ACCARES Wellness Center

Dr. Kathy Howell, PhD, LPC, & Associates
Ga State Lic# LPC003284
786 River Bend Road Dawsonville, GA 30534
Cell 678-794-8749 * Main: 706-216-6356 * Fax: 706-265-6295
www.accareswellness.com drkathyhowell@gmail.com

Please complete the following questionnaire as thoroughly as possible. If something does not apply, use N/A in the space provided.

Today's Date __________ Full Name: ____ DOB: ___________ Age: __

SS# __________________ Mailing Address: ____ Phone: ___________________

Cell: _____________________

Ok to send text/emails: **Y N** Email :____

Emergency Contact Information:____ PCP Release:

How did you hear about us? ____

Self Assessment

Three words you would use to describe yourself:____

Your main goal/reason for seeking counseling:____

What have you tried so far? ____

Have there been times when the problems seem to resolve, improve, or disappear? If so, when?

____

____

Were there times when the problem was especially bad or worse? If so, when?

____

____

What do you think contributed to that?

____

Do other people play a major role? Contributing to causing your problem(s)?____

____

What do you believe Spiritually?

____

____

Demographics

Education Completed: __________________________ Current Employer/position: ____

How many hours per week do you work? ___________________________ How satisfied are you with your job? _________________

Do you have a valid DL? Yes No Do you have reliable transportation? Yes No Marital Status: _________________

If married, how long? __________ Have you been married before? ________________How many children do you have? _____

Names/Ages: ____

Do you have custody? If no, please explain:

____

Are you currently in any sort of litigation/probation? If yes, please give

details:____

On Parole? Please give officer's name/phone: ____

Are you taking any medication/supplements on a regular basis for a psychological/psychiatric condition? ________ Please list:

Medication Name/ Strength	Dosage per day	Reason for taking / Prescribed By

Have you ever been diagnosed with a mental disorder/condition? Yes___No___Please list:

Diagnosis	Date of Diagnosis	Do you accept it as true?/ additional comments:

Please circle all that have (currently or in the past) drug or alcohol problem in your family: (please circle)

Spouse Child Mother Father Brother Sister Aunt Uncle Grandmother Grandfather Other Do you live with anyone who has a current drug/alcohol problem Yes No_____Uses prescription drugs? Yes______No

Age you started using drugs/alcohol: ____ How much alcohol do you drink per day?_______ Would you say you are currently addicted? _____ If no, have you ever been addicted in the past? ______ If yes, to what substance: ____________________

What is/are your substance(s) of choice? ___________________________ When was the last time you used? ___________

In the following list, please place ONE checkmark next to each item that identifies an area of **concern for you**. Place TWO check marks by those items that are MOST important. You may also add comments or further details to check areas if desired.

	Anger		**Religious/Spiritual**
	Depression		**Sexuality**
	Education		**Thoughts of Suicide**
	Eating Difficulties		**Trouble Making Decisions**
	Fearfulness		**Unhappy Most of the TIme**
	Financial Concerns		**Use of Alcohol**
	Marital Issues		**Use of Drugs**
	Physical Difficulties		**Abuse of Substances By a Family Member**
	Problems with Social Relationships		**Work Concerns**
	Problems with Children		**Worry Constantly**
	Problems with Parents		**Other (Specify)**

Have you ever had a nutritional evaluation? Yes No If yes, what Practitioner/Title? ______________________________

Are you taking any nutritional supplements? Please list or attach sheet if needed. ______________________________

____

Have you had Health Issues of been Injured in the past year? Please circle: Food Reaction Infection Cold/Flu Major Stress Injury Medication Change Slip/Fall Medical Emergency Please provide details:______________________________

Energy Level: Please rate your current condition (Best = 10 Worst = 1) **1 2 3 4 5 6 7 8 9 10**

Please check any/all areas that you are having physical issues with currently. Add comments if desired...

	Exhaustion/Fatigue		**Digestive Problems**
	Hot Flashes		**Memory**
	Seasonal Allergies		**Weight Loss/Gain**
	Blood Pressure		**Depression**
	Anxiety		**Cholesterol**
	Joint Pain/ Inflammation		**Diarrhea**
	Acid Reflux		**PMS Symptoms**
	Mood Swings		**Heart Palpitations**
	Sinus Issues		**Cold Feet/Hands**
	Blood Sugar		**Constipation**

Any other area/issue not listed?

