LOUISVILLE SEMINARY
COUNSELING TRAINING CENTER

OPERATING MANUAL

(Revised August 2013)

LOUISVILLE SEMINARY
COUNSELING TRAINING CENTER (LSCTC)

1044 Alta Vista Road
Louisville, KY 40218
502 / 894-2293

Welcome to Louisville Seminary Counseling Training Center (LSCTC), a professional counseling site serving the Kentuckiana area. Interns serving this site provide professional clinical care of their clients from initial interview to final session, under clinical supervision.

The policies and procedures in this manual are designed to clarify the clinical operations of LSCTC and to provide guidance for interns working with LSCTC clientele. LSCTC is committed to the highest quality of care for clients and to consistency in the way both interns and clients are treated. Questions regarding interpretation and implementation of these policies and procedures should be directed to Jenny Schiller, Director of Clinical Training or Becky Timerding, Administrative Assistant.

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LSCTC Operations

Confidentiality and Ethics

Interns serve the Louisville community as professional staff of the Louisville Seminary Counseling Training Center and are therefore held to the same limits of confidentiality as licensed therapists. All session information and clinical material is considered confidential and kept in the strictest manner of confidence. Any use of clinical material or case material in writing (hard copy or e-mail) or phone communication should be approved by the client in writing prior to its being shared with other persons. If particular information is shared, appropriate documentation and a time-limited release needs to become part of the client's file. There are three (3) exceptions to the confidentiality of case material.

1. Cases of serious danger of homicide or suicide. If a client's threat of homicide or suicide is deemed serious, the intern has the responsibility to break confidentiality to work within the statutes of the Commonwealth of Kentucky concerning these issues. Under Kentucky law, counselors are bound to warn an intended victim of the threat of violence and to contact local law authorities (See "Laws Impacting Therapy" in Appendix). Clients are informed of this exception to confidentiality at the initial interview.

2. Cases of child abuse, spouse abuse, or elder abuse, as specified in the Kentucky statutes concerning notification of authorities (See "Laws Impacting Therapy" in Appendix).

3. If there are legal court proceedings, the possibility exists that clinical records may be subpoenaed.

Professional misconduct by a previous therapist

While not required to break confidentiality, in cases where the client divulges sexual or other professional misconduct by a previous psychotherapist, the intern shall:

1. Inform the client of the unethical, unprofessional, and dishonorable conduct of the previous psychotherapist's actions.

2. Advise the client that professional misconduct is cause for disciplinary action.

3. In consultation with her/his supervisor and informing the Director of Clinical Training, refer client to appropriate licensure or accreditation bodies.

Professional Codes and Conduct

The staff of Louisville Seminary Counseling Training Center (Director of Clinical Training, Clinical Supervisors, and Interns) is expected to adhere to the Ethical Code of the American Association of Pastoral Counselors (AAPC) and the Code of Ethics of the American Association for Marriage and Family Therapy (AAMFT) concerning relationships with clients and others. This includes all parameters of the relationship, including boundary issues.

Those serving at LSCTC are expected to follow the above named ethical codes and conduct themselves in a responsible and professional manner. Any violation of these codes or the policies and procedures described in this manual, including inappropriate dress, counseling without coverage, and inappropriate administration of client records (i.e., removing client records from LSCTC, failure to document therapeutic sessions or use appropriate forms in a timely manner, failure to close files in a timely manner) is considered a breach of the agreement between the Intern and Louisville Seminary Counseling Training Center. Violations will be documented in the Intern's personnel file and could result in probationary action or dismissal from service.

Supervisors and Types of Supervision

Supervisors

All interns serving at Louisville Seminary Counseling Training Center are under the care and guidance of persons who are faculty or adjunct clinical supervisors in the Marriage and Family Therapy program as defined by the Marriage and Family Therapy Program Manual. Supervisors are either an Approved Supervisor in the American Association of Marriage and Family Therapy or a Supervisor Candidate under ongoing supervision of supervision. They are approved as a Fellow or Diplomate of the American Association of Pastoral Counselors, if qualified by theological training. Those supervisors not theologically trained are Members of the American Association of Pastoral Counselors.

Types of Supervision: Individual and Group

Individual Supervision

Interns are assigned a clinical supervisor for individual supervision with whom they will discuss their clients. *Individual supervision* is defined as a weekly 1 to 1 ½ - hour meeting in which one supervisor meets face-to-face with one student or one dyad (two students) to reflect upon each student's client cases and clinical concerns in marriage and family therapy. The majority of supervision (at least 50%) will focus upon raw data from the intern's clinical work made available to the supervisor by means of direct observation, videotapes/DVDs, or audiotapes.

Informed Consent - Prior to seeing clients in the MFT program, all students will discuss informed consent with their supervisor and demonstrate their understanding of each of the seven articles as they relate to supervised clinical practice.

1. The specific procedures to be used in therapy and their purposes.

2. The role of the therapist in treatment and his/her qualifications to offer treatment. For students this includes a full disclosure of student status and the place of supervision in treatment. (Professional disclosure statements can be created as an exercise for students but may not be shared/offered to clients. Information regarding the supervisor's credentials will be provided only if requested by the client.)

3. Specific discomforts or risks to be expected in counseling.

4. Benefits **reasonably** to be expected from counseling.

5. Alternative methods of treatment for the same problem that may produce similar results.

6. The client's right to ask questions about the nature and process of therapy at any time.

7. The client's right to end therapy at any time.

Providing therapy with another intern ("co-therapy")

After consultation with the Director of Clinical Training, interns may have the opportunity to do co-therapy with another intern. (These opportunities could be with couples or families.) In these circumstances, the intern originally assigned the client is the lead therapist and has primary responsibility for the client's care. They take the lead in treatment direction while cooperating with their co-therapist. On a regular basis (monthly if client contact is weekly) the two interns meet with the lead therapist's supervisor. This is to coordinate treatment direction and procedures.

Entire client records may not be removed from LSCTC offices at any time. Individual documents needing a supervisor's signature and client video/DVD or audio tapes may be removed for a supervisory session on rare occasion. Such media must be transported in a secure, confidential manner. Lock bags are provided for this purpose.

Group supervision ("Live Supervision") is defined as face-to-face meetings between a supervisor and no more than ten students. Students rotate with peers in presenting cases on which there is group reflection. Live Supervision groups meet for two-hour weekly sessions.

Preparation for Live Supervision*:* When an intern is scheduled to present a client for consultation, the intern will have the client family sign the "Authorization for Live Observation and Audio-Visual Recording" form (see Appendix). The intern will also prepare copies for all participants of the following:

Written case study with theological reflection (see "How to Write an Intake Evaluation," Section II or "Senior Integration Experience Format," Section IV, MFT Program Manual);
Copy of genogram;
Be prepared to give a verbal overview of treatment to date, including theory of choice (10-20 minutes);
Be prepared to state what is hoped to be gained out of consultation (3 sentences), mentioning specific areas of concern.

LSCTC Dress Code

The Louisville Seminary Counseling Training Center does not have a standardized dress code. However, when at LSCTC during normal operating hours, interns' attire should be modest and professional in appearance. Casual clothing such as jeans, flip-flops, beach wear, scrubs, shorts, T-shirts, halter tops, bare midriffs or baggy pants are inappropriate for the office.

