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 distance counseling. Paperwork can be either emailed of faxed to my office prior to your scheduled appointment.

In addition to the information I collect from in-office clients, I also require the following information from clients receiving distance counseling. They include a crisis-safety plan with local information in case of an emergency, a consent to release information for me to contact at least one professional care provider in your area in case of an emergency (if you are not receiving services from anyone else, it can be your local community mental health clinic), and a specific informed consent regarding distance counseling. You will notice within this informed consent that I am reiterate that you must be either be a resident of Texas or residing out of the United States for me to provide you counseling services

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.

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

Faith G. Harper

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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 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 www.faithgharper.com
Phone: (210)705-2121 Fax: (210) 568-4816

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) 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:

Name	Dosage	Prescribed for

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.	❒	❒	❒	❒	❒	❒
I have missed work/school due to drinking.	❒	❒	❒	❒	❒	❒
After drinking, I have forgotten where I was or what I did.	❒	❒	❒	❒	❒	❒
I use other recreational drugs*.	❒	❒	❒	❒	❒	❒
I have missed work/school due to recreational drugs*.	❒	❒	❒	❒	❒	❒
After using recreational drugs*, I have forgotten where I was or what I did.	❒	❒	❒	❒	❒	❒

***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.

_____

_____

FAMILY MENTAL HEALTH HISTORY

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

Other family mental health information: _____

_____

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

_____

_____

Do you have any major health concerns?

_____

CURRENT & PREVIOUS SYMPTOMS/BEHAVIORS/EXPERIENCES

NOW	PAST		NOW	PAST	
DISTRESSING SYMPTOMS			**WORK/ACADEMIC CONCERNS**		
☐	☐	Stress	☐	☐	Procrastination
☐	☐	Anxiety/nervousness	☐	☐	Time management
☐	☐	Panic attacks	☐	☐	Poor performance evaluations/grades
☐	☐	Perfectionism	☐	☐	Test, speech, or performance anxiety
☐	☐	Fearfulness/paranoia	☐	☐	Conflict with a colleague, boss, or professor/teacher
☐	☐	Obsessive thoughts	**BODY IMAGE AND FOOD USE**		
☐	☐	Compulsions/rituals	☐	☐	Binge eating
☐	☐	Depression	☐	☐	Purging (vomiting)
☐	☐	Difficulty concentrating	☐	☐	Laxative use/abuse
☐	☐	Motivation problems	☐	☐	Diet pill use/abuse
☐	☐	Difficulty *falling* asleep	☐	☐	Restricting food intake or avoiding food/fasting
☐	☐	Difficulty *staying* asleep	☐	☐	Overeating
☐	☐	Loss of appetite	☐	☐	Dieting
☐	☐	Excessive crying	☐	☐	Being overweight or underweight
☐	☐	Irritability/anger/hostility	☐	☐	Excessive exercise
☐	☐	Mania (overly energized with unusual thoughts or behaviors)	**ADDICTION/DEPENDENCE CONCERNS**		
☐	☐	Suicidal feelings/thoughts	☐	☐	Alcohol addiction/dependence/overuse/abuse
☐	☐	Suicide attempt(s)	☐	☐	Drug addiction/dependence/overuse/abuse
ROMANTIC RELATIONSHIP CONCERNS			☐	☐	Prescription drug addiction/dependence/overuse/abuse
☐	☐	Dating concerns	☐	☐	Smoking/tobacco use
☐	☐	Concerns about sex	☐	☐	Gambling
☐	☐	Conflict with partner/spouse	☐	☐	Excessive internet use
☐	☐	Break-up/end of romantic relationship	☐	☐	Sexual addiction
SOCIAL RELATIONSHIP CONCERNS			**CONCERNS INVOLVING VIOLENCE**		
☐	☐	Difficulty making friends	☐	☐	Unwanted sex
☐	☐	Loneliness	☐	☐	Being stalked
☐	☐	Social anxiety	☐	☐	Intimate relationship violence
☐	☐	Conflict with friend(s)	☐	☐	Problems with anger control
GENDER/SEXUAL ORIENTATION CONCERNS			☐	☐	Participant in a violent incident
☐	☐	Gender identity or gender issues or questions	☐	☐	Witness of a violent incident
☐	☐	Lesbian/gay/bisexual issues or orientation questions	☐	☐	Perpetrator of abuse (physical/sexual/psychological)
☐	☐	Asexual/Demisexual/Greysexual issues or questions	☐	☐	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	❒	❒	❒
Frequent, hostile arguing among family members	❒	❒	❒
Death of a parent or sibling	❒	❒	❒
Parent(s) or sibling(s) with a drinking or drug problem	❒	❒	❒
Family member with an eating problem	❒	❒	❒
Family member with a debilitating illness, injury, or disability	❒	❒	❒
Family member prosecuted for criminal activity	❒	❒	❒
Family member attempted/committed suicide	❒	❒	❒
Physical abuse in your family	❒	❒	❒
Sexual abuse in your family	❒	❒	❒

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.

