Asheville Psychotherapy Services, PLLC

Change Is Possible.

Date: _____ Name: _____

Permanent Address: _____
Street Address, City, State

Phone Number: _____ Email Address: _____

Emergency Contact: _____ Phone Number: _____

Birth date: _____ Age: _____ Gender: _____

Racial or ethnic heritage? _____

Are you married? Y N Separated? Y N Widowed? Y N

Are you currently in a committed relationship? Y N

If yes, partners name and how long? _____

Level of satisfaction with relationship? Excellent Good Fair Poor

Do you have any children? Y N

If yes, names and ages: _____

Health Insurance Provider (If Applicable): _____

Military Experience/Involvement (If Applicable): _____

Were you referred to counseling services by a particular person, place or website? Y N
If Yes, please list? _____

Concern Checklist:

***Step 1:** Check only those items that are of concern to you. Skip those that are not.
***Step 2:** For each checked item, circle the degree to which the concern is currently problematic.

	Mild	Moderate	Serious	Severe
___ 1. **Relationship difficulties**: breakup/loss of relationship; problems with romantic partner, friends or roommates	1	2	3	4
___ 2. **Family problems**: divorce, separation, abuse; conflicts over money, roles, relationships or responsibilities	1	2	3	4
___ 3. **Depression/moods**: depressed mood, loss of interest or pleasure, hopelessness; alternating periods of elevated and depressed mood	1	2	3	4
___ 4. **Suicidal thoughts or concerns**: problems related to thoughts of suicide	1	2	3	4
___ 5. **Anxiety**: excessive or uncontrolled worry, nervousness, chronic fears, performance anxiety, panic attacks, social anxiety, obsessive thoughts	1	2	3	4
___ 6. **Stress or psychosomatic symptoms**: overwhelmed by circumstances, problems with headaches, stomach pains, etc.	1	2	3	4
___ 7. **Sleep**: insomnia; frequent or premature waking.	1	2	3	4
___ 8. **Emotional regulation**: concerns about managing anger or other difficult emotions	1	2	3	4
___ 9. **Academic difficulties**: academic performance problems, missing classes	1	2	3	4
___ 10. **College adjustment**: problems adjusting to campus life, relationship between academics and future goals	1	2	3	4
___ 11. **Cultural adjustment**: difficulties adjusting or readjusting to North American social customs and mores	1	2	3	4
___ 12. **Racial harassment**: targeted by words or behaviors that interferes with full participation in community life	1	2	3	4
___ 13. **Self-esteem**: concerns about self-image, shyness, insecurity	1	2	3	4

___ 14. **Death or loss**: grief related to loss of a valued other	1	2	3	4
___ 15. **Existential/spiritual concerns**: search for meaning in life, concern about the role of religion in one's life	1	2	3	4
___ 16. **Eating concerns and body image**: purging, restricting, compulsive overeating, unhealthy dieting, excessive exercise, poor body image	1	2	3	4
___ 17. **Alcohol and/or chemical use**: concerns about abuse or developing dependency on alcohol or other drugs	1	2	3	4
___ 18. **Addiction**: other than chemical	1	2	3	4
___ 19. **Self-inflicted harm**: physical self-harm, i.e., cutting, burning, etc.	1	2	3	4
___ 20. **Sexual abuse, assault or harassment**:	1	2	3	4
___ 21. **Sexual orientation**: concerns around issues related to sexual orientation	1	2	3	4
___ 22. **Gender identity**: concerns with how or whether to identify with a given gender label	1	2	3	4
___ 23. **Sexual health**: concerns related to sexual behavior	1	2	3	4
___ 24. **Autism-Asperger spectrum**:	1	2	3	4
___ 25. **ADD/ADHD**: attention deficit disorder /attention deficit hyperactivity disorder	1	2	3	4
___ 26. **Physical disability**: issues related to coping with aspects of a physical disability	1	2	3	4
___ 27. **Medication**: concerns or questions about the appropriateness of medications	1	2	3	4
___ 28. **Other**: _____	1	2	3	4

***Areas of Impairment:**
Check the areas of your life that are most affected by your current symptoms or problems:

___ 1. School performance/attendance
___ 2. Work performance/attendance
___ 3. Romantic relationships
___ 4. Friendships/social life
___ 5. Family relationships
___ 6. Physical health
___ 7. Spirituality/religion
___ 8. Other: _____