____

****Rate your interest in nutritional therapies as a part of your Spirit/Soul/Body treatment plan**:____ (Very = 10/ Not Interested = 1)

Please complete the last 3 days of your eating history as thoroughly and honestly as you remember:

Day	Breakfast	Lunch	Dinner

❏ This information is true and correct to the best of my knowledge

❏ I give permission to ACCARES to add me to their email base

❏ I would like to request a free nutritional consultation with Dr. Howell

Patient Signature: ______________________________ **Date:** ______________

Credentials & Certifications for Kathy A. Howell, PhD, LPC, CPC, Owner/Director of ACCARES

Ph.D. Psychology & Counseling, Logos Christian College & Graduate School Jacksonville, FL

M.A. Counseling, Liberty University Lynchburg, VA

B.S. Psychology/Sociology, North Georgia College & State University Dahlonega, GA

Nutritional Response Testing Practitioner
CISM- Critical Incident Stress Management
Theophostic (God's Light) Inner Healing
Cognitive Behavioral Therapy
Prepare-Enrich Marriage/Pre-marital Counselor
Splankna Emotional Energy Release Therapy
Parenting: ADHD & Non-compliant Children
Emotion Code Therapy
Hypnosis - Past Life Regression
Spiritual Awakening/Struggling with life issues

Certified Professional Life/Wellness Health Coach
Crisis Care Network Mass Disaster Victim Counselor
Stress & Trauma Crisis Certified (Military)
Peacemakers Mediation/Conciliator
Creation Therapy- Temperament Counselor
Grace Ministries International Counselor
Seven Steps to Freedom in Christ (Neil Anderson)
Certified Anxiety Disorder Specialist
EMDR
Emotional Freedom Therapy

Affiliations: Licensed Professional Counselors Association; American Association of Christian Counselors, Ga Christian Counselors Association; Phi Kappa Phi; The Society of Christian Psychology; International Board of Professional & Pastoral Counselors; Board Certified Professional Life Coach Counselor (BCPCC); Ordained Minister (Logos Global Network Ministries)

Important Office Policies

Counseling Therapy Services exist to provide therapy at affordable rates for individuals, couples, and families regardless of race or religious affiliation. From a Biblical foundation of personhood, an integrated counseling framework of cognitive-behavioral, psychodynamic (aka Theophostic core issues), and family systems is used. Therapy is a voluntary, cooperative venture. **As a part of our Spirit, Soul, Body evaluation, we recognize the link between physical and emotional health**. When the underlying causes of the issue(s) are corrected through safe, natural means, the body and mind can repair itself in order to attain and maintain optimum health and emotional wellbeing. If you have any questions, please ask ______ **Please initial that you have read and understand this information.**

Confidentiality: Confidentiality and privileged communication remain the right of all clients of counselors according to Georgia State Law. I understand that information concerning treatment or evaluation may be released only with the sole authorization and consent of the person being treated or evaluated, or such person's parent/guardian, and with the agreement of the counselor.

Can we contact you via email? _____ Yes _____ No, by checking yes – you understand that complete confidentiality cannot be protected. However, we do everything we can to protect your identity.

Can we contact you via text message? _____ Yes _____ No, by checking yes – you understand that complete confidentiality cannot be protected. However, we do everything we can to protect your identity.

Counseling Fees: The fee for a 45-60 minute counseling session is $150. Cash, checks, bartering/trade arrangements are accepted. Make checks payable to "Dr. Howell". If a check is returned, you will incur a $25 fee. ______ **Please initial that you have read and understand this information.**

Phone Communications: Should you need to contact your counselor, voicemail or text will be available to receive your message 24/7. When leaving a message, please speak your full name and contact number clearly. Your call or text will be returned as soon as possible. If a counselor has a heavy client loas at that time, calls may be returned the following day. If you have an emergency dial 911.

______ **Please initial that you have read and understand this information.**

Responsibility of Client: Client voluntarily agrees to treatment and can terminate at any time without penalty. Client is expected to complete assigned therapies/directives and to process the emotions and thoughts arising from issues discussed in sessions. Client is expected to punctually attend all sessions as scheduled. As clients work through issues, painful emotions may be felt and processed before moving forward in therapy. This process takes time and commitment is required for a successful outcome. Prioritize keeping your appointments. 24 hours notice is required for any changes or the full session fee will be charged. ______ **Please initial that you have read and understand this information.**

Ethical Guidelines: Counselor will adhere to the ethical guidelines of the Licensed Professional Counselors Association and the American Association of Christian Counselors. You may obtain a copy, if desired. ______ **Please initial that you have read and understand this information.**

"To exist is to change, to change is to mature, to mature is to go on creating oneself endlessly"

- Henri L Bergson

I have read, understand, and agree to all that is stated above.

Printed Name____

Signature________________________________ Date ____________