Client InformationBrochure

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Upper Circle Inc.

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If You Need to Contact Me

My office hours are Monday through Friday, from 9:00 a.m. to 6:00 p.m. I return calls when time allows.

If you have an emergency or crisis, please contact your probation or parole officer; if you cannot reach me or your P.O. , you and your family should call the county mental health office at **588-5351**, or the crisis center at **581-5535,** or the **370-5373 Hospital emergency room**. Call your own medical doctor or go to the nearest emergency room.

Information for Clients

Welcome to therapy! I appreciate your giving me the opportunity to be of help to you. This brochure answers some questions clients often ask about therapy. Please read all of it and mark any parts that are not clear to you. Write down any questions you think of, and we will discuss them at our next meeting. When you have read and fully understood this brochure, please sign it at the end.

About Psychotherapy

My theoretical approach is a mixture of many different theories and techniques depending on the client's need and my clinical judgement.

It is my intention to have a very open and honest therapeutic relationship, which requires that you be informed about where we are starting from and where we are going at each step in the process.
An important part of your therapy will be practicing new skills that you will learn in our sessions. I will ask you to practice outside our meetings, and we will work together to set up homework assignments for you. I might ask you to do exercises, to keep records, and perhaps to do other tasks to deepen your learning.

You will work on building healthy relationships between yourself and others, to get the best therapy results. Change will sometimes be easy and quick, or at times it will be slow and frustrating, and you will need to keep persisting at the work. However, you *can* learn new ways of looking at your problems that will be very helpful for changing your thoughts, feelings and reactions. Psychotherapy requires your very active involvement; it requires your best efforts to change thoughts, feelings, and behaviors. If I don't ask a certain question or for more information, please tell me about important experiences, what they mean to you, and what strong feelings are involved.

While each individual approaches treatment with different expectations and motivations, it is your willingness and drive to complete your treatment program, that will determine your success. You determine the length of your treatment program by completing your work in the Twelve Treatment Sections. You work at your own pace by maintaining your momentum; set a comfortable and consistent pace for yourself. Generally, it takes two months to complete any treatment section. If you take longer, then your time frame for treatment completion may be extended. It is in your best interest to keep yourself on track within your time frames.

Clients attend group once a week for 24 to 36 months with intensive work (Drama Therapy, Clarification, Reunification, Abel Screening, etc) and individual sessions as well. If you wish to stop therapy at any time, we will need to meet for at least one session to review our work together. Please recognize that stopping treatment will have consequences of it's own regarding your probation or parole.

The Benefits and Risks of Therapy

As with any procedure, therapy has some risks and benefits. We may work with uncomfortable levels of sadness, guilt, anxiety, anger, frustration, loneliness, helplessness, or other negative feelings for a time. You may recall unpleasant memories, or feelings that may bother you at home, work or school. Family secrets may be told, therapy may disrupt your relationships or lead to life changing decisions. Problems may temporarily worsen before they get better.

Your emotional experience may seem overwhelming or too intense to deal with at this time; you may not accept or forgive yourself, or you may have difficulty in leaving therapy. Your therapy experience may result in your calling into question many of your beliefs and values. Most of these risks are to be expected when you are making important changes in your life. Even with our best efforts, there is a possibility that therapy may not work out well for you.

While you consider these risks, you should know that the benefits of therapy have been shown by scientists in hundreds of well-designed research studies; people who are depressed find their mood lifting, feelings of fear, anger, or anxiety decrease; relationships and coping skills improve greatly; you have more satisfaction in social and family relationships; your personal goals and values are clearer, and you may grow in many other directions—as a person, in relationships, work or schooling, and in your ability to enjoy your life. No promises can be made to you about the results of treatment, the effectiveness of the procedures used by your therapist, the number of sessions necessary for therapy to be effective, or a guarantee you will not abuse or offend again.

About Confidentiality

You can expect me to be honest with you about your problems and progress. I expect you to be honest with me about your expectations for therapy, your compliance with parole, treatment rules, homework, medication, or any other personal or family problems. I will treat with great care all the information you share with me, I will keep your records private. I will tell no one what you tell me. I will not even reveal that you are receiving treatment from me.

I also ask you not to disclose the name or identity of any other client being seen in this office. I do not divulge the fact that you are a client or anything about you or your sessions to anyone, unless requested by you. In all but a few rare situations, your confidentiality is protected by state law and by the rules of my profession. Here are the most common cases in which confidentiality is not protected:

1. If you were sent to me by a P.O., Court or Attorney for evaluation or treatment, I must report your attendance, participation and results of your work including any violations of your court ordered conditions of supervision to your P.O. when I suspect these violations.

2. If you are suing someone or being sued; have pending charges or being charged with a new crime. Your therapy may be discussed in the pending court case. Please consult your lawyer.

3. If you make a serious threat to harm yourself or another person, the law requires me to protect you or that other person. This usually means telling others about the threat.

