ACCARES Wellness Center

Dr. Kathy Howell, PhD, LPC, & Associates
Ga State Lic# LPC003284
786 River Bend Road Dawsonville, GA 30534
Main: 706-216-6356 Fax: 706-265-6295
accaresdkh@windstream.net

Please complete the following questionnaire as thoroughly as possible. If something does not apply, use N/A in the space provided.

Today's Date __________ Full Name: ____ DOB: ___________ Age: ___

SS# __________________ Mailing Address: ____ Phone: ___________________

Gender: **M F** ____ Cell: ____________________

Ok to send text/emails: **Y N** Email : ____

Office Use Only ___________

PCP Release:

Emergency Contact Information: ____

How did you hear about us? ____

Self Assessment

Three words you would use to describe yourself:____

Your main goal/reason for seeking counseling:____

What have you tried so far? ____

Have there been times when the problem seem to resolve, get better, or disappear? If so, when?

____

Were there times when the problem was especially bad or worse? If so, when?

____

What do you think contributed to that?

____

Do other people play a major role? Contributing to causing your problem(s)?

____

Do you prefer Christian counseling from a biblical perspective or secular counseling?____

Demographics

Education Completed: ___________________________ Current Employer/position: ____

How many hours per week do you work? ____________________________ How satisfied are you with your job? _________________

Do you have a valid DL? Yes No Do you have reliable transportation? Yes No Marital Status: __________________

If married, how long? __________ Have you been married before? ________________How many children do you have? _____

Names/Ages: ____

Do you have custody? If no, please explain:

____

Are you currently in any sort of litigation/probation? If yes, please give details:

____

On Parole? Please give officer's name/phone: ____

Are you taking any medication/supplements on a regular basis for a psychological/psychiatric condition? ________ Please list:

Medication Name/ Strength	Dosage per day	Reason for taking / Prescribed By

Have you ever been diagnosed with a mental disorder/condition? Yes No Please list:

Diagnosis	Date of Diagnosis	Do you accept it as true?/ additional comments:

Please circle all that have (currently or in the past) drug or alcohol problem in your family: (please circle)

Spouse Child Mother Father Brother Sister Aunt Uncle Grandmother Grandfather Other

Do you live with anyone who has a current drug/alcohol problem Yes No Uses prescription drugs? Yes No

Age you started using drugs/alcohol: ____ How much alcohol do you drink per day?_______ Would you say you are currently addicted? _____ If no, have you ever been addicted in the past? ______ If yes, to what substance: ____________________ What is/are your substance(s) of choice? ___________________________ When was the last time you used? ___________

In the following list, please place ONE checkmark next to each item that identifies an area of **concern for you**. Place TWO checkmarks by those items that are MOST important. You may also add comments or further details to checked areas if desired.

	Anger		**Religious/Spiritual**
	Depression		**Sexuality**
	Education		**Thoughts of Suicide**
	Eating Difficulties		**Trouble Making Decisions**
	Fearfulness		**Unhappy Most of the TIme**
	Financial Concerns		**Use of Alcohol**
	Marital Issues		**Use of Drugs**
	Physical Difficulties		**Abuse of Substances By a Family Member**
	Problems with Social Relationships		**Work Concerns**
	Problems with Children		**Worry Constantly**
	Problems with Parents		**Other (Specify)**

Have you ever had a nutritional evaluation? Yes No If yes, what Practitioner/Title? ____

Are you taking any nutritional supplements? Please list or attach sheet if needed. ____

____

Have you had Health Issues of been Injured in the past year? Please circle: Food Reaction Infection Cold/Flu Major Stress Injury Medication Change Slip/Fall Medical Emergency Please provide details:____

Energy Level: Please rate your current condition (Best = 10 Worst = 1) **1 2 3 4 5 6 7 8 9 10**

Please check any/all areas that you are having physical issues with currently. Add comments if desired...

	Exhaustion/Fatigue		**Digestive Problems**
	Hot Flashes		**Memory**
	Seasonal Allergies		**Weight Loss/Gain**
	Blood Pressure		**Depression**
	Anxiety		**Cholesterol**
	Joint Pain/ Inflammation		**Diarrhea**
	Acid Reflux		**PMS Symptoms**
	Mood Swings		**Heart Palpitations**
	Sinus Issues		**Cold Feet/Hands**
	Blood Sugar		**Constipation**

Any other area/issue not listed? ____

****Rate your interest in nutritional therapies as a part of your Spirit/Soul/Body treatment plan**:____ (Very = 10/ Not Interested = 1)

Please complete the last 3 days of your eating history as thoroughly and honestly as you remember:

Day	Breakfast	Lunch	Dinner

- ❑ This information is true and correct to the best of my knowledge
- ❑ I give permission to ACCARES to add me to their email base
- ❑ I would like to request a free nutritional consultation with Dr. Howell

Patient Signature: ____ **Date:** _______________

Credentials & Certifications for Kathy A. Howell, PhD, LPC, CPC, Owner/Director of ACCARES

Ph.D. Psychology & Counseling, Logos Christian College & Graduate School Jacksonville, FL

