

I am very pleased that you have chosen me as your counselor and are allowing me to be a tool in reaching your personal goals. I appreciate your confidence in contacting me for assistance. Below is a brief explanation of the things that will be helpful in preparing for your first visit. Please read through and complete all the paperwork.

Paperwork (see attached):

Please review, sign, and bring all the attached paperwork to our first visit together. I ask as a new client that you fill out the new client forms in their entirety.

Scheduling Appointments:

Upon scheduling, you will have an account on our scheduling software. The receptionist should give you a username and password when you call to schedule your first appointment. Additionally, you will be asked for a credit card number to secure your appointment. After your first visit, please access this portal to schedule or cancel and future appointments. To access the portal, visit www.therapyappointment.com and select my name.

Confirmation of Appointments:

When you schedule, you will be asked if you prefer a text or email reminder. However, regardless of whether you receive a reminder, you are responsible for remembering your appointment.

Therapy Fees:

Please review the attached Declaration of Practices and Procedures for my fee schedule. If utilizing insurance, it is your responsibility to find out the following information prior to using health insurance: determine that I am on the "provider" list for your insurance, the number of sessions authorized, your co-payment, and the amount remaining on your deductible. If your deductible is not met, I will bill your insurance accordingly, however you are responsible for payment in FULL per the contracted rate until your deductible is met. Fees/co-payments are due at the time of service. Payment can be made by cash, check, or credit card. If paying with cash, you must have the exact fee or you will be issued a credit toward your next visit. My policy and the policy of BRCCC is to securely store the client's encrypted credit card number for payment purposes. It can then be used for sessions or for fees from any no shows or cancellations with less than 24 hours' notice. At time of service, you may use any form of payment you wish. NOTICE: All credit cards will have a 3% convenience fee. Debit, HSA, cash, and checks will not have the 3% fee.

Cancellations:

If you need to cancel, you are required to give at least 24 hours' notice, preferably 48 hours or more, so that others have an opportunity to schedule. Please cancel via online portal, by leaving a voicemail, or by emailing me. Except in the case of emergencies, no shows or cancelling with less than 24 hours' notice will result in a \$125 charge to your credit card on file.

Getting Here:

My office is on the third floor in the administration building of the First Presbyterian Church campus at 763 North Blvd (NOT North Street). There are only 2 entrances to the counseling center. Park at a meter on 8th street and enter via the 8th street door (WILL BE REQUIRED TO USE THE STAIRS) OR park in the big parking lot on Convention (between 7th and 8th) (WILL BE REQUIRED TO USE THE ELEVATOR) and enter via the Chapel door. At each of these two doors is a buzzer for the counseling center. Please do not buzz the church. Once you buzz the counseling center someone will unlock the door. Proceed to the third floor by way of the stairs or elevator. You may want to allow extra time to find the center on your first visit. You will find a map attached to this packet or on our website (www.brchristiancounseling.com). For additional assistance call 387-2287.

I am looking forward to meeting with you and beginning your counseling journey!

Melissa

Declaration of Practices and Procedures

This statement is designed to inform you of my background and to ensure that you understand our professional relationship. **After reading, please sign and date.**

1. Counseling Relationship:

In an effort to promote a positive therapeutic environment, it is my desire to provide a safe, warm, and open atmosphere in which you feel free to examine your thoughts, emotions, and patterns of behavior which are a concern to you. It is my desire to establish a counseling relationship based on mutual respect, trust, and honesty.

My approach to counseling is multi-theoretical and utilizes a diverse array of techniques and strategies that will allow me to best meet your needs while addressing areas of concern, patterns of behavior, thought patterns, and mood. Through this approach it is my hope that we will work together to accomplish your goals in counseling.

After gathering information, addressing any concerns or hesitations you may have, and becoming acquainted, goals are established through collaboration of the counselor and client. The ultimate goal of therapy is the successful resolution of the problems that are deemed most important by the client. Oftentimes I may ask you to complete assignments outside of session. These are used for you to get the most out of your counseling experience.

It is my goal to assist you in the problem-solving process; however, my code of ethics does not allow me to advise you to make a specific decision. Clients must make their own decisions regarding such things as deciding to marry, separate, divorce, reconcile and how to set up custody and visitation.

2. Qualifications:

I received my Master of Social Work degree from Louisiana State University in 2015. I earned a Bachelor's Degree in Social Work from Southeastern Louisiana State University in 2013. I completed my graduate study internships with Bogalusa Mental Health, Capital Area Human Services District, and Health Centers in Schools. I am a Licensed Clinical Social Worker (LCSW) granted by the Louisiana State Board of Social Work Examiners, 18550 Highland Road, Suite B, Baton Rouge, LA 70809, (225) 756-3470. My license number is 13439.

3. Areas of Expertise:

I have a general counseling practice with a specialization in trauma with adolescents, and young adults. Additional areas of interest and experience include the treatment of depression, anxiety, grief, anger management, and trauma. I am an EMDR certified therapist.

