

CONFIDENTIAL - Preliminary Questionnaire - AWARENESS

The first step in this program is to determine your present level of awareness with respect to your spouse, parents, brothers, sisters, friends, Boss. Please **do not** mistake these questions as some sort of evaluation as none is intended. In order for this program to be effective for you, it is critical that both of us are clear as to your present level of awareness. The following questions are designed to help make that determination. Please **do not** miss-construe these questions as some sort of judgment about you, none is intended. Please be as honest with yourself as possible in answering these questions. All this information is kept in your confidential file.

On A Scale of 1 To 10: ARE YOU... (LOWER) 1 2 3 4 5 6 7 8 9 10 (HIGHER)

First Name _____	Scale
1. Are you angry with your spouse, parents, brothers, sisters, friends, Boss? (Please circle)	1. _____
(If you feel the need, please give as much detail as your wish on a separate sheet of paper).	
2. Are you disappointed, frustrated, with your spouse, parents, brothers, sisters, friends, Boss?	2. _____
(If you feel the need, please give as much detail as your wish on a separate sheet of paper).	
3. Are you critical of your spouse, parents, brothers, sisters, friends, Boss?	3. _____
(If you feel the need, please give as much detail as your wish on a separate sheet of paper).	
4. Are you quick to respond when someone questions your intelligence and/or honesty?	4. _____
(If you feel the need, please give as much detail as your wish on a separate sheet of paper).	
5. Are you depressed over the outcome of your relationship with your spouse, parents, brothers, sisters, and/or friends, Boss?	5. _____
(If you feel the need, please give as much detail as your wish on a separate sheet of paper).	
6. Are you depressed, sad or angry over the present state of your health?	6. _____
(If you feel the need, please give as much detail as your wish on a separate sheet of paper).	
7. Who do you feel is to blame for where you are in your life _____?	7. _____
8. On a scale of 1 to 10, to what degree do you feel they are responsible?	8. _____

Confidential Personal History Questionnaire

Score: NEVER 0, SELDOM 1, OCCASIONALLY 2, OFTEN 3, VERY OFTEN 4.

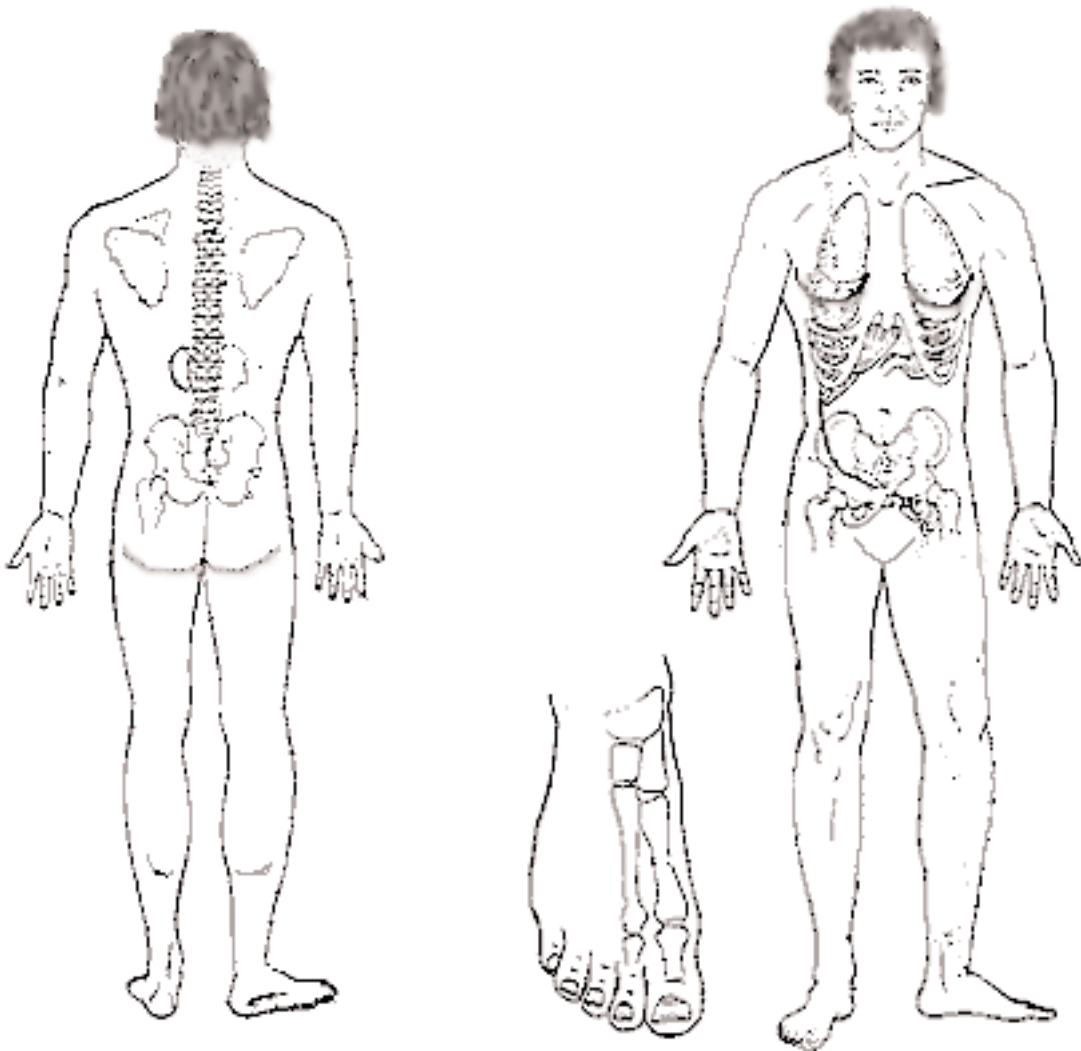
How Often Do You:

Score:

1. Experience indifference (don't care about anything)? 1. _____
2. Lose you sense of humor (seldom laugh about anything)? 2. _____
3. Experience a sense of doubt or indecision (find it difficult to make up your mind)? 3. _____
4. Find yourself worrying or anxious? 4. _____
5. Feel pessimistic or over cautious? 5. _____
6. Feel stressed out? 6. _____
7. Feel nervous or tense? 7. _____
8. Feel a lack of self confidence? 8. _____
9. Feel a sense of low self-esteem? 9. _____
10. Feel irritable? 10. _____
11. Feel oversensitive? 11. _____
12. Have difficulty concentrating? 12. _____
13. Experience inadequate energy (feel fatigued)? 13. _____
14. Use stimulants (coffee, tea, sugar, chocolate)? 14. _____
15. Have problems with digesting your food? 15. _____
16. Experience loss of sex drive? 16. _____
17. Start crying for no apparent reason? 17. _____
18. Have difficulty sitting quietly (no talking, no fidgeting)? 18. _____
19. Have difficulty in expressing your feelings? 19. _____
20. Feel moody (blue)? 20. _____
21. Wonder if life is really worth living? 21. _____
22. Feel your heart beating rapidly for no apparent reason? 22. _____
23. Have a fear of ill health? 23. _____
24. Have a fear of being criticized? 24. _____
25. Sense of anxiety about not having enough money everyday? 25. _____
26. Experience the feeling of not being loved by anyone? 26. _____
27. Have a nagging fear of old age? 27. _____
28. Have a fear of dying? 28. _____
29. Experience wondering..."is there something wrong with me"? 29. _____
30. Experience yourself thinking... "am I losing it"? 30. _____
31. Have concerns with constipation (less than two bowel movements a day)? 31. _____
32. Have concerns with diarrhea? 32. _____
33. Experience abdominal bloating? 33. _____
34. Have lower back pain? 34. _____
35. Have strong body odor (feel the necessity to use deodorants)? 35. _____

Sub-Total _____

Confidential Personal History Questionnaire



Please identify any areas of stiffness or discomfort you may have at this time.

