FACTOR

Counseling Services

Lisa Factor, LPCA, NCC

New Client Intake Paperwork

Please review and carefully complete the following intake packet and bring to our first session together.

101 E Buck Mountain Road • West Jefferson, NC • 28694
factorcounselingservices.com • 336-902-3888

Lisa Factor, LPCA, NCC

Professional Disclosure Statement & Consent for Treatment

I am very pleased to be working with you today. This information is intended to inform you of my background while also giving you information regarding our therapeutic relationship. Please read it carefully and feel free to ask any questions that you may have.

Qualifications/Experience: I hold a master's degree in mental health counseling from Lenoir-Rhyne University, graduating in December 2015. I currently have 1.5 years counseling experience since graduating, but prior to becoming a counselor I worked for over 20 years as a Registered Nurse. I am currently licensed as a Licensed Professional Counselor Associate in North Carolina. I hold a bachelor's degree in applied science from Campbell University, along with an associate's degree in science, and a diploma in nursing. I am a registered nurse with a currently inactive professional license. As nurse I worked with diverse populations primarily in critical care/ emergency areas. I currently see individuals ages 14 years and older, and also provide family and couples counseling. I am a member of the American Counseling Association.

Approach to Counseling: My approach to counseling demonstrates my belief that therapy allows a person to increase their self- awareness, allowing for growth and self-discovery in a safe, supported environment. I integrate different theories of change in my style of counseling but rely most heavily on experiential techniques believing that change occurs for many individuals more quickly when they involve several senses during the counseling process. I have over 100 hours of specialized training in experiential therapy techniques. I believe that the relationship that we build will be the key for reaching the goals that you set for therapy. You are the expert on you, and it is my belief that we will use our combined resources to work together to bring positive change to your life. If at any time I feel that I do not have the expertise needed to work as your counselor, I will refer you to a mental health professional that I believe may be better able to help you.

Fees: Sessions are billed at a rate of $125/hour. Initial sessions last 1.5 hours. Most individual sessions are 60 minutes but longer sessions may be scheduled if believed beneficial for, and agreed upon, by the client. Family and couples sessions are scheduled for a minimum of 1.5 hours. I am not accepting insurance at this time and will notify all clients if that should change. Cash, check and major credit cards are accepted for payment of services. A $25 fee will be charged for any checks returned for insufficient funds. Payment for all services is expected on the day service is received unless other arrangements have been agreed upon.

Use of Diagnosis: Some health insurance companies will reimburse clients for counseling services and some will not. In addition, most will require that a diagnosis of a mental-health condition and indicate that you must have an "illness" before they will agree to reimburse you. Some conditions for which people seek counseling do not qualify for reimbursement. If a qualifying diagnosis is appropriate in your case, I will inform you of the diagnosis before we submit the diagnosis to the health insurance company. Any diagnosis made will become part of your permanent insurance records.

Cancellation Policy: Appointment times are reserved for each client and a $50 fee will be charged for the first appointment that is missed without notice. If a second appointment is missed without notice the time will be charged for at the full rate of $125. A $25 late cancellation fee will be charged for any appointment canceled without 24- hour notice. This fee may be waived at the provider's discretion in the case of an emergency or other unforeseen event.

Counseling Relationship: The client/counselor relationship can involve the sharing of intimate situations and emotions, but it is important that it is maintained as professional. I do not enter into social relationships with my clients during, or after, the time that therapy begins. If we were to see each other outside of this office I will not make contact with you unless you approach me and then will not discuss any aspect of therapy. I will uphold these boundaries, as it is not only ethical, it is important to maintaining the therapeutic relationship.

Confidentiality: As a member of the American Counseling Association, I am bound to a set of ethical standards that includes maintaining all information discussed in our sessions to remain confidential unless:

1. I believe that you may be a danger to yourself or someone else.
2. You provide information that leads me to believe that a child (under 18 years of age), elderly person, or disabled adult is, or has been the victim of abuse or neglect.
3. A court order has been issued requiring me to release information about you and your clinical record.
4. You provide a written request that I release information.

Client Rights: There are no guarantees that counseling will help you achieve the goals you have set. Some clients work through problems very quickly and others need lengthy therapy. As the client, you have the right to terminate therapy at any time. You are also encouraged to bring any concerns or questions to me whenever they occur. During our work together, you may be assessed for a diagnosis. This diagnosis will become a part of your record.

Emergency/Crisis: As I am not trained for emergency or crisis situations, I do not provide these services. If you experience a mental health emergency, please go to the nearest hospital Emergency Room or call 911 for care.