4. Session Fees:

I accept private pay. Payment can be made by cash, check, or credit card. Payment is due at the time of service. When paying with cash you must have the exact fee, or you will be issued a credit toward your next visit. Please write checks out to Melissa Bond. Fees are subject to change. There will be a \$50.00 NSF charge on all returned checks. I charge \$145.00 for the first session and \$125.00 for all sessions after that.

I also accept BlueCross BlueShield. Please know what your co-pay is at the time of arrival. Co-payment must be made on the date of service. You are also responsible for knowing what your deductible is and the remaining amount on it. Bring your insurance card with you to the first appointment.

5. Cancellations:

The time you schedule for appointments is reserved for you. In the event you are unable to keep an appointment, a 24-hour advance notice will allow for the scheduling of another person who may benefit from the time. If not cancelled, you are responsible for payment of the unused time, which is the full session fee of \$125.00. If you try to call and cannot get an answer it is acceptable to leave a voice message and the time will be registered. You may also email me (melissa@brchristiancounseling.com) to cancel an appointment 24 hours in advance.

6. Code of Ethics:

I am required by state law to adhere to the Louisiana Code of Conduct for Louisiana Licensed Clinical Social Workers. Copies of this code is available upon request.

7. Privileged Communication/Confidentiality:

I am required to abide by the professional practice standards and Louisiana Law. I do not disclose client confidences and information to any third party except materials shared during supervision without clients written consent or waiver except when mandated or permitted by law. Verbal authorization will not be sufficient except in emergency situations. State law mandates that I report to the appropriate authorities suspected cases of child abuse/neglect, elder abuse/neglect, or disabled abuse/neglect and instances of danger to self or others when reasonably necessary to protect the client or other parties from clear and imminent threat of serious physical harm. Certain types of litigation may lead to the court-ordered release of information without your consent.

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. When working with a family or couple, information shared by individuals in sessions, when 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.

8. Litigation Limitation

Given that certain types of litigation (such as child custody suits) may lead to the court ordered release of information without your consent, it is expressly agreed that should there be legal proceedings (such as, but not limited to, divorce and custody disputes, injuries, lawsuits, etc.) neither you or any attorney, or anyone else acting on your behalf, will call Melissa Bond to testify in a deposition or in court or any other proceeding,

nor will a disclosure of any information contained in the chart, including but not limited to the psychotherapy notes, as defined and protected under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) be requested. If this is to occur, you will be financially responsible for time including preparation of documents as well as time spent outside of the office in court etc. You will be charged my hourly rate of \$125.

9. Physical Health:

Physical health can be an important factor in the emotional well-being of an individual. If you have not had a physical within the last year, it is recommended that you do so. Also, you agree to list any medications that you are taking on the intake form and who your primary care physician is.

10. Potential Counseling Risks:

As a result of mental health or individual/couples/family counseling, the client may realize that he/she has additional issues, which may not have surfaced prior to the onset of the counseling relationship. Specifically, these issues may present possible risks in couple or family counseling. If one partner changes, additional strain may be placed on the relationship if the others involved refuse to change. Marital or family conflicts may initially intensify as feelings are expressed. If any of the aforementioned concerns occur, the client(s) should feel free to share these new concerns with me.

11. Emergency Situations:

In case of emergency, call 911, The Crisis Intervention Center (The Phone) at (225) 924-3900, a psychiatric hospital, an/or go to the nearest emergency room, if warranted.

12. Client Responsibilities:

You, the client, are a full partner in counseling. Your honesty and effort are essential to your success. The client is expected to follow billing, scheduling, and office procedures. If you have suggestions or concerns about your counseling, I invite you to share these with me so that we can make the necessary adjustments. If you or I come to believe that you would be better served by another mental health professional, I am happy to help you with the referral process. If you are currently receiving services from another mental health professional, I need you to inform me of this in order to coordinate your treatment. I may ask you to grant me permission to obtain information from or share information with that professional.

I have read, or have had read to me, and understand the above information. I hereby sign in agreement and authorize this provider to release information to my primary care physician as needed.

Client Signature_____ Date_____

Melissa Bond, MSW, LCSW_____ Date_____

If client is a minor, parental authorization is needed: I, _____, give permission for Melissa Bond, MSW, LCSW to conduct therapy with my

_____,
(Relationship)

_____,
(Name of Minor)

Melissa Bond, MSW, LCSW

TO HELP WITH YOUR FIRST SESSION, PLEASE FILL OUT THE FOLLOWING INFORMATION AS COMPLETELY AS YOU CAN.

