



WELCOME

Please print out these documents and take a few moments to complete them before your first visit:

- 1) Fill out and sign the top “New Client Information Form”
(all family members over 18 years of age will need to sign);
- 2) Fill out and return the “Extended Information Form” *(for couples, please print out two copies so each can submit a separate form)*
- 3) Read and sign the back of the “Declaration of Practices and Procedures” form *(all family members over 18 years of age will need to sign the submitted copy);*
- 4) Retain the “Fee Sheet”; and

THANK YOU



COUNSELING SERVICES OF AUSTIN, LLC

NEW CLIENT INFORMATION FORM

We appreciate this opportunity to serve your counseling needs. Please take a moment to provide us with the following information.

Name: _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Can we call you at work? Y / N

Place of Employment: _____ Occupation: _____ Education: _____

Age: _____ Birth Date: ___ / ___ / ___ Social Security #: _____ Marital Status: _____

Approximate **Gross** Family Income Per Year *or* That of the Sponsoring Third Party: _____

Briefly describe your reason(s) for seeking help: _____

When were you last examined by a physician? _____ Name of physician: _____

Phone: _____ List any medications you are now taking: _____

Have you ever received psychiatric or psychological help or counseling of any kind before? Y / N

If yes, please explain: _____

List the members of your family and all others in your home:

<u>Name(s)</u>	<u>Age/Birth Date</u>	<u>Relationship</u>	<u>Occupation</u>	<u>Place of Employment</u>

Who referred you to this office? _____

Name of person to contact in case of emergency: _____ Phone: _____

*If you believe insurance may cover a portion of your visits here, please complete the following information:
 Name of Insurance Company: _____ Phone: _____
 Group #: _____ Policy Holders S.S.#: _____ Policy #: _____

Client(s) signature(s): _____ Date: ___ / ___ / ___

_____ Date: ___ / ___ / ___

COUNSELING SERVICES OF AUSTIN, INC.

Extended Information Form

Today's Date _____

Client's Name _____ Age _____ Birth Date _____

Parent/Guardian's Name(s) _____ Age(s) _____

Address _____
street city state zip

Phone (home) _____ (work) _____ (cell) _____ Best Time to Call _____

Marital Status: Single Engaged

Married (how long _____ times married _____)

Separated (how long _____) Divorced (how long _____)

Education _____ Occupation _____ Social Security # _____

Spouse's Name _____ Age _____ Birth Date _____

Spouse's Education _____ Spouse's Occupation _____

List name, birth date, sex, relationship of all children, and whether they live at home with you.

Name	Birth Date	Sex	Relationship	At Home?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Who is coming for counseling? _____ Any prior counseling? Yes No

If yes, when? _____ Where? _____ With whom? _____

Why? _____

Are you, or another family member, currently seeing a psychiatrist or another counselor? Yes No

If so, what family member? _____ Name of helper _____

For what purpose? _____

Person to contact in emergency (name, relationship, phone, address) _____

PLEASE FILL OUT THE FOLLOWING INFORMATION AS IT APPLIES TO THE CLIENT

State the nature of the problem in your own words: _____

What is your most difficult relationship right now? _____

What is your most difficult emotion right now? _____

CRISIS INFORMATION: Any current suicidal thoughts, feelings, or actions? Yes No
If yes, explain _____

Any current homicidal thoughts or assaultive thoughts or feelings, or anger control problems? Yes No
If yes, explain _____

Any past problems, hospitalizations, or jailing for suicidal or assaultive behavior? Yes No
If yes, explain _____

Any current threats of significant loss or harm (illness, divorce, custody, job loss, etc.)? Yes No
If yes, explain _____

FAMILY BACKGROUND:

Father: First name _____ Age _____ Occupation _____
State of health _____ Resides in _____
If deceased, how and when _____
List three words that best describes him (ex. loving, mean, etc.) _____

How do/did you get along? _____

Mother: First name _____ Age _____ Occupation _____
State of health _____ Resides in _____
If deceased, how and when _____
List three words that best describes her (ex. loving, mean, etc.) _____

How do/did you get along? _____

Stepfather: First name _____ Age _____ Occupation _____
State of health _____ Resides in _____
If deceased, how and when _____
List three words that best describes him (ex. loving, mean, etc.) _____

How do/did you get along? _____

Stepmother: First name _____ Age _____ Occupation _____
State of health _____ Resides in _____
If deceased, how and when _____
List three words that best describes her (ex. loving, mean, etc.) _____

How do/did you get along? _____

Brothers and Sisters: Please list in birth order.

