PATRICIA E. (PAT) Gossett, M.A., LPC
Phone: 214-909-0829 Fax 972-525-8536
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500 Turtle Cove, Suite 220, Rockwall, TX 75087

Please read this document carefully as it contains important information that affects you and our professional relationship.

COUNSELING AGREEMENT & INFORMED CONSENT

Thank you for choosing me, Pat Gossett, MA., LPC, for your counseling needs. These documents are designed to ensure that you understand our professional relationship, provide me with your consent for counseling, and to collect pertinent information to assist me in your counseling process. Please be thorough as you complete these important documents.

CONFIDENTIALITY

All communication between you and your counselor will be held in confidence in accordance with the law and professional standards of the Texas State Board of Professional Counselors and will not, except under the circumstances explained below, be disclosed to anyone without your written prior authorization. ***Recording of counseling sessions by Client, any Collateral Participant, or Pat Gossett, MA., LPC is strictly prohibited without prior written consent of all parties present.*** Exceptions to confidentiality include, but may not be limited to, the following:

- Imminent harm to self or others, including information regarding any sexually transmitted diseases
- Suspicion of abuse or neglect of the elderly or disabled
- Suspicion of abuse (sexual or otherwise) or neglect of children
- Compliance with a court order to do so
- Child custody case suits in which the mental health of a party is an issue
- Fee disputes between the therapist and the client
- A negligence suit brought by client against therapist or filing of a complaint with the licensing board
- Processing third party payor forms, obtaining payment for third party payers, answering required questions from third party payers in order tor client benefits to continue ***(Please be aware, if you are filing with your health insurance carrier, your carrier has the right to request from me a copy of your session notes at any time without your knowledge to conduct an internal audit. Furthermore, a representative of your health insurance carrier may call this counselor seeking information required for continuation of policy payments at any time. This counselor cannot be held responsible for the confidentiality of records released in this way.)***

Please note that exceptions to confidentiality are extremely rare; however, if one should occur, it is my policy whenever possible, to discuss with you any action being considered. Legally I am not obligated to seek your permission if I need to secure your safety or the safety of others. If disclosure of confidential information does become necessary, I will release only the information necessary to protect you or someone else. Texas Law requires

Licensed Professional Counselors to notify medical and/or law enforcement personnel in the event of imminent harm to self or others. You may designate an individual that I may call in an emergency; however, please note that notification is not limited to that person and may involve medical or law enforcement personnel as deemed appropriate.

Initial here indicating you have read & understand the above section _____

RECORD KEEPING

If I, Pat Gossett, MA, LPC, terminate practicing as a counselor, it will become necessary for another counselor (to be determined) to take possession of my files and records. Should that become necessary, by signing this Agreement you are giving me your consent to allow another licensed mental health professional selected by me to take possession of all your records.

Initial here indicating you have read & understand the above section _____

FEES / LENGTH OF SESSIONS

My fee per session is one hundred twenty dollars ($120.00) payable by cash, acceptable credit card, or check and is collected at the beginning of each session. Each session duration is 55-60 minutes. Arriving at your appointment on time will allow you to take full advantage of the allotted time.

I accept a limited number of insurance company assignments. If I am a provider with your insurance carrier, I will file a claim for the reimbursable amount with your carrier. You are responsible for payment of your portion at the time services are rendered. If your carrier requires that you meet a certain annual deductible dollar amount and you have not met that amount, you will be chartged at the provider reimbursement rate of your insurance carrier per session at the time of your session. ***Be aware, I file insurance for clients as a courtesy. You are responsible for any and all charges for each counseling session appointment, regardless of insurance coverage. Any disputes with payment from your insurance carrier are your responsibility and payment for sessions will default to you.***

Insurance companies require that a diagnosis be given regarding your mental health before they will consider for payment any claim submitted by a medical professional for services rendered. Any diagnosis made will become a part of your permanent medical records. Upon your request I will inform you of the diagnosis code(s)S that will be submitted for you to your insurance carrier.