PLEASE NOTE: ALL INFORMATION WILL BE KEPT CONFIDENTIAL

Date: _____

Birth Date: _____

Name: _____ (if couple, please each fill out forms)

Address: _____ City/St _____ Zip: _____

Your Phone #'s: (Home) _____, (Work) _____

(Cell) _____

Email Address: _____

Your Employment/Job Title: _____

Briefly describe your spirituality: _____

Last year of school completed: _____ or GED College: 1 2 3 4 Degree: _____ Other: _____

Single _____ Married _____ Separated _____ Divorced _____ Remarried _____ Widowed _____

Total number of prior marriages for you _____ for your spouse/partner _____

Spouse's Name: _____ Age of spouse: _____ # of yrs. Married _____

Spouse's Employment: _____

Who referred you? _____

Person to contact in case of an emergency(name/phone):

Briefly describe your reason for seeking counseling: _____

Do you have children? _____ Yes _____ No

If yes:

First Name

Age

Sex

Relationship to you

Live in Home?

(biological/step/adopted/foster)

Your parents: (Father) Age: _____ or _____ Deceased (Mother) Age: _____ or _____ Deceased

Number of Brothers: _____

Number of Sisters: _____

Has anyone in your family ever had counseling before? If so, for what? _____

Any history of drug/alcohol abuse for self, father, mother, siblings? _____ Yes _____ No

If yes, please describe: _____

Do you use alcohol or nonprescription drugs? _____ Yes _____ No

If yes, describe frequency and type:

Have you ever experienced any sexual difficulties: _____ Yes _____ No If yes, describe:

Have you ever had counseling before? _____ Yes _____ No

If yes, describe and list counselor, rough number of session, any psychiatric hospitalizations:

Describe any major changes that have occurred to you or your family in the last few years?
(moves, changes in number of family members, marital status, situation, or income)

List any major health problems for which you have received treatment for in the last 24 months:

Primary Care Physician: _____

Phone: _____

Are you taking any prescription drugs at this time? _____ Yes _____ No

If yes, what type, for what purpose, and who prescribed it?

PLEASE CIRCLE or CHECK ANY OF THE FOLLOWING PROBLEMS WHICH PERTAIN TO YOU:

Nervousness	Depression	Fear
Shyness	Sexual Problems	Suicidal Thoughts
Separation	Divorce	Finances
Drug Use	Alcohol Use	Friends
Anger	Self-Control	Unhappiness
Sleep	Stress	Work
Relaxation	Headaches	Tiredness
Legal Matters	Memory	Ambition
Energy	Insomnia	Making Decisions
Loneliness	Inferiority Feelings	Concentration
Education	Career Choices	Health Problems
Temper	Nightmares	Marriage
Children	Appetite	Stomach Problems

Any additional information it would be helpful for me to know:

NOTICE OF PRIVACY PRACTICES CONSENT FORM

Effective April 14, 2003, a federal regulation, commonly known as the "HIPAA Privacy Rule", requires that we must provide all of our clients with a detailed notice, in writing, of our privacy practices. We have this lengthy "Notice of Privacy Practices" available in our waiting room and it is also on our website: www.brchristiancounseling.com. A written copy of this policy is available upon request.

I understand that as a condition to my receiving treatment, Baton Rouge Christian Counseling Center may use or disclose my personally identified health information for treatment, to obtain payment for the treatment provided, and as necessary for the operations of this office. These uses and disclosures are more fully explained in the Privacy Notice that has been provided to me, and which I have had the opportunity to review.

I understand that the privacy practices described in the "Notice of Privacy Practices" may change over time, and that I have a right to obtain any revised Privacy Notices, if requested.

I also understand that I have the right to request BRCCC to restrict how my health information is used or disclosed. BRCCC does not have to agree to my request for the restriction, but BRCCC is bound to abide by the restriction as agreed.

Finally, I understand that I have the right to revoke/withdraw this consent in writing, at any time. My revocation/withdrawal will be effective except to the extent that BRCCC has taken action in reliance on my consent for use or disclosure of my health information. Provision of future treatment may be withdrawn if I withdraw my consent.

Signature: _____ Date: _____

Signature: _____ Date: _____

Policy for Cancellations and “No Shows”

Melissa Bond, MSW, LCSW
melissa@brchristiancounseling.com
(225) 387-2287

I, _____, agree to have my/our credit/debit card
Print Name(s)
charged the **FEE of \$50 for first appointment and the FULL FEE of \$125 (60 minutes) for all successive appointments:**

1. For any session not cancelled with **at least** 24-hour notice, and/or
2. For any appointment, I/we neglect to appear (“no show”)
3. For any balance owed 30 days past due

Signature

Date

Melissa Bond’s policy is that payment is due at the time of the session.

Keeping appointments is the responsibility of the client.

All new or returning clients will need to have a credit card number on file.

Credit card numbers will be securely stored.

PLEASE FILL IN THE INFORMATION BELOW

Card Type: __Visa __Master Card __American Express __Discover __Other_____		
Card Number:	Security Code:	Zip Code:
Cardholder Name:	Expiration Date:	
Signature:	AMOUNT: Maximum of \$125 for missed appointments or ANY balance due past 30 days.	

