BETTER LIFE

BETTER LIFE INTELLECTIVE HEALING, LLC

Patient Registration Form

Patient name _____ **Date of Birth** _____

Preferred Pronouns _____

Mailing Address _____ **City** _____ **State** _____ **Zip** _____

Cell Phone _____ **Best way to contact:** _____

Is it okay to leave medical information on your voicemail if we are unable to reach you (Circle one)?
Yes No

Email _____ **Is it okay if we email you (Circle one)?**
Yes No

Please note: Email correspondence is not considered to be a confidential medium of communication

Employer _____ **Phone** _____

Emergency Contact _____ **Relation to Patient** _____

Phone _____

Referred by:

Doctor Pastor/Spiritual Leader Family Member Friend Website

Other: _____

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Medical Insurance Information

Primary Insurance

_____

ID Number _____ **Group Number** _____

Insurance Name _____ **DOB** _____

Secondary Insurance

_____

ID Number _____ **Group Number** _____

Scheduling Agreement

Welcome to BETTER LIFE INTELLECTIVE HEALING, LLC. We look forward to partnering with you in your care. It is our priority to make our clinic an environment where patients will receive the highest quality of professional care. The providers with BETTER LIFE INTELLECTIVE HEALING, LLC are committed to maintaining a cooperative and effective relationship with their clients who have entrusted their care to us. Please review the following guidelines:

Coordination of Care

• If my care pauses for 90 days or more between sessions, unless other agreements have been made in advance, I will likely be transitioned to an inactive client status for legal and ethical reasons.

• I understand that I can resume my care at any time but may be asked to re-establish with a provider depending on the length of absence.

Scheduling

• It is important that patients at BETTER LIFE INTELLECTIVE HEALING, LLC keep their scheduled appointments to receive the care they need. Each patient is responsible for scheduling all their appointments.

• Appointments cannot be scheduled for more than 1 month in advance without a provider's recommendation.

• I understand that if I reschedule often, even with notice, I may possibly be limited to how many appointments can be scheduled at a time and/or be limited to scheduling so far in advance.

No Show/Late Cancellation Policy

• I understand that if I need to cancel my appointment, I am required to give BETTER LIFE INTELLECTIVE HEALING, LLC a full 24 hours' notice.

• I understand that if I do not give 24 hours' notice, my cancellation can be considered a late cancellation or a no notice appointment.

• A late cancellation or no notice appointment can incur a fee of $70 per occurrence. Insurance companies do not pay for missed appointments; therefore, you will be responsible for the full amount charged.

• If I have 3 no notice or late cancellations, I will possibly be terminated from BETTER LIFE INTELLECTIVE HEALING, LLC and referred to outside care.

Payment Authorization

• I give permission to BETTER LIFE INTELLECTIVE HEALING, LLC to hold my credit card on file and authorize automatic payment should I incur any cancellations/no show fees.

• I have given the credit card ending in: _____ (last 4) and agree to maintain a valid card on file if I remain an active patient.

• I understand my card will be charged on the same day as the scheduled appointment.

My signature acknowledges that I have read and agree to the scheduling guidelines listed above. I understand my responsibilities as a client with BETTER LIFE INTELLECTIVE HEALING, LLC

Initial Below and Sign Form

_____ **If patient arrives more than 10 minutes late for a follow-up appointment, patient may be unable to be seen and will possibly be charged a $70 "No-Notice/No-Show" occurrence. Late arrivals for follow-up appointment may be subject to a $70 fee.**

Printed Name: _____ **Date:** _____

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Signature: _____

Therapy Agreement & Informed Consent

Kindall Baker, LCSW

Before starting mental health therapy, it is important to know what to expect, and to understand your rights as well as commitments. This consent form is an attempt to be as transparent with you as I can about the therapy process, so you are fully informed prior to starting treatment. I will give you a copy to take home.

Treatment Philosophy

• Mental health therapy is a process of opening up about your life experiences and your genuine thoughts and feelings in order to increase your self-awareness of psychological and emotional conflicts that keep you stuck in unwanted patterns. This means we will focus on helping you uncover the root causes, thought patterns, emotions, and actions that contribute to current life distress. For the therapy to be most successful, you will have to work on things we discuss both during our sessions and at home. I may also make other appropriate referrals if I find it necessary (i.e., psychiatric evaluation; neuropsychological evaluation). Remember, you always retain the right to request change in treatment or to refuse treatment at any time.

