James Bowen Counseling

Application for Care

At James Bowen Counseling, we utilize a whole-person approach to the counseling process. Our approach takes into consideration several areas of your life and your family's life in an effort to assess how you are managing these areas. In order for us to provide you with the highest level of professional care, we need you to complete the following form with as much detail as possible.

Name _____
(Last) (First) (M.I.)

Circle: Male Female Date of Birth _____

Address _____
City State Zip

Home Phone: _____ Cell Phone: _____ Business Phone: _____

Is it okay to leave messages on your telephone message devices? ☐ Yes ☐ No n/a
Is it okay to leave messages at home and\or work? ☐ Yes ☐ No n/a

At which number would you prefer to be contacted? _____

Name of parent or guardian (if under 18) _____

Parent/Guardian SSN# _____ Date of Birth _____

Current marital status: (parent's status if minor) ☐ Single ☐ Married ☐ Separated ☐ Remarried ☐ Divorced ☐ Widowed

FAMILY INFORMATION

Spouse (if married) _____

Children at home:

Name	Age	School	Grade

Children not living in your home:

Name	Age	School	Grade

Other persons currently living in your home and their relationship to you:

_____

Has there ever been any serious illness in your family? ☐ Yes ☐ No. If yes, please describe:

_____
_____

Are any of your family members currently experiencing special problems? ☐ Yes ☐ No. If yes, please describe:

_____
_____

Have you experienced any significant loss such as: death of family members, divorce, loss of job, pregnancy losses (Ex. Miscarriage, abortion, stillbirth) etc?

☐ Yes ☐ No If yes, when did this occur?

_____

_____

Have you or any family members ever experienced and/or sought treatment for issues involving emotional distress such as addiction, depression, anxiety, etc? ☐ Yes ☐ No. If yes, please describe:

_____

_____

PERSONAL INFORMATION

EDUCATION:

Highest grade/level attained _____

Other training _____

OCCUPATION:

Place of employment _____

Position _____
How long in this position? _____

Please describe any problems you have experienced at work/school:

_____

Veteran status: ☐ Yes ☐ No. If yes, please describe: _____

SOCIAL:

How long have you lived in your community? _____

How many close friends would you say you have? _____

To what organizations do you belong? _____

Describe the extent to which you feel accepted by other people presently:

_____

SPIRITUAL:

Religious affiliation: _____

Name of church/place of faith you currently attend: _____

PHYSICAL

How often do you go to the doctor? _____

Are you satisfied with the medical care you are receiving? ☐ Yes ☐ No

Date of last physical: _____

Please list any chronic/serious illness and date of onset:

Accidents:

Hospitalizations (in the last year):

Current medications:

Name	Dosage	Reason

Are you currently sexually active? ☐ Yes ☐ No.
If yes, does this involve high-risk behaviors such as multiple partners, unprotected sex, etc?

Do you exercise regularly? ☐ Yes ☐ No

How would you describe your eating habits:

Estimated daily caffeine intake (in oz.)

Do you smoke cigarettes? ☐ Yes ☐ No. If yes, estimate quantity per day:

At present, I would assess my physical condition as being:
☐ poor ☐ fair ☐ average ☐ good ☐ excellent

ADDICTIVE SUBSTANCE AND BEHAVIOR HISTORY:

Do you now or have you in the past gambled? ☐ Yes ☐ No

Do you have concern or have others expressed concerns about your gambling behaviors or patterns?
☐ Yes ☐ No

Have others told you they were concerned about your drug or alcohol use? ☐ Yes ☐ No

Does it annoy you when others tell you how they feel about your drinking/drugs/gambling use?
☐ Yes ☐ No

Have you ever felt guilty about drinking/drugs/gambling? ☐ Yes ☐ No

Have you ever had a drink(s) to help you wake up? ☐ Yes ☐ No

Have you had any problems directly due to your drinking/drugs/gambling? ☐ Yes ☐ No

Have you ever stopped drinking/drugs/gambling? ☐ Yes ☐ No

For how long? Longest period of time

Have you ever ☐ temporarily or ☐ permanently lost your memory due to alcohol or drugs? ☐ Yes ☐ No

Have you ever had a seizure (convulsion) because of withdrawal from alcohol or drugs? ☐ Yes ☐ No

Have you ever hallucinated or had shakes, anxiety, agitation, or craving after stopping? ☐ Yes ☐ No

Have you ever overdosed:
☐ on purpose? ☐ accidentally? ☐ go to the hospital? ☐ stomach pumped? ☐ admitted?