INFORMED CONSENT CHECKLIST FOR TELEMENTAL HEALTH (VIDEO) COUNSELING

Prior to starting video-counseling services, we discussed and agreed to the following:

- There are potential benefits and risks for video-conferencing that differ from in-person sessions (secure internet connection).
- Confidentiality still applies and no one will record the session without the permission of the other person.
- We will use the video-conferencing platform app called VSee for our video session. Please be online at the appointment time. I will initiate the video call with you.
- You will need a webcam or a smartphone/tablet for the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- It is important to be in a quiet, private space that is free of distractions during the session.
- It is important to be on time. Use the chat feature on VSee to let me know when you're online, especially if you're "late" for an appointment.
- The same 24-hour cancellation rules apply to video counseling.
- We need a back-up plan (e.g., phone number where you can be reached) in case we have technical difficulties. If we get disconnected, I will continue to try to reach you. If we both initiate, we will miss each other.
- We need a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation.
- Confirm reimbursement with your insurance company.
- As your counselor, I may determine that due to certain circumstances, video counseling is no longer appropriate and that we should resume our sessions in-person.

Counselor Melissa Bond, MSW, LCSW

Client Name _____

Signature _____

Date _____

INFORMED CONSENT FOR IN-PERSON THERAPY DURING THE COVID-19 CRISIS

Decision to Meet Face-to-Face

If we mutually decide to meet in person (Face-to-Face, hereinafter - F2F) for some or all future counseling sessions, precautions must be in place to mitigate the COVID-19 pandemic. This document contains information about those precautions and guidelines to safely meet F2F. Your signature(s) below indicates that you understand and agree to undertake these actions concerning all F2F appointments. Please read this carefully and let me know if you have any questions.

If we mutually decide to meet in person (F2F) and there is a subsequent resurgence of the pandemic, or subsequent changes in local, state, or federal guidelines, or if other health concerns arise, I may require that we meet via teletherapy. If you decide at any time that you would prefer teletherapy, I will respect that decision, provided it is clinically appropriate.

Also be mindful that if your therapist files for reimbursement for any teletherapy services, such reimbursement is determined by insurance companies and applicable law. You are responsible for payment whether services are provided via teletherapy sessions or F2F, and whether insurance companies reimburse or not.

Risks of Opting for In-Person F2F Services

Although there are potential benefits for in-person F2F counseling, there are also risks. You understand that by attending F2F sessions, you would be assuming the risk of exposure to the coronavirus, or other public health risks, and that this risk may increase if you travel by public transportation, cab, or ridesharing service.

In consideration of the services of Baton Rouge Christian Counseling Center (hereinafter BRCCC) and my therapist, I hereby agree to release, indemnify, defend and discharge both BRCCC and my therapist, on behalf of myself, my spouse, my children, my parents, my heirs, assigns, personal representative and estate as follows:

I have been offered by BRCCC and my therapist to conduct the therapy session remotely via Zoom or other online means, however, I desire a face to face therapy session. I am aware of the risk of infection with COVID 19 and I understand that such risk simply cannot be eliminated without completely avoiding a face-to-face therapy session.

I expressly agree and promise to accept and assume the risk of infection with COVID 19 existing in a F2F therapy session. My participation in a F2F therapy session at BRCCC and with my therapist is purely voluntary, and I elect to participate despite the risks.

Your Responsibility to Minimize Your Exposure

To obtain counseling in person (F2F), and signing this document, you will take the following precautions which will help keep all of us (you, me, our families, my staff, and other clients) safer from exposure, sickness, and possible death. Failure to adhere to these safeguards may result in our starting or returning to a teletherapy arrangement.

- If you reasonably believe that you have recently been exposed to, are infected with, or have symptoms of the coronavirus, you will cancel your F2F appointment or proceed using teletherapy.
- You will wait in your car or outside until no earlier than 5 minutes before your appointment time.
- You will wash your hands or use alcohol-based hand sanitizer when you enter the building.
- You will wear a mask in all areas of the office (I, and my staff will too). Clients agree to:
 - bring their own face mask that covers their nose and mouth,
 - wear the face mask upon entering the building,
 - continue to wear the face mask until entering the counseling session, (face masks are not required during the counseling session, unless your therapist deems them necessary), and
 - wear a face mask after the session while exiting the building.
- You will adhere to the safe distancing precautions we have set up in the waiting areas and offices.
- You will keep a distance of 6 feet from all other persons and there will be no physical contact (i.e. no shaking hands) with me, other clients, or with my staff.
- You will try not to touch your face or eyes with your hands. If you do, you will immediately wash or sanitize your hands.
- You will not bring guests and/or non-client children to BRCCC.
- You will take steps between F2F appointments to minimize your exposure to COVID-19.
- If you have a job, other responsibilities, or activities that put you in close contact with others infected with COVID, you will notify me immediately.