LSCTC Staff Meetings

Those serving clients at LSCTC are expected to attend any scheduled staff meetings. Meeting times will be announced two weeks prior. Interns are encouraged to contact the Director of Clinical Training with areas of concern to be discussed.

Vacations and Holidays

LSCTC adheres to Louisville Presbyterian Theological Seminary's holiday schedule. Student interns serving at off-campus sites are expected to check with their site's Administrative Supervisor regarding the site's holiday schedule. The student should initiate conversation with their Administrative Supervisor regarding any time away outside of their site's holiday schedule.

Standard holidays for LSCTC include the following:

- New Year's Day
- Martin Luther King Day
- Easter Holiday (Thursday & Friday)
- Memorial Day
- July 4th
- Labor Day
- Thanksgiving (Thursday & Friday)
- Christmas Holidays

LSCTC is open all other breaks in Seminary community life including Research & Study Weeks, final days and additional days at Christmas.

When an intern expects to be unavailable at other times due to holiday travel or limited vacation time, their plans should include arranging for continued client care during their absence. The intern should make arrangements for the following before leaving town **at any time**:

1. Advise clients of upcoming absence and inform them of the Seven Counties Crisis 24-hr "Hope Now" crisis number (589-4313) for emergencies.
2. Plan to call into the office every day while you are gone or contact a counseling peer to screen phone messages at LSCTC for any urgent care situation*. Peers may contact the

client to assess their situation and offer contact information for a local hospital or the crisis "Hope Now" hotline number (589-4313). Peers may not see clients for sessions.

3. Advise supervisor of absence and name of peer supplying client urgent care.
4. Notify MFT Office of dates of absence and name of peer supplying client urgent care and your contact information. Be clear that your peer can supply coverage for the entire time you are away.

** Urgent care situations exist when the client indicates they are in crisis and need to be seen immediately. Voice mail messages regarding changes of session dates or other client matters should be retained and addressed by the traveling intern when they return to duty.*

In the event the intern is unable to obtain a counseling peer to supply client care during their absence, he/she should discuss the situation with their supervisor. After a resolution is made, the intern should contact the MFT Office with dates of absence and client care plan.

Inclement Weather Policy

In events of inclement weather, Louisville Seminary Counseling Training Center will adhere to the following policy:

- In the event of snow or other inclement weather conditions, Louisville Presbyterian Theological Seminary will notify employees and students of the status of the Seminary, Open or Closed or On Delay, through announcements placed on local television stations, the voice message on the Seminary switchboard, and an announcement on the Seminary's web site. Any announcement by JCPS will be taken into consideration but will not determine the status of the Seminary.

- Louisville Seminary Counseling Training Center will follow decisions made by Louisville Seminary regarding closures and delays. If Louisville Seminary is closed, the center will also be closed. If Louisville Seminary is on a delayed schedule, the center will also be on a delayed schedule.

- When weather related concerns develop during the business day, clients will be contacted by their therapist if a session will be cancelled. We would appreciate receiving notification from our clients when they are unable to attend due to inclement weather.

LSCTC Phone System Guide

Office Number: 502 / 894-2293
Office Fax: 502 / 895-0319

When answering the phone at LSCTC, interns should respond "Louisville Seminary Counseling Training Center. This is _____." If the caller asks to leave a message for an intern, the message should be taken. At the close of the call, the message can be left on the LSCTC voice mail by this method:

Call the office number – 894-2293
Press - # to skip voice message
Leave the message for the therapist, stating the name of the therapist first.

Other actions regarding the LSCTC phone systems include:

To **call out** from LSCTC: Dial 9 + number
To **call long distance**: Dial 9 + 1 + area code and number (to be used for LSCTC business only)

To **retrieve** LSCTC voice messages from an <u>outside line</u>:
Dial – 502 / 992-5439
Enter the password
Enter the mailbox number

To **retrieve** messages from the <u>Chart Room</u>:
Press – "Mailbox" on the phone face
Press – the √ at the bottom of the phone face
Enter the password
Enter the mailbox number

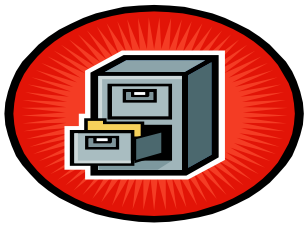
To **skip** a message: Press 3
To go **back**: Press 1
To delete a message: Press 0 0

Supportive Resources and Referral Contact Information

Resources to assist interns with counseling session topics (parenting skills, couple work, treatment planning, DSM-IV, etc.) are located in the Resource Room. Materials for expressive therapy work with youth and adults can also be found there.

A list of community references is maintained on the LSCTC computer desktop. The references are listed by area of concern.

New entries to the resource room and the computer referral list are invited and encouraged. The desire is to maintain a large collection of resources and a growing list of references to better serve LSCTC clients. Those wishing to add to the Resource Room and computer referral list should contact the LSCTC Administrative Assistant with their resource.



Closing LSCTC for the Day

At the end of each counseling day, the intern leaving last is responsible for closing the LSCTC. This includes

- ✓ checking that lights and television monitors in all counseling and supervision spaces are off and the doors locked,
- ✓ seeing that the session signs show “LSCTC,”
- ✓ confirming the white noise machine in the hallway is off, and
- ✓ confirming the client file cabinet and money cabinet are locked.

Safety Measures and Crisis Procedures

Safety Measures

LSCTC cares for the safety of the therapists and clients being served. Steps have been taken to provide a safe environment at LSCTC. For example, cameras monitor the waiting room and the hallway leading to the chart room door so therapists in the chart room can observe clients' arrival and departures. A door bell has been installed by the entry door to the LSCTC waiting room for use when interns provide coverage during counseling sessions or at other times when no one is available to greet clients, especially in the evenings. The installation of an alarm system in the near future is anticipated. Therapists who identify other ways safety can be enhanced are encouraged to contact the Administrative Assistant or Director of Clinical Training.

Incidents / Accidents

When someone is hurt or there is an incident on campus, a report must be filed with the Facilities Department. (See "Incident/Accident Form" in the Appendix.) Include as much detailed information on the form as possible. Place the completed form in the Director of Clinical Training's box in the chart room.

Crisis Situations

Counseling interns should assess the severity of the crisis situation and attempt to contact their supervisor or the Director of Clinical Training for assistance before contacting local police or EMS. Crises that might warrant intervention would include:

1. Client is threatening intern with physical harm.
2. Client is a threat to him/herself within session.
3. Client is harming or threatening to harm another individual
4. Client is harming or is threatening to harm property.
5. Client has a medical condition that needs immediate attention.

If you are in the office providing coverage and a crisis arises:

1. Ask counseling intern what assistance is needed.
2. Contact the counseling intern's clinical supervisor for guidance.
3. Notify the Director of Clinical Training or other designated "on-call" supervisor.
4. If necessary, use the nearest phone to call the police or EMS.
5. Complete the Incident/Accident form.

Emergency Notification Operating Procedures

If a dangerous situation or an emergency requiring a lockdown occurs, the counseling intern should notify the Vice President for Finance (x 288) or the Director of Facilities (x 387). If neither is available, contact the emergency facilities number (376-1572). In all cases, notify the Director of Clinical Training as soon as possible.

