honest feedback to me so I know how you're doing. (Example: "I want to focus on my anger more" or "I like doing relaxation exercises.")
4	If you feel the need to increase or decrease the frequency of your sessions, or to end counseling, feel free to communicate that to me.
5	If you feel the need to bring a partner, relative, or friend in with you for your session in order to work on interpersonal issues, feel free to do so. Please discuss it with me prior to their arrival.
6	If you have another professional involved in your care (i.e. physician, chiropractor, attorney, etc) I would be happy to coordinate with him/her if you wish. It is not advisable to have more than one mental health counselor involved in your treatment at one time.
7	Try and make a commitment to yourself to remain in therapy and attend regular sessions for as long as you feel necessary. If you wait until a crisis, it will be more difficult to build long-lasting coping skills.
8	If for any reason you would like to see a different therapist, please let me know. I can provide you with names of other therapists.

Kelsie Wheeler MA, ABS, LMHC / 1106 Harris Ave, Suite 302, Bellingham WA 98225 / 360-303-6639

Patient Report of Problems

Name _____ Date _____

Read each of the statements below and check the boxes that apply to your situation:

- ☐ Difficulty learning to trust
- ☐ Shyness
- ☐ Feelings of guilt
- ☐ Unable to quit using alcohol
- ☐ Unable to quit using drugs
- ☐ Gender questions
- ☐ Depression / anxiety / excessive worry
- ☐ Anger control problems
- ☐ Unable to make and keep friends
- ☐ Feeling crazy
- ☐ Unable to express anger (stuffing it)
- ☐ Unable to control temper
- ☐ Unable to express ideas to others
- ☐ Unable to express feelings
- ☐ Other: _____

_____

_____

_____

- ☐ Unable to feel cheerful or optimistic
- ☐ Physically ill
- ☐ Lonliness
- ☐ Having no self-confidence
- ☐ Lack of self-respect
- ☐ Behavior issues at school or work
- ☐ Financial problems (unpaid bills, bankruptcy, etc)
- ☐ Physically abusive to others
- ☐ Emotionally abusive to others
- ☐ Feeling over-stressed
- ☐ Unable to avoid dependant relationships
- ☐ Unable to have fun without alcohol/drugs
- ☐ Unable to get along with signifcant other
- ☐ Difficulty controlling emotions
- ☐ Compulsive behavior (spending, eating, talking, gambling, etc). Please list below:

_____

_____

- ☐ None of these problems apply to me

Now, please go back and review the statements you checked. Put a 1, 2, 3, 4, or 5 in front of the problem you feel most affects your life, with 1 being the most impactful.

Signature _____ Date _____

Kelsie Wheeler MA, ABS, LMHC / 1106 Harris Ave, Suite 302, Bellingham WA 98225 / 360-303-6639

Initial Interview Form

Date _____

1. Personal Information

Name _____ Date of birth _____

Address _____ Gender ☐ Male ☐ Female

State _____

Zip _____

Phone cell _____ home _____ work _____

2. Family Information

Current status ☐ Single ☐ Married ☐ Partnered ☐ Divorced # times married _____

Names of biological children and stepchildren. Circle those that still live with you:

_____

_____

How do/did you get along with your:

Partner? _____

Biological mother? _____

Biological father? _____

Stepmother? _____

Stepfather? _____

Siblings? _____

Social connections are important to our health. Please document your support group. List the first names of your significant friendships and indicate how long you have had each relationship, age, how long you have known this person, how often you are in contact, and your closeness :

First name	Age	Duration	Contact frequency	Closeness (close ↔ distant)
				☐ ☐ ☐ ☐ ☐
				☐ ☐ ☐ ☐ ☐
				☐ ☐ ☐ ☐ ☐
				☐ ☐ ☐ ☐ ☐

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3. Employment Information

Employer _____ How long? _____

Occupation _____

How satisfied are you in this job?

- ☐ Not satisfied
- ☐ Somewhat satisfied
- ☐ Comfortable
- ☐ Very satisfied

Are you satisfied that your income adequately covers your living expenses?