_____
_____
_____
_____
_____
_____

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

_____
Signature

_____
Name

_____
Date

My Personal Crisis Response Safety Plan

Should I experience a mental health crisis, I will do the following:

1. I will try to identify specifically what is upsetting me.

2. I will write down other responses I can have to this situation that do not involve harming myself.

3. I will review the thoughts and conclusions that I've come to about this situation and try to figure out if they are either accurate or helpful.

4. I will do something I enjoy that helps me feel better for at least 30 minutes. Some of these activities may include:
   _____
   _____
   _____

5. I will talk with someone whom I trust to be supportive about how I'm feeling. These people may include (list names and numbers):
   _____
   _____
   _____

6. I repeat all of the above *at least one more time.*

7. If the thoughts continue, and I find myself preparing to do something to myself, I will call my preferred local crisis line or suicide hotline (example: 1-800-273-TALK). Please list options below:
   _____
   _____
   _____

8. If I still feel in danger of harming or killing myself and don't feel I can control my behavior I will call 911 or go to the ER. My preferred ER is:
   _____

Name and Phone Numbers of Other Important Contacts for Me

Case Manager: _____
Therapist: _____
Psychiatrist: _____
Clinic Where I Get Services: _____
PCP: _____
Emergency Contact: _____

_____ _____ _____
Name Signature Date

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

I _____ authorize Faith G. Harper to:

_____ release to:
_____ obtain from:
_____ exchange with:
_____
_____
_____
_____

The following information pertaining to myself:
_____ treatment summary
_____ history/intake
_____ diagnosis
_____ psychological test results
_____ psychiatric evaluation/medication history
_____ dates of treatment attendance
_____ other (specify) _____

For the purpose of:

_____ evaluation/assessment and/or coordinating treatment efforts
_____ other (specify) _____

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event _____

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

_____ _____

Signature of Client
or Legally Authorized Representative

Date

Informed Consent for Technology-Assisted Counseling

Signing this form is your agreement for psychotherapy services conducted by
Faith G. Harper, PhD, LPC-S, ACS, ACN

The purpose of this Informed Consent for Technology Assisted Counseling is to inform you, the client, about the process of online counseling services, the counselor and the potential risks and benefits of these services. The purpose is to also help safeguard you, the client, and give you information regarding alternatives to online services. This consent is an addendum to the face-to-face informed consent you, the client, are required to sign.

Please read the entire document. Please print the document, place a check mark stating you have read the document, sign, and then mail to the address located at the bottom of the page.

The Technology-Assisted Counseling Process

Privacy and Confidentiality

Maintaining client confidentiality is extremely important. The counselor will take extraordinary care and consideration to prevent unnecessary disclosure. Information about the client will only be released with his or her permission except obligated to do during a crisis situation or otherwise obligated to do so by law.

Although the internet provides the appearance of anonymity and privacy in counseling, privacy is more of an issue online than in person. The client is responsible for understanding the potential risks of confidentiality being breached through unencrypted email, lack of password protection or leaving information on a public access computer in a library or internet café.

Other potential risks of breaching confidentiality could include messages failing to be received if they are sent to the wrong address or if they are just not noticed by the counselor. Confidentiality could be breached in transit by hackers or internet service providers or at either end by others with access to the client's account or computer. Clients accessing the internet from public locations such as a library, computer lab, or café should consider the visibility of their screen to people around them. Position yourself to avoid others seeing your screen. Using cell phones can be risky in that signals are scrambled but rarely encrypted.

The counselor has a right to his or her privacy and may restrict the use of any copies or recordings the client makes of their communications. Clients must seek the permission of the counselor before recording any portion of the session and/or posting any portion of said sessions on internet websites such as Facebook or YouTube.

The client is responsible for securing their own computer hardware, internet access points, chat software, email and passwords that are encrypted, secure, and Hippa compliant when possible. If encryption is not made available to client, client should be aware that they are risking unauthorized monitoring of transmissions and/or records of Internet counseling sessions.

You agree to work with me online using Doxy.Me, or another encrypted video and/or chat service determined to be suitable by me or by phone call (for voice chat only). I understand that my therapist will provide me a link to the host site for our session.

Additionally,

- Text messaging via mobile phone is acceptable for appointments and housekeeping issues only.
- I do not store your name in my phone.
- If you call me, please be aware that unless we are both on land line phones, the conversation is not confidential.
- I will not respond to personal and clinical concerns via regular email.
- If you wish to use email as a way to "journal" information between sessions, you understand that I may not have the opportunity to review your journal emails until our next scheduled session.