Have you ever misused prescription drugs, added or switched doctors to get a prescription? ☐ Yes ☐ No

If you no longer use drugs, why did you stop? _____

Did you ever go to ☐ AA ☐ NA ☐ GA ☐ ACOA ☐ Al Anon ☐ Other: _____

Do you have a sponsor? ☐ Yes ☐ No. Are you familiar with the 12 steps? ☐ Yes ☐ No

ALCOHOL AND DRUG USE TABLE

Rank Favorite	Drugs/Alcohol Use	Amount/ Day	How Often	How Long Used	Age First Used	Last Time/How Much
	Alcohol					
	Downers (tranquilizers)					
	Marijuana					
	Cocaine					
	Crack					
	Speed/Crank					
	Hallucinogen/PCP					
	Narcotic(s)					
	Inhalants/huff					
	Prescribed drugs/other					

COUNSELING/PSYCHOTHERAPY/FAMILY THERAPY:

Have you previously received counseling or some other form of mental health or family therapy?
☐ Yes ☐ No
(Please understand that previous counselors/therapists will not be contacted without your consent)

Presenting Problem Therapist Place Date

_____

_____

Reason for termination: _____

Are you presently receiving counseling or other form of therapy? ☐ Yes ☐ No.
If yes, please advise us:
From whom _____ Where _____
Reason _____ For How Long? _____

Who referred you to these services?

_____

_____

In a few words, how might you describe your main concern at present?

_____

_____

What do you hope to gain by coming here? _____

_____

Are you currently feeling overwhelmed by difficulties in your life? ☐ Yes ☐ No

I would assess my current mental/emotional condition as:
☐ poor ☐ fair ☐ average ☐ good ☐ excellent

LATE CANCELLATION / NO SHOW POLICY

If you are unable to keep a scheduled appointment, please give Bowen Counseling/Consulting 24 hours to avoid being charged; this is necessary because there is often someone wanting an appointment that could be scheduled with sufficient notice. If you do miss an appointment, you will be charged for the session.

James Bowen Counseling/Consulting

Informed Consent & Limits of Confidentiality

1. Calling James Bowen Counseling at (775) 537-4453, you can make cancellations and changes in scheduled appointments. You may leave a message if you reach our after-hours recording. In an emergency, you may wish to call 911/311, the Suicide Hotline at 731-2990, MonteVista Hospital at 364-1111 or another community agency. If you are unable to keep your scheduled appointment with James Bowen M.S. MFT-Intern, please call (775) 537-4453 to cancel at least **24 hours** in advance to avoid incurring your fee for the missed session.

2. Fees for services per 50-minute session will be $75.00 - $115.00. Fees are payable at the time of service. Sliding scale is available if there is a hardship. A $25.00 fee will be charged for each returned check due to insufficient funds. Psychological tests, psychiatric evaluations and books are at your option when recommended.

3. In an attempt to improve our services, we may conduct follow-up studies in which we ask you to assess the services you receive. In the future, we may send you follow-up questionnaires or ask you to participate in ongoing studies of the counseling process. All participation in these activities is voluntary and any information gathered will remain confidential to the extent stated.

No information about you or your treatment will be divulged to any person outside of counseling/consulting without your written consent, with the following exceptions: 1. when required by your insurance to authorize or as a condition of payment; 2. in the event that there is a clear and imminent threat of harm towards yourself or against another person; 3. if there is intent to commit criminal activity or awareness or suspicion of such toward a minor or an elder; 4. in the event of a court order requiring the personal testimony of the counselor, under legal consultation, in response to a client's raising the issue of mental health in a lawsuit or when minors have limited rights of confidentiality.

In couple or family counseling, individual confidentiality is rarely in the best interest of all parties, and by signing below you agree to forgo individual confidentialities that are judged counterproductive to the goals of treatment.
The counselor will not acknowledge you should you meet in public without your acknowledgement first, except as would be appropriate in another non-counseling relationship. Finally, the therapeutic relationship generally precludes simultaneous dual relationships.
Due to protection of client confidentiality, Social Media Networking connections (Ex. Facebook, Twitter, LinkedIn, etc) and other non-secure forms of communication, i.e., text or email are hereby discouraged and will not be engaged in.

_____
(INITIAL HERE)

I hereby give consent to be informed of upcoming groups, workshops or classes that might be of interest to me.

I have read and understand the nature and limits of the counseling I have elected and voluntarily agree to participate under these conditions.

_____
Printed Name of Client

_____ _____
Signature of Client Date