4. If I believe a child has been or will be abused or neglected, I must report this to the authorities.

5. As a therapist, my legal and moral duty is to protect your confidentiality, but I also have a duty under the law to the wider community and to myself, if there is harm, threat of harm, or neglect.

You may review your own files at any time. You may add to them or correct them, and you may make copies of them. I ask you to understand and agree that you may not remove any of the records, or examine records created by anyone else and sent to me. I will keep your case records in a safe place.

About Our Appointments

An appointment is a commitment to our work, we agree to meet here and to be on time. If you are late, we will probably be unable to meet for the full time. It is likely that I will have another appointment or group scheduled after yours. When you must cancel, please give me at least a week's notice. Please

schedule your doctor, lawyer, P.O., or polygraph appointments around therapy.

My schedule is very full, and I am not able to meet with you or talk with you when you drop by to ask me a question, please schedule an appointment.

Attend our sessions comfortably and cleanly dressed, please arrive clean, odor free, without dirty, muddy, oily, paint or gas-covered clothes/shoes. Please remember your personal hygiene, bathe, use deodorant, brush your teeth and avoid cologne. You are requested to smoke or chew thirty feet from the building.

Fees, Payments, and Billing

You are responsible for full payment at the end of each individual session. Full payment is due every therapy session or may be paid in advance. I suggest you make out your check before each session begins, so that our time will be used best.

At the beginning of each month, I will give you a statement for group. Payment is due by the 15th of the month. Returned checks will be charged $25.00 banking fee and payment will need to be cash or money order thereafter. I examine my fee schedule yearly, and may change my fees each year. You will be given one month advance notice when my fees change.

Group Therapy Sessions: Weekly Group sessions are $45.00. If you are attending an on-going therapy group which meets once per week, your partner attends free of charge at group sessions.
Individual, & chaperon approval Therapy Services: A therapy session of 50 minutes is $90.00.
Reports or Telephone Consultations: $90.00 per hour, for prorated conferences with DHS, P.O., Attorney, etc.***;*** Reports to the courts, parole board, DHS, etc. These reports must be fully paid for before they are provided or released to any third party.
Court Testimony: Charges for other services, such as hospital visits, consultations with other therapists, home visits, or any court-related services, depositions, or attendance at courtroom proceedings will be based on the total time involved including travel time and require advance payment. $150 per hour
Abel Screening of Sexual Interest: This test is a required part of your therapy, to be taken a minimum of once during your program. Payment of $350.00 must be made in advance of administering the test.
Clarification and Reunification: These are sessions with spouse, children, family members and victims. The rate is $90.00 hourly including preparations, and processing of the sessions.

Delinquent Payments

If you think you may have trouble paying your bills on time, please discuss this with me. I will also raise the matter with you so we may arrive at a solution. If your unpaid balance reaches **$200.00,** I will notify you and request a **payment deadline.** If it then remains unpaid, I must stop therapy with you.

Fees that continue unpaid after this will be turned over to small-claims court or a collection service. A late payment fee of 1.5% will be charged each month that a balance remains unpaid. The results of terminating your treatment will need to be discussed with your probation or parole officer.

My Background

I have over 20 years of experience in the delivery of psychotherapy, psychological assessment, and consultation to children, adults, and families. I hold a Masters degree in counseling and educational psychology.

I have worked in university, Employee Assistance Programs, supervisory/grievance, elderly, adolescent, adult outpatient mental health settings, psychiatric hospital admitting, as well as maximum security prison settings in violent and sexual offender programs. For five years I was a Parole & Probation Officer in Linn and Polk Counties, writing Pre-sentence Reports and supervising a Sexual Offender caseload. For the past twelve years, I have worked with sexual abuse clients and their families.

Informed Consent

I understand I can choose to discuss my concerns with the therapist, before I start formal therapy or not sign this form. I also understand that any of the points mentioned above may be discussed. If at any time during the treatment I have questions about any of the subjects discussed in this brochure, I may talk with you about them, and you will do your best to answer them.

I understand that after therapy begins, I have the right to withdraw my consent to therapy at any time, for any reason. However, I will make every effort to discuss my concerns about my progress with you before ending therapy with you and will make one final appointment to discuss this matter.

I have read, or have had read to me, the issues and points in this brochure. I have discussed those points I did not understand, and have had my questions, fully answered. I agree to act according to the points covered in this brochure. I agree to enter into therapy with The Upper Circle Inc. and to pay all fees for services given, to cooperate fully and to the best of my ability, as shown by my signature here.

_____

Signature of Client Date Printed Name

Relationship to Client: ❑ Self ❑ Parent ❑ Guardian

I have met with this client and informed him/ her of the issues and points raised in this brochure. I have responded to all his or her questions. I believe this person fully understands the issues, and I find no reason to believe this person is not fully competent to give informed consent to treatment. I agree to enter into therapy with the client, as shown by my signature here.