I make every effort to keep all information confidential. Likewise, if we are working online together, I ask that you determine who has access to your computer and electronic information from your location. This would include family members, co-workers, supervisors and friends and whether or not confidentiality from your work or personal computer may be compromised due to such programs as a keylogger.

I encourage you to only communicate through a computer that you know is safe i.e. wherein confidentiality can be ensured. Be sure to fully exit all online counseling sessions and emails. If you used location-based services on your mobile phone, you may wish to be aware of the privacy issues related to using these services. I do not place my practice as a check-in location on various sites such as Foursquare. However, if you have GPS tracking enabled on your device, it is possible that others may surmise that you are a therapy client due to regular check-ins at my office on a weekly basis.
Please be aware of this risk if you are intentionally “checking in,” from my office or if you have a passive LBS app enabled on your phone.

I may need to consult with other professionals regarding my clients, however, the client’s name or other identifying information is never disclosed. The client’s identity remains completely anonymous, and confidentiality is fully maintained.

It is not a regular part of my practice to search for client information online through search engines such as Google or social media sites such as Facebook. Extremely rare exceptions may be made during times of crisis. If I have a reason to suspect that you are in danger and you have not been in touch with me via our usual means (coming to appointments, phone, or email) there might be an instance in which using a search engine (to find you, find someone close to you, or to check on your recent status updates) becomes necessary as part of ensuring your welfare. These are unusual situations and if I ever resort to such means, I will fully document it and discuss it with you when we next meet.

Lack of Non-Verbal Cues and Asynchronous Communication

The client should be aware that misunderstandings are possible with telephone, text- based modalities such as email, and real-time internet chat, since non-verbal cues are relatively lacking. Even with video chat software, misunderstandings may occur since bandwidth is always limited and images lack detail. Counselors are observers of human behavior and gather much information from body language, vocal inflection, eye contact and other non-verbal cues. If you have never engaged in online counseling before, have patience with the process and clarify information if you think your counselor has not

understood you well. Be patient if your counselor asks periodically for clarification as well.

Since asynchronous communication is "not in real time," turnaround time for responding to emails will "lag" a response. Be aware of different time zones as well. The counselor will make every effort to respond to email requests within a 12-24 hour period. Work with your counselor to identify local resources if you have concerns about the timeliness of responses.

Benefits of Receiving Technology-Assisted Counseling

Potential benefits of receiving mental health services online include both the circumstances in which the counselor considers online mental health services appropriate and the possible advantages of providing those services online. For example, the potential benefits of email may include 1) being able to send and receive messages at any time of the day or night; 2) never having to leave messages with intermediaries, avoiding voice mail and "telephone tag"; 3) being able to take as long as one wants to compose and having the opportunity to reflect upon one's messages; 4) automatically having a record of communications to refer to later; and 5) feeling less inhibited than in person.

Text-based chat has many of the same advantages of convenience, feeling reduced scrutiny from the counselor having time to compose a response and being able to refer back to chat logs for reference. Video chat is also convenient, allowing clients to potentially be counseled from anywhere once one gains an internet signal and can operate the necessary hardware.

Potential Risks of Receiving Technology-Assisted Counseling & Safeguards

There are various risks related to providing technology-assisted counseling services related to the technology used, the distance between counselor and client, and issues related to timeliness. These risks of concerns for privacy and confidentiality were mentioned in section A. above. Your counselor has selected a video- conferencing account that is encrypted with a HIPPA compliant secure platform to allow for the highest possible security and confidentiality of the content of your sessions. Your personal information is encrypted and stored on a secure server.

The client is responsible for creating and using additional safeguards when the computer used to access services may be accessed by others such as creating passwords to use the computer, keeping their Email and chat IDs and passwords secret, and maintaining security of their wireless internet access points (where applicable.) Please discuss any such concerns with your counselor during your first session so as to develop ways to limit risks. If there is ever a disruption or disconnection of services on the internet, the client will need to call Dr. Harper directly (210-705-2121) if phone service is available.

Dual Relationships & Social Media

Dual relationships can impair the therapeutic process, your therapist's objectivity, clinical judgment, or therapeutic effectiveness that could be exploitative in nature. I will never acknowledge working therapeutically with anyone without his/her written permission. In

some instances, even with permission, I will preserve the integrity of our working relationship. For this reason, my social media policy is the same for distance counseling clients as it is for in-office clients.

Alternatives to Technology-Assisted Counseling, Termination & Referrals

Online counseling may not be appropriate for many types of clients including those who have numerous concerns over the risks of internet counseling, clients with active suicidal/homicidal thoughts, clients who are experiencing active manic/psychotic symptoms, or clients who are minors. An alternative to receiving mental health services online would be receiving mental health services face to face with the counselor or adjunct using both modalities or working with another counselor. The online counselor can and will assist clients who would like to explore face-to-face options in their local area. Many state and local agencies will treat low-income clients on a sliding scale fee.

