Paraclaysis, Inc.
4003 N. Weber Street, Ste B
Colorado Springs, Colorado 80907
(719) 210-9744
Fax (888) 619-0027

Date: ____________

Your name: ______________________Date of birth: _______________________ Age: ______
Your nicknames: ___________________________ Social Security #: ______________________
Home street address: ____
City: ___________________________________ State: _________Zip: ____________________
Phone: _(H)________________(W)_________________ (Any calls will be discreet, but please indicate any restrictions)
E-Mail Address: ___________________________

Referral: Who gave you my name to call?

Name:____
Phone:____
Address:____

How did this person explain how I might be of help to you?
____
____
____

Have you ever received psychological or psychiatric or counseling services before? • No • Yes If yes, please indicate:

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

Have you ever taken medications for psychiatric or emotional problems? • No • Yes If yes, please indicate:

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

Employer: ______________________________ Address: __________________________________

I authorize Paraclaysis to mail any correspondence regarding my treatment, satisfaction with treatment, updates about my treatment and educational programs during and after the completion of my treatment to my home mailing address. _____ Yes ______ No

Briefly described why you are currently seeking counseling:
____
____
____

When did these problems begin?

____

____

Marital/relationship history:

	Spouse's age at marriage	Your age at marriage	Your age when divorced/widowed	Is spouse remarried?
First	____________	________	_________	___________
Second	__________	________	_________	___________
Third	___________	________	_________	___________
Fourth	__________	________	__________	___________

Have either you or your spouse been arrested for domestic violence? Year: ___________

Have either you or your spouse been convicted of a domestic violence offense? When ______

Family-of-origin history

Relative	Name	Current age (or age at death)	Illness (or cause of death, if deceased)	Occupation
Father	____________________	______________	_________________	__________
Mother	____________________	______________	__________________	__________

Please describeYour parents' relationship with each other:

____

____

____

____

Your parents' physical health problems, chemical use, and mental or emotional difficulties: ___________

____

____

____

Your relationship with each parent and with other adults present: _________________________________

____

____

____

____

Stepparents	________________	______________	_________________	__________
	________________	______________	_________________	__________
Grandparents	_______________	______________	_________________	__________
	________________	______________	_________________	__________
	________________	______________	_________________	__________
	________________	______________	_________________	__________
Brothers	___________________	______________	_________________	__________
	___________________	______________	_________________	__________
	___________________	______________	_________________	__________
	___________________	______________	_________________	__________

Sisters____________________ ______________ _________________ ___________
____________________ ______________ _________________ ___________
____________________ ______________ _________________ ___________
____________________ ______________ _________________ ___________

Your relationship with your brothers and sisters, in the past and present:

____
____
____
____

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

Your age	Kind of abuse	By whom?	Effects on you?	Whom did you tell?	Consequences of telling?
____	______	____________	__________________	________________	_______________
____	______	____________	__________________	________________	_______________
____	______	____________	__________________	________________	_______________
____	______	____________	__________________	________________	_______________
____	______	____________	__________________	________________	_______________
____	______	____________	__________________	________________	_______________

Significant nonmarital relationships

	Name of person	Person's age when started	Your age when started	Your age when ended	Reasons for ending
First	______________________	__________	_____________	____________	_________________
Second	___________________	__________	_____________	____________	_________________
Third	______________________	__________	_____________	____________	_________________

Children

(Indicate which are from a previous marriage or relationship with the letter P in the last column)

Name	Current age	Sex	Grade	Adjustment problems?	P?
_____________	__________	_____	____	______________________	__
_____________	__________	_____	____	______________________	__
_____________	__________	_____	____	______________________	__
_____________	__________	_____	____	______________________	__
_____________	__________	_____	____	______________________	__
_____________	__________	_____	____	______________________	__

Consent to Treatment

I do hereby seek and consent to take part in the treatment by the counselor named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may seek a second opinion from a different counselor or stop my treatment with this counselor at any time.