Service At Off Campus Sites

Under the guidance of the Director of Clinical Training, interns will have opportunities to serve off-campus Practicum sites. Each site has its own procedures and documents. Interns are required to learn and adhere to the specific guidelines of their off-campus site.

A binder containing information regarding active off-campus sites is housed in the Administrative Assistant's office and can be viewed during normal office hours. Off-campus sites include such places as schools, senior care facilities, counseling agencies, community shelters, and hospitals. Interns with interest in a particular Practicum site may submit their request to the Director of Clinical Training.

Because of circumstances and the number of interns and Practicum sites, there is no guarantee that an intern may be at a site requested. The final decision remains with the Director of Clinical Training.

Termination of Service to Off-Campus Site

At times, concerns can arise for an intern while serving an off-campus Practicum site. Issues may include conflict at the Practicum site with staff and/or administrative supervisor or a low number of available client hours. When this occurs, an intern should share their concerns with their clinical supervisor. If the concerns cannot be rectified through supervision, the intern should then consult with the Director of Clinical Training regarding the placement. Possible solutions will be explored and a course of action determined. This may include possible closure of the intern's work at the site and reassignment to another Practicum site.

NOTE: Interns can only begin or end placement at an off-campus site following consultation the LSCTC Director.

Client Care

Client Intake and Assignment Process

When an intake telephone contact is received from a prospective client, a Telephone Intake form (See Appendix) will be completed including name, age, telephone numbers, referral source, and brief summary of the presenting problem. The prospective client will be informed of the expected timing of an initial appointment and any current waiting list.

An intern is notified that an intake is waiting for pickup by two methods – contact via cell phone and e-mail message. If after a reasonable amount of time the client intake information has not been retrieved, the intake will be given to another intern. The receiving intern will contact the client to schedule an initial interview appointment. The Administrative Assistant will forward the Telephone Intake form to the intern for inclusion in the client's file.

Each semester, interns need to verify their contact information with the Administrative Assistant to assure they can be reached for intakes. Interns must be readily available to receive intakes either by cell phone or e-mail.

If an appointment with the client cannot be arranged, or the client fails to attend scheduled appointments, the intern should record their attempts to contact the client on a "Case Activity Note" and return the intake and note to the Administrative Assistant. This information will be archived for future reference.

Assignment of Clients

Clients are assigned, on a rotating basis taking into account the client's needs and the interns' readiness for working with the presenting problem. As students enter the Practicum series, their clinical supervisor will determine their readiness to receive intakes and notify the Director of Clinical Training as this occurs. **It is the ultimate responsibility of the intern to contact the Administrative Assistant and the Director of Clinical Training if they feel they have a full caseload.** If the client has been referred to a particular intern, attempts will be made to honor their referral request.

Seeing Children Under the Age of 18

When receiving an intake for a child, the parental/custodial status will be determined and information will be included on the Telephone Intake form. If appropriate, the counseling intern will request that a copy of the custody papers be provided at the first session. Because it is necessary to know if the presenting parent has appropriate legal rights to obtain counseling for the child, with or without the other parent's permission, counseling cannot begin without a copy of the custody papers. A copy of the child custody agreement will be maintained in the

file so the interpretation can be read at any time. This document will then be available to respond to any future questions related to the child attending sessions.

LSCTC will adhere to the provision of any custodial agreement in effect regarding a child seen for therapy. Custodial documentation will be reviewed prior to seeing the child at the initial session. If appropriate, each parent should be available to attend client sessions. When this is not possible, if required by custodial agreement, the absent parent must complete a "Permission to Counsel a Minor" form before a child can be seen in therapy.

Seeing Court Ordered Clients

Prior to seeing a client ordered by the courts to obtain counseling, the intern will request and obtain copies of court documents in order to insure required counseling is completed and appropriate verification can be prepared. This requirement extends to clients recommended by attorneys for counseling. Court ordered clients will be advised to bring a copy of the court document with them to the first session. If a copy is not available from the client, the intern will request that the client sign a "Consent of Release of Information" form in order to obtain a copy of the order from the court.

Scheduling & Coverage

Scheduling Appointment Times and Office Space

Appointments are to be scheduled on the hour only and can be scheduled by interns any time during operating hours, as long as another intern, a staff member or a supervisor is present in the LSCTC at the same time. Client appointments are not permitted on Friday, Saturday, or Sunday. Appointments and office space should be recorded in the calendar using the Outlook program on the LSCTC computer as described on the following pages.

> For the safety of the client and themselves, interns should NEVER hold a client session while alone in the LSCTC Offices**.** Violation of this policy will constitute a breach of standard of care. A Critical Incident Report will be written up and placed in the intern's personnel file at LSCTC and a copy will be forwarded to their supervisor.

Interns may ask clients to obtain paperwork from the website or to arrive 15-20 minutes prior to their first session to complete required paperwork. It is the intern's responsibility to arrive before the client and prepare the paperwork the client will need to complete.

Therapy is to be conducted within a "fifty-minute session" model. The intern and client should be out of the office by 10 minutes until the hour. If a circumstance exists and additional time is needed, the intern in the session should step out and communicate/ negotiate with the next intern about room usage. The second intern knocking on the door at 5 minutes to the hour could also initiate this communication. This is a necessary aspect of working in community. Any session that goes over 50 minutes is one that the intern should discuss with her/his supervisor for feedback regarding additional fee or other boundary issues.

Coverage During Client Sessions

When scheduling a client session, care should be given to assure that another intern, a staff member or a supervisor will be present at LSCTC to provide "coverage." The individual covering for a counseling intern provides protection for both the intern counseling and the client by being on hand for unforeseen circumstances/events. The Student Assistant at LSCTC will post his/her times of scheduled coverage at the beginning of each semester. Interns scheduling client sessions outside of these posted times are responsible for obtaining coverage for themselves and their clients.

> For the safety of the client and themselves, interns should <u>NEVER</u> hold a client session while alone in the LSCTC Offices**.**

Therapist Contact Information

Interns should ask clients to use the LSCTC voice mail (894-2293) as their contact number for messages. For ease in identifying messages, clients should state, "This message is for (therapist's name)," then leave their message. Clients should be directed to contact the "New Hope" hotline or nearest hospital for crisis or emergency care.

Interns serving at LSCTC are expected to retrieve their messages a minimum of twice daily – morning and afternoon – and return client calls promptly. Client messages should be erased after they have been retrieved UNLESS the message is needed for supervision purposes. Interns who plan to retrieve messages and return client calls while on vacation must do so twice daily, contact clients promptly, and erase messages.

Inclement Weather Policy

In events of inclement weather, Louisville Seminary Counseling Training Center will adhere to the following policy:

When weather related concerns develop during the business day, clients will be contacted by *their therapist if a session will be cancelled. We would appreciate receiving notification from* our clients when they are unable to attend due to inclement weather.

If weather concerns develop overnight, Louisville Seminary Counseling Training Center will follow decisions made by Louisville Seminary regarding closures and delays. If Louisville Seminary is closed, the center will also be closed. If Louisville Seminary is on a delayed schedule, the center will also be on a delayed schedule.

When a counseling session is cancelled due to inclement weather, it is the therapist's responsibility to contact their client and reschedule the missed appointment.