Also, I do not accept clients who, in my opinion, I cannot help. In such a case, I will give you a number of referrals that you may contact. If at any point during psychotherapy I assess that I am not effective in helping you reach your therapeutic goals, I am obliged to discuss this with you up to and including termination of treatment. In such a case, I would give you a number of referrals that may be of help to you. You have the right to terminate therapy at any time. Please feel free to request a referral any time you think a different counseling relationship would be more practical or beneficial for you. If you choose to do so, I will offer to provide you with names of other qualified professionals whose services you might prefer.

Proxies

The counselor only provides treatment via technology to clients who are legally able to consent for themselves to receive mental health services. Clients who are n o t in such positions include children under the age of consent (age 18 in most cases) or clients who have a legally appointed guardian.

Telephone & Emergency Procedures

If you need to speak with me between sessions to alert me of an emergency, please call my office at 210-705-2121. Your call will be returned as soon as possible. Messages are checked daily (but never during the night time.) Messages are checked less frequently on weekends and holidays.

If the client is in a state of crisis or emergency, the counselor recommends the client dial 911 or go to the local emergency room. Clients 1- 800-SUICIDE or 1-800-273-TALK. Deaf clients can call 1-800-799-4TTY.

All distance clients will be required to complete a Crisis Safety Plan before beginning therapeutic services as well as a consent to release information for any of your local treatment providers (or your local community mental health agency should you not be in services locally). If I suspect you are in crisis either during our sessions or between sessions, I will contact this treatment provider or agency to ensure you receive support. If I am unable to do so, I will contact local law enforcement and request a welfare check on your behalf.

Records

The counselor will maintain records of online counseling services. These records can include reference notes, copies of transcripts of chat and internet communications, and session summaries. These records are confidential and will be maintained as required by applicable legal and ethical standards according to the American Counseling Association and the Texas Administrative Code. The client will be asked in advance for permission before recording any audio or video session.

J. Fee for Service and Cancellation Policy

All payments will be processed through Paypal.com. My practice is “fee for service” and that means that fees are due at the time of your appointment.

Since scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24-hour notice is required for re-scheduling or canceling an appointment. Unless we reach a different agreement, the full fee will be charged for sessions missed without such notification. If we are scheduled for an online synchronous chat, audio or video conference and we are unable to connect or are disconnected during a session due to a technological breakdown, please try to reconnect within 10 minutes. If reconnection is not possible, contact me to schedule a new session time.

{ } Yes, I have read and agree to the terms listed above in the Informed Consent. I understand that Faith Harper is a Licensed Professional Counselor who follows the laws and professional regulations of the State of Texas. I understand the psychotherapy treatment will be considered to take place in the state of Texas. I understand that telephone/online psychotherapy is not a substitute for medication under the care of a psychiatrist or doctor.I understand that online and telephone therapy is not appropriate if I am experiencing a crisis or having suicidal or homicidal thoughts. In case of emergency situations, I will contact the resources listed in section H above.

I understand my signature is an agreement for psychotherapy services conducted by Faith G. Harper, PhD, LPC-S, ACS, ACN.

_____
Client Printed Name

_____
Client Signature

_____
Date

Systems Survey Form | Restricted to Professional Use

Standard Process

NAME: AGE: HEALTH CARE PROFESSIONAL: DATE:

INSTRUCTIONS: Circle the number that applies to you. **If a symptom does not apply, don't circle anything** for that symptom.

Circle the corresponding number.	
1	MILD symptom (occurs rarely)
2	MODERATE symptom (occurs several times a month)
3	SEVERE symptom (occurs almost constantly)

GROUP 1

1. 1 2 3 Acid foods upset
2. 1 2 3 Get chilled often
3. 1 2 3 "Lump" in throat
4. 1 2 3 Dry mouth, eyes, nose
5. 1 2 3 Pulse speeds after meal
6. 1 2 3 Keyed up, fail to calm
7. 1 2 3 Gag occasionally
8. 1 2 3 Unable to relax, startle easily
9. 1 2 3 Extremities cold, clammy
10. 1 2 3 Strong light irritates
11. 1 2 3 Occasionally weak urine flow
12. 1 2 3 Heart pounds after retiring
13. 1 2 3 "Nervous" stomach
14. 1 2 3 Appetite reduced occasionally
15. 1 2 3 Cold sweats often
16. 1 2 3 Get heated easily
17. 1 2 3 Nerve discomfort
18. 1 2 3 Staring, blink little
19. 1 2 3 Sour stomach frequent