- | | | |
|--|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Upper back stiffness | <input type="checkbox"/> Calf stiffness |
| <input type="checkbox"/> Neck stiffness | <input type="checkbox"/> Mid back stiffness | <input type="checkbox"/> Leg or calf cramping |
| <input type="checkbox"/> Chest stiffness | <input type="checkbox"/> Lower back stiffness | <input type="checkbox"/> Ankle pain or stiffness |
| <input type="checkbox"/> Shoulder stiffness | <input type="checkbox"/> Hip joint stiffness | <input type="checkbox"/> Weak ankles |
| <input type="checkbox"/> Upper arm stiffness | <input type="checkbox"/> Sacroiliac stiffness | <input type="checkbox"/> Foot or toe aches |
| <input type="checkbox"/> Elbow stiffness | <input type="checkbox"/> Thigh/groin stiffness | <input type="checkbox"/> Tingling in the feet |
| <input type="checkbox"/> Wrist stiffness | <input type="checkbox"/> Knee stiffness | <input type="checkbox"/> Numbness in the feet |
| <input type="checkbox"/> Numbness in the hands | <input type="checkbox"/> Weak knees | |

confidential. The therapist cannot be forced to disclose the information without the client's consent.

Information disclosed to a licensed marriage and family therapist, a licensed social worker, a licensed professional counselor, a licensed psychologist, or an unlicensed psychotherapist is privileged communication and cannot be disclosed in any court of competent jurisdiction in the State of Colorado without the consent of the person to whom the testimony sought relates.

There are exceptions to the general rule of legal confidentiality. These exceptions are listed in the Colorado statutes (C.R.S. 12-43-218 Please request a copy of this statute if you wish to read its contents.) You should be aware that provision concerning disclosure sure of confidential communications shall not apply to any delinquency or criminal proceedings, except as provided in section (13-90-107 C.R.S. Please request a copy of this statute if you wish to read its contents.) There are exceptions that I will identify to you as the situations arise during the therapy.

5. If you have any questions or would like additional information, please feel free to ask.
6. Cancellation Policy

An appointment agreed to by the client and the therapist constitutes a contract.

When this appointment is set by the client and then cancelled by the client, with no appointment rescheduled, the full cost of the appointment will be charged to the client

When this appointment is set by the client and then cancelled by the client more than 24 hours or more before the appointment, and a new appointment is scheduled at that time, there will be no cancellation fee.

When this appointment is set by the client and then cancelled by the client during the remaining 24 hours before the appointment, and a new appointment is scheduled at that time, there will be a cancellation fee of 50% of the cost of the appointment.

I have read the terms of this contract and agree to them.

Client Signature

Date

Schedule Of Charges Per Scheduled Session*

Initial Session (this session can last up to two hours or more)	\$180.00
When possible, I like to have an introductory session prior to the Initial session (fifteen to twenty minutes). Questionnaire must be completed before Initial Session.	
Charges for scheduled Session (in the office).	\$ 90.00
Charges for scheduled Session (by phone).	\$ 90.00
Charges for sessions exceeding ninety minutes (in the office).	\$ 1.50 per-minute.
Charges for sessions exceeding ninety minutes (by phone).	\$ 1.50 per-minute.

*Session: In order to avoid the traditional constraints of charges incurred for therapy by charging by the minute, I schedule a ninety-minute period for each appointment (Almost all sessions are about one hour in length). This avoids the possibility of a person attempting to find some guidance in the middle of a significant concern, being told their session is over.

Note: Please ask if there are any additional charges for service at the end of your session. I encourage you to question and/or challenge any charges you do not understand. *Arrangement for payment must be made at the beginning of the session.*

Schedule Of Charges Per Unscheduled Session*

Charges for unscheduled Session (in the office).	\$50.00 per 30-minute session.
Charges for unscheduled Session (by phone).	\$50.00 per 30-minute session.
Charges for unscheduled Session exceeding sixty minutes.	\$ 2.00 per minute.

*Unscheduled Session: There will be no charge for the first five minutes of any Unscheduled Session. Each active client will be allowed four five-minute calls or office visits during the length of their scheduled therapy.

Note: Please ask if there are any additional charges for service at the end of your session. I encourage you to question and/or challenge any charges you do not understand. *Arrangement for payment must be made at the beginning of the session.*

Schedule Of Charges For Person Of Need*

**Person Of Need* is defined as any person who is able to demonstrate their need for therapy (completing the THIS thERAPY Questionnaire). It is also crucial that they are willing to commit to the rigors/demands of this therapy. Any charges incurred will be adjusted according to their ability to pay. The caseload (number of these clients) for this service will be governed by the amount of time I have available. *Arrangement for payment (if any) must be made at the beginning of the session.*