- ☐ Not satisfied
- ☐ Somewhat satisfied
- ☐ Comfortable
- ☐ Very satisfied

Do you have any other sources of income?

☐ Yes ☐ No If yes, please describe _____

4. Financially Responsible Persons Information (if different from client)

Name _____ Relationship _____

Address _____ Date of Birth _____

State _____ Employer _____

Zip _____ SSN# _____

Phone _____

5. Spiritual Information

How significant a role does spirituality play in your life? How does this affect your daily life?

- ☐ No role
- ☐ Somewhat important
- ☐ Significant
- ☐ Very significant

6. Medical Information

Primary physician _____ Phone _____

Last exam _____

List any current medications and dosage: _____

_____

_____

Allergies: _____

Major (or chronic) operations/ illnesses/ injuries: _____

_____

_____

Please indicate your major life stressors over the least 12 months:

- ☐ Serious Illness or Injury
- ☐ Major Illness in Family
- ☐ Divorce/ Separation
- ☐ Death of a Close Friend or Family Member
- ☐ Gain of New Family Member
- ☐ Job Change
- ☐ Other (please explain) _____

_____

_____

Describe what you would like to be different in your life when you are done with therapy:

_____

_____

_____

_____

Have you ever received psychological or psychiatric help before? ☐ Yes ☐ No

When _____

From whom _____

Purpose _____

Results _____

Have you ever been prescribed medication for a psychiatric or emotional problem? ☐ Yes ☐ No

When _____

From whom _____

Purpose _____

Results _____

7. Other

How were you referred to my office? _____

Who may we thank for referring you? _____

Nearest relative (other than spouse) _____

What brings your child to therapy?

What would you like me to know about your child?

What are your child's interests and strengths?

Is there anything else you would like me to let me know?

Informed Consent

This form is to welcome you and inform you of your rights and responsibilities as a client. Please read the following information, then sign and date on the last page.

Kelsie Wheeler MA ABS LMHC
1106 Harris Ave, Suite #302
Bellingham, WA 98225
360-303-6639

Education:
Master in Applied Behavioral Science, Bastyr University, Leadership Institute of Seattle
Bachelor in Human Services, Western Washington University

I am required to give you this notice under the federal Health Insurance Portability and Accountability Act of 1996 (HIPPA). This notice describes how psychological/-medical information about you may be used and disclosed and how you can get access to this information. Please review this carefully.

Your "Protected Health Information" (PH) is any information about your past, present, or future physical or mental health conditions or treatment, billing and payment information relating to this treatment, or any other information I have that could identify you. The law protects the privacy of the health information I create and obtain in providing my care and services to you.

Part I: Your Rights as a Client(s)

1. You have the right to ask questions about any procedures used during therapy; if you wish, I will explain my approach and methods to you.

2. You have the right to decide not to receive therapeutic assistance from me; if you wish, I will provide you with the names of other qualified professionals whose services you might prefer as a cost equal to or less than my own usual customary fee.

3. You have the right to end therapy at any time without any moral, legal, or financial obligations other than those already accrued. I ask that you contact me by phone if you make such a decision.

4. You have a right to review your records at anytime. I do not keep any "secret notes," so please do not ask me to do so.

5. One of the most important rights involves **confidentiality**: Within limits of the law, information revealed by you during therapy will be kept strictly confidential and will not be revealed to any other person or agency without your written permission. Additionally, when more than one family member is seen in therapy, I view the family as a whole as the client and confidentiality extends to all those involved in therapy. Therefore,

releases of information for family sessions require the written approval of every consenting member of the family who was present at any time during the treatment. However, I will not necessarily be bound by confidentiality in joint sessions with information I have obtained in individual sessions and discussions. This means I reserve the right to discuss in joint sessions information that you have shared in individual sessions and discussions if I believe it helps facilitate the achievement of the goals set forth in therapy.

You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that we have already released information based on that authorization; or if the authorization was obtained as a condition of insurance coverage.