____ ____ ____ TOTAL
1 2 3

GROUP 2

20. 1 2 3 Joint stiffness after arising
21. 1 2 3 Muscle, leg, toe cramps at night
22. 1 2 3 "Butterfly" stomach, cramps
23. 1 2 3 Eyes or nose watery
24. 1 2 3 Eyes blink often
25. 1 2 3 Eyelids swollen, puffy
26. 1 2 3 Indigestion soon after meals
27. 1 2 3 Always seem hungry, feel "lightheaded" often
28. 1 2 3 Digestion rapid
29. 1 2 3 Vomit occasionally
30. 1 2 3 Hoarseness frequent
31. 1 2 3 Uneven breathing
32. 1 2 3 Pulse slow
33. 1 2 3 Gagging reflex slow
34. 1 2 3 Difficulty swallowing
35. 1 2 3 Temporary constipation or diarrhea
36. 1 2 3 "Slow starter"
37. 1 2 3 Get "chilled"
38. 1 2 3 Perspire easily
39. 1 2 3 Sensitive to cold
40. 1 2 3 Upper respiratory challenges

____ ____ ____ TOTAL
1 2 3

GROUP 3

41. 1 2 3 Eat when nervous
42. 1 2 3 Excessive appetite
43. 1 2 3 Hungry between meals
44. 1 2 3 Irritable before meals
45. 1 2 3 Get "shaky" if hungry
46. 1 2 3 Fatigue, eating relieves
47. 1 2 3 "Lightheaded" if meals delayed
48. 1 2 3 Heart palpitates if meals missed or delayed
49. 1 2 3 Fatigue in afternoon
50. 1 2 3 Overeating sweets upsets
51. 1 2 3 Awaken after few hours sleep, hard to get back to sleep
52. 1 2 3 Crave candy or coffee in afternoon
53. 1 2 3 Moods of "blues" or melancholy
54. 1 2 3 Craving for sweets or snacks

____ ____ ____ TOTAL
1 2 3

GROUP 4

55. 1 2 3 Hands and feet go to sleep easily, numbness
56. 1 2 3 Sigh frequently, "air hunger"
57. 1 2 3 Aware of "breathing heavily"
58. 1 2 3 High-altitude discomfort
59. 1 2 3 Open windows in closed room
60. 1 2 3 Immune system challenges
61. 1 2 3 Afternoon "yawner"
62. 1 2 3 Get "drowsy" often
63. 1 2 3 Swollen ankles worse at night
64. 1 2 3 Muscle cramps, worse during exercise; get "charley horse"
65. 1 2 3 Difficulty catching breath, especially during exercise
66. 1 2 3 Tightness or pressure in chest, worse on exertion
67. 1 2 3 Skin discolors easily after impact
68. 1 2 3 Tendency to anemia
69. 1 2 3 Noises in head or "ringing in ears"
70. 1 2 3 Fatigue upon exertion

____ ____ ____ TOTAL
1 2 3

GROUP 5

71. 1 2 3 Dizziness
72. 1 2 3 Dry skin
73. 1 2 3 Burning feet
74. 1 2 3 Blurred vision
75. 1 2 3 Itching skin and feet
76. 1 2 3 Hair loss
77. 1 2 3 Occasional skin rashes
78. 1 2 3 Bitter, metallic taste in mouth in morning
79. 1 2 3 Occasional constipation
80. 1 2 3 Worrier, feels insecure
81. 1 2 3 Nausea occasionally after eating
82. 1 2 3 Greasy foods upset
83. 1 2 3 Stools light-colored
84. 1 2 3 Skin peels on foot soles
85. 1 2 3 Discomfort between shoulder blades
86. 1 2 3 Occasional laxative use
87. 1 2 3 Stools alternate from soft to watery
88. 1 2 3 Sneezing attacks
89. 1 2 3 Dreaming, nightmare-type bad dreams
90. 1 2 3 Bad breath (halitosis)
91. 1 2 3 Milk products cause upset
92. 1 2 3 Sensitive to hot weather
93. 1 2 3 Burning or itching anus
94. 1 2 3 Crave sweets

____ ____ ____ TOTAL
1 2 3

GROUP 6

95. 1 2 3 Loss of taste for meat
96. 1 2 3 Lower bowel gas several hours after eating
97. 1 2 3 Burning stomach sensations, eating relieves
98. 1 2 3 Coated tongue
99. 1 2 3 Pass large amounts of foul-smelling gas
100. 1 2 3 Indigestion ½-1 hour after eating; may be up to 3-4 hours after
101. 1 2 3 Watery or loose stool
102. 1 2 3 Gas shortly after eating
103. 1 2 3 Stomach "bloating"