- If a resident of your home tests positive for the coronavirus infection, you will notify me immediately. Continuing treatments will be conducted via teletherapy until quarantine is over.
- To minimize contact with support staff, you will do all scheduling of appointments either online through the Therapy Appointment software, or over the phone with support staff.
- To minimize the exchange and handling of payment(s), you will have your credit card information on file with BRCCC at least one day prior to the counseling session.

I reserve the right to change the above precautions if additional local, state, or federal orders or guidelines are published. If that happens, you will be notified about any necessary changes.

My Commitment to Minimize Exposure

My practice has taken steps to reduce the risk of spreading the coronavirus within the office and we have posted our efforts on our website and in the office. Please let me know if you have questions about these efforts.

If You or I are Sick

You understand that I am committed to keeping you, me, my staff, all clients, and all of our families safe from the spread of this virus. If you show up for an appointment and I, or my office staff believe that you have a fever or other symptoms, or believe you have been exposed, I will have to require you to leave the office immediately. We can follow up with services by teletherapy as appropriate.

If I, or my staff, test positive for the coronavirus, I will notify you so that you can take appropriate precautions.

Your Confidentiality in the Case of Infection

If you have tested positive for the coronavirus, I may be required to notify local health authorities that you have been in the office. If I am required to report this, I will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for your visits. By signing this form, you are agreeing that I may do so without an additional signed release.

Informed Consent

This agreement supplements the general informed consent/business agreement that we agreed to at the start of our work together.

Your signature(s) below shows that you agree to and will abide with these terms and conditions. By signing this document, I acknowledge that I waive my right to maintain a lawsuit against BRCCC and my therapist based on any claim that I released herein. I also agree to pay BRCCC and my therapist attorneys' fees and costs in enforcing this agreement.

Client

Date

Client (if couple, both sign)

Date

Therapist

Date

Written incorporating sample-informed-consent-form-1 from APA-1
Dee Adams, PhD, LPC, LMFT; LCC
May 18, 2020
X\BRCCC Covid CLIENT consent form

This page is for EMDR, EMDR Extended Sessions and Intensive Clients Only

EMDR Fees:

1-hour EMDR Session: 125.00 per hour. Can be billed to BCBS-Paid at time of service

EMDR Extended Sessions: (sessions are not billable to insurance) Paid at time of service.

2-Hour 250.00

3-Hour 375.00

EMDR Intensive (sessions are not billable to insurance)-Half paid at time of scheduling and remaining balance due at time of service.

5-Hour 625.00

6-Hour 750.00

Intensive sessions will be scheduled for the entire day. If additional hours are needed clients will be responsible for remaining balance upon leaving.

What brings you to counseling at this time? Is there something specific, such as a particular event? Be as detailed as you can:

When did this problem first appear?

Why are you choosing to come to therapy now?

Has someone already given you a mental health diagnosis? If yes, who was it and what was the diagnosis? What do you think about the diagnosis? (i.e., do you agree with them, did you feel better or worse when you were diagnosed). Has it helped you to be diagnosed? Why or why not?

Please list 3-5 specific goals you have for therapy.

- 1.
- 2.
- 3.
- 4.
- 5.

How will you know the problem is solved, and what will be different once the problem is part of the past?

How do you cope with stress, feeling sad, angry, or other challenges in life? What do you do?

Relationship History: If you are in a relationship, please describe the nature of the relationship and months or years together. Are you satisfied in your relationship? Have you had any previous relationships (positive/negative or both) that are influencing the current issue? Please describe, if applicable.

Legal History: Do you have any legal history? If so, what is it and are the proceedings still pending? This could include deportation, child custody or divorce proceedings, DUI's, crime, probation/parole, arrests, imprisonment, etc. Please give details.

Financial Situation: Do you feel financially stable? Do you experience financial stress in your life that affects the issue at hand or your relationships? Do you live in poverty? Do you have excessive debt? Gambling issues? Impulsive spending?

Social History: What hobbies and community activities do you enjoy? Are you currently participating in these activities? If not, why not? Do you believe you have a good group of friends that support you and are a positive influence in your life?

Have you ever had an experience that you would consider traumatic? (i.e., a deeply distressing or disturbing experience).

_____Yes _____No

Have you ever had a concussion, head injury where you lost consciousness or been diagnosed with a Traumatic Brain Injury (TBI)?

_____Yes _____No

Do you have suicidal thoughts?

_____Yes _____No

* Have you ever attempted suicide?

_____Yes _____No

Do you have thoughts or urges to harm others?

_____Yes _____No

Have you ever used self-harm as a coping mechanism?

_____Yes _____No

Have you ever been hospitalized for a psychiatric issue?

_____Yes _____No

Is there a history of mental illness in your family (ex: schizophrenia, bipolar, depression, addiction, anxiety, OCD, mania, borderline personality disorder, etc.).