Employment and Other Extracurricular Activities:

*Are you currently employed? Y N

If Yes, where? _____

If Yes, what is your job title? _____

How many hours/week do you work? _____

*Are you currently involved in any other extracurricular activities, organizations, groups, etc.? Y N

If Yes, where? _____

How many hours/week are involved? _____

Family Background:

*Please indicate any family history of the following: (Check all that apply)

___ 1. Physical abuse
___ 2. Emotional or verbal abuse
___ 3. Sexual abuse
___ 4. Depression, anxiety, or psychological difficulties
___ 5. Medications for psychological difficulties
___ 6. Problems with alcohol or other drugs
___ 7. None of the above

*Please indicate if you personally have been the target of any the following: (Check all that apply)

___ 1. Physical abuse
___ 2. Emotional or verbal abuse
___ 3. Sexual abuse
___ 4. None of the above

Health History:

How would you describe your overall physical health? *(circle one)* Excellent Good Fair Poor

Have you ever had any chronic health conditions, major illnesses, serious injuries, or significant head trauma? Y N

If Yes, please describe: _____

_____

*Do you have a diagnosed pre-existing mental health condition? Y N

If Yes, please specify: _____

*Do you have any previous experience with counseling? Y N

If Yes, please list the approximate date(s), and issues discussed (optional): _____

_____

_____

Do you regularly take any medications, including over-the-counter medications? Y N

If Yes, please list the name(s) and dosage(s): _____

_____

*Are any of these medications for psychological difficulties? Y N

Is your medication being monitored by an M.D. or other health care professional? Y N

*Have you ever been hospitalized for psychological problems? Y N

If Yes, please describe what happened and give the date(s): _____

_____

*Have you ever attempted suicide? Y N

If Yes, please describe what happened and give the date(s): _____

_____

_____

Eating Concerns:

Have you ever had significant concerns about your eating habits? Y N

Have family, friends, doctors, or others ever told you they were concerned about your eating habits? Y N

*Have you ever been treated for an eating disorder? Y N

If Yes, please describe the nature of the treatment and give the approximate date(s): _____

_____

_____

Alcohol and Other Drug Use:

*Please check the box that best describes your current use of the following:

	6 or More Times a Week	4-5 Times A Week	2-3 Times A Week	Once A Week	1-3 Times A Month	Once a Month or Less	No Current Use
Alcohol	☐	☐	☐	☐	☐	☐	☐
Marijuana	☐	☐	☐	☐	☐	☐	☐
_____ (Other, please list)	☐	☐	☐	☐	☐	☐	☐

When you drink alcohol, how many drinks do you typically have? _____

Have you ever thought that you had a problem with alcohol or other drug use? Y N

Has anyone else ever thought you had a problem with alcohol or other drug use? Y N

*Have you ever sought treatment? Y N

If yes, please describe the nature of the treatment and give the approximate date(s): _____

_____

*Are you currently in recovery from any addiction? Y N

If yes, please indicate addiction and sobriety date: _____

Lifestyle Checklist:

*Do you exercise regularly? Y N

*If so, what type of exercise do you enjoy? _____

*How many times per week on average do you exercise? _____

*Are you satisfied with the quality and quantity of your sleep? Y N

*How many hours of sleep do you average per night? _____

*Do you consider yourself to be spiritual or religious? Y N

*If yes, please describe your faith or belief: _____

Strengths Checklist:

What are the main sources of support in your life? _____

_____

_____

_____

What helps you to manage stress? _____

_____

_____

What would you consider to be your greatest strengths? _____

_____

_____

_____

Goals for Therapy:

Please list the goals you wish to achieve in therapy (in order of priority), for example problems you wish to solve or coping skills you would like to learn:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

How will you know if you have reached your goal(s)? _____

_____

_____

_____

_____

_____

_____

Thank you for taking time to complete this questionnaire. This information will assist us in assessing your current needs. Please note that this information will be kept strictly confidential even after therapy is complete.

Asheville Psychotherapy Services, PLLC

Change Is Possible.