Please tune in to local television stations for weather related announcements.

OUTLOOK CALENDAR PROCEDURE

Appointment times and office space are recorded using the Outlook Calendar on the LSCTC computer.

To add a new appointment time or reserve office space:

1. Access the appropriate week using the calendar in Outlook.

2. Click on the green/yellow line next to the start time you desire (make sure you are on the correct day). The dialogue box for that time will open.

3. in the subject box, type
   - "Appointment" if you are working alone.
   - "Appointments" if you are working with a co-therapist. The plural indicates more than one therapist is working, therefore, you are covered.

4. Skip the "Location" entry section.

5. The "Start Time" should show the day and hour you wish to have the space. If it doesn't, change it to the appropriate day and time.

   Note: If the appointment is for supervision, the appointment must start on the hour and end on the hour. (Example: For a supervisory session that begins at 9:00 a.m. and ends at 10:30 a.m., make two separate appointment times; the first from 9:00-10:00 a.m. and the second 10:00-11:00 a.m.)

6. Click on the end time and select one hour. All appointments will be in one-hour increments beginning and ending on the hour.

7. In the text box at the bottom, type the room number you are using. Then press tab and type your last name. If you are working with a co-therapist, type a slash (/) and then the co-therapist's name. After the therapist's last name, type a colon and type the client's initials or the reason for use of the room.

   Client Examples: CR2 Berry/Timerding: JC **or** CR1 Smith: TM (intake)
   Use Examples: PT Hyde: study **or** GPA&B Ruf: Live Supervision

   Note 1: You must use the room you have reserved. If you decide to change rooms for a session, be sure to make the appropriate change on the computer.

   Note 2: Counselors needing a room for a session take first priority and can ask an intern using an office for other reasons to move to a new room.

8. Click “Save and Close” at the top of the screen.

   If saved correctly, the date and time you have selected will appear in white on the calendar with “Appointment(s)” showing.

To check the availability of a room and/or add an appointment to a date and time already highlighted:

If the date and time you wish to use appear in white, an appointment has been added to the calendar. Double click on the area. The Appointment Box will open allowing you to check if the room you would like to reserve is available. If the room number does not appear in the text box at the bottom, you may add it.

1. Change Appointment on the “Subject” line to read “Appointments” indicating more than one therapist is working at that time.

2. Click in the text box and add the room you would like to reserve in numerical order. Take care not to delete the appointments already scheduled. If this should happen, use the red “X” at the top of the screen to exit the appointment time and indicate “No” when asked if you want to save changes. You can now safely begin again to schedule your appointment.

3. Continue your entry as described above adding therapist(s) and client names.

4. When completed, click “Save and Close”. 

To check the calendar from off-campus:

1. Go to the bottom of the Louisville Seminary website (www.lpts.edu) and click “Campus email.”

2. Select “Seminary Employees.”

3. Enter the User Name: counselor@lpts.edu and the password: Ptamge60 (be sure the “P” is capitalized.)

You should now be at the proper site to view the calendar.

The Louisville Seminary Counseling Training Center Financial Policy

Clients demonstrate their investment, or lack of investment, in their counseling via means of their payment (or lack of payment) of fees. Collection is a therapeutic issue, and non-payment often represents some issue on the part of the client. This action needs to be explored in the context of the therapy session.

Sliding Scale Fee and Financial Assistance

LSCTC has an initial session fee of $20.00 for all clients. Future session fees are negotiated at the beginning of the initial session by the intern with the client using the sliding fee scale. The current scale is $1.00 per $1,000 of annual income, not to exceed $65.00. Interns should consider $10.00 the minimum fee. Fees can be re-negotiated whenever needed.

Clients will not be turned away due to inability to pay. For clients unable to meet the initial session fee or minimum $10.00 session fee, financial assistance is available. Interns should request that these clients complete a *Financial Assistance Application*. Interns will then indicate if the application has been approved or denied, the amount of assistance approved, and the number of sessions assistance will be given.

Collection of Fees

Interns are expected to collect fees from clients at the time of service. When money (cash or check) is collected, fill out a LSCTC receipt. The white copy is for the client and verifies that payment was given to the intern. The yellow copy should be kept in the client file. Clip the pink copy to the payment, and place the payment in the money lock box. The intern's yellow receipt will serve as verification that payment was placed in the money lock box. At no time should payments be kept in the files.

For each session held, including those where payment is not received, make an entry on the Attendance/Payment Log. (See Appendix for an example of a completed Attendance/Payment Log.) In the event of a returned check, any fees charged to LPTS must be reimbursed by the client prior to continuing in therapy.

Clients may not accumulate an account in excess of the equivalent of the client's fee for three (3) sessions. Clients with an outstanding account balance are expected to pay in full as soon as possible. All clients are expected to liquidate their accounts within 60 days after termination of services.

Activating Client Accounts

Client accounts are activated by informing the Administrative Assistant that a new client is being seen. This is accomplished by preparing an index card with the following information:

Client's last name, first name Phone
Address
Ethnicity
Family members being seen with ages
First appointment date
Referral Source
Intern / Supervisor

After completing the information, the intern will place the card in the money box to be given to the Administrative Assistant who will begin a new account for the client.

Cancellations

Ordinarily, at least a 24-hour advance notice of a cancellation is required in order not to be charged for a session. There are, however, several reasons that might warrant not charging for a missed session (illness, death in family, car accident, etc.).

Financial Policy Exceptions

School Clients – School families/clients seen at LSCTC after school hours or in the summer will not be charged nor will the school site be charged. Qualifying school families are those whose child is being seen by a counseling intern at the school during the school year.

Others – Additional exceptions to the Louisville Seminary Counseling Training Center Financial Policy must be pre-authorized by the Director of Clinical Training.

Outcome and Session Rating Scales (ASIST Program)

Clients seen at LSCTC are asked to complete an Outcome Rating Scale prior to beginning each session, including the initial session. This scale/measure provides data on how the client perceives how they have managed the time prior to beginning sessions or following their last session. This information can identify at-risk cases in real time. At the end of each session, clients are asked to complete a Session Rating Scale which provides effectiveness data for the therapist. The ORS and SRS give the client a platform/voice for direct feedback regarding the counseling experience and provide empirically-based data that can assist therapists in adjusting interventions and methods to meet the needs of their client.

Treatment Procedures

The first three sessions in the therapeutic process include several tasks: define the problem, collect relevant history and make assessment, and do treatment planning. These tasks may be repeated at various points in the process when new information is revealed, new problems are discovered or new goals for therapy are established.

Professional Courtesy

Interns must demonstrate a high level of professional courtesy to LSCTC clients at all times.

- ✓ As a matter of developing as a therapist ethically, it is important for interns to be present and ready to begin counseling at or before the session's appointed time.
- ✓ Conversation in the hallway should be limited. Remember that the waiting room area is our first impression to new clients.
- ✓ Interns should refrain from smoking outside the LSCTC entry.

Initial Interview

Prior to the Initial Interview

These forms will be used during the initial interview with your client:

1. "Welcome" to Louisville Seminary Counseling Training Center
2. Client's Bill of Rights
3. Confidential Client Information (Adult) or Confidential Client Information (Child/Adolescent under 18)
4. Limits of Confidentiality
5. Video Recording Release
6. Informed Consent
7. Outcome Rating Scale (ORS)
8. Financial Assistance Application, if appropriate

(Examples of these forms can be found in the Appendix.)