• The therapy may involve temporary periods of discomfort as you begin to work through past trauma or confront psychological conflicts you have previously been avoiding. You may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, therapy has been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress.

• Your psychotherapy sessions will be approximately 50-60 minutes in length and are generally conducted once per week. We will discuss if a different meeting frequency (i.e., once every two weeks) will work best depending on your specific situation.

• Treatments supported by research to help people with specific problems are generally shorter-term in nature (e.g., 16-20 sessions). By learning helpful skills and ways of thinking about your concerns in treatment, clients often find they are well equipped to manage on their own or with occasional support.

• **APPOINTMENT RESCHEDULING OR CANCELING:** Once an appointment is set, that time is reserved for you. I cannot typically fill that time within 24 hours. Therefore, **APPOINTMENTS MUST BE RESCHEDULED OR CANCELED 48 HOURS IN ADVANCE;** I may make an exception for a true emergency.

• I can be reached at the clinic by calling (541) 673-0190. I am often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. At these times, you may leave a message on the clinic's confidential voicemail and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. If, for any number of unseen reasons, you do not hear from me or I am unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe:

1. Contact Douglas County Mental Health Crisis Line (541-440-3532 or 1-800-866-9780)
2. Go to your Local Hospital Emergency Room.
3. Contact the Mental Health National Helpline at 1-800-662-4357; or
4. Call 911 and ask to speak to the mental health worker on call.

• According to the laws in many states and all professional ethics codes, any kind of sexual conduct or asking for sexual conduct, or sexual misconduct by a mental health provider with a client is illegal, as well as unethical.

Initial Intake/Evaluation

• The purpose of the intake process is to fully evaluate your needs and ensure you receive the best treatment possible. The evaluation itself may vary across clients and may include activities such as completing a structured interview (i.e., every client is asked the same questions to ensure comprehensiveness), questionnaires, or several other options.

• By the end of this intake period (first 1-2 sessions), I will be able to offer you an initial impression of your needs and a plan for what treatment might include if you decide to continue with therapy. If we are unable to work together, I will provide you with a list of referrals.

Scope of My Services

• I am qualified to work with a wide variety of clients and problems, but sometimes I may not have the training needed to address a particular concern. If this is the case, I will discuss it with you and make sure that you receive a referral to another professional who is better qualified to serve you.

• Also, if you are having current hallucinations/delusions, severe thoughts of suicide or self-harm, or extreme mood swings, you may need more support than I can offer you through weekly psychotherapy, and I reserve the right to refer you to a different or more intensive treatment if I believe you exceed the level of care I can offer.

LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the patient or

the patient's legal guardian. However, there are limits to this confidentiality that you should know about.

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to the legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify the legal authorities and make reasonable attempts to notify the family of the patient.

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients may have the right to inspect the clients records unless the health care provider determines that access to the client's record would have a detrimental effect on the providers' professional relationship with the minor client, or the minor's physical safety or psychological wellbeing.

GENERAL CONSENT TO DO PSYCHOTHERAPY

- ❖ I have read and fully understand these client policies and give my full-informed consent.
- ❖ I apply for and consent to psychotherapy with my provider: _____
- ❖ I further understand that I am responsible for payment even though my insurance company may or may not reimburse me later.
- ❖ I understand any conversations over seven (7) minutes in duration will be charged in fifteen (15) minute increments.

Patient Signature _____ **Date**_____

Provider: _____

BETTER LIFE
WELLNESS CENTER

**If you feel that you are currently struggling with a crisis, please note that we are not capable of monitoring phone calls 24/7 and may not be able to respond for several days. There are many other organizations within our community who are better equipped to help in crisis situations, and we are including referrals to those on the next page. Please keep this referral sheet for your reference.

Crisis Referrals

If you or a loved one are a danger to yourself or others, please call 9-1-1 or go to your nearest emergency room. Below are additional crisis resources, but note this list is not comprehensive.