M.A. Counseling, Liberty University Lynchburg, VA

B.S. Psychology/Sociology, North Georgia College & State University Dahlonega, GA

Nutritional Response Testing Practitioner
CISM- Critical Incident Stress Management
Theophostic (God's Light) Inner Healing
Sexual Addictions Certified Counselor
Prepare-Enrich Marriage/Pre-marital Counselor
Splankna Emotional Energy Release Therapy
Parenting: ADHD & Non-compliant Children
Divorce Recovery Facilitator (Fresh Start)
Certified Criminal Justice Addictions Specialist

Certified Professional Life/Wellness Health Coach
Crisis Care Network Mass Disaster Victim Counselor
Stress & Trauma Crisis Certified (Military)
Peacemakers Mediation/Conciliator
Creation Therapy- Temperament Counselor
Grace Ministries International Counselor
Seven Steps to Freedom in Christ (Neil Anderson)
Certified Anxiety Disorder Specialist
Life Pathways Career Counseling

Affiliations: Licensed Professional Counselors Association; American Association of Christian Counselors, Ga Christian Counselors Association; Phi Kappa Phi; The Society of Christian Psychology; International Board of Professional & Pastoral Counselors; Board Certified Professional Life Coach Counselor (BCPCC); Ordained Minister (Logos Global Network Ministries)

*All associates are under the supervision of Dr. Kathy Howell. We meet as a treatment team to decide upon individualized plans.

Important Office Policies

Counseling Services exist to provide therapy at affordable rates for individuals, couples, families, and groups regardless of race or religious affiliation. From a Biblical foundation of personhood, an integrated counseling framework of cognitive-behavioral, psychodynamic (aka Theophostic core issues), and family systems is used. Counseling is a voluntary, cooperative venture. In order to enable us to work most effectively together, we ask that you carefully read the information that follows. **As a part of our Spirit, Soul, Body evaluation, we recognize the link between physical and emotional health**. When the underlying causes of the issue(s) are corrected through safe, natural means, the body and mind can repair itself in order to attain and maintain optimum health and emotional wellbeing. If you have any questions, please ask

______ **Please initial that you have read and understand this information**

Confidentiality: Confidentiality and privileged communication remain the right of all clients of counselors according to Georgia State Law. I understand that information concerning treatment or evaluation may be released only with the sole authorization and consent of the person being treated or evaluated, or such person's parent/guardian, and with the agreement of the counselor. There are exceptions to the confidentiality of information in the following circumstances (as provided by law): 1) Where there is a clear and imminent danger to the client or others, the counselor may take reasonable personal action or inform the responsible authorities; such as in, suspect of child abuse of suicidal ideation or homicidal ideation will be reported; and 2) if the counselor is required by a court to give information. Except as required by law, you, the client/parent/guardian must sign a consent to authorize release of clinical records. Counselors will be discreet if it is necessary to contact you at home or work. In keeping with generally accepted standards of practice, counselors frequently consult with other mental health professionals regarding the management of cases. The purpose of the consultation is to ensure quality of care. Every effort is made to protect the identity of clients, including any financial records or payment information.

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Acknowledgement of Disclosure: The client/parent/guardian has the responsibility and right to 1) choose the therapist and treatment modality that best suits their needs; 2) discuss any concerns about treatment,3) request change in approach or referral to another therapist; and/or 4) discontinue therapy. The counselor can make no guarantees of results. We follow the ethical guidelines set forth by the Georgia Counselors Association and the Georgia Composite Board of Professional Counselors.

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Informed Consent: Client voluntarily agrees to complete assignments and to punctually attend all scheduled sessions. Psychotherapy may involve the risk of remembering unpleasant events and can arouse intense emotions of fear, anger, anxiety, depression, loneliness, or helplessness. You should know that your therapist/counselor is not a physician and cannot prescribe or provide you with any medication, prescriptions, or perform medical procedures. If medical treatment is indicated, your therapist can recommend a physician or psychiatrist for you at your request.

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Liability: Client voluntarily releases ACCARES/ Dr. Kathy Howell & Associates from all liability and claims resulting from any injuries incurred during activity on the Wellness Center's grounds. Client assumes the foreseen and unforeseen risks of walking or playing on the property and will 1) wear appropriate outdoor walking shoes,2)stay on the well-marked mulched trails. *Children under the age of 18 must be accompanied by an adult.*

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Release of Information: To be compliant with HIPPA, we must have your written consent to release any of your clinical records. Please list the names and contact information for anyone you give permission to have your records released to if needed.

Name	Relationship to Client	Phone Number to Contact

______ **Please initial that you have read and understand this information**

Fees/Insurance Payments: Client is responsible for obtaining written confirmation of the benefits and claims information so insurance coverage can be verified before the initial appointment. The fee for a typical 45-50 minute counseling session is $130.00. This is to be paid in full until the first payment from the insurance company has been received. Any overpayments will be applied to your account or refunded. The client is ultimately responsible for payment to ACCARES & Associates. Counselors ask that your account be kept current and that **payment be made at the beginning of each session** in order that the focus remain on therapy and to save time- unless other arrangements have been made prior. *Please make all checks payable to: Dr. Kathy Howell* If a check is returned (NSF), a $15.00 fee will be added to your account.