Professional Disclosure Statement

Marc McKinnis, M.A., LCMHC

Training:

- I hold a Master of Arts degree (M.A.) in Counseling Psychology from Lewis & Clark Graduate School of Education and Counseling located in Portland, Oregon.
- I received my Master's Degree on May 14, 2010.

Licensure:

- I am a Licensed Clinical Mental Health Counselor (LCMHC) in the State of North Carolina, which is recognized through the North Carolina Board of Licensed Clinical Mental Health Counselors (License # 8458).

Experience:

- I have worked as a licensed clinical mental health counselor and psychotherapist over the past decade in various University and College Counseling Centers, including the University of North Carolina at Chapel Hill, Portland Community College, as well as Asheville-Buncombe Technical Community College.
- I have also maintained a private practice over the past decade working with clients within the community.
- Throughout my experience as a licensed clinical mental health counselor and psychotherapist, I have worked with a diverse range of adult clients. The clients that I have worked with have come from a broad range of cultural backgrounds, ethnicities, ages, sexual orientations, socio-economic backgrounds, cognitive and physical abilities/disabilities, religious orientations, and have come in to counseling for a variety of mental health related issues.

Techniques/Procedures:

- The theoretical orientation that I most closely identify with in my counseling and psychotherapy practice is Existential-Humanistic Person-Centered Psychotherapy.
- As a licensed clinical mental health counselor, I apply a variety of counseling techniques and approaches to match the specific needs of each individual client.
- Examples of the approaches and techniques that I may use with clients include, but are not limited to, Existential-Humanistic Person-Centered Psychotherapy, Solution-Focused Therapy, Motivational Interviewing, Positive Psychology, EMDR, Trauma Resiliency Model, as well as Cognitive-Behavioral Therapy.

Length of Session:

- Each counseling session will last for 55-minutes unless otherwise noted.

Cost of Session:

- Each counseling session will cost $150 unless otherwise negotiated.
- Cash, checks, and credit cards are accepted. Checks can be made payable to Marc McKinnis or Asheville Psychotherapy Services, PLLC.
- Payment for counseling is expected on the day of your scheduled appointment.
- In addition, I am an in-network mental/behavioral health provider with Blue Cross/Blue Shield and Aetna. If you have a health insurance policy with any of these providers, please contact them directly to learn more about your outpatient mental health benefits as well as any applicable co-pay and/or deductible information.

Diagnosis:

- If you are a private pay client, then I am not required to assign and record a mental health diagnosis for you using the DSM-5, and will not do so, unless explicitly requested by clients.
- If you are utilizing my services through your health insurance provider, then I am required to submit an official clinical mental health diagnosis to your health insurance provider using the DSM-5 in order to receive reimbursement for my services. Once a mental health diagnosis is recorded with your health insurance provider, then this diagnosis will become a permanent part of your health records with that health insurance organization.

No Show/ Cancellation Policy:

- I ask that clients notify me by email or phone at least 24 hours prior to a scheduled appointment to cancel or re-schedule.
- If a client does not contact me within 24 hours prior to a scheduled appointment to cancel or re-schedule, then that client is responsible for paying a $50.00 cancellation fee for the missed session.

Confidentiality:

- All of the information that is exchanged between client and counselor is held strictly confidential by the counselor except under the following conditions, in which confidentiality may be broken:
  A. If you pose a danger to yourself or others.
  B. If there is a reasonable suspicion of abuse or neglect of either a child or a dependent elder.
  C. If a court of law issues a legitimate order for your client records.

Registering a Complaint:

- Complaints may be registered with the North Carolina Board of Licensed Clinical Mental Health Counselors (NCBLCMHC) at any point during or after counseling.
- Clients should attempt to resolve any complaint directly with the counselor. However, if this attempt is unsuccessful, then clients may put complaints into writing citing the ACA ethical code(s), which are believed to have been broken, and submit this along with a completed NCBLCMHC Complaint Form to the board.
- Complaints may be sent to: North Carolina Board of Licensed Clinical Mental Health Counselors, P.O. Box 77819, Greensboro, NC 27417, Phone: 844-622-3572 or 336-217-6007, Fax: 336-217-9450, or Email: through contact form on the NCBLCMHC website.

_____

(Client's Printed Name) (Date)

_____

(Client's Signature)

_____

(Counselor's Printed Name/ Credentials) (Date)

_____

(Counselor's Signature)