Before the interview, the intern will prepare a client file containing the first 6 forms listed above. The client must read, complete and sign these forms prior to or at the beginning of the first session. **The intern should ask the client to arrive at least 15-20 minutes prior to the appointment time to process the forms.** It is the intern's responsibility to arrive before the client and prepare the paperwork the client will need to complete. The intern should be knowledgeable of these forms and able to answer any questions or concerns the client may have.

Everyone who comes to therapy must give his or her permission to be seen. All adults attending counseling sessions with a client should complete and sign these forms: Participant Confidential Information Form, Informed Consent, Limits of Confidentiality and Video Recording Release. Adults attending more than one counseling session with a client should also complete the remainder of the Confidential Client Information form.

During the Initial Interview

Several items should be covered with the client during the interview.

1. Informed Consent – Marriage and family therapy interns will provide full disclosure of the following seven articles of informed consent to all clients.

    a. The specific procedures to be used in therapy and their purposes.

    b. The role of the therapist in treatment.

    c. Specific discomforts or risks to be expected.

    d. Benefits **reasonably** to be expected.

    e. Alternative methods of treatment for the same problem that may produce similar results.

    f. The client's right to ask questions about the nature and process of therapy at any time.

    g. The client's right to end therapy at any time.

2. The intern will collect any legal documentation for children being seen in session (custody papers, Permission to Treat a Minor, etc.). A copy of the child custody agreement should be maintained in the file. The consent of both parents is desired for a child to be seen in therapy and, if possible, both parents should attend the first session at a minimum.

3. The intern should review and sign the forms the client has completed and be available to answer any questions the client might have about the LSCTC, the intern, or the process of psychotherapy. Answer any questions about completing the ORS.

4. The intern should negotiate the fee for sessions based on the sliding-fee scale, in consultation with her/his supervisor. (See **The Louisville Seminary Counseling Training Center Financial Policy**). The fee will be recorded on an Informed Consent form. The client's signature on this form gives Louisville Seminary Counseling Training Center permission to treat the client and to collect fees. The client should be informed that payment is expected at time of service.

5. The intern should review the Informed Consent with the client and obtain the client's signature.

6. The intern should discuss with the client the expectations of the likely time frame of therapy, the 24-hour cancellation policy, the inclement weather policy, ringing the door bell outside the entry door when no one is present at the reception desk, and the structure of the initial sessions of therapy.

7. The intern should complete the Initial Session form to help assess the problem that brought the client to counseling.

8. The intern should ascertain whether the client has previously sought medical assistance, been hospitalized for psychotherapeutic reasons, sought psychotherapy or been on psychotropic medication. The intern should ask the client to sign a Consent for Release of Confidential Information form to be sent to prior providers requesting pertinent information. (See **Consent for Release of Confidential Information** for further information regarding this form and information; also see Appendix for form example.)

9. Whenever a client presents at risk or any homicidal or suicidal intent is present, a Safety Plan should be established during the initial interview. If intent is indicated, immediate consultation with the intern's supervisor or the Director of Clinical Training is required to determine if hospitalization, referral, or a contract with the intern is necessary. (A Safety Plan form is included in the Appendix.)

10. The time and date for the next appointment needs to be set and recorded on the computer calendar program. When possible, a regular time for the client's sessions should be established.

11. The intern should explain the Session Rating Scale (SRS) and ask the client to complete form prior to leaving.

Following the Initial Interview

After the initial session, the intern will report his/her findings by completing the initial case write-up form. No progress note is needed for the first session. The information from the

initial case write-up will be discussed in supervision (see Appendix for form examples). Together the supervisor and the intern will review the information and other pertinent data and make a determination as to whether the client is suitable to be treated within the context of LSCTC. In some cases, client suitability could take up to 3 sessions to determine.

Entire client records may not be removed from LSCTC offices at any time. On rare occasion, individual documents needing a supervisor's signature and client video or audio tapes may be removed for a supervisory session. Such documentation and media must be transported in a secure, confidential manner. Lock bags are provided for this purpose.

Following the initial session, the intern will input demographic information for their client into the ASIST Program, including ORS and SRS scores.

Future Sessions

In each case (relational or individual) the intern, in consultation with the couple, family or individual, will construct a Family Genogram (See Appendix) as an additional aide in visualizing the context. This will often spotlight important contributing factors in the client's developmental history (e.g., the use of divorce to solve marital problems, or chemical abuse). Depending on the presenting problem, this may take 2-3 sessions to complete.

After sufficient assessment, generally by the 5th session, a Treatment Plan (see Appendix) for on-going counseling needs to be established by the intern and the client. The treatment planning phase defines more precisely what will happen in therapy. The presenting problem and the goals describe **what** will be addressed which establishes the focus. The treatment plan describes **how** the problem will be addressed. The diagnosis provides clarification and understanding for the presenting problem related to symptoms, and is reviewed and/or corrected if new information is given in later sessions. Systemic diagnostic information should appear in the "Assessment" section of this document.

Video Recording Release

It is a requirement of the Marriage and Family Therapy Program for all students to video record client sessions at the Counseling Center. Session clips are used in supervision for educational purposes only. This requirement is explained to prospective clients during the intake process and only those agreeing to be recorded are accepted as clients at LSCTC.

1. One DVD should be designated to each client for their sessions. Interns are never to use a single DVD for different clients.

2. DVDs should be stored in the designated area at LSCTC.

3. Recordings should be locked in a document bag for transport to and from supervisory sessions.

4. Once a session has been seen in supervision, it may be erased or taped over. The only exception to this is if the recording will be used in an ICC or Live Supervision presentation or for the Senior Integration Experience (SIE).

5. Interns terminating service at LSCTC must destroy recordings belonging to their clients before clearance will be given for graduation.

Video Recording at Off-Campus Sites

Recording sessions at off-campus sites is expected and encouraged. Two portable digital cameras are available in the MFT Office and may be checked out for this purpose. Instructions on the use of these cameras appears in the Appendix.

Consent for the Release of Confidential Information Form

HIPPA guidelines and Kentucky law indicate clients, and those they designate, are permitted access to client records with appropriate written authorization. Additional medical information can be of benefit to the therapist when caring for a client. LSCTC is often contacted by attorneys, court personnel, and Child Protective Services regarding information to be used during court hearings. In all cases, confidential client information must be protected within the boundaries established by LSCTC. A "Consent for Release of Confidential Information" form must be completed and signed by the client prior to the release of any information.

Medical Documentation – Consent to Receive Information

When a client has previously had psychotherapy or has some medical condition that may have psychological or psychiatric ramifications, the intern, after consultation with their supervisor, is to request permission to obtain records pertaining to the condition that can be examined for purposes of evaluating the implications of the client's condition for treatment.

1. In completing the form, the intern will need to obtain the complete mailing address for the professional to whom the Release form is to be sent.

2. The usual purpose for which a request for information is sought is that of "evaluation and assessment for psychotherapy" or "continuity of care."

