

 OPEN DOORS COUNSELING

Ormond Beach Counseling Center  
120 East Granada Blvd.  
Ormond Beach, FL 32176  
Phone: 386.492.6938  
Email: [wecare@opendoorscounseling.org](mailto:wecare@opendoorscounseling.org)

Port Orange Counseling Center  
4639 Clyde Morris Blvd., Unit #107  
Port Orange, FL, 32129  
Phone: 386.492.6938  
Email: [wecare@opendoorscounseling.org](mailto:wecare@opendoorscounseling.org)

Daytona Beach Counseling Center  
215 South Palmetto Avenue  
Daytona Beach, FL 32114  
Phone: 386.492.6937  
Email: [wecare@opendoorscounseling.org](mailto:wecare@opendoorscounseling.org)

## CONFIDENTIAL CLIENT INFORMATION

### CLIENT INFORMATION

Date: \_\_\_\_\_ Referred by: \_\_\_\_\_  
Full Name: \_\_\_\_\_ Sex:  Male  Female  
Name you prefer: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Employer: \_\_\_\_\_ Length of Employment: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Special Training: \_\_\_\_\_  
Highest Level of School Completed: 9 10 11 12 GED College: 1 2 3 4 Other: \_\_\_\_\_

### CONTACT INFORMATION

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
May we send mail here:  Yes  No  
Home Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ May we leave a message here:  Yes  No  
Cell Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ May we leave a message here:  Yes  No  
Email Address: \_\_\_\_\_ May we send a message here:  Yes  No

### REASONS FOR COUNSELING AND GOALS

What do you hope to gain or change by coming for counseling? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### LEVEL OF DISTRESS

Indicate how distressed you are by circling 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 had them in the past?  Yes  No

Have you ever attempted suicide?  Yes  No. If yes, when & how? \_\_\_\_\_

**PREVIOUS COUNSELING**

Please list any previous counseling, psychiatric treatment, or residential/in-patient care you have received:

Location	Therapist	Dates	Reason

**LEGAL HISTORY**

- Are you facing any current or future civil or criminal legal issues?  Yes  No
- Have you been subject to a restraining order in the last 10 years?  Yes  No
- Have you filed for a restraining order in the last 10 years?  Yes  No
- Have you experienced any legal issues relating to divorce or child custody in the last 10 years?  Yes  No
- Do you expect the possibility of legal issues relating to divorce or child custody in the next 5 years?  Yes  No

**CURRENT STATUS**

Please check any of the following physiological symptoms that apply to you presently or in the recent past:

- |                    |  |                    |  |                  |  |
|--------------------|--|--------------------|--|------------------|--|
| Headaches          | <input type="checkbox"/> Past <input type="checkbox"/> Present | Visual Trouble     | <input type="checkbox"/> Past <input type="checkbox"/> Present | Weakness         | <input type="checkbox"/> Past <input type="checkbox"/> Present |
| Insomnia           | <input type="checkbox"/> Past <input type="checkbox"/> Present | Change in Appetite | <input type="checkbox"/> Past <input type="checkbox"/> Present | Hearing Voices   | <input type="checkbox"/> Past <input type="checkbox"/> Present |
| Dizziness          | <input type="checkbox"/> Past <input type="checkbox"/> Present | Sleep Trouble      | <input type="checkbox"/> Past <input type="checkbox"/> Present | Tension          | <input type="checkbox"/> Past <input type="checkbox"/> Present |
| Intestinal Trouble | <input type="checkbox"/> Past <input type="checkbox"/> Present | Tiredness          | <input type="checkbox"/> Past <input type="checkbox"/> Present | Seeing Things    | <input type="checkbox"/> Past <input type="checkbox"/> Present |
| Stomach Trouble    | <input type="checkbox"/> Past <input type="checkbox"/> Present | Trouble Relaxing   | <input type="checkbox"/> Past <input type="checkbox"/> Present | Rapid Heart Rate | <input type="checkbox"/> Past <input type="checkbox"/> Present |
| Hearing Noises     | <input type="checkbox"/> Past <input type="checkbox"/> Present | Pain               | <input type="checkbox"/> Past <input type="checkbox"/> Present | Other            | <input type="checkbox"/> Past <input type="checkbox"/> Present |
- Has your weight changed in the last 2-3 months? (If so, how?) \_\_\_\_\_

Please check any of the following problems that apply to you and/or your family.