_____

Signature of Therapist Date

Treatment Contract

Attendance:

1. I agree to attend all treatment sessions. Group therapy sessions are once a week for two hours each. Groups will start and end on time. I must participate each group and be prepared to work on my treatment issues when it is my turn. I am expected to attend treatment sessions properly attired, and prepared with assignments and supplies including handouts, paper, pens or pencils. I will be expected to use the rest room prior to treatment to avoid interruptions in group.

   Failing to attend group will result in Automatic Consequences ($5 to graduation kitty, with $5 increments for each absence; written report of thinking errors, or writing my thinking errors on the board during the entire group session). Come to group prepared to perform the consequence the next meeting. Missing two groups will result in jail, suspension or termination.

2. I will attend all scheduled treatment sessions, individual, group, family, couple, and physiological testing appointments. My absences must be approved **in advance** by the therapist; recognizing that my missing group, has an impact on many other people. I agree to notify my counselor 24 hours in advance of any absence due to a true emergency.

3. Ms. Doyle agrees to provide sexual offender treatment once per week that is designed to assist me in learning how to deal with my sexual problems without re-offending. It is understood that in order for therapy to succeed, I must be motivated to change, and abide by all rules of treatment.

4. Ms. Doyle will provide reports to the Court, Parole Board, or my P.O. as required, or requested. Ms. Doyle agrees to consult with my P.O. and with chaperons from time to time, as needed. Reports and special meetings will be billed to me at her hourly rate.

5. Some treatment groups may be video or audio taped, this is for my benefit in treatment and also used in improving treatment sessions. The use of the tapes is for me to see myself as others see me in group. I give my consent to participate in sessions which are taped, and release these tapes for treatment use only.

Participation:

6. I must actively participate in treatment to demonstrate my compliance, with written work, in group discussion, in active listening and in any other treatment exercises that are assigned.

7. I can voluntarily remove myself from treatment, that if I exercise that option, a formal written notice will be provided to the Parole Office regarding the fact that I did not complete the treatment process.

8. If I fail to abide by the Treatment Contract, I may be terminated from treatment and a notice of my termination will be included in my file, indicating that I did not successfully complete the treatment program and am in violation of my parole/probation.

9. My therapy will last until I have completed all the requirements of group. All these requirements are listed in detail in my Section One Material listing Group Therapy Goals.

10. I must demonstrate respect for other participants in treatment by using language that is non-threatening and non-assaultive. I will read the section on feedback and will gauge my interactions with other members in a way that will benefit them and myself. I have a right to be assertive and express my views while, at the same time, being required to show respect to all participants.

11. I will actively participate in treatment. If I attempt to sleep, to dissociate myself, carry on conversations with another member, or if I indicate in any other way that I am not participating in treatment; this is not acceptable group behavior.

Treatment Rules and Expectations:

12. I may remain in treatment only if I am motivated & compliant; my treatment will be terminated if I am non-compliant or fail to make progress. My participation in the treatment program requires me to demonstrate mutual respect, honesty and dignity to both professionals and other participants.

13. I must successfully present issues each week. Failing to complete homework each week, or to successfully complete a

treatment section within two months, may result in consequences which will lead to termination from treatment. I must be successful at each group session by presenting and working on my issues and working on other group members issues.

14. I will participate in treatment in three Phases; I must successfully complete the first section of treatment: Orientation, designed to begin the treatment process and develop personal motivation in my treatment.

    The second phase of treatment: Long Term Phase, is the bulk of the treatment program and covers sections 2 - 11 and addresses understanding , altering, and continuing changes in myself in the community.

    The third and final section: Aftercare, is a year or more maintenance of treatment. The total length varies by case, since it is meant to help me integrate what I have learned into my daily living and to provide me with a support group during this process. I must be successful in all three phases of treatment in order to complete.

Homework:

15. The therapeutic process will provide me with an opportunity to understand the concepts in group and then work on written assignments outside of group. My written work is as important as my participation in group. Homework is a way for me to extend and maximize my treatment time, and progress at a more even pace.

16. I will use my first name and last initial on homework, for my confidentiality. My homework will be legible, neat, and written on **one side of the paper.** Written work must be titled and dated in the top right hand corner. All written work must be prepared in the format as directed for that assignment. If I am using notebook paper, I will cut the fringe off.

17. It is my responsibility to complete the assigned homework and to request assignments and group time to work on areas I need additional help in completing. I will be provided with all of the necessary assignments when I request them, as long as I have completed all the prior work. I may work on multiple sections at the same time. I may request time to work on these areas in group. This means that I am prepared to do my own work in group.

