Owner:
Holly Johnson, LCSW
(706)207-7863

Email: holly@pathwayscounselingathens.com

c/o Pathways
1041 Oconee Forest Lane
Watkinsville, GA. 30677

Informed Consent

Confidentiality

No information will be disclosed about you to another party without your explicit authorization, unless required by law. The law may require disclosure in circumstances such as orders of a court, subpoenas, or where necessary to protect you or someone else from imminent danger. As part of my efforts to provide the best possible care, I participate in peer consultation as well as clinical supervision with other mental health professionals. Although I may discuss specific cases, I will keep confidential your name and any other identifying information.

Group Therapy

I ask that all group members agree to protect one another's confidentiality, and it is my policy to remove from the group anyone who does violate another member's confidentiality.

Cancellation Policy

If you need to cancel or change an appointment, I require 24 hours notice. All other appointments will be charged at the full fee.

Contacting Me:

My telephone number is (706)207-7863. This is a confidential voicemail. I will generally return calls within 24 hours with the exception of weekends and holidays. Please leave your phone number even if you think I have it and some good times to reach you. If it is an emergency and I have not returned your call, please assume that I have not received your message and proceed to contact a friend, sponsor, back-up therapist or the emergency helpline for the county in which you live.

You are also welcome to e-mail me at holly@pathwayscounselingathens.com, but please know that I do not check my email as often as I do my voicemail.

I understand and agree to these conditions and I consent to treatment.
I have read and agree to the terms of HIPPA.

Print Name: _____

Signature: _____

Date: _____

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NEW CLIENT INFORMATION FORM

Name:_____

Date of Birth:_____ Age: _____

Address:_____

City/State/Zip:_____

Home Phone Number_____ Is it okay to leave a message here? **Y/N**
Work Number _____ Is it okay to leave a message here? **Y/N**
Cell Number _____ Is it okay to leave a message here? **Y/N**
Email: _____

Would you like to be on an e-mail list for future workshops or groups? **YES / NO**
Highest level of education_____
Employer_____
Occupation_____
Who referred you? How did you learn about our services? _____

_____

Have you ever consulted a Psychotherapist or mental health professional before? **YES / NO**

If so, when, with whom, and for how long? _____
_____

Previous diagnosis:_____

What are the reasons you are seeking therapy now? _____

_____

What do you hope to gain/accomplish from therapy? _____

_____

_____

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Local Physician_____

Do you take any medications regularly?_____If yes, please list them:
_____
_____
_____

Relationship Status

_____Single _____Married/committed relationship
_____Widowed _____Divorced/separated

How long married/committed relationship? _____

Number and ages of children_____

Parental Status

_____Living together _____Divorced/separated (If so, what year:_____)

Father deceased (year of death) _____ Mother deceased (year of death) _____

During your childhood, did either parent have a drinking or drug problem? **Y/N**
(Or other family members?) **Y/N** _____

Age and gender of siblings (Please list in order of youngest to oldest including yourself). _____

_____

_____

_____

In case of medical or psychological emergency, name of relative or friend to contact:

Name_____Relationship_____

Address_____

Phone_____

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Who is responsible for payment?

Name_____

Address (if different from page one)_____

Phone_____

_____Date_____
Client Signature

_____Date_____
Holly Johnson, LCSW

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Please complete the following checklist. Check only the items that are TRUE or mostly true for you.

_____1. A life transition is causing me stress.
_____2. I have just had a major loss.
_____3. I have feelings of overwhelming panic and/or anxiety.
_____4. I am afraid that I'm losing my mind.
_____5. My mind keeps racing and it is hard to shut out thoughts.
_____6. I am (or have been) seeing or hearing things that others don't see or hear.
_____7. I have disturbing nightmares.
_____8. I have done things to hurt myself physically (suicide attempts, self mutilation, etc.).
_____9. I have serious thoughts of suicide.
_____10. My future seems hopeless.
_____11. I am very depressed.
_____12. My appetite is not like it used to be.
_____13. I have recently lost/gained a significant amount of weight.
_____14. I have sometimes vomited, fasted, or used laxatives or vigorous exercise in order to control my weight.
_____15. My physician has told me that I was too thin.
_____16. I have had an intense fear of gaining weight or becoming fat.
_____17. I have felt fat even though others have said I was thin.
_____18. I have had recurring periods of binge eating (rapid consumption of a large amount of food in a short amount of time).
_____19. I used to sleep normally (7-8 hours) every night but now I sleep too much/too little.
_____20. I am concerned about issues of sexuality.
_____21. I sometimes use too much alcohol/drugs.
_____22. I have sometimes felt like I ought to cut down on my drinking/drug use.
_____23. I have sometimes felt bad or guilty about my drinking/drug use.
_____24. I sometimes spend too much time looking at pornography or engaging in unhealthy sexual practices.
_____25. I have sometimes had a drink first thing in the morning to steady my nerves or get rid of my hangover.
_____26. I have had a sudden inability to recall important personal information (more than ordinary forgetfulness, not due to a stroke, seizure, or alcohol-related blackouts)
_____27. I have (past or present) experienced sudden unexpected travel away from my home or work place with the inability to recall my past (not due to stroke, seizure, or alcohol-related blackouts).
_____28. I have (past or present) assumed a new identity, partial or complete (not due to stroke, seizure, or alcohol-related blackouts).
_____29. I have had a persistent or recurrent experience of feeling detached from reality, as if I was an outside observer of my mental processes or body.
_____30. I have (past or present) had a persistent or recurrent experience of feeling like an automaton or as if in a daydream**.**

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_____31. I have felt like there were two or more very different personalities within myself, each of which is dominant at a particular time.
_____32. I feel I have some gaps in my memory after the age of five.
_____33. When I was a child or adolescent, an adult overly criticized me, focused on my failures, belittled and/or swore at me.
_____34. When I was a child or adolescent, an adult punched, bit, kicked, burned, or beat me.
_____35. When I was a child or adolescent, someone fondled me, exposed him or herself to me such that I felt frightened, exploited me sexually, and/or attempted sexual contact when I did not want to participate.
_____36. As an adult, someone overly criticized me, focused on my failures, belittled, and/or swore at me.
_____37. As an adult, someone punched, bit, kicked, burned, or beat me.
_____38. As an adult, someone fondled me, exposed him or herself to me such that I felt frightened, exploited me sexually, and/or attempted sexual contact when I did not want to participate.
_____39. I have recently been sexually assaulted.

_____Date_____
Client Signature

Please sign and mail completed form to:

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