- |                  |  |                      |  |                    |  |
|------------------|--|----------------------|--|--------------------|--|
| Abortion         | <input type="checkbox"/> You <input type="checkbox"/> Family | Eating Problems      | <input type="checkbox"/> You <input type="checkbox"/> Family | Trouble with Job   | <input type="checkbox"/> You <input type="checkbox"/> Family |
| Ambition         | <input type="checkbox"/> You <input type="checkbox"/> Family | Being a Parent       | <input type="checkbox"/> You <input type="checkbox"/> Family | Disaster           | <input type="checkbox"/> You <input type="checkbox"/> Family |
| Anxiety          | <input type="checkbox"/> You <input type="checkbox"/> Family | Depression           | <input type="checkbox"/> You <input type="checkbox"/> Family | Terminal Illness   | <input type="checkbox"/> You <input type="checkbox"/> Family |
| Bad Dreams       | <input type="checkbox"/> You <input type="checkbox"/> Family | Unwanted Thoughts    | <input type="checkbox"/> You <input type="checkbox"/> Family | Impulsive Behavior | <input type="checkbox"/> You <input type="checkbox"/> Family |
| Career Choices   | <input type="checkbox"/> You <input type="checkbox"/> Family | Children             | <input type="checkbox"/> You <input type="checkbox"/> Family | Recent Loss        | <input type="checkbox"/> You <input type="checkbox"/> Family |
| Communication    | <input type="checkbox"/> You <input type="checkbox"/> Family | Verbal Abuse         | <input type="checkbox"/> You <input type="checkbox"/> Family | Anger              | <input type="checkbox"/> You <input type="checkbox"/> Family |
| Concentration    | <input type="checkbox"/> You <input type="checkbox"/> Family | Memory               | <input type="checkbox"/> You <input type="checkbox"/> Family | Self-Control       | <input type="checkbox"/> You <input type="checkbox"/> Family |
| Grief            | <input type="checkbox"/> You <input type="checkbox"/> Family | Alcoholism           | <input type="checkbox"/> You <input type="checkbox"/> Family | Fears              | <input type="checkbox"/> You <input type="checkbox"/> Family |
| Hopelessness     | <input type="checkbox"/> You <input type="checkbox"/> Family | Loneliness           | <input type="checkbox"/> You <input type="checkbox"/> Family | Friends            | <input type="checkbox"/> You <input type="checkbox"/> Family |
| Making Decisions | <input type="checkbox"/> You <input type="checkbox"/> Family | Finances             | <input type="checkbox"/> You <input type="checkbox"/> Family | Guilt              | <input type="checkbox"/> You <input type="checkbox"/> Family |
| Marriage         | <input type="checkbox"/> You <input type="checkbox"/> Family | Emotional Abuse      | <input type="checkbox"/> You <input type="checkbox"/> Family | Temper             | <input type="checkbox"/> You <input type="checkbox"/> Family |
| Nervousness      | <input type="checkbox"/> You <input type="checkbox"/> Family | Unhappiness          | <input type="checkbox"/> You <input type="checkbox"/> Family | Apathy             | <input type="checkbox"/> You <input type="checkbox"/> Family |
| Physical Abuse   | <input type="checkbox"/> You <input type="checkbox"/> Family | Sexual Abuse         | <input type="checkbox"/> You <input type="checkbox"/> Family | Aggressiveness     | <input type="checkbox"/> You <input type="checkbox"/> Family |
| Pregnancy        | <input type="checkbox"/> You <input type="checkbox"/> Family | Trauma               | <input type="checkbox"/> You <input type="checkbox"/> Family | Alcohol Use        | <input type="checkbox"/> You <input type="checkbox"/> Family |
| Racing Thoughts  | <input type="checkbox"/> You <input type="checkbox"/> Family | Loss of Control      | <input type="checkbox"/> You <input type="checkbox"/> Family | Compulsivity       | <input type="checkbox"/> You <input type="checkbox"/> Family |
| Recent Death     | <input type="checkbox"/> You <input type="checkbox"/> Family | Inferiority Feelings | <input type="checkbox"/> You <input type="checkbox"/> Family | Shyness            | <input type="checkbox"/> You <input type="checkbox"/> Family |
| Sexual Problems  | <input type="checkbox"/> You <input type="checkbox"/> Family | Legal Matters        | <input type="checkbox"/> You <input type="checkbox"/> Family | Drug Use           | <input type="checkbox"/> You <input type="checkbox"/> Family |
| Stress           | <input type="checkbox"/> You <input type="checkbox"/> Family | Panic                | <input type="checkbox"/> You <input type="checkbox"/> Family | Other              | <input type="checkbox"/> You <input type="checkbox"/> Family |

**PERSONAL STRENGTHS**

Please list three things that you are proud of:

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_

Please list three personal strengths:

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_

**RELATIONAL INFORMATION**

Current Marital Status:  Single  Engaged  Married  Separated  Divorced  Widowed

If married, how long? \_\_\_\_\_ Number of previous marriages for you: \_\_\_\_\_

If separated or divorced, how long? \_\_\_\_\_ If widowed, how long? \_\_\_\_\_

Please list family members and other household members (continue on back if necessary):

Name:	In home or Out of home?	Age:	Gender:	Relationship:

**MEDICAL INFORMATION**

Primary Physician: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone number: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Fax number: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Are you currently receiving medical treatment?  Yes  No. If yes, please specify: \_\_\_\_\_

List all current medications you are taking, including those you seldom use or take only as needed.

