

## A HEALING ALTERNATIVE COUNELING AND WELLNESS CENTER, LLC

8603 CROWNHILLE SUITE 29 SAN ANTONIO, TX 78233

PHONE: (210)705-2121

FAX: (210) 568-4816

INFO@FAITHGHARPER.COM

Hey there, new person!

Enclosed in this packet is all the basic forms you will need to complete before your first in-office appointment. Paperwork can absolutely be completed during your first appointment, though many people prefer it all completed ahead of time. It can be printed and brought in the day of your appointment or emailed or faxed to me before the appointment time.

Copies of my HIPPA policy and my Social Media Policy are available as separate downloads and should be read before completing this packet. Additionally, I keep printed copies of them in the office and can provide them to you at your request.

There are other forms available on my website that you may need to complete such as a consent to release information if you are working with other treatment providers.

Please have each person who is entering services complete a packet. (Though don't freak out by the counseling contract...if you are attending as a couple or family unit you will only pay for the service visit, not per person!)

If you have any questions, do not hesitate to contact me at [info@faithgharper.com](mailto:info@faithgharper.com)

Faith G. Harper

Faith G. Harper, PhD, LPC-S, ACS, ACN  
A Healing Alternative Counseling and Wellness Center, LLC  
info@faithgharper.com www.faithgharper.com  
Phone: (210)705-2121 Fax: (210) 568-4816

## Counseling Contract

Counseling is most helpful when it takes place in a framework of trust, clarity, and understanding. This contract is intended to clarify and help this relationship. Should you have any questions concerning this covenant, please discuss them with me.

### Financial Understanding

I/we understand that the fee for a 50 minute session is **\$135.00**; this fee is the same for an initial visit.

I have discussed this amount with the therapist along with my ability to pay. **I agree to a fee in the amount of \_\_\_\_\_.**

If I choose to use my insurance benefits to offset the cost of my therapy, then I understand that the full fee will be charged.

I agree to be responsible for that full fee amount.

### Cancellation Policy

I understand that I will be charged the full fee of **\$135.00 for a missed appointment or if I fail to cancel without 24 hours notification.** This can be discussed with your therapist if special circumstances result in a missed appointment.

### Limits of Confidentiality

I understand that while confidentiality is central to the process of therapy, it must be broken and a report made to the proper authorities when there is abuse or neglect of children, disabled persons, and the elderly; when there is intent to harm oneself, another, or property; or when a court order is issued.

### Terminating Therapy

I understand that though I may stop therapy at any time, the ending of therapy is best if discussed with my therapist at least one session before it ends.

### Consent to Counseling

I understand that there are certain risks in therapy and that there may be alternatives to therapy. I agree to counseling with Faith G. Harper. These services may also include group therapy, psychoeducation, assessment and diagnostic impressions, and referrals for other needed services.

Signed \_\_\_\_\_

Printed Name \_\_\_\_\_

Date \_\_\_\_\_

Faith G. Harper, PhD, LPC-S  
A Healing Alternative Counseling and Wellness Center, LLC  
[info@faithgharper.com](mailto:info@faithgharper.com) [www.faithgharper.com](http://www.faithgharper.com)  
Phone: (210)705-2121 Fax: (210) 568-4816

**CONTACT INFORMATION**

Today's Date \_\_\_\_\_ Reverified Date \_\_\_\_\_ Reverified Date \_\_\_\_\_

Legal Name \_\_\_\_\_  
*Last First MI*

Preferred Name \_\_\_\_\_

DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Legally Authorized Representative (if applicable) \_\_\_\_\_  
*Last First MI*

Local Address \_\_\_\_\_  
*Street Apt#*  
\_\_\_\_\_  
*City, State, Zip*

Preferred Form of Contact? \_\_\_Phone \_\_\_Cell Phone \_\_\_Text \_\_\_Email

Cell Phone \_\_\_\_\_  
If Phone Contact checked, OK to leave message? \_\_\_\_\_

Home Phone \_\_\_\_\_  
If Phone Contact checked, OK to leave message? \_\_\_\_\_

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

**If you marked that you prefer email contact or text contact, please note the following:**

I understand that the confidentiality of information transmitted via email or text cannot be guaranteed.

\_\_\_\_\_ *Your Initials*

**In Case of Emergency, Notify:**

Name \_\_\_\_\_  
*First Last*

Relationship \_\_\_\_\_

Contact info: \_\_\_\_\_  
*Street Apt#*  
\_\_\_\_\_  
*City, State, Zip*

Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

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Signed \_\_\_\_\_

Witness \_\_\_\_\_

Date \_\_\_\_\_

Signed \_\_\_\_\_

Witness \_\_\_\_\_

Date \_\_\_\_\_

**Receipt of Notice of Privacy Practices Form**  
**A Healing Alternative Counseling and Wellness Center, LLC**  
**Faith G. Harper, PhD, LPC-S**

I, \_\_\_\_\_, hereby acknowledge receipt of the  
NOTICE OF PRIVACY PRACTICES from my therapist.