First Name	Age	Where resides	Relationship now		
			Close	Distant	In Between
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Your happiest memories of childhood and family are:

Your most unpleasant memories of childhood and your family are:

Have you ever experienced any of the following:

- Harsh physical punishment or abuse as a child
- Sexual advances made toward you as a child
- Sexual abuse
- Incest
- Rape
- Physical by spouse or lover
- Verbal or emotional abuse as a child or adult

If so, please explain:

SUBSTANCE USE/ABUSE HISTORY (N/A if not applicable)

SUBSTANCE	FIRST USE	LAST USE	12-MONTH USE	CURRENT USE
Depressants				
Alcohol	_____	_____	_____	_____
Inhalants	_____	_____	_____	_____
Barbiturates	_____	_____	_____	_____
Hallucinogens				
Marijuana	_____	_____	_____	_____
LSD	_____	_____	_____	_____
Mushrooms	_____	_____	_____	_____
PCP	_____	_____	_____	_____
Stimulants				
Amphetamines	_____	_____	_____	_____
Cocaine (powder)	_____	_____	_____	_____
(crack freebase)	_____	_____	_____	_____
Other _____	_____	_____	_____	_____

MEDICAL INFORMATION:

Current Medical Problems: Please list any current medical problems or symptoms that you are concerned about.

- 1. _____
- 2. _____
- 3. _____

Current Medications: Please give the following information for all prescription or over the counter medications being taken. (Include vitamins, laxatives, diet pills, hormones, birth control, etc.)

NAME	DOSAGE/HOW OFTEN	REASON TAKEN	HOW LONG TAKEN	RESPONSE

Caffeine Usage: Please specify the amount of any of the following products with caffeine that you drink or use in a typical 24 hour day.

- Cola Beverage _____ Brewed Coffee _____ Instant Coffee _____
- Instant Tea _____ Brewed or Sun Tea _____
- Chocolate Beverage _____ Chocolate Candy _____
- Other _____

Surgical History: Please list all surgeries you have had and age at the time of surgery.

- 1. _____
- 2. _____
- 3. _____

Check any of the following that you have had and beside it please indicate when:

- AIDS or a positive AIDS blood test
- Alcohol abuse or alcoholism
- Anemia
- Anxiety disorder
- Asthma
- Cancer, tumor or growth
- Chronic or frequent colds
- Concussion or head injury/trauma
- Depression
- Diabetes
- Drug abuse or addiction
- Eating disorders
- Eye trouble
- Ear, nose or throat trouble
- Epilepsy, seizures, or convulsions
- Fainting spells, feeling light headed or dizzy
- Gambling problem or addiction
- Glaucoma

- Heart trouble
- Headaches that are frequent or severe
- Hepatitis, liver disease, or jaundice
- High blood pressure
- Kidney disease or urinary problems
- Low blood pressure
- Lung disease or respiratory problems
- Manic depression or bipolar disorder
- Migraines
- Mitral valve prolapse
- Mononucleosis
- Panic attacks
- Phobias or severe fears
- Premenstrual Syndrome
- Rheumatic fever
- Schizophrenia
- Sexual addiction
- Sinus or allergy problems
- Stroke
- Stomach or intestinal problems
- Suicide attempt
- Thyroid problem or goiter
- Ulcers
- Venereal disease
- Psychiatric hospitalization (when, how long, reason for admission)

Other mental or emotional problems (please specify)

Please list other medical problems for which you have been treated or hospitalized. Please indicate when and where treated:

Please list any medications that you have taken in the past for anxiety, nervousness, depression or related types of problems.