Goals:

18. Group Treatment Goals are set as a standard to complete, it is up to me to work to my best ability to complete the materials so that I may reduce my risk of re-offending and develop a responsible life-style. I must set my own goals to accomplish the changes *within myself.*

19. I will set my own **Personal** and **Individual** Treatment Goals that will enable me to work on those treatment issues most important to my personal growth. While it is important for me to accomplish each of the assigned tasks listed in the Group Treatment Goals, my own treatment process will consist of work based on my own personal needs in treatment. I will set my goals on a three month basis, and modify these goals with my buddy and/or in group as needed. My progress in group is directly related to my work on my own treatment goals and completion of the areas of work that will result in a healthy lifestyle for me in the community.

20. I will develop my treatment goals weekly, monthly, and quarterly, to establish my own plan for completion of treatment and provide this to group in my weekly report, to my therapist and P.O. It is my responsibility to create my own plan for myself and to follow my own goals and expectations. I must develop my own motivation for treatment and initiate it.

Boundaries & Rules:

All information in your treatment program will be shared with group members, probation/parole officers, family members, and others when applicable.

21. I will respect appropriate boundaries of the therapist involved in the treatment program and my own issues, some personal questions to therapists will be viewed as inappropriate.

22. I agree to hold myself and other group members to the rules, standards and expectations of treatment, which are meant to establish responsible living for us in the community, and to report concerns or violations of other members.

23. I will obey all of the treatment rules that have been outlined for me in order to successfully complete treatment. This means both the rules and the spirit of the rules.

24. I will need to ask my questions during group session, if my questions cannot be answered or my comments are unable to be addressed, I will schedule individual therapy time when my questions or concerns need to be processed.

25. **Alcohol and Drugs:** I will not use alcohol or drugs while participating in the treatment program. If I have an alcohol or drug problem I am required to participate in an approved treatment program.

26. **Violence:** I will not verbally threaten or physically assault staff, group members, family or others. Threats by myself, family members, or significant others will result in group consequences and possibly criminal charges.

27. **Employment:** I will maintain full-time employment and/or academic work. ***Prior approval*** from Ms. Doyle, group and P.O. must be gained for any changes in employment. I need to bring proof of any disability which keeps me from working.

28. **No Contact with minor Children or Victims:** I will have no contact with minor children, male or female, under 18 years of age unless approved by the treatment provider and my parole or probation officer. Supervised contact with minor children will only occur upon completion of ***Section 3B*** when approved for contact with an approved supervisor. I need to complete and pass my Disclosure polygraph to have any changes made in this condition.

    I will not shop at stores where children might be present, this includes grocery, convenience, toy, clothing, book, etc. If it is a place I shop in or would like to shop in, I will present this to group prior to going there to shop. During holidays and when school is out, I will need to alter my schedule to best avoid children. I will not go to the theater to see movies, plays, or concerts. I won't go INTO fast food restaurants and will change my lifestyle and prior habits to adopt this very necessary change into my life.

Pornography:

29. I will eliminate my use of Pornographic material. It is a requirement to avoid all material which shows genitalia, women's nipples or breast, buttocks or any overt sexual activity. I Agree to Avoid All Contact with Pornographic Stimulus. I will not view films, videos, or broadcasts; read books or magazines; view nude or erotic dancers, or any other medium which will arouse my sexual interests. Only I know what arouses my sexual interest; therefore, if it is not listed, I will disclose this stimulus and agree to avoid it.

    I will abstain from all forms of pornographic material, including TV programming on pay-channels or premium channels, contact with prostitutes, frequenting of pornographic book or video stores, or massage or strip parlors. The contact that I have with pornographic materials will be reported in my journal.

Arousal To Children:

I will restrict my viewing of television by limiting sexual acts, nude views of adults or children, watching shows where children are the primary characters (if I am aroused to children) or shows where children are the targeted audience. I will remove all shows from my video collection from my possession which induce my deviant arousal.

Arousal:

30. Due to my offense and past sexual behaviors, I will discuss with Ms. Doyle any thoughts, urges or feelings which suggest even a possibility that I might re-offend. I will tell Ms. Doyle about any sexual misconduct that I engage in, of any sort and will fully discuss my sexual fantasies and desires. I agree to make full disclosure of my sexual history.

    I agree to limit my masturbation activity to *twice per week*. I must submit a written fantasy for approval and agree to limit my fantasies to those approved.

Arousal Conditioning:

31. Section Five, Deviant Arousal utilizes Aversive Conditioning practices, which I will administer to myself. I will receive instructions on how to administer them, and will practice them. I will administer these within **fifteen (15) seconds** or less of a situation where I find myself aroused or in pre-assault behaviors.

    The aversive conditioning is intended teach

me how to stop myself from harming another person. I will use these practices for the purposes they were intended in my treatment program. I will keep ammonia capsules with me at all times and use them immediately.