The NOTICE OF PRIVACY PRACTICE provides detailed information about how the practice may use and disclose my confidential information.

I understand that my therapist has reserved a right to change his or her privacy practices that are described in the NOTICE.

I also understand that a copy of any Revised NOTICE will be provided to me or made available.

\_\_\_\_\_  
CLIENT SIGNATURE

\_\_\_\_\_  
DATE

Faith G. Harper, PhD, LPC-S  
A Healing Alternative Counseling and Wellness Center, LLC  
[info@faithgharper.com](mailto:info@faithgharper.com) [www.faithgharper.com](http://www.faithgharper.com)  
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**Social Media Acknowledgement Form**

I acknowledge that I have been provided a copy of Faith Harper's social media policy which remains in effect even when I am no longer receiving services from her.

I understand that this policy is available for download and review at any time from her website ([www.faithgharper.com](http://www.faithgharper.com)) and updates in this policy will be discussed with me, if I am currently receiving services from her.

I understand that if any questions about social media arise are best discussed directly with her during our sessions.

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

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

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

Counselor Signature: \_\_\_\_\_

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

# Life History Questionnaire

FAITH G. HARPER, PhD, LPC-S, ACS, ACN

The purpose of this questionnaire is to obtain some information regarding the issues that bring you in today, as well as some of your experiences and background. Completing these questions as fully and as accurately as possible will benefit you through the development of a treatment plan suited to your specific needs.

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

Address: \_\_\_\_\_  
\_\_\_\_\_

Home Phone: (     ) \_\_\_\_\_ Cell Phone:(     ) \_\_\_\_\_

Email Address: \_\_\_\_\_

DOB:     /     /     Age:     Occupation: \_\_\_\_\_

## SIGNIFICANT RELATIONSHIP STATUS:

Single    Engaged    Married    Separated    Divorced    Widowed    Committed Relationship

## LIST ANY MEDICATIONS YOU ARE TAKING:

<u>Name</u>	<u>Dosage</u>	<u>Prescribed for</u>
_____	_____	_____
_____	_____	_____

## PLEASE STATE WHAT BRINGS YOU IN:

\_\_\_\_\_  
\_\_\_\_\_

## HOW LONG HAS THIS BEEN OCCURRING?

\_\_\_\_\_

On the scale below, please circle the severity:

**1**      **2**      **3**      **4**      **5**      **6**      **7**      **8**      **9**      **10**  
 mildly upsetting ← — — — — — — — — — — → incapacitating

## ALCOHOL AND OTHER DRUG USE

Please tell me about your use of alcohol and other substances:

	Never	Seldom	Once a month	2-3 times a month	Weekly	Daily
I drink 4 or more drinks in a 24-hr period.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have missed work/school due to drinking.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
After drinking, I have forgotten where I was or what I did.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I use other recreational drugs*.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have missed work/school due to recreational drugs*.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
After using recreational drugs*, I have forgotten where I was or what I did.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

\***RECREATIONAL DRUGS INCLUDE**, among others: marijuana; cocaine; ecstasy; heroin; meth; as well as any prescription or over-the-counter drugs taken for recreational purposes.

## PREVIOUS MENTAL HEALTH TREATMENT:

Please list any psychiatrists, therapists, hospitals, self-help groups, and residential treatment centers, and the issues for which you were seen.

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## FAMILY MENTAL HEALTH HISTORY

Clinical Diagnosis	NO ONE	If YES, please check the box for <u>all</u> applicable family members							Successfully Treated?	
		Mother	Father	Brothers	Sisters	Cousins	Aunts/Uncles	Grand-parents	Yes	No
Depression	<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"/>
Bipolar Disorder	<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"/>
Anxiety/Panic Disorder	<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"/>
Eating Disorder	<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"/>
ADD/ADHD (Attention Deficit)	<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"/>
Post-traumatic Stress Disorder	<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"/>
Obsessive-Compulsive Disorder	<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"/>
Borderline Personality Disorder	<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"/>
Schizophrenia or Psychosis	<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"/>
Alcohol or Other Substance Abuse	<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"/>

Other family mental health information: \_\_\_\_\_

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Please describe any illness, loss, accident, or hospitalization that had a big impact on your life, and give the dates of their occurrences

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Do you have any major health concerns?