Crisis Hotlines- phone or text lines:

988 Suicide and Crisis Line call or text 988; Available 24/7
Adapt Oregon Mental Health Crisis Line 541-440-3532 or 1-800-866-9780
Douglas County Mental Health Crisis Available 24/7

Same Day Walk In Services:

Adapt Oregon
548 SE Jackson Street, Roseburg, OR
(Mon-Thu 9:00 AM – 3:00 PM Walk-in Hours)

Psychiatric Hospitals/Inpatient Behavioral Health Units:

CHI Mercy Medical Center - Behavioral Health Unit
2700 Stewart Parkway
Roseburg, OR 97471 Phone: 541-673-0611

Local Emergency Rooms:

CHI Mercy Medical Center:

2700 Stewart Parkway
Roseburg, OR 97471 Phone: 541-673-0611

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Individual Therapy Intake Form

Thank you for your interest in BETTER LIFE INTELLECTIVE HEALING, LLC. We ask all potential patients to submit basic information to determine whether they will be an appropriate fit for our practice and thus eligible to join our waitlist or become a new client. Your Therapist will review your responses with you during your intake session and will likely ask some follow-up questions.

Patient Name (if you are filling this out for someone else, specify your name below):

_____

Patient Age:_____Guardian/Personal completing paperwork (if you are not the patient)

_____

What general areas of concern bring you/the patient into therapy? Circle all that apply.

Alcohol or Substance Abuse Issues

Other Addiction Issues (please specify):_____

Anger Management Concerns

Relationship Issues

Life Transitions

Generalized Anxiety

Social Anxiety

Panic Attacks

Sleep Problems

Body Image Issues

Gender Dysphoria

Grief

Crisis and/or Current Suicidality

Phobia/Specific Fear

History Suicide Attempts or Hospitalization

Depression or Low Mood

Stress Management

Bipolar and/or Manic Symptoms

Trauma (a single traumatic event)

Chronic Trauma (multiple traumatic events)

Court Ordered Treatment

Seeing/Hearing things others cannot

Other:

_____

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PRESENTING PROBLEM INFORMATION

Please describe the primary problem(s) or concern(s) that bring you here today:

Please describe an example of the problem as you see it:

How have you handled this situation in the past? What strategies have you tried and how have they worked?

Have you ever sought assistance for these or other problems (Circle one)? Yes No

If yes, please describe below:

Have you ever seriously considered harming/killing yourself (Circle one)? Yes No

Have you ever attempted suicide (Circle one)? Yes No

Do you have problems controlling violent behavior/impulses (Circle one)? Yes No

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Treatment History:

Dates: _____ **Where:** _____ **Diagnosis/Reason:** _____

Focus of Treatment: _____

Dates: _____ **Where:** _____ **Diagnosis/Reason:** _____

Focus of Treatment: _____

Have you ever been hospitalized in an inpatient psychiatric unit? Yes No

Psychiatric Hospitalization History:

Dates: _____ **Where:** _____ **Diagnosis/Reason:** _____

Focus of Treatment: _____

Dates: _____ **Where:** _____ **Diagnosis/Reason:** _____

Focus of Treatment: _____

Please list any psychiatric medications you are currently taking, the reasons they were prescribed, and medication effectiveness.

Medication 1: _____ **Prescribed for:** _____

Are you taking it? _____ **Is it helping?** _____

Medication 2: _____ **Prescribed for:** _____

Are you taking it? _____ **Is it helping?** _____

Medication 3: _____ **Prescribed for:** _____

Are you taking it? _____ **Is it helping?** _____

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Personal History and Background Information

For your therapist to work with you to reach your goals and move forward in the direction you would like to be going in your life, it will be important for them to understand your current difficulties as well as past experiences. We kindly request that you please answer the following questions below. Please note, the information you provide here is protected as confidential information.

CURRENT FAMILY/LIVING SITUATION

1. **Marital Status:**
   - ☐ Single
   - ☐ Married How long? _____
   - ☐ Cohabitating/Living Together How long? _____
   - ☐ Divorced How long? _____
2. **Number of Marriages:** _____
3. **Do you have any children?** ☐Yes ☐No
   a) **If yes, please list their names, gender, age, and whom they live:**

What are your living arrangements? (Please check one)

- ☐ Rent an apartment
- ☐ Rent a house
- ☐ Living with friend/roommate
- ☐ Own a house
- ☐ Unhoused
- ☐ Living with a family member/relative

Who else lives in the home with you?