3. When the form has been completed, the original form should be sent with a standard cover letter to the professional indicated. A copy of the signed form is always placed in the client's record, along with a case activity note about the information shared.

It is very important for the intern to communicate to the client that the Center does not provide psychological and/or physical testing or specific assessments for legal purposes.

Note: Consent for Release of Information expires 90 days from original signature date. A new Consent must be signed for information to be released after the original signature date has expired.

4. Clients may not have access to any information/reports from other professionals or agencies which have been released to the intern. Only the agency who prepared the report may provide the information to the client. Interns are not permitted to discuss or attempt to explain information obtained from other sources.

Absolutely NO information regarding a client can be released from LSCTC without the Director's knowledge and consent. Letters to those in the legal field or other inquirers regarding a LSCTC client must be prepared by the Administrative Assistant and will be provided only after the client has signed a release of information for that specific purpose.

Legal Documentation – Consent to Provide Information

For intern protection, contacts from those within the legal system must be managed carefully. In all cases, information regarding a client cannot be released without a Consent for Release of Information signed by the client.

Phone Contacts

If an intern receives a phone message from an attorney's office, the call **should not** be returned. Without a signed "Consent for Release of Information" from the client for information to be released to the attorney's office, even acknowledging the client is seen at LSCTC is a breach of confidentiality. Instead, document receipt of the message on a Case Activity Note noting the date and time of the call.

Should the client indicate to the intern that their attorney's office will be contacting the intern for information, the intern should notify the client that only requests for information made in writing with appropriate release consent signed by the client will be honored. The intern should ask the client to complete a LSCTC Consent for Release of Information form for their file.

Legal Written Requests for Information

Requests for information made in writing by legal officials, with appropriate consents, will be honored. Typically, these requests are general in nature. When received, the intern should manage them in this way.

1. Inform the Administrative Assistant that a legal request for client information has been received. Be ready to provide the name of the client, the requesting attorney or organization, and the information being requested.

2. Unless otherwise guided by the Director of Clinical Training, submit the following information to the MFT Office:
    a. Original request for release of information
    b. Full name of the client
    c. Date sessions began
    d. Number of sessions held to date
    e. Date of next session

3. After the response letter has been prepared by the Administrative Assistant and signed by the intern and Director of Clinical Training, a copy for the client's file will be made and the letter forwarded to the requester.

4. Should additional information be requested, the intern and Director of Clinical Training will work with the attorney or legal organization to comply within the boundaries of confidentiality for the client.

It is very important for the intern to communicate to the client that the Center does not provide psychological and/or physical testing or specific assessments for legal purposes.

Requests for File Copy by Client

It is the policy of LSCTC not to release full copies of client files. In the event a client requests a copy of their file, the intern should explore with the client if a summary of their records would be sufficient for their needs and attempt to limit the amount of information being released from the client file. However, if the client is insistent, the intern should obtain a Consent of Release of Information from the client and present the client's request to the Director of Clinical Training for approval. When the copy is available, the client will be asked to return to the office to receive the material. A minimum of two days should be given to fulfill the client's request.

NOTE: Copies of client files should not be sent through the mail. These copies should be retrieved in person by the client. A client is entitled to receive one copy of the client's file without a copy fee. Any additional copies will be provided at the cost of 10¢ per page.

Some Important Areas of Discussion for Supervision

Substance Abuse

Clients who are currently abusing a substance (e.g., alcohol, cocaine, etc.) are not candidates for psychotherapy unless the substance abuse has been discontinued or the client is established in substance abuse treatment, such as Alcoholics Anonymous or another appropriate support group. The intern will consult with their supervisor or the Director of Clinical Training about the referral of such clients out of the LSCTC for appropriate substance abuse treatment.

Medical Consultation

When clients present with issues of a medical concern, referral to a physician is advised, if the client has not already seen a physician for this issue. Examples of medical concerns would include chronic migraines, pain, digestive issues, or sexual dysfunction. Following a physician assessment, the intern should request a Consent for Release of Information form be signed by the client to allow consultation with the client's physician and release of documented findings.

Medical Examination

A client who has not had a basic physical examination within six (6) months before the initial visit may be encouraged to have a basic physical examination within the first six (6) months of counseling. When the basic physical examination has indicated a physiological cause for the signs and symptoms that caused the client to seek psychotherapy, the intern may consult quarterly with the consulting physician regarding the client's treatment plan and progress and request any pertinent medical input from the physician regarding the client.

Psychiatric Consultation and Medication

When a client needs to be evaluated for medication, there are several options:

1. Referral to their primary care physician
2. Referral to a consulting psychiatrist
3. Referral to low-cost health care providers locally

Cost for medication evaluations and medication needs are to be covered by the client. Referral for medication should be noted in the client's record and the outcome recorded as well. (A consulting psychiatrist should write a note concerning his/her evaluation.)

Psychological Testing

Occasionally, testing may be a useful assessment tool. Testing may be arranged by referring the client to appropriate professionals after consultation with the intern's supervisor.

Hospitalization

When a client is assessed to pose a threat of harm to him/herself or to others, hospitalization may be necessary to ensure safety.

Hospitalization may be:

1. Voluntary - a patient chooses to admit him/herself;
2. Involuntary - the intern notifies significant persons in the client's life and utilizes emergency resources as needed, i.e., police and ambulance.

If a client's family is unavailable or unwilling to hospitalize a person, the intern may seek a mental inquest warrant (MIW) after consulting the Director of Clinical Training or their clinical supervisor.

Violence or Abuse

When in the course of treatment domestic violence or child abuse is suspected, the intern should consult with their supervisor or the Director of Clinical Training immediately regarding how best to respond to these issues. When domestic violence is present, a couple **should not** be seen jointly for therapy as best standard of practice.

Care of Individuals with a History of Chronic Mental Illness

It is the mission of LSCTC to care for all individuals within our interns' expertise and training. Care to individuals with a history of chronic mental illness must be sensitive to this population's needs and clearly represent the limitations of our students.

1. Referrals of this nature will be given to Practicum III or Practicum IV level students.

2. The intern will assess the client's mental health needs for 3-4 sessions and, with guidance from their clinical supervisor, determine if the client's concerns are within the scope of the intern's training and can be managed appropriately at LSCTC.

    a. If the client can be seen at LSCTC, continue with step 3.
    b. If the client cannot be seen at LSCTC, provide appropriate referrals and follow the termination process to close the client's record.

3. Obtain a Consent for Release of Information from the client to speak with

    a. The client's psychiatrist or other mental health professional providing the client's medication.
    b. Any agency or institution which provides/has provided in-patient/out-patient mental health care.

4. Establish and maintain close contact with any medical professional who referred or is seeing the client.

    a. Confirm that the client is receiving appropriate medical care.
    b. Collaborate to address clinical concerns.
    c. Identify what care the intern will provide the client and any issue that needs to be addressed by another professional.

5. Establish and maintain regular family/guardian or close relationship involvement in session, when possible.

Responding to a Client's Suicide or Other Clinical Emergency

(Corresponding checklist appears in the Appendix)

Although Louisville Seminary Counseling Training Center is not an emergency facility, at times clinical emergencies do happen. The following procedure should be followed when client emergency events take place:

1. The student will immediately notify his/her clinical supervisor and the Director of Clinical Training after receiving information of a client death/suicide or other emergency event.