Medication	Dosage	Purpose for Medication

Are you taking these medication(s) according to your doctor’s recommendations.  Yes  No. If no, briefly explain:

\_\_\_\_\_

List significant conditions, illnesses, surgeries, hospitalizations, traumas, or treatments you’ve had.

\_\_\_\_\_

**VOLUNTARY MEDICAL RELEASE OF INFORMATION**

I authorize Port Orange/Daytona Beach/Ormond Beach Counseling Center to release and or obtain medication records and relevant medical information from \_\_\_\_\_ (doctor's name and office name) for the purpose of providing continuity of quality mental health services.

*I understand that I do not have to sign this authorization and my refusal to sign will not affect my ability to obtain treatment.*

*I understand that I may revoke this authorization at any time by written request to my counselor.*

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**SUBSTANCE USE**

Do you currently use or have you previously used: (Please Check all that apply)

	Current	Past		Current	Past		Current	Past
Beer			Hallucinogens/Acid/Ecstasy/etc			Amphetamines/Speed/Meth/etc		
Wine			Inhalant/Huffing/Whippets/etc			Cocaine/Crack/etc		
Liquor			Phencyclidine/Mushrooms/etc			Opioids/Heroin/Opium		
Marijuana/Pot/Has/etc			Sedatives/Valium/etc			Over the Counter/Prescriptions		

Are you a recovering alcoholic or drug addict?  Yes  No  Maybe If yes, please explain: \_\_\_\_\_

**TRAUMA/ABUSE HISTORY**

Have you ever experienced a severe trauma?  Yes  No  Maybe. If yes or maybe, please explain: \_\_\_\_\_

Have you ever been physically or sexually abused?  Yes  No  Maybe. If yes or maybe, please explain: \_\_\_\_\_

Have you ever been emotionally or mentally abused?  Yes  No  Maybe. If yes or maybe, please explain: \_\_\_\_\_

**RELIGIOUS/SPIRITUAL INFORMATION**

Is Faith, Religion or Spirituality important to you?  Yes  No  Maybe. If yes or maybe, please explain: \_\_\_\_\_

Would you like to include prayer as part of your counseling experience?  Yes  No

**SLIDING SCALE FEE**

**We believe money should never stand in the way of good counseling. We also believe that clients are adults and are well aware of what they can afford to pay for counseling. We ask that you look at the chart below and decide on a rate. We trust and honor your decision.**

<u>Annual Income</u>	
\$110,001 and Up	\$120
\$100,001 to \$110,000	\$110
\$90,001 to \$100,000	\$100
\$80,001 to \$90,000	\$90
\$70,001 to \$80,000	\$80
\$60,001 to \$70,000	\$70
\$45,001 to \$60,000	\$60
0 to \$45,000	\$50

Thank you. Fees are paid at the time of service. If you fail to show for a scheduled appointment or do not call to cancel 24 hours before a scheduled appointment (386.492.6938 or 386.269.0428), we ask that you pay the full amount of the agreed upon fee.

My Agreed Fee: \_\_\_\_\_ Initial: \_\_\_\_\_

**LEGAL FEES**

**\*\*The standard fixed rate for an assessment, letter, or other work for any third party (Court System, Lawyer, Investigator, Employer, School, etc.) is \$85 per hour.**

Sign: \_\_\_\_\_ Date: \_\_\_\_\_

**\*\*If your counselor receives a subpoena to appear in court, the fee is \$85 per hour for communication with your attorney and court preparation, with a minimum of 8 hours for each day subpoenaed to court, plus travel time to and from court. PAYMENT MUST BE PAID IN ADVANCE. (It is our policy to resist all subpoenas.)**

Sign: \_\_\_\_\_ Date: \_\_\_\_\_

**TERMS OF SERVICE**

*I understand that it is customary to pay for professional services when rendered. I accept full responsibility for payment of any balance incurred for services. I further understand that without 24-hour notice of cancellation, I will be charged the full fee for professional service.*

**PAYMENT**

*All accounts are requested to have a credit card on file to reserve appointments. This information will be kept confidential and will only be used to process payments at your request or to bill for late cancellations and missed appointments.*

Credit Card Number: \_\_\_\_\_ Exp Date: \_\_\_\_\_

Type of Card:  AMEX  VISA  MC Code on the back of card: \_\_\_\_\_ Name on card: \_\_\_\_\_

Billing Address: (Same as above  Yes) \_\_\_\_\_

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**CLIENT RIGHTS AND RESPONSIBILITIES**

The Port Orange/Daytona Beach/Ormond Beach Counseling Center and your counselor are committed to providing service to you, the client, without regard to race, sex, color, religion, handicapping condition, national origin, or ability to pay in a manner appropriate to your need.