_____Yes _____No

Adverse Childhood Experience (ACE) Questionnaire

This Questionnaire will be asking you some questions about events that happened during your childhood: specifically, the first 18 years of your life. The information you provide by answering these questions will allow us to better understand problems that may have occurred early in your life and allow us to explore how those problems may be impacting the challenges you are experiencing today. This can be very helpful in the success of your treatment.

Finding Your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often or very often... Swear at you, insult you, put you down, or humiliate you?
or
Act in a way that made you afraid that you might be physically hurt?
Yes No If yes enter 1_____
2. Did a parent or other adult in the household often or very often... Pugh, Arab, glam or throw connecting at you?
or
Ever hit you so hard that you had marks or were injured?
Yes No If yes enter 1_____
3. Did an adult or person at least 5 years older than you ever...
Touch or fondle you or have you touch their body in a sexual way?
or
Attempt or actually have oral, anal, or vaginal intercourse with you?
Yes No If yes enter 1_____
4. Did you often or very often feel that ...
No one in your family loved you or thought you were important or special?
or
Your family didn't look out for each other, feel close to each other, or support each other?
Yes No If yes enter 1_____
5. Did you often or very often feel that ...
You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
or
Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
Yes No If yes enter 1_____
6. Were your parents ever separated or divorced?
Yes No If yes enter 1_____
7. Was your mother or stepmother:
Often or very often pushed, grabbed, slapped, or had something thrown at her?
or
Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?

or

Ever repeatedly hit at least a few minutes or threatened with a gun or knife?

Yes

No

If yes enter 1_____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?

Yes

No

If yes enter 1_____

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?

Yes

No

If yes enter 1 _____

10. Did a household member go to prison?

Yes

No

If yes enter 1_____

Now add up your "Yes" answers: _____This is your ACE Score.

Burns Anxiety Inventory *

(Revised)

Instructions: Put a check (✓) to indicate how much you have experienced each symptom during the past week, including today. Please answer all 25 items.

	0 – not at all	1 - Somewhat	2 - Moderately	3 – A Lot	4 - Extremely
Anxious Thoughts and Feelings					
1. Feeling anxious					
2. Feeling nervous					
3. Feeling frightened					
4. Feeling scared					
5. Worrying about things					
6. Feeling that you can't stop worrying					
7. Feeling tense, agitated or on edge					
8. Feeling stressed					
9. Feeling "uptight"					
10. Thoughts that something frightening will happen					
11. Feeling alarmed or in danger					
12. Feeling insecure					
Anxious Physical Symptoms					
13. Feeling dizzy, lightheaded or off balance					
14. Rubbery, or "jelly" legs					
15. Feeling like you are choking					
16. A lump in the throat					
17. Feeling short of breath or difficulty breathing					
18. Skipping, racing or pounding of the heart					
19. Pain or tightness in the chest					
20. Restlessness or jumpiness					
21. Tight, tense muscles					
22. Trembling or shaking					
23. Numbness or tingling					
24. Butterflies or discomfort in the stomach					
25. Sweating or hot flashes					
Please total your score on items 1 to 25 here➡					

NAME _____

DATE _____

Burns Depression Checklist *

(Revised)

Instructions: Put a check (✓) to indicate how much you have experienced each symptom during the past week, including today. Please answer all 25 items.

	0 – not at all	1 - Somewhat	2 - Moderately	3 – A Lot	4 - Extremely
Thoughts and Feelings					
1. Feeling sad or down in the dumps					
2. Feeling unhappy or blue					
3. Crying spells or tearfulness					
4. Feeling discouraged					
5. Feeling hopeless					
6. Low self-esteem					
7. Feeling worthless or inadequate					
8. Guilt or shame					
9. Criticizing yourself or blaming yourself					
10. Difficulty making decisions					
Activities or Personal Relationships					
11. Loss of interest in family, friends or colleagues					
12. Loneliness					
13. Spending less time with family or friends					
14. Loss of motivation					
15. Loss of interest in work or other activities					
16. Avoiding work or other activities					
17. Loss of pleasure or satisfaction in life					
Physical Symptoms					
18. Feeling tired					
19. Difficulty sleeping or sleeping too much					
20. Decreased or increased appetite					
21. Loss of interest in sex					
22. Worrying about your health					
Physical Symptoms**					
23. Do you have any suicidal thoughts?					
24. Would you like to end your life?					
25. Do you have a plan for harming yourself?					
Please total your score on items 1 to 25 here➡					

NAME _____

DATE _____

****Anyone with suicidal urges should seek help from a mental health professional.**

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Name _____ Date _____ Age _____ Sex _____

Directions: This questionnaire consists of twenty-eight questions about experiences that you may have in your daily life. We are interested in how often you have these experiences. It is important, however, that your answers show how often these experiences happen to you when you are not under the influence of alcohol or drugs. To answer the questions, please determine to what degree the experience described in the question applies to you and **circle the number to show what percentage of the time you have the experience.**

Example:

0%	10	20	30	40	50	60	70	80	90	100%
(never)										(always)

1. Some people have the experience of driving a car and suddenly realize that they don't remember what has happened during all or part of the trip.