You are responsible for keeping your scheduled appointments. When you set your appointment, that time is reserved just for you. If you are unable to attend your appointment, I require ***at least a 24-hour*** cancellation / reschedule notice. This notice offers me the opportunity to give that appointment time to another client. **The cost for a missed appointment of cancellation of less than 24 hours is my full session fee of $120.00.** ***(Be aware that I cannot bill insurance for missed appointment and you are fully responsible for this charge.)***

If I am subpoenaed by either a client or client's legal representative, the following fees apply:

- In person subpoena:
  - Preparation time (including submission of records): $ 120.00 / hr ($60 min chg)
  - Phone calls $ 120.00 / hr ($60 min chg)
  - Depositions: $ 120.00 / hr ($60 min chg)

- Time required in giving testimony: $ 120.00 / hr ($60 min chg)
- Mileage: $ 1.00 per mile
- Time away from the office due to depositions or testimony (in addition to above charges): $ 120.00 / hr or portion thereof
- All attorney fees & costs incurred by me as a result of this legal action: TBD
- Filing a document with the court $ 120.00 per occurrence
- Minimum charge for a court appearance $2500.00 per occurrence addition to other charges listed above and is payable at least 48 hours prior to the court date.

If the costs for the testifying process exceed the amount of the retainer then those fees will be billed to the client and/or their legal representative.

- Client records subpoena:
  - Preparation time for treatment summaries or production of other new documentation: $ $120.00 / hr billed in 15 minute increments
  - Printing costs $ 75.00 for the first 20 pages, $.50 per page thereafter

Initial here indicating you have read & understand the above section _____

EMAILS / TEXT MESSAGES / TELEPHONE CALLS

Please limit text messaging and emails to matters having to do with scheduling of appointments or billing issues and save all other matters for discussion during your scheduled session time unless I have personally instructed you otherwise in special circumstances. Any emails, texts, or phone calls that concern counseling matters will be billed at $30.00 per quarter hour with a $30.00 minimum.

Initial here indicating you have read & understand the above section _____

OFF HOURS EMERGENCIES

If you experience an emergency requiring immediate action during hours that I am not in the office, you are instructed to call 911 or go to your nearest medical emergency facility for assistance.

I do not return any client communications on Sunday. Crisis management calls to me will be brief and aimed at stabilizing the situation for processing at your next scheduled appointment. Calls will be billed to you at the rates designated above.

Initial here indicating you have read & understand the above section _____

THE COUNSELING PROCESS AND PROFESSIONAL RELATIONSHIP

Please be aware that my counseling is based on Christian, Biblical values. Because individuals and issues vary, length of treatment is hard to determine ahead of time. Some clients need only a few counseling sessions to achieve their goals, while others may require much longer. Please note that it is impossible for me to guarantee any specific results regarding your counseling.goals. There is a chance that you will feel worse before you feel better. During the counseling process your level of awareness may increase causing some emotional distress and/or anxiety. Furthermore, you may experience changes that could result in lifestyle and/or relationship disruptions or turmoil. Together, we will work to achieve the best possible results for you.

You can expect that therapy will end when you have received the maximum benefits or obtained what you were seeking. You have the right to end the counseling relationship at any time. I would hope, however, that you would discuss this decision with me first. If you or I feel you are no longer benefiting from our time together, we will end the counseling relationship by mutual consent.

You are best served while I am seeing you for counseling if our relationship stays strictly professional and if our sessions concentrate exclusively on your concerns. Our contact will be limited to sessions you arrange with me. Please do not invite me to social gatherings, offer me gifts, or ask me to relate to you in any way other than in the professional context of your counseling sessions. If I should run into you outside the counseling office, I will not acknowledge you unless you first acknowledge me. This is in order to proitect your privacy regarding our professional relationship.

Initial here indicating you have read & understand the above section _____

COMPLAINTS

If you have any complaints, please discuss them with me. If you are not satisfied with the resolution of the problem you have the right to call the Complaints Management & Investigations (1-800-942-5540, or write to Texas State Board of Professional Counselors, P. O/. Box 141369, Austin, Texas 78714.

Initial here indicating you have read & understand the above section _____

I, the Client, have read and understand my rights and responsibilities as described in this document and request Pat Gossett, M.A., LPC, to provide counseling services to me.