Name of Medication	When Taken	Degree of helpfulness
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>

Common Problem/Symptom Checklist:

Fill in the blank with the appropriate response related to the severity of each problem in your life:

0 = none 1 = mild 2 = moderate 3 = severe

- | | | | |
|-------------------|------------------------|----------------------|-----------------------|
| ___ Marriage | ___ Divorce/separation | ___ Alcohol/drugs | ___ God/faith |
| ___ Premarital | ___ Child custody | ___ Other addictions | ___ Church/ministry |
| ___ Singleness | ___ Disabled | ___ Grief/loss | ___ Past hurts |
| ___ Sexual issues | ___ Work/ Career | ___ Depression | ___ Codependency |
| ___ Family | ___ School/learning | ___ Fear/anxiety | ___ Intimacy |
| ___ Children | ___ Money/budgeting | ___ Anger control | ___ Communication |
| ___ Parents | ___ Aging/dependency | ___ Loneliness | ___ Self esteem |
| ___ In-laws | ___ Weight control | ___ Mood swings | ___ Stress Management |

Other (specify): _____

RELIGIOUS INFORMATION:

Religious affiliation during childhood and adolescence: _____

Religious affiliation now: _____

Level of meaningfulness of religious affiliation during childhood and adolescence: high medium low

Level of meaningfulness of religious affiliation now: high medium low

Who referred you to us?

Name _____ Relationship _____

Address _____ Phone Number _____

Do you have an objection to us sending a thank you note to the referral source previously mentioned? [] Yes [] No

If no, we will only send a thank you note, any other contact will require your express written permission.

Thank you for taking the time to fill out this information sheet. Your counselor will review this with you in the first session and use it to best assist you in your counseling work. We will maintain your strict confidence regarding this information, subject to the exceptions noted in your service contract (labeled Declaration of Practices and Procedures). Be sure you review and sign the elements of agreement detailed on your service contract.



Counseling Services of Austin, LLC

Courtney C. Putnam, Ph.D.

Phone: 512.351.4933

Email: cputnam@csoaustin.com

FEE SHEET

Fees represent my time on your behalf, including record keeping and session preparation. The fee for counseling sessions at CSOA is:

\$125.00 / 45-50 Minute Therapeutic Hour

All fees are to be paid at the time of service. **Checks should be made payable to Counseling Services of Austin or CSOA**. Health insurance may cover the cost of therapy. An invoice for services rendered will be provided in cases where the client desires to file an insurance claim. It is the responsibility of the client to check for insurance coverage for "outpatient psychotherapy."

Phone calls made after hours will be handled by voice mail and returned on the following day. Since Counseling Services of Austin, LLC provides outpatient diagnostic and psychotherapy services only, we cannot guarantee around-the-clock availability. Therefore, if you should experience an emotional or behavioral crisis and we cannot be reached immediately by telephone, you and your family members are instructed to call 911 or go to your nearest emergency room for assistance (You may call one of the following crisis lines for interim support; 1-800-749-2673 or 1-800-437-0303).

Calls that are returned at the request of the client which pertain to treatment issues will be billed at the rate of \$3.00 per minute (Billed in 15-minute blocks / \$45.00 per block). Long distance calls are returned collect.

Fees for in-home counseling sessions, testing, written treatment summaries, court appearances, consultations, or other special services will be outlined upon request.

Unless otherwise agreed to by the therapist, accounts in arrears over 2 sessions will result in the cessation of therapy until the outstanding balance is made current.

My services are by appointment only. **Because an appointment is reserved for each client, any change or cancellation requires 24 hours notice; otherwise the client will be charged the full fee**. Failure to provide a 24-hour notice of cancellation generally results in the non-availability of the time slot for another individual. The length of the therapy hour is approximately **45-50 minutes**.

PLEASE KEEP FOR FUTURE REFERENCE

Declaration of Practices and Procedures
Courtney C. Putnam, Ph.D., LPC, LMFT
Counseling Services of Austin, LLC
CSOA 512-351-4933 Direct 512-869-9698

Qualifications: I hold a Ph.D. in Psychology and Counseling, granted to me by New Orleans Baptist Theological Seminary. I also hold a Master of Arts degree in Professional Counseling, granted to me by Psychological Studies Institute in Atlanta, Georgia and a Masters of Theology from the New Orleans Baptist Theological Seminary. Additionally, I received a Bachelor of Science in Psychology from Louisiana State University. I am licensed as LPC # 64181 with the:

Texas State Board of Examiners of Professional Counselors
Texas Department of State Health Services
1100 West 49th Street
Austin, Texas 78756-3183
Phone: 512.834.6658/ Fax: 512.834.6677