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## CURRENT & PREVIOUS SYMPTOMS/BEHAVIORS/EXPERIENCES

NOW	PAST		NOW	PAST	
<b>DISTRESSING SYMPTOMS</b>			<b>WORK/ACADEMIC CONCERNS</b>		
<input type="checkbox"/>	<input type="checkbox"/>	Stress	<input type="checkbox"/>	<input type="checkbox"/>	Procrastination
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety/nervousness	<input type="checkbox"/>	<input type="checkbox"/>	Time management
<input type="checkbox"/>	<input type="checkbox"/>	Panic attacks	<input type="checkbox"/>	<input type="checkbox"/>	Poor performance evaluations/grades
<input type="checkbox"/>	<input type="checkbox"/>	Perfectionism	<input type="checkbox"/>	<input type="checkbox"/>	Test, speech, or performance anxiety
<input type="checkbox"/>	<input type="checkbox"/>	Fearfulness/paranoia	<input type="checkbox"/>	<input type="checkbox"/>	Conflict with a colleague, boss, or professor/teacher
<input type="checkbox"/>	<input type="checkbox"/>	Obsessive thoughts	<b>BODY IMAGE AND FOOD USE</b>		
<input type="checkbox"/>	<input type="checkbox"/>	Compulsions/rituals	<input type="checkbox"/>	<input type="checkbox"/>	Binge eating
<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Purging (vomiting)
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty concentrating	<input type="checkbox"/>	<input type="checkbox"/>	Laxative use/abuse
<input type="checkbox"/>	<input type="checkbox"/>	Motivation problems	<input type="checkbox"/>	<input type="checkbox"/>	Diet pill use/abuse
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty <i>falling</i> asleep	<input type="checkbox"/>	<input type="checkbox"/>	Restricting food intake or avoiding food/fasting
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty <i>staying</i> asleep	<input type="checkbox"/>	<input type="checkbox"/>	Overeating
<input type="checkbox"/>	<input type="checkbox"/>	Loss of appetite	<input type="checkbox"/>	<input type="checkbox"/>	Dieting
<input type="checkbox"/>	<input type="checkbox"/>	Excessive crying	<input type="checkbox"/>	<input type="checkbox"/>	Being overweight or underweight
<input type="checkbox"/>	<input type="checkbox"/>	Irritability/anger/hostility	<input type="checkbox"/>	<input type="checkbox"/>	Excessive exercise
<input type="checkbox"/>	<input type="checkbox"/>	Mania (overly energized with unusual thoughts or behaviors)	<b>ADDICTION/DEPENDENCE CONCERNS</b>		
<input type="checkbox"/>	<input type="checkbox"/>	Suicidal feelings/thoughts	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol addiction/dependence/overuse/abuse
<input type="checkbox"/>	<input type="checkbox"/>	Suicide attempt(s)	<input type="checkbox"/>	<input type="checkbox"/>	Drug addiction/dependence/overuse/abuse
<b>ROMANTIC RELATIONSHIP CONCERNS</b>			<input type="checkbox"/>	<input type="checkbox"/>	Prescription drug addiction/dependence/overuse/abuse
<input type="checkbox"/>	<input type="checkbox"/>	Dating concerns	<input type="checkbox"/>	<input type="checkbox"/>	Smoking/tobacco use
<input type="checkbox"/>	<input type="checkbox"/>	Concerns about sex	<input type="checkbox"/>	<input type="checkbox"/>	Gambling
<input type="checkbox"/>	<input type="checkbox"/>	Conflict with partner/spouse	<input type="checkbox"/>	<input type="checkbox"/>	Excessive internet use
<input type="checkbox"/>	<input type="checkbox"/>	Break-up/end of romantic relationship	<input type="checkbox"/>	<input type="checkbox"/>	Sexual addiction
<b>SOCIAL RELATIONSHIP CONCERNS</b>			<b>CONCERNS INVOLVING VIOLENCE</b>		
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty making friends	<input type="checkbox"/>	<input type="checkbox"/>	Unwanted sex
<input type="checkbox"/>	<input type="checkbox"/>	Loneliness	<input type="checkbox"/>	<input type="checkbox"/>	Being stalked
<input type="checkbox"/>	<input type="checkbox"/>	Social anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Intimate relationship violence
<input type="checkbox"/>	<input type="checkbox"/>	Conflict with friend(s)	<input type="checkbox"/>	<input type="checkbox"/>	Problems with anger control
<b>GENDER/SEXUAL ORIENTATION CONCERNS</b>			<input type="checkbox"/>	<input type="checkbox"/>	Participant in a violent incident
<input type="checkbox"/>	<input type="checkbox"/>	Gender identity or gender issues or questions	<input type="checkbox"/>	<input type="checkbox"/>	Witness of a violent incident
<input type="checkbox"/>	<input type="checkbox"/>	Lesbian/gay/bisexual issues or orientation questions	<input type="checkbox"/>	<input type="checkbox"/>	Perpetrator of abuse (physical/sexual/psychological)
<input type="checkbox"/>	<input type="checkbox"/>	Asexual/Demisexual/Greysexual issues or questions	<input type="checkbox"/>	<input type="checkbox"/>	Survivor of abuse (physical/sexual/psychological)

## HOME AND FAMILY EXPERIENCES

Did the following occur in your family/home environment?	Yes	No	Not Sure
Parents divorced or permanently separated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent, hostile arguing among family members	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Death of a parent or sibling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parent(s) or sibling(s) with a drinking or drug problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family member with an eating problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family member with a debilitating illness, injury, or disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family member prosecuted for criminal activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family member attempted/committed suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical abuse in your family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual abuse in your family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Is there any other information about your mental health/emotional wellness that you believe will be pertinent to or could impact your care and treatment? Please explain below.

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I hereby certify that all the above information is true and correct to the best of my knowledge and belief.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name

\_\_\_\_\_  
Date