_____ _____
Client Signature *Date*

_____ _____
Client Printed Name *Client's Telephone Number*

_____
Client Address

_____
City, State, Zip Code

_____ _____
Signature, Patricia E. Gossett, M.A., LPC *Date*

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PLEASE PRINT CLEARLY ALL INFORMATION

CLIENT INFORMATION

_____ _____
Client Name **Employer**
Male ____ Female ____ DOB_____ _____
Position Held / Title
_____
Contact Telephone Number
_____ _____
Street Address **Street Address**
_____ _____
City State Zip **City State Zip**

SPOUSE INFORMATION (If Applicable)

_____ _____
Spouse Name **Employer**
_____
Position Held / Title
_____ _____
Contact Telephone Number DOB
_____ _____
Street Address **Street Address**
_____ _____
City State Zip **City State Zip**

EMERGENCY CONTACT INFORMATION

The information you provide below is your authorization for me to contact these individuals

- ***should I deem it an emergency situation and / or necessary for your safety or the safety of others***
- ***for continuity of care (with other medical professionals)***

during the course of your treatment with me. This authorization fulfills Hipaa requirements for consent to release information heretofore considered confidential.

_____ _____ _____
Psychiatrist **City** **Phone**

_____ _____ _____
Primary Care Physician **City** **Phone**

_____ _____ _____
Personal Contact **Relationship** **Phone**

Patricia E. (Pat) Gossett, M.A., LPC
500 Turtle Cove, Suite 220 Rockwall, TX 75087
214-909-0829

PATIENT CONSENT FOR USE AND / OR DISCLOSURE OF Hipaa DEFINED PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, _____, hereby stated that by signing this Consent, I
(Please print full legal name)

acknowledge and agree as follows:

The Provider's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice ("Information and Informed Consent") includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Provider to provide treatment to me, and also necessary for the Provider to obtain payment for that treatment and to carry out her health care operations. The Provider explained to me that the Privacy Notice will be available to me in the future at my request. The Provider has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

The Provider reserves the right to change her privacy practices that are described in her Privacy Notice, in accordance with applicable law.

understand and consent to the following means of contact as deemed professionally necessary by Provider:

Yes_____ No_____ Telephoning my home and leaving a message on my answering machine or with individual answering the telephone

Yes_____ No_____ Telephoning my office and leaving a message on my phone mail or with the individual answering the telephone

Yes_____ No_____ Telephoning my cell phone and leaving a message on my voice mail or with the individual answering the phone if other than me

Yes_____No_____ Leaving a text message on my cell phone

Yes_____No_____ Leaving an email message at this address: _____

The Provider may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Provider to treat me and obtain payment for that treatment, and as necessary for the Provider to conduct its specific health care operations.

I understand that I have a right to request that the Provider restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Provider is not required to agree to any restrictions that I have requested. If the Provider agrees to a requested restriction, then the restriction is binding on the Provider.

I understand that this Consent is valid for seven years and that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Provider has already taken action in reliance on this consent.

I understand that if I revoke this consent at any time, the Provider has the right to refuse to treat me.

I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Provider will not treat me.

I have read and understand the foregoing notice. Any of my questions have been answered to my full satisfaction.

Client Signature	**Date**

Symptom Checklist

Please check all that apply, then please CIRCLE items that are especially bothersome to you.

Please check any of the following which are / may have been particularly stressful to you:

Recent	Past	
_____	_____	Job related stress
_____	_____	Marital conflict
_____	_____	Death or loss of loved one; Relationship to this person_____
_____	_____	Conflict with children
_____	_____	Children with behavior problems
_____	_____	Conflict with parent(s) or extended family
_____	_____	Feeling stress due to recalling memories of trauma or stress in my life
_____	_____	Family member with an alcohol or drug problem
_____	_____	Being abused by someone
_____	_____	Financial pressure

Any of the following symptoms for (*all* of these) MOST OF THE DAY, NEARLY EVERY DAY, FOR PERIODS LONGER THAN SEVERAL DAYS AT A TIME:

Recent	Past	
_____	_____	Depressed or sad mood
_____	_____	Loss of interest or pleasure in things I'm normally interested in
_____	_____	Difficulty going to sleep
_____	_____	Difficulty staying asleep or waking up too early
		What are the average number of hours you are sleeping per night? _____
_____	_____	Sleeping too much
_____	_____	Increased appetite / weight gain (Number of lbs you have gained: _____)
_____	_____	Decreased appetite / weight loss (Number of lbs you have lost _____)
_____	_____	Fatigue / Poor energy level
_____	_____	Decreased activity (work / social / physical / sexual – circle those that apply)
_____	_____	Poor concentration or slowed thinking
_____	_____	Thoughts of suicide
_____	_____	Excessive feelings of guilt or worthlessness