6. If you request it, any part of your record in the files can be released to any person or agency you designate. I will tell you at the time whether or not I think releasing the information in question to that person or agency might be harmful in any way to you.

7. You should also know that there are certain situations in which I am required by law to reveal information obtained during therapy to other persons or agencies without your permission. Also, I am not required to inform you of my actions in this regard. These situations are as follows: (a) information related to circumstances of actual or potential physical harm or death to yourself or another person, I am required by law to report this information to the governing authorities; (b) Court subpoena of the therapist or client file information; (c) if you reveal information relative to child abuse, child neglect, or elder abuse, I am required by law to report this to the appropriate authority; (d) if you are in therapy by order of a court of law, the results of the treatment ordered must be revealed to the court; and (e) if you are seeking payment through an insurance company, I will be required to reveal confidential information to them (each insurer is different).

8. You have the right to know about the possible harmful result of therapy. In my years of therapy service delivery, the only clear harm I have witnessed resulted from clients' insistence on using medical insurance for psychotherapy. Harmful events included: denial of insurability when applying for medical and disability insurance due to DSM-IV diagnosis (mental illness diagnosis, which are usually required for reimbursements under medical insurance); company (mis)control of information when claims are processed; loss of confidentiality due to the large number of persons handling claims; loss of employment, and repercussions of diagnosis in situations which require truthfulness about "mental illness," including driver's license applications, weapons permits, and job applications.

Part II: The Therapeutic Process

Therapy will seek to meet goals established by all persons involved, usually revolving around a specific presenting problem. A major benefit that may be gained from participating in therapy includes a better ability to handle or cope with marital, family, and other interpersonal relationships. Another possible benefit may be a greater understanding of family and personal goals and values that may lead to a greater maturity and happiness as individual and increased relational harmony. Other benefits relate to the probable outcomes resulting from resolving specific concerns brought to therapy.

In working to achieve these potential benefits, however, therapy will require that firm efforts be made to change and may involve the experiencing of significant discomfort. Therapeutically resolving unpleasant events and relationship patterns can arouse intense feelings. Seeking to resolve problems can similarly lead to discomfort as well as relationship changes that may not be originally intended.

I am required by law to maintain the privacy of your Protected Health Information and to provide you with this Notice of my legal duties and privacy practices with regard to PHI.

Part III: Client Contract

1. I (the client) agree to pay $_____ for each session (a typical session is 60 minutes). Payment is due at the end or beginning of each session or as arranged in advance.

2. I am expected to pay for all time reserved unless I cancel an appointment 24 hours in advance.

3. I am responsible for arriving at the scheduled appointment time. If I am ½ hour late for my appointment, the time is lost. If my therapist is late, it is the therapist's responsibility to make up the missed time.

4. As outlined above, all the contents of session are confidential unless I sign a written release of information waiver or Washington law requires such disclosure.

5. I understand that my therapist may at times consult on my behalf with professional colleagues. In consulting with any who have not worked with me, my therapist will keep my identity protected.

6. I (we) give permission for Kelsie Wheeler to contact my General Practitioner, if needed and in strict confidence, to ensure my best interests.

7. As a licensed Mental Health Associate, by Washington State law it is required to have a supervisor to consult on client cases. Chris Lange, MA, LMHC, is Kelsie Wheeler's clinical supervisor for LMHC licensure.

Acknowledgment of Disclosure

I (we) understand the information and agree to the terms set forth in the above disclosure statement.

Client _____ Date _____

Client _____ Date _____

Therapist _____ Date _____

If you have any questions about these policies, please feel free to discuss these with me at anytime.

Acknowledgement of Receipt of Notice of Privacy Practices

By my signature below I, _____, acknowledge that I received a copy of the Notice of Privacy Practices for Kelsie Wheeler, MA, ABS, LMHCA.

_____ _____

Signature of client (or personal representative) Date

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

Personal representative's name _____

Relationship to client _____

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I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify) _____

_____

_____