Counseling Relationship: Each person who seeks counseling comes with unique experiences and concerns. Professional dignity, expertise, warmth and acceptance will characterize the relationship of the counselor to the client. Individual, marital, family, and group therapy is a learning process and a process of change and growth that seeks for the persons involved to better understand themselves and others. There are several steps in the therapeutic process. First, time will be spent exploring the problem(s) which brought you to therapy. I will need to get to know you, how you view yourself, and the quality of the relationships that you have with others. Openness and honesty are crucial. Second, when we have developed sufficient background to proceed, we will begin to decide upon specific goals and objectives, and to develop a treatment plan that will outline how these goals will be achieved. This plan will undoubtedly require strong effort and feelings of discomfort inherent if change will be experienced. Periodic assessment of progress to determine the effectiveness of the treatment plan will take place by reflecting upon any improvements in the problem situation from when therapy began. Treatment efforts will conclude when the sought-after goals have been sufficiently achieved, the client chooses to leave, or if it becomes evident that the client should continue therapy with another therapist due to a therapeutic impasse or need of increased specialization.

Area of Expertise: The majority of my experience has been in working with clients affected by mental health concerns, with clients seeking direction in terms of career and other life decisions, and with families experiencing turmoil in their relationships. Training and experience provide me with abilities to assist with concerns including anxiety, depression, adjustment problems, stress, grief, behavior problems in adolescents, crisis situations, spiritual concerns, marriage and family counseling and other issues. I have been trained to work with problems of adolescence, parenthood, marital difficulties and the difficulties which may arise related to family relationships. I am a National Certified Counselor. I am a certified also a PREPARE/ENRICH Counselor. I especially enjoy working with couples on issues such as communication, forgiveness, trust-building, healthy sexuality, and marriage enrichment.

Fee Scales/Office Procedures: All information regarding fees, payment requirements, insurance, telephone consultations and missed appointments is discussed in the Counseling Services of Austin "Fee Sheet" form. All fees are paid at the time of service directly to Counseling Services of Austin. No fee will be charged if you cancel your appointment more than 24 hours in advance. However, since 50 minutes has been set aside for you, the usual fee will be charged if you fail to keep a scheduled appointment without giving prior notice. Appointments are typically set at the close of each session. I have morning, afternoon, and evening appointments available Monday through Thursday. Therapy sessions are normally 45-50 minutes. Appointments are usually scheduled one time a week for approximately one hour, with the first session devoted to gathering necessary information. Predicting how many sessions will be need is difficult. We will be better able to discuss the probable number of sessions after we have explored and gained insight into your particular situation. The entire therapy process varies in length dependent on the nature of each client's situation.

Services Offered and Clients Served: I provide therapy for individuals, couples, and families of all ages and backgrounds with the exception that I do not work individually with clients under ten years of age. I provide therapy for clients under age ten as part of a family systems approach with the parents/guardians present.

My therapeutic approach is eclectic, depending on the nature of the problem being addressed. My typical approach will be from a family systems, interpersonal, and cognitive-behavioral perspective. I also use other therapeutic approaches such as solution-focused, social learning, structural, strategic, reality, narrative, and insight-oriented therapies. My approach is straightforward and based on the counselee's unique goals. In addition, the holistic nature of my views concerning mental health recognizes a person's spirituality as the central organizing principal around which lasting mental health and strong relationships may be achieved. While I do not necessarily make a systematic presentation on the subject, I am Christian in my orientation. Though I do see individuals alone, I attempt to involve the entire family where appropriate and when possible.

Code of Conduct: As a LPC, I am required to adhere to the Texas Codes of Conduct for Licensed Professional Counselors. A copy of the Code of Conduct is available upon request.

Privileged Communications: Materials revealed in counseling will remain strictly confidential except under the following circumstances in accordance with state law:

- The client signs a written release of information indicating informed consent of such release
- The client expresses intent to harm him/herself or someone else.
- There is a reasonable suspicion of abuse/neglect against a minor child, elderly person (65 or older), or a dependent adult.
- A court order is received directing the disclosure of information

It is my policy to assert privileged communication on behalf of the client and the right to consult with the client if at all possible, except during an emergency, before mandated disclosure. I will endeavor to apprise clients of all mandated disclosures as conceivable.