**AS A CLIENT YOU HAVE THE RIGHT TO:**

*INDIVIDUAL DIGNITY*, to be treated in a respectful and confidential manner.

*QUALITY SERVICES*, suited to your needs, administered skillfully, safely, humanely, with full respect for your dignity and personal integrity, and in accordance with all statutory and regulatory requirements.

*WITHDRAW YOUR CONSENT* for any specific activity.

*CONFIDENTIALITY OF CLIENT RECORDS*, Your counselor has the obligation to obtain your written consent prior to any exchange of confidential information. There are a few exceptions to confidentiality listed below: If you present a danger to yourself or others, we are legally, ethically and morally required to protect the safety of threatened persons. If abuse or neglect of a child, elder or disabled person is known or suspected, we are required by law to report it to the Florida Abuse Hotline. If your counselor receives a court order for client records, deposition or court testimony, and we are required by law to comply, we will. We are also required to report attendance compliance by court ordered clients. In the event that group or family services are provided, it is acknowledged that Port Orange/Daytona Beach/Ormond Beach Counseling Center or its counselors/therapists cannot be held responsible for a breach of confidentiality on the part of a family member.

**AS A CLIENT YOUR RESPONSIBILITIES INCLUDE:**

*APPOINTMENTS*: Regular attendance is very important to ensure progress with the concerns and issues that have been presented. If there is an emergency and you need to cancel or reschedule an appointment, please call as soon as you know.

*PARTICIPATION*: Your honest and accurate reporting of dilemmas and concerns is vital to your progress. To the best of your ability you must be open and honest in your sessions.

*SAFETY*: It is important that you and your children exercise appropriate caution, control and safe behavior on the premises.

*WEAPONS*: No handguns or weapons of any kind are allowed on property.

*TERMINATION*: Services may be discontinued for repeatedly missed appointments, if you come to appointments intoxicated and/or under the influence of substances, or if you show evidence of inappropriate behavior.

*TRANSFER PLAN*: Files/Records are the responsibility of your therapist as long as they work at Port Orange/Daytona Beach/Ormond Beach Counseling Center.

**THERAPY INFORMED CONSENT**

*SERVICES*: We provide many different types of therapy and counseling. Counseling services can vary in length depending on the collaborative effort between therapist and client. The goals for counseling are developed with the therapist and are based on the client's needs and concerns, and are reviewed on a regular basis to monitor progress. Our counseling services are voluntary. If the client has court documentation for counseling a copy of this documentation must be provided by the next counseling session. When bringing children for counseling services, the adult providing transportation is required to stay on the premises during the session.

*STAFF*: Counselors providing services are Licensed or Registered Clinical Social Workers, Marriage and Family Therapists, Mental Health Counselors, or they are Master Level Student Interns in these fields supervised by Licensed Therapists.

*FEES*: Counseling session fees are based on the client's agreed upon rate, set at the first counseling session. All fees are due at the beginning of each session.

*AUDIO/VIDEO TAPES*: Videotapes are sometimes used to assist with supervision, consultation, safety and training of counselors working with their clients. These tapes are not considered part of client files and will be used only to assist the progress of the client's case. The tapes are then destroyed on a regular basis. Sessions will not be audio recorded without prior written consent.

*TERMINATION*: The client is expected to inform the therapist if the client plans to discontinue counseling for any reason. If a client fails to show up or cancel two appointments, their file will be closed. Counselors may have to discontinue therapy if the client is currently involved in domestic violence, substance abuse, or has shown violent or threatening behavior. The client may be given a referral to other more appropriate services for issues of substance abuse, violence, or severe mental health issues.

*BENEFITS/RISKS*: The majority of individuals and families that obtain counseling, benefit from the process. Self exploration, gaining insight, exploring options for dealing with problem behavior, learning new skills, or venting difficult feelings and experiences are generally quite useful. But, some risks do exist. As counseling is begun some individuals experience unwanted feelings. Examining your life can produce unhappiness, anger, guilt or frustration. These unwanted feelings are a natural part of the psychotherapeutic process and often provide the basis for change. Also, sometimes a decision that is positive for one family member will be viewed quite negatively by another.

*QUESTIONS*: Do not hesitate to discuss counseling goals, procedures, concerns, or your impression of services provided. If there is something you do not understand, please ask for a clarification.

**I have read and understand the nature and limits of therapeutic services provided by the Port Orange/Daytona Beach/Ormond Beach Counseling Center.**

Client: \_\_\_\_\_ Date: \_\_\_\_\_

Counselor/Therapist: \_\_\_\_\_ Date: \_\_\_\_\_