Any of the following symptoms for (*all* of these) MORE DAYS THAN NOT, FOR MONTHS AT A TIME:

Recent	Past	
_____	_____	Excessive anxiety or worry for no good reason

_____ _____ Trembling, twitching or feeling "shaky"
_____ _____ Muscle tension or muscle aches
_____ _____ Easily fatigued
_____ _____ Dry mouth
_____ _____ Dizziness or light headedness
_____ _____ Nausea, diarrhea, or other stomach problems
_____ _____ Frequent urination
_____ _____ Irritability
_____ _____ Trouble falling or staying asleep

Panic attacks (any period of extreme, increased anxiety lasting from a few minutes up to several hours) with any of the following symptoms:

Recent Past

_____ _____ Panic attacks / anxiety attacks
_____ _____ Persistent worry that I will have a panic attack
_____ _____ Heart pounding or racing heart
_____ _____ Trembling or shaking
_____ _____ Sweating
_____ _____ Choking
_____ _____ Nausea or stomach problems
_____ _____ Feelings of unreality
_____ _____ Numbness or tingling sensations
_____ _____ Feeling of smothering or shortness of breathe
_____ _____ Fear of dying
_____ _____ Fear of going crazy or doing something uncontrolled
_____ _____ Chest pain or discomfort
_____ _____ Dizziness, unsteady feelings or faintness
_____ _____ Flushes, hot flashes or chills
_____ _____ Avoiding situations or places that may cause panic or severe anxiety

Any of the following symptoms for (*all* of these) MOST OF THE DAY, NEARLY EVERY DAY, FOR MORE THAN FOUR (4) DAYS AT A TIME:

Recent Past

_____ _____ Euphoric or "high" mood
_____ _____ Irritable mood
_____ _____ Decreased need for sleep without feeling tired
_____ _____ Increased energy level
_____ _____ Increased activity (work / social / physical / sexual – circle those that apply)
_____ _____ Thoughts speeded up or racing thoughts
_____ _____ Increased talkativeness or being much more socially outgoing
_____ _____ Making decisions too impulsively
_____ _____ Going on spending sprees

Check any of the following relating to your alcohol or drug use:

Recent Past

_____ _____ I've felt alcohol or drugs were causing a problem for me
_____ _____ I have felt guilty about my use

_____ _____ Others have annoyed me about my use
_____ _____ I have had a desire (or made unsuccessful efforts) to cut down or control my use
_____ _____ I've tried unsuccessfully to control my use
_____ _____ I've used alcohol or drugs more often or in larger amounts than I intended
_____ _____ I've had to increase my use of alcohol or drugs to get the desired effect
_____ _____ I've had problems with withdrawal (shakes, nervousness, insomnia, etc.) when
I've cut down or stopped using alcohol or drugs
_____ _____ I've been to a meeting of Alcoholics Anonymous, Narcotics Anonymous, or
Celebrate Recovery (circle any / all that apply)

Any of the following disturbances in eating or maintaining normal weight:

Recent **Past**

_____ _____ Insistence on maintaining body weight below expected for age and height
_____ _____ Intense fear of gaining weight or becoming fat even though underweight
_____ _____ I feel "fat" even when others see me as underweight
_____ _____ Eating binges
_____ _____ Feeling of lack of control of eating during eating binges
_____ _____ Vomiting or using laxatives to prevent weight gain
_____ _____ Being over-concerned about body weight and shape

Check any of the following that apply:

Recent **Past**

_____ _____ I tend to do things on impulse which end up being damaging to me or others
_____ _____ I have mood swings (depression, irritability, anger) lasting up to several hours
_____ _____ I have tried to commit suicide
_____ _____ I have made cuts, burns, or other injuries to myself without wanting to kill myself
_____ _____ My mood often shifts from being either overconfident to having low self-esteem
_____ _____ I have a hard time sympathizing with other's pain
_____ _____ I often feel others do not understand me
_____ _____ I tend to get very hurt or angry when I am criticized or rejected by someone
_____ _____ I tend to need a lot of reassurance or approval from others
_____ _____ I am very concerned about my appearance
_____ _____ Others often expect too much of me

_____ _____ Hearing voices that sound real even though they are not actually there
_____ _____ Vivid voices in my head that do not seem like my ideas
_____ _____ Feeling that others might be putting thoughts in my head
_____ _____ Feeling others might be able to read my thoughts
_____ _____ Others feel I am too suspicious or paranoid
_____ _____ Feeling others might be talking about me