When working with couples, families, or groups, I cannot disclose any information outside of the treatment context without a written authorization from all individuals competent to sign such authorization. For example, I cannot release *any* information about either or both spouses I have seen for marital therapy to an attorney without signed authorizations from both spouses.

When working with a family or couple, information shared by adult individuals in sessions where other family members are not present must be held in confidence (except for the mandated exceptions already noted) unless all individuals involved sign written waivers at the outset of therapy. Clients may refuse to sign such a waiver but should be advised that maintaining confidentiality for individual sessions during couple or family therapy could impede or even prevent a positive outcome to therapy. Any material obtained from a minor client may be shared with that client's parent or guardian.

After Hours and Emergency Situations: Should you need to contact me between appointments, call 512-869-9698. You may leave a message on the office answering machine and I will return your call as soon as possible. In an emergency situation when an immediate response is necessary, you may call the Austin Travis County Mental Health Crisis Line at 512-472-HELP (4357) for prompt, professional service 24 hours a day.

Client Responsibilities: You, the client, are a full partner in counseling. Your honesty and effort is essential to success. If as we work together you have suggestions or concerns about your counseling, I expect you to share these with me so that we can make the necessary adjustments. If it develops that you would be better served by another mental health provider, I will help you with the referral process. If you are currently receiving services from another mental health professional, I expect you to inform me of this and grant me permission to share information with this professional so that we may coordinate our services to you.

Clients must make their own decisions regarding such things as deciding to marry, separate, divorce, reconcile and how to set up custody and visitation. That is, I will help you think through the possibilities and consequences of decisions, but my Code of Ethics does not allow me to advise you to make a specific decision.

Physical Health: Physical health can be an important factor in the emotional well being of an individual. If you have not had a physical examination in the last year, it is recommended that you do so. As a routine part of the initial session, you will be asked the name of your physician and to list any medications that you are now taking.

Potential Counseling Risk: The counseling process may be immensely advantageous for some clients, while there are instances in which individuals experience intense feelings of sadness, fear, anger, anxiety or guilt. Any time a person makes major life decisions, it is natural to experience disturbing thoughts and feelings. Other risks include remembering traumatic experiences, and confronting distressing thoughts and/or beliefs. In addition, major life changes may be made as a result of therapy. Such changes can lead to unwanted outcomes. When one member of a marriage or family experiences intense emotions or makes major life changes, all members are affected. This is why it is essential that all members of the counseling experience commit to the therapeutic process. Though I cannot foresee all potential risks, I will attempt to inform you of expected potential risks specific to our work. I cannot guarantee a positive outcome to our work. As your therapist, I will be happy and available to discuss any of your concerns, problems, or possible negative side effects of our work together.

The Professional Contract: _____
(Name/s/ of client/s/, hereinafter referred to as the Client)

has this day retained Courtney Putnam, Ph.D. LPC of Counseling Services of Austin to provide psychotherapy and/or family therapy. The agreed fee per 45 to 50-minute session is _____. It is expressly understood that Courtney Putnam, Ph.D., LPC has not and will not issue any guarantee of cure or treatment effect, number of sessions necessary, or total cost of service. It is further understood that Courtney Putnam, Ph.D., LPC,, shall be obligated to maintain a reasonable standard of care for practicing Licensed Professional Counselors. The Client agrees that all fees (discussed in the Counseling Services of Austin "Sliding Fee Scales" form) shall be due and paid at the time of treatment and the payments in arrears over two sessions will result in the cessation of therapy until the balance is made current. We, the undersigned counselor and client/s/, have read, discussed together, and fully understand this agreement and the stated policies. We agree to honor these policies, including the commitment to negotiate and mediate as stated above, and will respect one another's views and differences in their outworking. This agreement is entered into voluntarily by the Client/s/ with competency, and with knowledge and understanding of the consequences.

Client(s) Signature(s): _____ Date: ____/____/____

_____ Date: ____/____/____

_____ Date: ____/____/____

Counselor: _____ Date: ____/____/____

PARENTAL AUTHORIZATION FOR MINORS: I _____ give permission for Courtney Putnam, Ph.D., LPC to conduct counseling with my (relationship) _____ (name of minor) _____.