2. The Director of Clinical Training will contact the student, the student's clinical supervisor, the student's academic advisor, and the Program's Administrative Assistant within 24 hrs of receiving emergency information to schedule a meeting.

   During the meeting, the clinical supervisor will guide the team in the following:
   - To process what has happened and the student's experience.
   - To develop a continuance plan for the student's emotional and spiritual well being and health.
   - To determine appropriate contact and process to be used in addressing concerns such as counseling spouse, partner, or other family members of the deceased, and documentation of event.
   - To determine the appropriate process to use in sharing specific information with the MAMFT student body.
   - To determine if a release of information to the wider seminary community is appropriate. Any plan of notification to the seminary community will be created in consultation with the Seminary Dean and/or Dean of Students.

3. The Program Administrative Assistant will help coordinate the flow of information and guide the student in the closing of the client's file.

4. An assessment will be made collaboratively by the Director of Clinical Training and the clinical supervisor, in consultation with the student, and a "wellness" plan will be set in place for the student therapist and "others" immediately impacted by the event.

5. The student's clinical supervisor will continue to assess and consult with the student therapist regarding her/his emotional, spiritual, and physical well-being and explore other appropriate resources, i.e., referral to counselor or spiritual director for student, material resources available, continued assessment of student's self-care. The supervisor will submit a report to the Director of Clinical Training if further assistance is needed.

Adopted March 2011

Record Keeping and Client File Audits

Clinical records are kept on all clients who are seen at the LSCTC. **Interns are responsible for maintaining these records in a timely fashion.** Any personal or process notes kept should be held in a separate folder and shredded when no longer needed or when the client has terminated their contact with LSCTC.

Forms Contained in Each Clinical File

Left side of file:

Informed Consent
Financial Assistance Application
Monthly account ledgers
Yellow payment receipts

Right side of file:

Telephone Intake
Confidential Client Information (Adult) and/or
Confidential Client Information (Child/Adolescent under 18)
Video Recording Release
Limits of Confidentiality
Family/Couple Initial Session or Individual Initial Session
Initial Session Case Write-Up
Family Genogram
Treatment Plan
Consent for Release of Confidential Information, if appropriate
Progress Notes for each session
Case Activity Notes

NOTE: Personal notes and Live Supervision case write-ups should never be stored in client files. Personal notes should be kept in a separate file. Live Supervision sessions should be documented on a progress note and signed by the student's clinical supervisor.

Progress Notes

Progress notes begin with the second session. (The first session is documented by the Initial Case Write-Up" form.) Adequate progress notes can usually be accomplished in 10 to 12 sentences. In addition to the information requested on the Progress Note form, include documentation of medication or "over the counter"/herbal remedies the client is taking for psychiatric reasons, symptoms and the name of the physician who is monitoring the medication. Interventions recommended by a Clinical or Live Supervisor should be noted on the client's progress note, signed by the supervisor and placed in the client's file.

In addition to the information requested on the Progress Note form, client files should contain case activity notes regarding actions outside the therapy session. This may include:

- Phone contact with the client;
- Interactions with other professionals or other contact made;
- Documentation of reports to Adult Protective Services or Child Protective Services;
- Documentation of any supervision or consultation received.

Other documentation such as release forms or information about "duty to warn" (See "Laws Impacting Therapy" in the Appendix) may also be kept in the client folder.

Client File Audits

There are four types of client file audits performed at LSCTC:

Quarterly Audit	Typically performed in April, August, and November
Transition Audit	Performed prior to the intern's completion of Practicum II and move to Practicum III clinical supervisor
Transfer of Client Audit	Performed prior to the transfer of a client from one intern to another
Client Termination Audit	Performed when a client has terminated contact at LSCTC

These audits include inspection of all client records for inclusion of appropriate forms, Progress Notes, and account entries. Although interns are expected to consistently maintain their client files, these checks insure that all necessary paperwork is available and accurate.

Transfer of Client and Termination Processes

The ending of client sessions can be due to many reasons, among them the client's wish to terminate with LSCTC, client's needs, expectations, or new developments beyond the intern's scope of practice, or the intern's graduation or ending of Practicum. In any case, it is important to handle the client's records appropriately.

Transfer of Client Process

When an intern can no longer see a client but the client wishes to continue sessions, a transfer to another intern or referral outside of LSCTC is done. In order to provide appropriate and continuing client care, interns transferring clients and interns receiving transferred clients should follow these guidelines.

Intern Transferring Client

1. Discuss transfer/termination options and final resolution of payment due with client.

2. When preparing to transfer a client to another therapist,

    a. Discuss possible transfer recipients with your clinical supervisor and the Director of Clinical Training.

    b. Contact the suggested intern to receive transfer to discuss receiving client and introduction and transfer date.

    c. Prepare a Termination Summary for the client being transferred, complete with supervisor's signature.

    d. Request a "Transfer Audit" from the Administrative Assistant.

    e. It is desirable, if appropriate and possible, to hold one session with the client and the new therapist to facilitate transfer.

3. Transferring outside of LSCTC is done only after consultation with the Director of Clinical Training. If a client wishes to pursue this option, the intern should request a consultation with the Director of Clinical Training and consider possible referral options.

Intern Receiving Transfer

When contacted regarding receiving a transferring client, indicate acceptance or decline transfer. Should you agree to accept the transfer, follow this procedure to assist in the transition.

1. Discuss receiving new client and possible introduction and transfer session date.

2. Prior to scheduled transfer session date, confirm that the client file has a Termination Summary from transferring intern and has been audited. **NEVER** accept a file that has not been audited.

3. During the transfer session, obtain a Consent for the Release of Confidential Information from the client before you take possession of the client's file. Other forms that will need to be completed are Video Recording Release and Limits of Confidentiality.

4. From the transfer session, the client record becomes the responsibility of the receiving intern and should follow standard protocol.

Termination Process

The process of termination is as important as the initial assessment process. Consequently, much care must be exercised by the intern during this critical phase, both with the client, as well as in the procedures used in closing the client's file.

Please follow these procedures when terminating clients to accomplish the termination of the client file and the closing of the client's account:

1. The client indicates to the intern that he/she wishes to terminate therapy.

2. The intern seeks input from supervisor as needed.

3. The intern and client process the relationship and deal with termination issues. In the termination process, the intern seeks to have the client settle any balance remaining on the account. The intern provides the client with any necessary referrals. The intern documents the termination process in progress notes that are usually lengthier than normal session notes.

4. The intern prepares the Termination Summary and the Client Termination Letter Information and takes them to their supervisor. (See Appendix for form examples) The supervisor reviews the case and signs the Termination Summary. The supervisor reviews the Client Termination Letter Information form to ensure that the letter is appropriate and that needed referrals are included.

5. The intern should review the client's file to be sure that all required forms are present, and that Progress Notes and account entry dates match to assure the file is complete. **The file is understood to be the property of Louisville Seminary Counseling Training Center.**

6. The intern places the Termination Summary in the client's file and the Client Termination Letter Information in the LSCTC Student Assistant's box to be prepared. The active client index card should be placed in the client's file and, after assuring the file is in order, the file should be placed in the designated area for "Terminations in Progress."