Polygraph/Abel Screening:

32. I will participate in regular polygraph examinations. The polygraph will aid me in making full disclosure of my lifetime sexual history. I must take and pass polygraphs to remain in treatment group and to complete group. I will complete and participate in regular examinations to verify my progress in treatment. Failure to pass these tests will be a major issue in continuing my sexual offender treatment, and I will review the consequences for failing a polygraph and accept these consequences for continuing to remain in the community.

33. I will participate in Abel Screening examinations as requested by Ms. Doyle. I understand the Abel will aid me in determining the extent of my sexual interests. Using the Abel will aid me in determining the decrease of my arousal in Section Five, and this will require that I attend two or more sessions on the Abel.

Confidentiality:

34. Sexual offender treatment is not privileged to the same confidentiality that exists with other forms of psychotherapy; I give Ms. Doyle permission to discuss my case with my P.O. and other significant persons in my life, including, family, friends, boss, co-workers, supervisors and any other persons determined by Ms. Doyle with a need to know.

35. I will not discuss names and details about other group members with people not involved in treatment. I will report specific concerns, if it is a clear danger to self or society. Any new sexual assaults will be reported immediately to law enforcement officials. I will respect all therapy issues, I may discuss my personal work with group members or support people. I cannot discuss another group members issues outside of the group. I may discuss my assignments and homework and discuss general treatment issues while outside of group, but I am to avoid discussing personal issues regarding other clients.

Treatment Fees:

36. I will pay for my treatment sessions at the current monthly fee rate. I will purchase workbooks and reading books. I will also need to pay for polygraphs, Abel Screening, Drama therapy, Clarification, Victim Therapy, Individual sessions, and any other therapy or training.

37. I will pay for the treatment at the **first of the month.** Payment is expected no later than the fifteen of the month. Failing to be financially responsible for my treatment will result in suspension or termination from treatment.

Hold Harmless:

38. Ms. Doyle will make decisions which may seem to hurt me, or which I may interpret as unfair. While I may not agree that the actions she takes are necessary, I do understand that these decisions are without malice to me, and are in the interest of community safety. I will hold her harmless for any circumstances which might result from these decisions.

39. If I violate any of the terms of the treatment contract, I will be removed from the program. I understand that some serious behaviors may be grounds for immediate expulsion from group and termination.

40. If I wish to discontinue my treatment, I will make the request for removal from the program. A written request must be made for release from this treatment program, but it does not mean that I will be released from this program, simply because I am requesting it and realizing that I will be in violation of my supervision by quitting.

Privileges and Chaperon:

41. I may apply for Chaperons when I have completed my work through Section 3B. There is no limit on information revealed to the Chaperons about me or my offenses. I will refer all possible Chaperons who could supervise my contact with children so that she may meet with them to evaluate their suitability, as well as a Release of Information form. Supervisor approval will require additional time and fees to me.

Family Participation:

42. Parts of my treatment may involve the participation of other members of my family or significant others; without their willing participation, some aspects of my progress

will be diminished. I recognize the need for significant others to participate with me in treatment and without their participation, I may not be able to gain the goals or privileges that I have identified as necessary for myself.

Relationships:

43. I will attend weekly buddy meetings in person, with my assigned buddy(s). These meetings are as important as group to attend and participate in. I will attend these meetings to better develop my healthy relationships with peers.

    I will complete all of the requirements of my buddy meetings and provide my buddy with feedback, both written and verbal. I will report to group any thoughts, feelings or behaviors, I recognize in my buddy as being pre-assault cycle, or detrimental to my buddy's responsible living in the community.

44. **Significant Relationships:** I will not engage in any type of dating or sexual behavior with another adult without prior approval by the treatment program. I will not date individuals who reside with children, if I have been sexually abusive with children.

    In order to engage in a sexual relationship with another consenting adult, they will need to meet with my therapist first, and attend the support groups a minimum of twice per month and I must complete my treatment materials on Relationships in Section Seven.

45. If a partner is found to be unacceptable, I will need to terminate my relationship with this person. While I may not initially understand or agree with the reasons, I will follow this rule.

    Any request for me to terminate a relationship is based on the best interests of the community, others, and myself. I will honor this rule, even if I do not agree with it.

46. Should I blatantly ignore this rule it is grounds for suspension or termination from group. I have been exploitive in relationships, and I will need to have a great deal of assistance in selecting partners and friends in my life that are healthy relationships. I am not skilled at selecting these people at this time, and will continue to pick friends and others who fit my deviant and exploitive desires.

Structure in Life:

47. I will not make changes in significant areas of my life, such as residence, employment, religious involvement, major economic purchase (over $300), or relationships unless approved by the treatment program **FIRST**.

48. I will report any decisions which affect me, my family, my parole or probation, my relationships with other group members, including information or knowledge that I have which is important for my treatment group to know about, this includes everything mentioned above and anything which is significant or meaningful in my life not mentioned.