I understand that any kind of sexual relationship between a therapist and client is completely inappropriate, a violation of the counselor's professional code of ethics and should be reported to the therapist's licensing board.

I understand that information provided by me during therapy sessions is legally confidential. I understand there are exceptions defined in Colorado legal statutes (listed below in the section regarding your rights as a client).

I understand that if my health insurance benefits are being used to pay for my counseling that my health insurance policy sets the rates or reimbursement and may also require me to make part of the payment (co-pay) for the service receive. As a courtesy the counseling provider will bill my insurance company if he/she is credentialed with the insurance company. Furthermore, I understand that I must call to cancel an appointment at least 24 hours before the time of the appointment. Failure to cancel within this time will be considered a failure to show for a scheduled appointment. Since insurance companies do not generally pay for appointments that individuals fail to attend the counseling provider reserves the right to bill me for any missed appointments.

If you your insurance benefits expire or will only pay for a certain number of appointments or if you do not have insurance the following chart shows costs for services. This is a sliding scale fee schedule based on your annual income and the number of people who live in your household.

Family Size	1	2	3 or 4	5+	Cost per hour
Income	15,000	17,000	19,000	21,000	10
	19,000	21,000	23,000	25,000	20
	23,000	25,000	27,000	29,000	30
	27,000	29,000	31,000	33,000	35
	35,000	37,000	39,000	41,000	40
	43,000	45,000	47,000	49,000	50
	49,000	51,000	53,000	55,000	60

As a client of a Colorado Licensee you have the following rights:

1. To expect that a licensee has met the minimal qualifications of training and experience required by State law;
2. To examine public records maintained by the Board and to have the Board confirm credentials of a licensee;
3. To obtain a copy of the Code of Ethics;
4. To report complaints to the Board;
5. To be informed of the cost of professional services before receiving the services;
6. To be assured of privacy and confidentiality while receiving services as defined by rule and law, including the following exceptions: a) Reporting suspected child abuse; b) Reporting imminent danger to client or others; c) Reporting information required in court proceedings or by client's

insurance company, or other relevant agencies; d) Providing information concerning licensee case consultation or supervision; and e) Defending claims brought by client against licensee;

7. To be free from being the object of discrimination on the basis of race, religion, gender, or other unlawful category while receiving services.

You may contact the State of Colorado Marriage and Family Therapist Examiners Board at:

1560 Broadway, Suite 880
Denver, CO 80202
(303) 894-7766 - Phone
(303) 894-7747 - Fax

My signature below shows that I understand and agree with all of these statements and financial commitments.

____

Signature of client Date

____

Printed name

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

____

Signature of therapist Date

James L. Bixler

Printed Name

Philosophy and Approach:

People are experts about their own relationships. Often they have also become experts at the problems. Some individuals/couples may bring unresolved problems from the past. Like an old movie, they may be projecting unresolved issues from the past onto the screen of their current relationship. In the counseling process I seek to help individuals/couples redefine the problems by defining behaviors and attitudes for the kind of relationship they would like to have. Some call this solution focus therapy.

In addition, I also am trained in Eye Movement Desensitization and Reprocessing. This is an approach to help individuals who have experienced traumatic events and who are having trouble enjoying life the way they did before they experienced the trauma.

As a licensee of the Colorado Marriage and Family Therapist Examiners Board, I will abide by its Code of Ethics.

Formal education and training:

I received a Masters of Science degree in Marriage and Family Counseling from Columbus State University.

Major course work included: human development; human sexuality; theories of marriage and family counseling; marriage and family therapy assessment, treatment, and techniques; ethical practice of counseling; statistics; and clinical or applied experience of counseling individuals, couples, and families.

I also completed Level I and Level II training in EMDR and have completed the minimum requirements recommended by EMDRIA (EMDR International Association) to be considered trained in using EMDR.

I am credentialed as an Approved Supervisor by the American Association for Marriage and Family Therapy.

I have conducted over 16,000 hours of therapy.

To maintain my professional expertise as a therapist I participate in continuing education, taking classes dealing with subjects relevant to this profession.