



6797 North High Street, Suite 350, Worthington, Ohio 43085  
614.888.9200 tel / 614.888.3239 fax

Male  Female

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First Name Middle Name Last Name

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Street Address

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City State Zip

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Date of Birth Home Phone Work Phone Cell Phone

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IF Parent/Guardian: First Name Last Name Relation to Client

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NAME, PHONE NUMBER AND RELATIONSHIP OF EMERGENCY CONTACT

### Appointment Notification

If you wish to receive an email confirmation regarding your appointments please complete the appropriate fields below.

Email address: \_\_\_\_\_

Signature of Authorization: \_\_\_\_\_ Date: \_\_\_\_\_

By providing my signature I consent and am aware that the email message I receive will contain the client's name listed above. I consent to receive email notifications regarding my appointment(s).

### Feedback

We welcome your comments, complaints, and compliments in person, via phone, letter, or our online survey. If you wish to receive an email link to our client satisfaction survey please check here:



DISCLOSURE OF POLICIES AGREEMENT

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**PARENTS OF MINOR CLIENTS:** It is very important that children have a sense of privacy in their counseling in order for them to be open and honest. A child's right to confidentiality will be honored within the limits of state law. Although parents generally have an unlimited right to information involving their children, the counselor will attempt to disclose information to parents based on the counselor's judgment of what is in the child's best interest from a therapeutic standpoint.

**THERAPY CONSIDERATIONS:** You should understand that there are various types of therapy that may be involved in your treatment and that there are some risks that may be involved, which could range from feeling uncomfortable to a more intense reaction. The purpose of therapy is to help you handle problems/situations in a constructive way. You should understand that you have the right to discontinue therapy at any time as well as the right to change therapists until you find one with whom you feel comfortable. You should also understand that your therapist can provide you with information on alternative ways to handle your issues, which may include a referral to another therapist who specializes in a specific area, or to an agency that may handle your care in the event that you are unable to fulfill your financial obligations to Directions Counseling Group.

**CRISIS SITUATIONS:** Directions Counseling Group is not a crisis intervention facility. If a life-threatening or other crisis situation arises, please take the following steps: (1) Call 911 or your local police, (2) Call Netcare at (614) 276-2273. (3) Call your counselor to make them aware of the situation.

**INTAKE PROCESS:** It is our ultimate goal that you get the help you are searching for. Directions Counseling Group employs numerous counselors to address the various needs of our clients. During our intake process we make every effort to schedule you with a counselor who is best suited to address your unique situation. If you feel uncomfortable directing your concerns to your counselor, please inform our intake staff and we will attempt to find another counselor for you or if necessary an outside referral.

**RECORDS RELEASE:** Requests for release of records are authorized by our counseling staff and/or the Executive Director. Record retrieval can take up to 2 weeks depending on storage location and administrative processing. Administrative staff will contact the party when the record is ready for pick-up. Costs will be determined by what is allowable under Ohio Revised Code 3701.741.

**LEGAL PROCEEDINGS:** I understand that my therapist may be required to become involved in legal proceedings involving my therapy (or my child's therapy). In that case, I agree to pay for the therapist's time in preparing for such legal action, including, but not necessarily limited to: traveling to and attending a deposition, hearing, or trial, including any time spent waiting to testify, responding to a subpoena, in addition to any legal fees my therapist may incur as part of my involvement in such legal action.

**COLLECTIONS:** I understand that if I do not fulfill my financial responsibilities to make payments that I owe to Directions Counseling Group, that Directions Counseling Group may take appropriate collection action against me, up to and including taking legal action to collect amounts due from me. If that happens, I understand that the minimal amount of information necessary for such collection activity will be released and I consent to that release.

**NO SHOW/CANCELLATION POLICY:** The following fees are assessed for less than 24 hour cancellation and no-show to appointment: 1<sup>st</sup> no show or less than 24 hour cancellation: \$50.00; 2<sup>nd</sup> no show or less than 24 hour cancellation (at any time during treatment process): \$65.00; 3<sup>rd</sup> no show or less than 24 hour cancellation: Full fee. Please leave cancellation messages in general or scheduling voicemail box, NOT counselor's voicemail box.

**FEES:** All fees are due at time of service. The following list is not an exhaustive list of all services available. You may receive services from us that are not listed. Please consult with our staff to verify fees prior to receiving services from us. Initial Session \$165.00, 60 minutes; Follow-up Session \$135.00, 45-50 minutes; Follow-up Session with Senior Counselor \$150.00, 45-50 minutes; Marriage or Family Session \$145.00, 45-50 minutes; Marriage or Family Session with Senior Counselor \$160.00, 45-50 minutes; 80-90 minutes \$190.00; 30 minutes \$80.00. Returned check fee: \$40.00. Phone calls may be billed in 15 minute increments at the discretion of your therapist.