____ ____ ____ TOTAL
1 2 3

GROUP 7A

104. 1 2 3 Difficulty sleeping
105. 1 2 3 On edge
106. 1 2 3 Can't gain weight
107. 1 2 3 Intolerance to heat
108. 1 2 3 Highly emotional
109. 1 2 3 Flush easily
110. 1 2 3 Night sweats
111. 1 2 3 Thin, moist skin
112. 1 2 3 Inward trembling
113. 1 2 3 Heart races
114. 1 2 3 Increased appetite without weight gain
115. 1 2 3 Pulse fast at rest
116. 1 2 3 Eyelids and face twitch
117. 1 2 3 Irritable and restless
118. 1 2 3 Can't work under pressure

____ ____ ____ TOTAL
1 2 3

GROUP 7B

119.	1	2	3	Increase in weight
120.	1	2	3	Decrease in appetite
121.	1	2	3	Fatigue easily
122.	1	2	3	Ringing in ears
123.	1	2	3	Sleepy during day
124.	1	2	3	Sensitive to cold
125.	1	2	3	Dry or scaly skin
126.	1	2	3	Temporary constipation
127.	1	2	3	Mental sluggishness
128.	1	2	3	Hair coarse, falls out
129.	1	2	3	Tension in head upon arising wears off during day
130.	1	2	3	Slow pulse below 65
131.	1	2	3	Changing urinary function
132.	1	2	3	Sounds appear diminished
133.	1	2	3	Reduced initiative

____ ____ ____ TOTAL
1 2 3

GROUP 7C

134.	1	2	3	Failing memory with age
135.	1	2	3	Increased sex drive
136.	1	2	3	Episodes of tension in head
137.	1	2	3	Decreased sugar tolerance

____ ____ ____ TOTAL
1 2 3

GROUP 7D

138.	1	2	3	Abnormal thirst
139.	1	2	3	Bloating of abdomen
140.	1	2	3	Weight gain around hips or waist
141.	1	2	3	Sex drive reduced or lacking
142.	1	2	3	Tendency for stomach issues
143.	1	2	3	Immune system challenges
144.	1	2	3	Menstrual disorders

____ ____ ____ TOTAL
1 2 3

GROUP 7E

145.	1	2	3	Dizziness
146.	1	2	3	Headaches
147.	1	2	3	Hot flashes
148.	1	2	3	Hair growth on face or body (female)
149.	1	2	3	Sugar in urine (not diabetes)
150.	1	2	3	Masculine tendencies (female)

____ ____ ____ TOTAL
1 2 3

GROUP 7F

151.	1	2	3	Weakness, dizziness
152.	1	2	3	Tired throughout day
153.	1	2	3	Nails weak, ridged
154.	1	2	3	Sensitive skin
155.	1	2	3	Stiff joints
156.	1	2	3	Perspiration increase
157.	1	2	3	Bowel discomfort
158.	1	2	3	Poor circulation
159.	1	2	3	Swollen ankles
160.	1	2	3	Crave salt
161.	1	2	3	Areas of skin darkening
162.	1	2	3	Upper respiratory sensitivity
163.	1	2	3	Tiredness
164.	1	2	3	Breathing challenges

____ ____ ____ TOTAL
1 2 3

GROUP 8

165.	1	2	3	Muscle weakness
166.	1	2	3	Lack of stamina
167.	1	2	3	Drowsiness after eating
168.	1	2	3	Muscular soreness
169.	1	2	3	Heart races
170.	1	2	3	Hyperirritable
171.	1	2	3	Feeling of a band around head
172.	1	2	3	Melancholia (feeling of sadness)
173.	1	2	3	Swelling of ankles
174.	1	2	3	Change in urinary function
175.	1	2	3	Tendency to consume sweets/carbohydrates
176.	1	2	3	Muscle spasms
177.	1	2	3	Blurred vision
178.	1	2	3	Involuntary muscle action
179.	1	2	3	Numbness
180.	1	2	3	Night sweats
181.	1	2	3	Rapid digestion
182.	1	2	3	Sensitivity to noise
183.	1	2	3	Redness of palms of hands and bottom of feet
184.	1	2	3	Visible veins on chest and abdomen
185.	1	2	3	Hemorrhoids
186.	1	2	3	Apprehension (feeling that something bad is going to happen)
187.	1	2	3	Nervousness causing loss of appetite
188.	1	2	3	Nervousness with indigestion
189.	1	2	3	Gastritis
190.	1	2	3	Forgetfulness
191.	1	2	3	Thinning hair

____ ____ ____ TOTAL
1 2 3

FEMALE ONLY

192.	1	2	3	Very easily fatigued
193.	1	2	3	Premenstrual tension
194.	1	2	3	Menses more painful than usual
195.	1	2	3	Depressed feelings before menstruation
196.	1	2	3	Painful breasts during menses
197.	1	2	3	Menstruate too frequently
198.	1	2	3	Hysterectomy/ovaries removed
199.	1	2	3	Menopausal hot flashes
200.	1	2	3	Menses scanty or missed
201.	1	2	3	Acne, worse at menses