0%	10	20	30	40	50	60	70	80	90	100%
----	----	----	----	----	----	----	----	----	----	------

2. Some people find that sometimes they are listening to someone talk and they suddenly realize that they did not hear all or part of what was said.

0%	10	20	30	40	50	60	70	80	90	100%
----	----	----	----	----	----	----	----	----	----	------

3. Some people have the experience of finding themselves in a place and having no idea how they got there.

0%	10	20	30	40	50	60	70	80	90	100%
----	----	----	----	----	----	----	----	----	----	------

4. Some people have the experience of finding themselves dressed in clothes that they don't remember putting on.

0%	10	20	30	40	50	60	70	80	90	100%
----	----	----	----	----	----	----	----	----	----	------

5. Some people have the experience of finding new things among their belongings that they do not remember buying.

0%	10	20	30	40	50	60	70	80	90	100%
----	----	----	----	----	----	----	----	----	----	------

6. Some people sometimes find that they are approached by people that they do not know who calls them by another name or insist that they have met them before.

0%	10	20	30	40	50	60	70	80	90	100%
----	----	----	----	----	----	----	----	----	----	------

7. Some people sometimes have the experience of feeling as though they are standing next to themselves or watching themselves do something as if they were looking at another person.

0%	10	20	30	40	50	60	70	80	90	100%
----	----	----	----	----	----	----	----	----	----	------

8. Some people are told that they sometimes do not recognize friends or family members.

0%	10	20	30	40	50	60	70	80	90	100%
----	----	----	----	----	----	----	----	----	----	------

9. Some people find that they have no memory of some important events in their lives (for example, a wedding or graduation).
- 0% 10 20 30 40 50 60 70 80 90 100%
10. Some people have the experience of being accused of lying when they do not think that they have lied.
- 0% 10 20 30 40 50 60 70 80 90 100%
11. Some people have the experience of looking in a mirror and not recognizing themselves.
- 0% 10 20 30 40 50 60 70 80 90 100%
12. Some people sometimes have the experience of feeling that other people, objects, and the world around them are not real.
- 0% 10 20 30 40 50 60 70 80 90 100%
13. Some people sometimes have the experience of feeling that their body does not belong to them.
- 0% 10 20 30 40 50 60 70 80 90 100%
14. Some people have the experience of sometimes remembering a past event so vividly that they feel as if they were reliving that event.
- 0% 10 20 30 40 50 60 70 80 90 100%
15. Some people have the experience of not being sure whether things that they remember happening really did happen or whether they just dreamed about them.
- 0% 10 20 30 40 50 60 70 80 90 100%
16. Some people have the experience of being in a familiar place but finding it strange and unfamiliar.
- 0% 10 20 30 40 50 60 70 80 90 100%
17. Some people find that when they are watching television or a movie, they become so absorbed in the story that they are unaware of other events happening around them.
- 0% 10 20 30 40 50 60 70 80 90 100%
18. Some people sometimes find that they become so involved in a fantasy or daydream that it feels as though it were really happening to them.
- 0% 10 20 30 40 50 60 70 80 90 100%
19. Some people find that they are sometimes able to ignore pain.
- 0% 10 20 30 40 50 60 70 80 90 100%
20. Some people find that they sometimes sit staring off into space, thinking of nothing, and are not aware of the passage of time.
- 0% 10 20 30 40 50 60 70 80 90 100%
21. Some people sometimes find that when they are alone, they talk out loud to themselves.
- 0% 10 20 30 40 50 60 70 80 90 100%

22. Some people find that in one situation they may act so differently compared with another situation that they feel almost as if they were different people.

0% 10 20 30 40 50 60 70 80 90 100%

23. Some people sometimes find that in certain situations they can do things with amazing ease and spontaneity that would usually be difficult for them (for example, sports, work, social situations, etc.)

0% 10 20 30 40 50 60 70 80 90 100%

24. Some people sometimes find that they cannot remember whether they have done something or have just thought about doing that thing (for example, not knowing whether they have just mailed a letter or have just thought about mailing it).

0% 10 20 30 40 50 60 70 80 90 100%

25. Some people find evidence that they have done things that they do not remember doing.

0% 10 20 30 40 50 60 70 80 90 100%

26. Some people sometimes find writings, drawings, or notes among their belongings that they must have done but cannot remember doing.

0% 10 20 30 40 50 60 70 80 90 100%

27. Some people find that they sometimes hear voices inside their head that tell them to do things or comment on things that they are doing.