Supervisory Contacts: As an LPCA I will be receiving supervision from an experienced counselor that is licensed as a Licensed Professional Counselor Supervisor by the NC Board of Professional Licensed Counselors. To facilitate this, I will at times be required to audio or videotape sessions so that I can provide my supervisor evidence of my skills. I will notify you at the beginning of any session that is being recorded and you have the right to refuse without effect on your treatment. My current supervisor is Sheila Maitland, LPCS, and can be reached at (704) 560-4388.

Complaints: Although clients are encouraged to discuss any concerns with me, you may file a complaint against me with the organization below should you feel I am in violation of any of these codes of ethics. I abide by the ACA Code of Ethics (http://www.counseling.org/Resources/aca-code-of-ethics.pdf).

North Carolina Board of Licensed Professional Counselors
P.O. Box 77819
Greensboro, NC 27417

Phone: 844-622-3572 or 336-217-6007
Fax: 336-217-9450
E-mail: Complaints@ncblpc.org

Consent to Treatment: Signing below indicates that you have read and understand this statement and have had the opportunity to discuss any questions or seek clarification regarding any aspect of treatment that you do not understand. Signing also acts as consent for video or audio taping of sessions for the purpose of clinical supervision.

Client Signature	Date
Parent Signature (if client under 18)	Date
Counselor's Signature	Date

Client Information

When beginning the therapy process, it is important to conduct a thorough assessment in order to provide your therapist with the information they need to make diagnostic determinations and to formulate a plan to help you reach your goals. Please carefully complete the questions on the following pages to the best of your ability.

Client Personal Information		
Client Name	Date of Birth	Current Age
Street Address		
City	State	ZIP Code
Preferred Email Address	Preferred Phone Number	
I give permission for the Factor Counseling Services to contact me and to leave messages for me using all of the media indicated to the right. I understand that text/SMS messages will be used only to coordinate scheduling of sessions.		☐ Email ☐ Telephone/Voicemail ☐ Text/SMS
Employment Status	Occupation	
Cultural/Ethnic Identity	Faith/Spiritual Identity	
Gender Identity	Sexual Orientation	Preferred Pronouns

Relationship Information (if applicable)			
Current Relationship Status *(complete section outlined below if applicable)*		# of Prior Marriages	
Partner Name		Date of Birth	Current Age
Employment Status	Employer	Occupation	
Cultural/Ethnic Identity		Faith/Spiritual Identity	
Length of Relationship		Partner's preferred pronouns	

Emergency Contact Information

Name	Phone Number	
Street Address		
City	State	ZIP Code
Relationship to Client		

Educational History

Highest level of education completed	How old were you when you left home?	
Most recent educational institution	Years attended	Degree/Certificate awarded

Presenting Concern & Counseling History

Please briefly describe the concern(s) that motivated you to seek counseling at this time
Briefly describe your past experience with counseling and psychiatric hospitalization, if any.
What are your goals for counseling?

Current Symptoms

Please indicate which of the following behaviors/symptoms are currently present

☐ Depression	☐ Anxiety	☐ Loneliness
☐ Sleep irregularity	☐ Crying Spells	☐ Nervousness
☐ Angry outbursts	☐ Violent Behavior	☐ Change in Sex Drive
☐ Loss of Energy	☐ Avoidance	☐ Suspicious thoughts
☐ Unable to enjoy activities	☐ Fatigue	☐ Phobias or Hallucinations
☐ Loss of interest	☐ Increased Fears	☐ Change in eating patterns
☐ Concentration/forgetfulness	☐ Difficulty with Relationships	☐ Increased use of Alcohol
☐ Change in appetite	☐ Difficulty at work	☐ Increase risky behavior
☐ Excessive energy	☐ Increased Medication	☐ Racing thoughts

Are there other symptoms/behaviors, not listed above that you would like to include?

Have you ever had feelings that you do not want to live? *If yes, please complete the section outlined in bold below*	☐ Yes ☐ No
Do you currently experience feelings that you do not want to live?	☐ Yes ☐ No

How often do you have these thoughts?	When was the last time you had thoughts of dying?

Has anything happened recently to make you feel this way?

On a scale of 1 (lowest) to 10 (strongest), how strong is your desire to kill yourself currently?

Would anything make it better?

Have you ever thought about how you would kill yourself?	☐ Yes ☐ No
Do you feel hopeless and/or worthless?	☐ Yes ☐ No
Is the method you would use readily available to you?	☐ Yes ☐ No
Have you planned a time for this?	☐ Yes ☐ No
Have you ever tried to kill or harm yourself before?	☐ Yes ☐ No

What, if anything, would keep you from killing yourself now?