49. It is my responsibility to share information, which has not been solicited or asked of me. It is up to me to make sure everyone is aware of what is happening in my life and lifestyle.

    I will make sure that I speak up in group meetings to alert people of anticipated changes or sudden changes in my life. I will also contact group members outside of group to make them aware of changes, and will call my buddy to get his feedback, or support.

50. I will contact Ms. Doyle and leave a message on her voice mail, to let her know of changes or concerns that I have. I realize that it is important to leave full and complete information about this situation on her voice mail.

51. Considering that it is important enough to contact Ms. Doyle and other group members, I will need to contact my P.O. with the same information to keep him/her aware of what is going on in my life, and to gain their support or input into this situation. By working together with everyone involved in my parole/probation and treatment, I am maximizing my life resources.

Treatment Contract Agreement

I understand that all rules, expectations, and obligations cannot be anticipated and that additions to this contract or rules will be made. I will comply with them. If I have questions or concerns, I am responsible to initiate the discussion of these concerns.

I understand that not following any of the above conditions is a violation of my treatment contract and, therefore, a violation of my Parole/Probation. I waive all rights to civil lawsuits, should my actions in treatment result in termination from treatment or revocation of my Parole/Probation.

By signing below, I agree to follow these group rules. I will make it my responsibility to understand and follow them completely, since I am a member of this treatment community. I am stating that I will be an active group member and hold myself and other group members to a high standard of responsible community living, not simply the rules and expectations themselves, but the spirit of these standards. I acknowledge that I have read and understand all of the above.

_____
Print your Name

_____
Sign your Name Date

_____
Sign your Name Date
Parental Permission

_____
Sign your Name Date
Parental Permission

Therapist: Beth Doyle

_____
Beth Doyle Date

Adult Checklist of Concerns

Name: _____ Date: _____

Please mark all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked. (For a child, mark any of these and then complete the "Child Checklist of Characteristics.")

- ❑ I have no problem or concern bringing me here
- ❑ Abuse—physical, sexual, emotional, neglect (of children or elderly), cruelty to animals
- ❑ Aggression, violence
- ❑ Alcohol use
- ❑ Anger, hostility, arguing, irritability
- ❑ Anxiety, nervousness
- ❑ Attention, concentration, distractibility
- ❑ Career concerns, goals, and choices
- ❑ Childhood issues (your own childhood)
- ❑ Children, child management, child care, parenting
- ❑ Codependence
- ❑ Confusion
- ❑ Compulsions
- ❑ Custody of children
- ❑ Decision making, indecision, mixed feelings, putting off decisions
- ❑ Delusions (false ideas)
- ❑ Dependence
- ❑ Depression, low mood, sadness, crying
- ❑ Divorce, separation
- ❑ Drug use—prescription medications, over-the-counter medications, street drugs
- ❑ Eating problems—overeating, undereating, appetite, vomiting (see also "Weight and diet issues")
- ❑ Emptiness
- ❑ Failure
- ❑ Fatigue, tiredness, low energy
- ❑ Fears, phobias
- ❑ Financial or money troubles, debt, impulsive spending, low income
- ❑ Friendships
- ❑ Gambling
- ❑ Grieving, mourning, deaths, losses, divorce
- ❑ Guilt
- ❑ Headaches, other kinds of pains
- ❑ Health, illness, medical concerns, physical problems
- ❑ Inferiority feelings
- ❑ Interpersonal conflicts
- ❑ Impulsiveness, loss of control, outbursts
- ❑ Irresponsibility
- ❑ Judgment problems, risk taking
- ❑ Legal matters, charges, suits
- ❑ Loneliness
- ❑ Marital conflict, distance/coldness, infidelity/affairs, remarriage
- ❑ Memory problems
- ❑ Mood swings
- ❑ Motivation, laziness
- ❑ Nervousness, tension
- ❑ Obsessions, compulsions (thoughts or actions that repeat themselves)

❑ Oversensitivity to rejection
❑ Panic or anxiety attacks
❑ Perfectionism
❑ Pessimism
❑ Procrastination, work inhibitions, laziness
❑ Relationship problems
❑ School problems (see also "Career concerns . . .")
❑ Self-centeredness
❑ Self-esteem
❑ Self-neglect, poor self-care
❑ Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")
❑ Shyness, oversensitivity to criticism
❑ Sleep problems—too much, too little, insomnia, nightmares
❑ Smoking and tobacco use
❑ Stress, relaxation, stress management, stress disorders, tension
❑ Suspiciousness
❑ Suicidal thoughts
❑ Temper problems, self-control, low frustration tolerance
❑ Thought disorganization and confusion
❑ Threats, violence
❑ Weight and diet issues
❑ Withdrawal, isolating
❑ Work problems, employment, workaholism/overworking, can't keep a job

Any other concerns or issues:

❑ _____

❑ _____

Please look back over the concerns you have checked off and choose the one that you most want help with is:_____

Upper Circle, Inc.
1300 Boone Road SE
503-391-1300

Beth Doyle, M.A.
Salem, Or 97306
Fax 503-391-0476

Agreement to Pay for Professional Services

I request that the Beth Doyle provide professional services to me and I agree to pay this therapist's fee of $90.00 per individual session and $45.00 per group session for these services. These fees may be increased with 10 days notice.

