ACCARES Wellness Center

Dr. Kathy Howell, PhD, LPC, & Associates
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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: _____

Gender: **M F** _____ Cell: _____

Ok to send text/emails: **Y N** Email : _____ Office Use Only _____

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)?

_____

Do you prefer Christian counseling from a biblical perspective or secular counseling?_____

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	Certified Professional Life/Wellness Health Coach
CISM- Critical Incident Stress Management	Crisis Care Network Mass Disaster Victim Counselor
Theophostic (God's Light) Inner Healing	Stress & Trauma Crisis Certified (Military)
Sexual Addictions Certified Counselor	Peacemakers Mediation/Conciliator
Prepare-Enrich Marriage/Pre-marital Counselor	Creation Therapy- Temperament Counselor
Splankna Emotional Energy Release Therapy	Grace Ministries International Counselor
Parenting: ADHD & Non-compliant Children	Seven Steps to Freedom in Christ (Neil Anderson)
Divorce Recovery Facilitator (Fresh Start)	Certified Anxiety Disorder Specialist
Certified Criminal Justice Addictions Specialist	Life Pathways Career Counseling

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)

*All associates are under the supervision of Dr. Kathy Howell. We meet as a treatment team to decide upon individualized plans.

Important Office Policies

Counseling Services exist to provide therapy at affordable rates for individuals, couples, families, and groups 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. Counseling is a voluntary, cooperative venture. In order to enable us to work most effectively together, we ask that you carefully read the information that follows. **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. There are exceptions to the