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Cancellations: Be mindful that resistance can occur when engaging in therapy. As you explore life's difficulties, it may be tempting to cancel your appointment. Often times, inconveniences arise, providing a seemingly legitimate excuse to cancel the appointment; however, cancelling may be a way to avoid the therapy work. The purpose of therapy is to bring healing. It requires commitment to your scheduled sessions and respectfulness of your therapist time and other clients in need of help. If you must cancel your appointment, please notify us by phone at least **48 hours** prior to your appointment time. Except in the case of extreme emergency, the client is responsible and will be charged for the time reserved when cancellations or changes in appointments are not received in advance. Please provide Debit/Credit Card for your records:

Type of Card (circle): Visa MasterCard Discover American Express FSA/HSA

Card Number: ___________________________________ **Exp Date:** ____________ **CVV:** ________

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Informed Consent for Text/Email/Electronic/Video Communication/Non-Traditional Settings:. Non-traditional settings are not covered by liability insurance of this therapist. Use of text/email/electronic/video/social media communications and non-traditional settings between clients and therapists has risks regarding protection of your private health care information because…

- They can be intercepted by someone who is not the intended recipient
- If intercepted, it can be stored and printed by the unauthorized recipient

* Your identity can be determined from using these types of non-traditional communications
* They are easily, and sometimes, accidentally, forwarded to unintended recipients
* They can transport computer viruses and other malicious software
* Receipt of these types of communication sometimes are not noticed, or not responded to, in a timely manner
* Details identifying information, diagnoses and treatment information about you should not be put in the subject line or body of, nor be transmitted as an attachment to an email
* Details identifying information, diagnoses and treatment information about you can be accessed when using non-traditional settings
* They should **never** be used to communicate emergency, urgent, or other time-sensitive information

If you choose to use Text/e-mails/electronic/video/social media communication and non-traditional settings as a way to communicate with your therapist, please read and sign below.

* I have read and understand the information provided regarding text/e-mails/electronic/video/social media communication and non-traditional settings. I have had my questions regarding this answered to my satisfaction
* I understand that ACCARES Wellness Center is required by Federal and State Law to try to protect my private health care information, which is the reason I am being informed of the risks involved with text/e-mails/electronic/video/social media communication and non-traditional settings.
* I understand that I am not required to participate in text/e-mails/electronic/video/social media communication or non-traditional settings. If I choose to consent, I may withdraw this consent at any time by notifying my therapist.

______ **Please initial that you have read and understand this information**

☐ **By checking this box, I give my informed consent to participate in text/email/electronic/video/social media communication and non-traditional settings with ACCARES Wellness Center.**

Please choose which method(s) you approve to contact you via by circling: Text Email Video SocialMedia

I have read and understood all the preceding statements including the confidentiality agreement, the disclosure information, the informed consent/liability agreement, the appointment cancellation policy, and the information regarding consent to release records. **My signature indicates that I hereby give my consent for counseling services. I authorize ACCARES Wellness Center /Dr. Kathy Howell, PhD/LPC; Gabrielle Crider, LAPC; Stephanie Fickle, LAPC; Victoria Nolen, M.A.; other approved therapist/counselor to render counseling services to the following:**

Clients Name (print):____

Clients Signature: ____ Date: ____________

Parent/Guardian Signature (if under 18 years): __________________________________ Date: ____________

Client Copy of Important Office Policies

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Nutritional Analysis using Kinesiology
Allergy Clearing (Turbo Tapping)
Splankna/Theophositcs- Inner Memory Healing
Zyto Biofeedback Scan
Heart Rate Variability Scan
EFT- Emotional Freedom Technique
LuxLight - Depression Therapy
HeartMap Biofeedback- Anxiety Therapy
“Energy Work”
DoTerra Essential Oils
Standard Process, Energetix, and Systemic Formulas supplements

Confidentiality: Confidentiality and privileged communication remain the right of all clients of counselors according to Georgia State Law. I understand that information concerning treatment or evaluation may be released only with the sole authorization and consent of the person being treated or evaluated, or such person’s parent/guardian, and with the agreement of the counselor. There are exceptions to the confidentiality of information in the following circumstances (as provided by law): 1) Where there is a clear and imminent danger to the client or others, the counselor may take reasonable personal action or inform the responsible authorities; such as in, suspect of child abuse of suicidal ideation or homicidal ideation will be reported; and 2) if the counselor is required by a court to give information. Except as required by law, you, the client/parent/guardian must sign a consent to authorize release of clinical records. Counselors will be discreet if it is necessary to contact you at home or work. In keeping with generally accepted standards of practice, counselors frequently consult with other mental health professionals regarding the management of cases. The purpose of the consultation is to ensure quality of care. Every effort is made to protect the identity of clients, including any financial records or payment information.

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Please make all checks payable to: Dr. Kathy Howell

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