I agree that this financial relationship with this therapist will continue as long as the therapist provides services or until I inform her, in person or by certified mail, that I wish to end it. I agree to meet with this therapist at least once before stopping therapy. I agree to pay for services provided to me up until the time I end the relationship.

I agree that I am responsible for the charges for all services provided by this therapist to me, other persons may make payments on my account and I may file these charges with my insurance company. I understand that the current fee rate may change and I will be given a 30 day notice prior to the effective date of the fee increase, and I will be liable for these fees as well.

I have also read this therapist's Client Information Brochure and Treatment Contract and understand the fees for various services stated there, as shown by my signature below and on the brochure.

_____ _____
Signature of client Date

_____
Printed name

I have discussed the issues above with this client. My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent to engage in therapy.

_____ _____
Signature of therapist Date

Client Social History

A. Personal Identification

Date: _____

Name: _____ Date of birth: _____ Age: _____
Nicknames or aliases: _____ Social Security #:_____

SID : _____ ODL: _____

Home street address:_____ Apartment: _____
City_____ State:_____ Zip:_____

Home phone: _____ Cell//Message phone_____
Work Phone:_____

Parents Name & phone: _____
Cell Phone_____ _____

Your Current Employer

Employer: _____
Address:_____
Work phone: _____Work Cell:_____
Calls will be discreet, but please indicate any restrictions: _____

B. Offense Details

Please describe the main people involved in your offense:
Victim Name and Age:
Date of Offense:
Date of Sentencing:

May you have contact with the victim or the victim family?

Have you taken any polygraphs during the court process and what were the results?

Did you take an evaluation? Who with?

Please list the parole or probation restrictions you have:

C. Prior Treatment

1. Have you ever received psychological, psychiatric or counseling services before?

❑ **Yes** ❑ **No** If yes, please indicate:

When? From whom? For what? With what results?

2. Have you ever taken medications for psychiatric or emotional problems?

❑ **Yes** ❑ **No** If yes, please indicate:

When? From whom? Which medications For what With what results?

D. Your Education and Training

Dates From	To	Schools	Special Classes?	Adjustment to school	Did you graduate?

E. Employment and Military Experiences

Dates From	To	Name of Military or Employers	Job Title or Duties	Reason for Leaving

F. Family-of-Origin History

Relative	Name	Current age (or age at death)	Illness (or cause of death, if deceased)	Occupation Education
Father				
Mother				
Stepparents				
Grandparents				

_____Uncles/Aunts_____
_____Brothers/Sisters_____

Other Family Members You Have Been Close To:_____

G. Relationships in Your Family of Origin.

Please describe the following, and use additional paper if needed:

1. What was your parents' relationship with each other like:

2. What was your relationship like with each parent or with other adults present in your life:

3. What were your parents' health problems, chemical use, mental or emotional difficulties:
4. What is your relationship with your brothers and sisters, in the past and present:

5. What is your relationship with your parents like currently? *How has it changed?*

6. What do you have in common or share with another family member?

7. Is any other family member a victim or convicted of any crime?

8. What worries you the most about your family?

9. What is your best quality that you get from your family?

10. Which family member are you most like, and do you like or dislike this fact?

H. Abuse History ❑ I was not abused in any way. ❑ I was abused.

If you were abused, please indicate the following. For kind of abuse, use these letters:

P = ***Physical***, such as beatings.
E = ***Emotional***, such as humiliation, etc.
N = ***Neglect***, such as failure to feed, shelter, or protect you.
S = ***Sexual***, such as touching/molesting, fondling, or intercourse.

Your Age	Kind of Abuse	By Whom?	Effects on You?	Whom Did You Tell?	Consequences Of Telling?

I. Marital/Relationship History

	Spouse's Name	Her Age at Marriage	Your Age at Marriage	Your Age When Divorced/widowed	Is Spouse Remarried?	Reasons For Ending
First						
Second						
Third						
Fourth						

J. Significant Non-marital Relationships

Name Of Person	Person's Age When Started	Your Age When Started	Your Age When Ended	Reasons for Ending

K. Children

Indicate which children are from which previous marriage or relationship with their mother's name in the last column

First Name	Current Age	Sex	School	Grade	Adjustment Problems?	Mother's Last Name

L. Present Relationships

1. How do you get along with your present spouse or partner?

2. What are the biggest difficulties you have in relationships?

3. How do you get along with your children?

4. What would you like to improve in your relationships?

5. What kind of qualities are you looking for in a future partner?

6. What do you offer a partner to make yourself attractive to them?

7. What do you think will be your biggest challenge in getting and keeping a partner?

8. What kind of support can therapy be for you in a relationship?

5. Your important friends, past and present: Please consider all the people who have been a part of your life over the years and list all of your friends during your life, consider the positive and negative aspects of your relationship with each of these friends.