Do you have access to firearms?	☐ Yes ☐ No

If you answered **Yes** to the previous question, please explain.

Household and Family Information

Please list the people that live in your home. Include their ages and their relationship to you.

Please list your current family members and/or relationships that are sources of strength

Please list your current family members and/or relationships that are sources of concern

Family History

Father's Name	Father's DOB	Mother's Name	Mother's DOB
Father's Occupation		Mother's Occupation	
Were your parents married?	☐ Yes ☐ No	Did your parents divorce?	☐ Yes ☐ No
Were you adopted?	☐ Yes ☐ No	If yes, who did you live with?	☐ M ☐ F ☐ Both ☐ Other

Please briefly describe your relationship with your parents	List members of your immediate family who have died.

Please indicate any of the following that were present in your home prior to the age of eighteen.

☐ Alcohol/Drug Addiction	☐ Financial Problems
☐ Physical Abuse	☐ Divorce
☐ Sexual Abuse	☐ Lived in Foster Care
☐ Emotional/Verbal Abuse	☐ Emotional Distance
☐ Unwanted Touching	

If you checked any items above, please provide additional details *(e.g. who, when, etc)*

Medical History

Primary Care Physician	Primary Care Physician Practice Name
Current Height	Current Weight
How many days per week do you typically exercise?	Date of most recent physical

Briefly describe any major illnesses/procedures you have experienced at any point in your life.

Describe any current medical conditions that are a current concern for you.

List any allergies that you have.

For Women Only

Date of last menstrual period		Are you currently pregnant?	☐Yes ☐No ☐Unsure
Number of Pregnancies	Number of live births	Are you planning to get pregnant in the near future?	☐Yes ☐No

What birth control methods do you currently use?

Current Medications & Supplements

Please provide a list of all medications (both prescription and over-the-counter) and supplements (e.g. vitamins, etc.) that you are currently taking.

Name & Dosage	Start Date	Reason	Prescribing Physician

Family Medical/Psychiatric History
Please indicate which of the following issues/concerns have been present in your immediate family. Please indicate which family member by using the following key (**F** = father, **M** = mother, **S** = sibling, **I** = self**).**

Example: Liver Disease	F	Heart Disease	
Thyroid Disease		Epilepsy/Seizures	
Anemia		Chronic Pain	
Liver Disease		High Cholesterol	
Chronic Fatigue		High Blood Pressure	
Kidney Disease		Head Trauma	
Diabetes		Liver Problems	
Asthma/Respiratory Problems		Cancer	
Gastrointestinal Problems		Fibromyalgia	
Bipolar Disorder		Depression	
Anxiety		Anger	
Schizophrenia		Post-traumatic Stress Disorder	
Alcohol Abuse		Other Substance Abuse	
Violence		Suicide	

Please describe any other significant family medical history

Alcohol & Substance Use

Substance	Frequency per week	Amount per use	Reason for use
e.g. alcohol	*2-3 times*	*1-2 drinks*	*Relaxation*

Have you ever received treatment for alcohol or substance use?	☐ Yes ☐ No
If yes, which substances?	

How many days per week do you drink alcohol?	Most drinks per day	Least drinks per day

Have you had used alcohol/drugs first thing in the morning to calm down or due to a hangover?	☐ Yes ☐ No
Have you ever felt you ought to cut down on your drinking/drug use?	☐ Yes ☐ No
Have you ever felt bad/guilty about your drinking/drug use?	☐ Yes ☐ No
Have other people annoyed you by saying you should cut down on your drinking/drug use?	☐ Yes ☐ No
Do you think you may have a problem with alcohol or drugs?	☐ Yes ☐ No
Have you used any illegal drugs in the last three months?	☐ Yes ☐ No
If yes, which drugs have you used?	
Have you ever abused prescription medication?	☐ Yes ☐ No
If yes, which prescription medications have you abused? How long?	

Caffeine Use
Please indicate the number of caffeinated beverages/substances you consume each day

Soda	Coffee	Tea	Other

Nicotine Use
The following questions are related to the use of nicotine.

Have you ever used nicotine?	☐ Yes ☐ No
Do you currently use nicotine? *If yes, please indicate your daily usage below*	☐ Yes ☐ No

Cigarettes	Pipes/Cigars/Etc	Vaporizer	Other

Military History

Are you currently serving or have you ever served in the military?	☐ Yes ☐ No
Dates of Active Service	
Branches Served	
Please list any deployments	

Legal System Involvement

Please list any court or legal system involvement including arrests, divorce, etc.

Other Information

Is there anything else that you think is important to share prior to beginning counseling?