Any of the following problems relating to a past severe trauma or stress:

Recent **Past**

_____ _____ I have had an experience that was so traumatic that nearly anyone would have been seriously stressed by it
_____ _____ History of relatives hurting my physically or touching me in sexual areas
_____ _____ History of unwanted sexual contact
_____ _____ I have memories or dreams of a stressful event I have trouble putting out of my head
_____ _____ I sometimes have flashbacks of past events or I act or feel as though I am re-living a stressful event from the past
_____ _____ I try to avoid situations or people that remind me of a stressful event in the past

Any of the following obsessions or compulsions:

Recent **Past**

_____ _____ Excessive doubting, or repeated, forced unreasonable thoughts, images or Sounds that I cannot get out of my mind
_____ _____ Urges to check things, wash things, or count repeatedly
_____ _____ Excessive concern about coming into contact with germs or dirt
_____ _____ Excessive concern with right / wrong or morality
_____ _____ Excessive need for things to be exact or symmetrical
_____ _____ Recurrent, excessive pulling out of hair on any area of the body resulting in hair loss

_____ _____

Client Signature **Date**

COUNSELING GOALS

Please be thoughtful as you consider your counseling goals as this is my "blueprint" for addressing the reasons you are here and will be my guide in providing you the best help that I can.

INDIVIDUALS:

When beginning or re-entering the counseling process, it is important for you to think about what you want to accomplish during our sessions together that will serve you well as you move through life. Questions to ask yourself might include: "What will be present either in me or in my life that isn't there now?" "What behaviors will I have changed or be adopting to bring healthier elements into my life and my relationships?"

COUPLES:

If you are here for marriage / couples counseling, please list those specific issues regarding your relationship with your partner that are problematic for you and about which you are seeking change.

List your goals / problematic issues below. You don't have to have six goals, or you can have more than 6. Use the back of this page if you need more space. Please do not rush this assignment.

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

_____ _____

Client Signature **Date**

CLIENT HISTORY

If you need more room in answering any questions, please continue on the back of that sheet at about the same space as the question is located on the front.

GENERAL INFORMATION

People living in your home with you:

Name	Age	Relationship to you

Spouse or other children not living in your home:

Name	Age	Relationship to you	City / State of Residence

Current Health Issues: Please list all physical, mental, and/or emotional issues for which you are currently being treated.

	How Long ?

Past Health Issues: Please list all physical, mental, and/or emotional issues for which you have been treated in the past, but for which you are no longer receiving treatment.

	What Year(s) ?

Current Care Team: Please list medical doctors, PA, NP, Psychiatrist, Psychologist, or LPC you are currently seeing.

Name	Specialty	City	Reason for seeing

Current Prescription Medications:

Med Name / Mg / Dose	Start Date	Reason for medication

Drug / Alcohol History: Please check if you currently use, or have used, any of the following.

Substance:	Current Use:	Past Use:	Amount / Frequency:
Tobacco			
Marijuana			
Caffeine			
Alcohol			
Cocaine			
Amphetamines			
LSD / Psychedelics			
Heroin			
Pain Killers (not prescribed)			
Benzodiazepines (not prescribed)			

FAMILY OF ORIGIN INFORMATION

Family history of mental or emotional distress: Please list any blood (relatives who have any history of the following:

	Relationship to you
Major Depression	
Bipolar Disorder	
Schizophrenia	
Anxiety	
Alcoholism	
Drug Addiction	
ADHD / Other Learning Difference	
Disordered Eating	
Other: _____	

FATHER:

Birth Father:

Is your birth father still living? Yes____ No____ If no, please answer the following:

- How old was he when he died? _____ In what year did he die?_____
- How old were you when he died? _____
- What was his cause of death? _____

Describe your birth father's personality: _____

_____

Describe your relationship with your birth father

- as a child: _____

  _____

  _____

- as an adult: _____

  _____

  _____

Step-Father(s):

If you had more than one step-father, how many did you have? _____

Complete the following information for the step-father who was the most significant in your life.