If un**housed, where do you stay?**

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FAMILY/CHILDHOOD HISTORY-DEVELOPMENTAL INFLUENCES

Place of birth? _____ **Who raised you?** _____

Who else lived at home while you were growing up? (E.g., siblings; extended family; other)

Stressful Events: Please describe any history of parental separation, divorce, moves, major accidents, deaths, traumatic events, abuse (physical, sexual or emotional) you may have had as a child/adolescent.

As you were growing up, were there any adults who were particularly kind to you? If yes, who?

MEDICAL HISTORY

Do you have any chronic medical problems? (E.g., diabetes, high blood pressure, heart problems) (Circle one)?

Yes No

EDUCATION

Did you graduate from High School (Circle one)?

Yes No

If not, what was your highest grade completed in school? _____

Did or are you attending Trade/Technical School or a College/University (Circle one)?

Yes No

If yes, what did you study/are you studying?

EMPLOYMENT

Are you currently employed (Circle one)?

Yes No

If yes, what is your job? _____

When did you begin this job? _____

Are you having any difficulties with your job (Circle one)?

Yes No

If yes, please describe:

If unemployed, when and what was your last job?

How are you financially supporting yourself?

Do you have enough money to cover basic expenses (Circle one)?

Yes No

Are you using any community resources/services currently (Circle one)?

Yes No

SPIRITUAL/PERSONAL INFORMATION

Who or what gives meaning to your life now?

Are you actively involved in religious/spiritual practices? If so, please describe.

What helps you get through difficult situations?

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BETTER LIFE INTELLECTIVE HEALING, LLC
Screening Questionnaire*

Name: _____

In order to help you move forward in the direction you would like to be going in your life, we would appreciate learning more about what problems or difficulties you might be experiencing as well as what you would like to see change in your life.

Over the **last two weeks**, how often have you been bothered by any of the following problems? (please circle your answer & check the boxes that apply to you)

For each item below, circle: 0 = Not at all, 1 = Several days, 2 = More than half the days, 3 = Nearly every day

1. Little interest or pleasure in doing things 0 1 2 3
2. Feeling down, depressed, or hopeless 0 1 2 3
3. Trouble falling or staying asleep, or sleeping too much 0 1 2 3
4. Feeling tired or having little energy 0 1 2 3
5. Poor appetite or overeating 0 1 2 3
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down 0 1 2 3
7. Trouble concentrating on things, such as reading the newspaper or watching television 0 1 2 3
8. Moving or speaking so slowly that other people could have noticed, or the opposite - being so fidgety or restless that you've been moving around a lot more than usual 0 1 2 3
9. Thoughts that you would be better off dead, or hurting yourself in some way 0 1 2 3

Anxiety Questions - Circle: 0 = Not at all, 1 = Several days, 2 = More than half the days, 3 = Nearly every day

1. Feeling nervous, anxious or on edge 0 1 2 3
2. Not being able to stop or control worrying 0 1 2 3
3. Worrying too much about different things 0 1 2 3
4. Trouble relaxing 0 1 2 3
5. Being so restless that it is hard to sit still 0 1 2 3
6. Becoming easily annoyed or irritable 0 1 2 3
7. Feeling afraid as if something awful might happen 0 1 2 3
8.

Physical Pain - Circle One: Are you currently in any physical pain..... No Yes

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Trauma Screening - In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you: (Circle No or Yes for each)

1. Have had nightmares about it or thought about it when you did not want to? .... No Yes
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it? ..... No Yes
3. Were constantly on guard, watchful, or easily startled? .....No Yes
4. Felt numb or detached from others, activities, or your surroundings? ..... No Yes

What are the top 1-3 things you would like to see change in your life right now?

1.

2.

3.

What are the most important reasons why you want to make the changes above?

What goals would you like to work on with a counselor/therapist, if any?

Thank you for taking the time to complete this questionnaire. We look forward to working with you on your goals!