Name	**Good Parts of Relationship**	**Bad Parts of Relationship**

M. Chemical Use

1. Have you ever felt the need to cut down on your drinking? ❑ **No** ❑ **Yes**

2. Have you ever felt annoyed by criticism of your drinking? ❑ **No** ❑ **Yes**
3. Have you ever felt guilty about your drinking? ❑ **No** ❑ **Yes**
4. Have you ever taken a morning "eye-opener"? ❑ **No** ❑ **Yes**
5. How much beer, wine, or hard liquor do you consume each week, on the average? _____
6. How much tobacco do you smoke or chew each week? _____
7. How much methamphetamine, pot, LSD, etc do you/have you used on a daily basis: _____

8. Which drugs *(not medications prescribed for you, unless you abused these drugs)* have you used in the last 10 years? Please provide details about your use of these drugs or other chemicals, such as amounts, how often you used them, their effects, and so forth: _____

9. Please describe the last time you used, the substance, quantity and duration of use:

H. Legal History

1. Are you presently suing anyone or thinking of suing anyone? ❑ **No** ❑ **Yes**
2. Is your reason for coming to see me related to an accident or injury? ❑ **No** ❑ **Yes**
3. Are you required by a court, the police, or a probation/parole officer to have this therapy appointment, or to attend certain treatment? ❑ **No** ❑ **Yes**
4. List all the contacts with the police, courts, and jails/prisons you have had. Include all open charges and pending ones.

Under **Jurisdiction,*** write in a letter: **F** = federal, **S** = state **Co** = county.
Under **Sentence,*** write in the time and the type of sentence you served or have to serve **CS** = community service, **F** = fine, **I** = incarceration, **Pr** = probation, **Po** = parole, **O** = other, **R** = restitution, **WRC** = Work Release Center.

Month /Year	**Charge(s)**	**Jurisdiction * (F, S, C, Ci)**	**Sentence * (F, I, Pr, Pa)**	**Probation/parole Officer's Name**	**Your Attorney Name**

_____

5. Your current attorney's name: _____Phone:_____
Is your attorney on retainer for continuing work? ❑ **No** ❑ **Yes**
What legal action or work are you expecting to do?_____

6. Are there any other legal involvements I should know about? Including pending charges or investigations which are currently on-going, including DHS/Welfare ❑ **No** ❑ **Yes**

_____
_____
___

O. Other

Is there anything else that is important for me as your therapist to know about, that you have not written about on any of these forms and that you believe is important for me to know? If so, please tell me about it here or on another sheet of paper:

Brief Health Information Form

A. Identification

Client's name: _____ Date: _____

B. History

1. Starting with your childhood and proceeding up to the present, list *all* diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have had.

Age	Illness/diagnosis	Treatment received	Treated by	Result

2. Describe any allergies you have.

To What?	Reaction You Have	Allergy Medications You Take

3. Have you done any kinds of work where you were exposed to toxic chemicals?

Date	Kinds of Chemicals	Kind of Work	Effects

4. List *all* medications or drugs you take or have taken in the last year—prescribed, over-the-counter, and others.

Medication/drug	Dose (How Much?)	Taken for	Prescribed by

C. Medical Providers

1. Your current family or personal physician or medical agency:

Name	Specialty	Address	Phone #	Date of Last Visit

2. Other physicians treating you at present or in last 5 years:

Name	Specialty	Address	Phone #	Date of Last Visit

D. Health habits

1. What kinds of physical exercise do you get? _____

2. How much coffee, cola, tea, or other caffeine do you consume each day?

3. Do you try to restrict your eating in any way? How? Why?

4. Do you have any problems falling asleep, staying asleep or getting enough sleep?

5. Do you have difficulty with erections? Too many? Too few? Soft? Do you have painful ejaculation or difficulty reaching ejaculation?_____

6. Do you find yourself thinking about sex or masturbating more than you are comfortable doing? Are you worried about your sexual drive: too high or too low? _____

7. What are your most rewarding relationships?_____

8. What relaxing, recreational, leisure, fun things do you engage in? How often?

9. Have you had periods of unconsciousness or seizures?

E. Other

Are there any other medical or physical problems you are concerned about?

F. Family History

Please list all significant diseases, illnesses, hospitalizations, accidents, deaths, or surgeries of family members. If family members are substance users, please indicate this as well (past and current)

G. Current Situation

Please indicate the current stressors in your life, describe the situations and people involved. This could involve on-going or new health concerns, work, partner, children, family, money, or home situations.