- Is your step-father still living? Yes____ No____
- If no, how old were you when he died? _____

- Describe your relationship with your step-father,
  - as a child: _____

    _____

    _____

  - as an adult: _____

    _____

    _____

MOTHER:

Birth Mother:

Is your birth mother living? Yes____ No____ If no, please answer the following:

- How old was she when she died?_____ In what year did she die?_____
- How old were you when she died?_____
- What was the cause of death?_____

Describe your birth mother's personality:_____

_____

_____

Describe your relationship with your birth mother

- as a child: _____

  _____

  _____

- as an adult: _____

  _____

  _____

Step-Mother(s):

If you had more than one step-mother, how many did you have? _____

Complete the following information for the step-mother who was the most influential to you:

- Is your step-mother still living? Yes_____ No_____
- If no, how old were you when she died?_____
- Describe your relationship with your step-mother
  - as a child: _____

    _____

    _____

  - as an adult: _____

    _____

    _____

YOUR PARENTS' MARRIAGE: Please complete this section for the most influential marriage relationships you experienced by your parents. If it was not your birth parents, please complete one section for mother's most significant relationship to you and anther for father's most significant relationship to you.

Check one: **Birth Parents_____** **Birth Father and Step-mother_____**

What kind of marriage did your parents create? _____

_____

_____

_____

Did their relationship change over the years? (If so, how and when?)

_____

_____

Please describe any events / situations you recall that were significant during this time:

_____

_____

_____

_____

Complete this section only if applicable: Birth Mother and Step-father:
What kind of marriage did your parents create? _____

Did their relationship change over the years? (If so, how and when?)

Please describe any events / situations you recall that were significant during this time:

SIBLINGS:
Names, ages of all siblings, including you, in birth order: _____

YOUR CHILDHOOD: (Birth to 18 yrs. old or graduation from high school.)
What was it like for you growing up in your family? _____

Were you and your siblings all treated the same, or were there differences (e.g., favored, picked on, etc.)? _____

Elaborate on any events / situations that were present or occurred during your child that were significant, such as domestic abuse, drug or alcohol abuse or addictions, hospitalizations, house fires, etc. _____

During your school years did you have to deal with any of the following: bullying, learning differences, being held back a grade, or any other events that were significant for you (please elaborate)? _____

_____

Did you experience any religious trauma or abuse? Yes_____ No_____

Elaborate if yes: _____

_____

Did you graduate from high school? Yes____ No____ GED: Yes____ No____

Overall, what was your high school experience like for you (such as, "uneventful, involved; athlete; loner," etc.)? _____

_____

_____

_____

HIGHER / OTHER EDUCATION:

After leaving high school, list any institution of higher learning you attended, including trade schools, or other specialized training:

Name of school	**Years attended**	**Certification / Degree obtained**
_____	_____	_____
_____	_____	_____
_____	_____	_____

RELATIONSHIP HISTORY:

- Currently are you: single____; married____; divorced____; widowed___; living together____.
- If applicable, length of current relationship: _____ Years married_____
- Divorce history: How many times have you been divorced? _____
  - At the time of each divorce, please list the following:

Your age:	Year of divorce:	Duration of marriage:
_____	_____	_____
_____	_____	_____
_____	_____	_____

- If you are currently married or involved in a significant relationship describe what the relationship is like: _____

_____

_____

ABUSE / TRAUMA HISTORY:

Please briefly explain here any of trauma(s) you have experienced in your life time. Some examples might be military experiences, sexual, prison, natural disaster.
List *anything* that, for you, was a traumatic or significantly emotionally charged event.

_____

_____

_____

SPIRITUALITY / FAITH:

By signing this document, you indicate that you understand and agree that counseling sessions with me, Pat Gossett, LPC, are based on Christian, Biblical principals and the use of Biblical precepts, scripture verses and references are a natural part of this counseling process.

- What church denomination do you most identify with? _____
- How often do you attend religious services? _____
- What church do you attend? _____

MISCELLANEOUS PERSONAL INFORMATION:

- **Hobbies:** List any activities you pursue in your spare time: _____

  _____

  _____

- **Personal Strengths:** List those qualities you possess that you consider strengths.

  _____

  _____

  _____

- **"Room for Growth":** List any personal areas you think might need some improvement or growth. _____

  _____

  _____

- **Other Relevant Information:** Please elaborate on any other important or relevant information that has not been covered in this questionnaire that you think would be helpful for me to know about you.

  _____

  _____

  _____

  _____

How did you hear about me? _____ **If you were referred to me by an individual, if you feel comfortable doing so, please tell me the name:**

_____

_____ _____

Your printed name Date

Your signature