____ ____ ____ TOTAL
1 2 3

MALE ONLY

202.	1	2	3	Less involved in exercise/social activities
203.	1	2	3	Difficult to postpone urination
204.	1	2	3	Weak urinary stream
205.	1	2	3	Feeling of "blues" or melancholy
206.	1	2	3	Feeling of incomplete bowel evacuation
207.	1	2	3	Lack of energy
208.	1	2	3	Muscles in arms and legs seem softer/smaller
209.	1	2	3	Tire too easily
210.	1	2	3	Avoid activity
211.	1	2	3	Leg nervousness at night
212.	1	2	3	Diminished sex drive

____ ____ ____ TOTAL
1 2 3

IMPORTANT | Please list below the five main physical complaints you have in order of their importance.

1. _____
2. _____
3. _____
4. _____
5. _____

TO BE COMPLETED BY HEALTH CARE PROFESSIONAL

Digestion

_____ Hydrochloric Acid Point

_____ Enzyme Point

_____ Murphy's Sign

Large Intestine (Palpate)

_____ Ascending

_____ Transverse

_____ Descending

Adrenals

Pass/Fail Pupil Dilation Exam

Postural Hypotension

_____ Supine

_____ Standing

Pass/Fail Zinc Taste Test

Pass/Fail Cuff Test

_____ Cuff Pressure

_____ pH of Saliva

_____ Pulse

BARNES THYROID TEST

The test is conducted by the patient in the morning before leaving bed, with the temperature being taken for 10 minutes. The test is invalidated if the patient expends any energy prior to taking the test such as getting up for any reason, shaking down the thermometer, etc. It is important that the test, be conducted for exactly 10 minutes, making the prior positioning of both the thermometer and a clock important.

PRE-MENSES FEMALES AND MENOPAUSAL FEMALES (any two days during the month)
FEMALES HAVING MENSTRUAL CYCLES (the second and third days of flow or any five days in a row)
MALES (any two days during the month)

Day 1 _____ Day 2 _____ Day 3 _____ Day 4 _____ Day 5 _____

RESTRICTIONS ON USE

The systems survey is to be used only by trained health care professionals. If you are a patient, you should not use the systems survey. If you are not a trained health care practitioner, you should not use the systems survey. Health care practitioners should only use the systems survey to provide services that are within the scope of their license or professional training. The systems survey is intended to be used as a helpful tool for health care practitioners in collecting information concerning the health and wellness of patients.

Name: Date:

Toxicity Questionnaire

The Toxicity Questionnaire is designed to aid the practitioner in assessing a patient's or client's potential need for a purification program.

Section I: Symptoms

Rate each of the following based upon your health profile for the past 90 days.

Circle the corresponding number.	
0	Rarely or Never Experience the Symptom
1	Occasionally Experience the Symptom, Effect is Not Severe
2	Occasionally Experience the Symptom, Effect is Severe
3	Frequently Experience the Symptom, Effect is Not Severe
4	Frequently Experience the Symptom, Effect is Severe

1. DIGESTIVE

a. Nausea and/or vomiting	0 1 2 3 4
b. Diarrhea	0 1 2 3 4
c. Constipation	0 1 2 3 4
d. Bloated feeling	0 1 2 3 4
e. Belching and/or passing gas	0 1 2 3 4
f. Heartburn	0 1 2 3 4

Total: ____

2. EARS

a. Itchy ears	0 1 2 3 4
b. Earaches or ear infections	0 1 2 3 4
c. Drainage from ear	0 1 2 3 4
d. Ringing in ears or hearing loss	0 1 2 3 4

Total: ____

3. EMOTIONS

a. Mood swings	0 1 2 3 4
b. Anxiety, fear, or nervousness	0 1 2 3 4
c. Anger, irritability	0 1 2 3 4
d. Depression	0 1 2 3 4
e. Sense of despair	0 1 2 3 4
f. Uncaring or disinterested	0 1 2 3 4

Total: ____

4. ENERGY / ACTIVITY

a. Fatigue or sluggishness	0 1 2 3 4
b. Hyperactivity	0 1 2 3 4
c. Restlessness	0 1 2 3 4
d. Insomnia	0 1 2 3 4
e. Startled awake at night	0 1 2 3 4

Total: ____

5. EYES

a. Watery or itchy eyes	0 1 2 3 4
b. Swollen, reddened, or sticky eyelids	0 1 2 3 4
c. Dark circles under eyes	0 1 2 3 4
d. Blurred or tunnel vision	0 1 2 3 4

Total: ____

6. HEAD

a. Headaches	0 1 2 3 4
b. Faintness	0 1 2 3 4
c. Dizziness	0 1 2 3 4
d. Pressure	0 1 2 3 4