**SLIDING FEES:** Your fee may differ if a courtesy sliding-fee was previously arranged. All sliding fee arrangements are re-evaluated every six (6) months and may increase by up to \$10.00.

I have read and agree to the terms of the policies on this page. I have had the opportunity to ask questions about them; and agree to abide by and be bound by them.

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PRINT CLIENT NAME

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SIGNATURE (Client / Parent / Guardian / Responsible Party)

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DATE

Client Medical History and Current Concerns

Client Name: \_\_\_\_\_

Height:                      Weight:                      Recent Weight Gain/Loss:

Number of Children:                      Allergies:

Date of Last Physical:                      Physician and phone:

Current Medical Problems:
ALL Current Medications (include dosage, prescribing doctor, and phone number):
Past Medical Problems (include prior mental health treatment and psychotropic medications):

Number of Pregnancies:      Use of Alcohol x/week:      Use of Caffeine x/week:

Use of Tobacco x/week:      Exercise x/week:

What changes or benefits do you hope to obtain from counseling?

- 1.
- 2.
- 3.
- 4.
- 5.

Client Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

**Please check any symptoms or emotions you have experienced in the last month**

- Often feeling restless and irritable
- Being preoccupied with sexual thoughts and urges
- Lack of interest in sex
- Risky sexual behavior
- Excited
- Optimistic
- Trouble making myself slow down
- My thoughts going faster than I can speak
- Impulsive behavior
- Concentration difficulties
- Bored
- Happy
- Can't keep a job
- Feeling up one minute and down the next
- Lack of motivation

- Trouble keeping my mind on task
- Fatigue
- Feeling that I'm not good
- Losing interest in sex
- Gaining weight
- Thinking about dying or killing myself
- Feeling guilty about past misdeeds
- Regretful
- Losing pleasure in my daily activities
- Helpless
- Insomnia or sleep disturbance
- Crying
- Sadness
- Feeling hopeless about the future
- Depressed
- Conflicts with co-workers

- Conflicts with my boss
- Hard to make my child obey
- Losing my temper with my child
- Child has academic problems
- Other problems with my child
- Using alcohol excessively
- Using drugs
- Blackouts
- Withdrawal
- Spells of Violence
- Overeat
- Take too many risks
- Aggressive Behavior
- Spending money on things when I shouldn't
- Difficulty controlling my temper
- Temptation to hurt or punish

- Parents interfering with decisions
- Arguing with my parents
- Other problems with my parents
- Problems in my marriage or relationship
- Being uninterested in my mate
- Sexual problems in my marriage or relationship
- My mate being critical of me
- Sexual infidelities in my relationship
- Arguing with my mate
- Other marital problems
- Conflicted

- Unhappy
- Lonely
- Envious
- Annoyed
- Betrayed
- Guilty
- Jealous
- Don't like being touched
- Fear of having or getting a disease
- Itchy or burning skin
- Sexual Disturbances
- Experiencing sexual attractions that bother me
- Becoming aroused by children

- Fearful
- Fear of crowds in public places
- Fear of speaking in public places
- Fear of heights
- Other fears
- Losing someone close to me
- Losing my hopes and dreams
- An important romance ending
- Taking laxatives to control weight
- Vomiting to control calorie intake
- Going on "eating binges"
- Worrying about maintaining my figure
- Feeling afraid of becoming fat

- Dizziness/fainting
- Rapid heartbeat
- Unable to relax
- Vomiting
- Panicky
- Tense
- Palpitations
- Dry mouth
- Flushing
- Tingling/numbness
- Excessive sweating
- Stomach trouble
- Bowel disturbances
- Chest pains
- Anxious
- Having thoughts I can't suppress
- Feeling the urge to check things I've done
- Feeling the urge to avoid certain places or objects

- Feeling troubled by repetitive thoughts
- Being preoccupied with cleanliness
- Compulsions
- Feeling emotionally "numb"
- Recurring nightmares
- Trouble keeping my mind on task
- Being troubled by painful memories
- Thinking about a frightening event
- Feeling that I've lost time
- Difficulty remembering things about my past
- Feeling strange and distant from myself
- Problems with my memory
- Problems with knowing where I am
- Headaches
- Visual disturbances
- People following me or out to hurt me

- Hearing voices
- Special messages coming to me
- Thoughts being stolen from my mind
- Trouble keeping track of my thoughts
- Procrastination
- Muscle pain/spasms
- Back pain
- Hearing Problems
- Tremors
- Tics
- Twitches
- Work too hard
- Loss of control
- Watery eyes
- Skin problems
- Angry

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

Today's Date: \_\_\_\_\_

**DX:**

Therapist: \_\_\_\_\_

Supervisor: \_\_\_\_\_

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

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