0% 10 20 30 40 50 60 70 80 90 100%

28. Some people sometimes feel as if they are looking at the world through a fog so that people or objects appear far away or unclear.

0% 10 20 30 40 50 60 70 80 90 100%

BRCCC Parking and Entering Directions

You may park in the free parking lot of First Presbyterian located behind the church off Convention Street between 7th and 8th. It is located directly across from the Post Office.

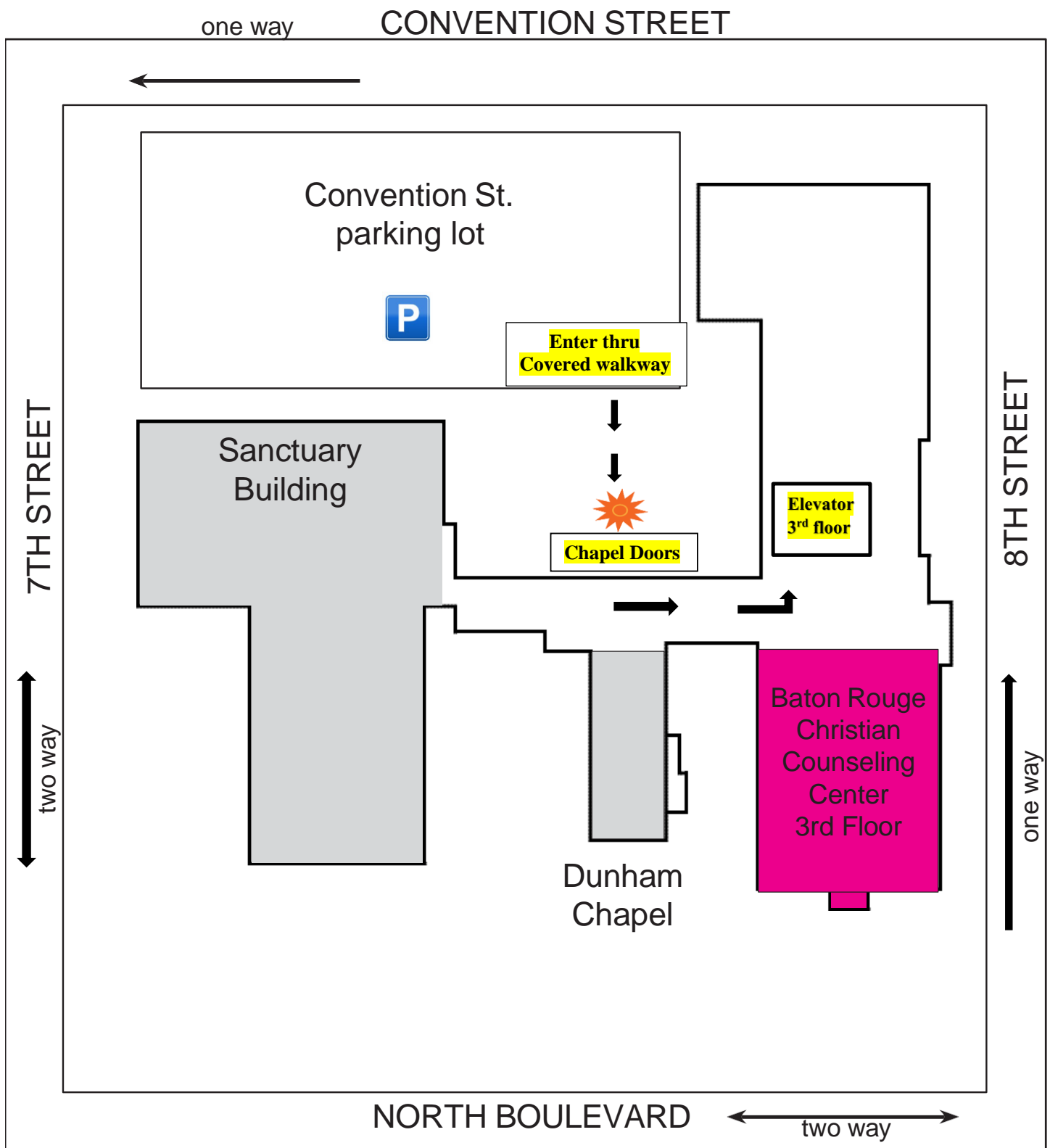
From that lot, look for the black iron gate and follow the sidewalk to the Dunham Chapel doors. There is a plaque on the wall by the doors.

You then press the box which says, "Counseling Center" and we will answer and unlock the doors for you.

Once you enter, take a left toward the elevator, and ride it to the 3rd floor.

Exit the elevator and go toward the end of the hall to the open door on your right that reads "Check In."

IF you MUST use stairs to reach the 3rd floor, you will need to park on 8th street. Be advised that the city charges for parking and you will be limited to using the stairs both up and back down.



 Enter at the Convention Street Dunham Chapel entrance.

 Parking available in the Convention St. lot (free).

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