Total: ____

7. LUNGS

a. Chest congestion	0 1 2 3 4
b. Asthma or bronchitis	0 1 2 3 4
c. Shortness of breath	0 1 2 3 4
d. Difficulty breathing	0 1 2 3 4

Total: ____

8. MIND

a. Poor memory	0 1 2 3 4
b. Confusion	0 1 2 3 4
c. Poor concentration	0 1 2 3 4
d. Poor coordination	0 1 2 3 4
e. Difficulty making decisions	0 1 2 3 4
f. Stuttering, stammering	0 1 2 3 4
g. Slurred speech	0 1 2 3 4
h. Learning disabilities	0 1 2 3 4

Total: ____

9. MOUTH/THROAT

a. Chronic coughing	0 1 2 3 4
b. Gagging or frequent need to clear throat	0 1 2 3 4
c. Swollen or discolored tongue, gums, lips	0 1 2 3 4
d. Canker sores	0 1 2 3 4

Total: ____

10. NOSE

a. Stuffy nose	0 1 2 3 4
b. Sinus problems	0 1 2 3 4
c. Hay fever	0 1 2 3 4
d. Sneezing attacks	0 1 2 3 4
e. Excessive mucous	0 1 2 3 4

Total: ____

11. SKIN

a. Acne	0 1 2 3 4
b. Hives, rashes, or dry skin	0 1 2 3 4
c. Hair loss	0 1 2 3 4
d. Flushing	0 1 2 3 4
e. Excessive sweating	0 1 2 3 4

Total: ____

12. HEART

a. Skipped heartbeats	0 1 2 3 4
b. Rapid heartbeats	0 1 2 3 4
c. Chest pain	0 1 2 3 4

Total: ____

13. JOINTS / MUSCLES

a. Pain or aches in joints	0 1 2 3 4
b. Rheumatoid arthritis	0 1 2 3 4
c. Osteoarthritis	0 1 2 3 4
d. Stiffness or limited movement	0 1 2 3 4
e. Pain or aches in muscles	0 1 2 3 4
f. Recurrent back aches	0 1 2 3 4
g. Feeling of weakness or tiredness	0 1 2 3 4

Total: ____

14. WEIGHT

a. Binge eating or drinking	0 1 2 3 4
b. Craving certain foods	0 1 2 3 4
c. Excessive weight	0 1 2 3 4
d. Compulsive eating	0 1 2 3 4
e. Water retention	0 1 2 3 4
f. Underweight	0 1 2 3 4

Total: ____

15. OTHER:

a. Frequent illness	0 1 2 3 4
b. Frequent or urgent urination	0 1 2 3 4
c. Leaky bladder	0 1 2 3 4
d. Genital itch, discharge	0 1 2 3 4

Total: ____

Section I Total: _____

Section II: Risk of Exposure

Rate each of the following situations based upon your environmental profile for the past 120 days.

16. Circle the corresponding number for questions 16a-16f below.

0	Never	**1**	Rarely	**2**	Monthly	**3**	Weekly	**4**	Daily

a. How often are strong chemicals used in your home?
(disinfectants, bleaches, oven and drain cleaners, furniture polish, floor wax, window cleaners, etc.) 0 1 2 3 4

b. How often are pesticides used in your home? 0 1 2 3 4

c. How often do you have your home treated for insects? 0 1 2 3 4

d. How often are you exposed to dust, overstuffed furniture, tobacco smoke, mothballs, incense, or varnish in your home or office? 0 1 2 3 4

e. How often are you exposed to nail polish, perfume, hairspray, or other cosmetics? 0 1 2 3 4

f. How often are you exposed to diesel fumes, exhaust fumes, or gasoline fumes? 0 1 2 3 4

Total: _____

17. Circle the corresponding number for questions 17a-17b below.

0	No	**1**	Mild Change	**2**	Moderate Change	**3**	Drastic Change

a. Have you noticed any negative change in your health since you moved into your home or apartment? 0 1 2 3

b. Have you noticed any change in your health since you started your new job? 0 1 2 3

Total: _____

18. Answer yes or no and circle the corresponding number for questions 18a-18d below.

	No	Yes
a. Do you have a water purification system in your home?	2	0
b. Do you have any indoor pets?	0	2
c. Do you have an air purification system in your home?	2	0
d. Are you a dentist, painter, farm worker, or construction worker?	0	2

Total: _____

Section II Total: _____

Grand Total (Section I & Section II) _____

Add up the numbers to arrive at a total for each section, and then add the totals for each section to arrive at the grand total. If any individual section total is 6 or more, or the grand total is 40 or more, you may benefit from a purification program.

Adapted with permission from the author of *Clinical Purification™: A Complete Treatment and Reference Manual*, Dr. Gina L. Nick.