7. The LSCTC Student Assistant will prepare the termination letter, return the letter to the intern to be signed, and will perform an audit of the client file for accuracy. Any needed paperwork will be requested from the intern and should be promptly completed so the client file can be terminated.

8. When the termination letter to the client is placed in the intern's box, the letter should be signed and placed back in the Student Assistant's "In Box" for copying and mailing.

9. When the client returns a completed Client Evaluation of Treatment form, it will be reviewed by the Director of Clinical Training and then forwarded to the intern's supervisor. These will not be placed in the client file.

Appendix

LOUISVILLE SEMINARY COUNSELING TRAINING CENTER

LAWS IMPACTING THERAPY

HOMICIDE

Under Kentucky law (KRS 202A.400) we are bound to warn an intended victim of the threat of violence. The statute reads in part:

> (1) No monetary liability and no cause of action shall arise against any qualified mental health professional for failing to predict, warn of or take precautions to provide protection from a patient's violent behavior, unless the patient has communicated to the qualified mental health professional an actual threat of some specific violent act.
>
> (2) The duty to warn a clearly or reasonably identifiable victim shall be discharged by the qualified mental health professional if reasonable efforts are made to communicate the threat to the victim, and to notify the police department closest to the patient's and the victim's residence of the threat of violence.

The key phrase "an actual threat of some specific violent act" can help us decide our duty to report. We must distinguish between expressions of frustration such as "Sometimes I want to . . ." or "I ought to . . ." and expressions of intent, such as "I am going to . . ." or "I plan to . . .". When we assess that there is reasonably a threat, we must do the following:

* Note the actual means of carrying out the threat — does the person know exactly how he/she will carry out the threat.

* Make notes of such statements — write them down verbatim.

SPOUSE AND PARTNER ABUSE

Spouse abuse in general is defined as "assaultive behavior between adults in an intimate relationship".

Specific forms of abuse include:

> physical: pushing, hitting, striking with an object, kicking, choking, biting, hair pulling, burning with a cigarette, pushing out of a moving car, tying up, holding down;
>
> sexual: forced sexual relations, rape, insertion of foreign objects into vagina or rectum, assault on the breasts, genitals and buttocks;
>
> emotional/psychological: threats to harm or kill victim or significant other, threats to abduct children, intimidation, derogatory or demeaning comments, forced isolation, actions to imply victim is "crazy," forcing the victim to perform degrading acts, locking out of the house, refusing medical treatment, constant inquiry as to whereabouts or presumed affairs;
>
> destruction of property or pets: cutting/destroying clothes, treasured heirlooms, family photographs, furniture; harming or giving away a family pet.

These examples make it clear that spouse abuse constitutes far more than physical injury.

Kentucky state law mandates a duty to report suspected abuse. The statute reads in part as follows:

> KRS 209.030: Any person, including but not limited to, physician, law enforcement officer, nurse, social worker, department personnel, coroner, medical examiner, alternate care facility employee, or caretaker, having reasonable cause to suspect that an adult has suffered abuse, neglect, or exploitation, shall report or cause reports to be made in accordance with the provisions of this chapter. Death of the adult does not relieve one of the responsibility of reporting the circumstances surrounding the death.

Persons reporting abuse are immune from civil and criminal liability.

What can an abuse victim do?

(1) Go to an emergency shelter.

(2) Get an Emergency Protective Order (EPO). The EPO can order the respondent to 1) stop the abuse; 2) leave the residence shared; and 3) refrain from disposing of or damaging property. An EPO is in effect until a court hearing is held (14 days). At the full hearing, a Domestic Violence Order (DVO) is issued, which may order any of the following:

1. Dismissal of the case.
2. Cease the abuse and threats.
3. Refrain from disposing of or damaging property.
4. Leave the shared residence.
5. Temporary custody.
6. Temporary child support.
7. Counseling for either or both parties.
8. Other relief, e.g., no contact, supervised visitation or mental health evaluation.

The DVO is effective for as long as ordered by the judge, up to one year. It is also important to know that no attorney or fees are required to file a petition for protection from domestic violence, and that a DSS worker will contact the victim to offer assistance with protection and support services after an EPO or DVO has been issued. Victims may also file a criminal complaint against the perpetrator. The County Attorney's office can provide the necessary information.

CHILD PROTECTION: REPORTING SUSPECTED ABUSE/NEGLECT

The Kentucky Unified Juvenile Code:

This code requires the reporting of neglect, physical, sexual, or emotional abuse, and dependence of children whether it occurs in the home, the school, or other community settings. It requires that these reports will be assessed and investigated and requires that social services will be provided to children found to be experiencing maltreatment.

When to report:

When there is a reasonable cause to suspect child neglect, abuse or dependency, call child protective services. When in doubt abut whether or not to report, call child protective services to discuss the situation. If a client reports such abuse to you — if at all possible, get the client to report the abuse. Give the client the opportunity to make the report in your presence. If the report does not happen from your office, let the client know they have a limited amount of time in which

to make the report and that you will be calling child protective services after the designated time to verify that the report was made. If the client has not reported at that time, you will make the report.

If you feel a child is in imminent danger and is in need of immediate protection, call the police.

Who must report:

According to the law, anyone who has reasonable cause to believe that a child is dependent, abused, or neglected is to report this information.

What Child Protective Services needs to know:

* The child's identity.
* Any person believed to be responsible for the abuse or neglect to the child, if the person is known
* The nature and extent of the abuse or neglect.
* The name and address of the reporter if he or she chooses.
* Where the child can be found.

THE LAW STATES THAT THE FAILURE TO REPORT CHILD ABUSE AND NEGLECT CAN RESULT IN CRIMINAL CHARGES.

THE STALKING LAW

This law was passed in April of 1994. Following are the current provisions of the law:

Definition:

1. To "stalk" means to engage in an intentional course of conduct directed at a specific person or persons, which seriously alarms, annoys, intimidates, or harasses the person or persons and which serves no legitimate purpose. The course of conduct shall be that which would cause a reasonable person to suffer substantial mental distress.

2. "Course of conduct" means a pattern of conduct composed of two or more acts, evidencing a continuity of purpose. Constitutionally-protected activity is not included within the meaning of "course of conduct." If the defendant claims that he was engaged in constitutionally-protected activity, the court shall determine the validity of that claim as a matter of law and if found valid, shall exclude that activity from evidence.

Stalking in the first degree:

A person is guilty of stalking in the first degree when:

1. He/She intentionally stalks another person and makes an explicit or implicit threat with the intent to place the person in reasonable fear of sexual contact, serious physical injury or death, and

2. A. A protective or judicial order has been issued by the court to protect the same victim or victims and the defendant has been served with the summons or order, or has been Given actual notice; or

   B. A criminal complaint is currently pending with a court, law enforcement agency or prosecutor by the same victim or victims, and the defendant has been served with a Summons or warrant or has been given actual notice; or

C. The defendant has been convicted of or pled guilty within the previous five years to a felony or to a Class A misdemeanor, other than a violation of Section 3 of this statute (stalking in the second degree), against the same victim or victims; or

D. The acts or acts were committed while the defendant had a deadly weapon on or about his person.

Stalking in the first degree is a Class D felony, punishable by up to five years in prison.

Stalking in the second degree:

A person is guilty of stalking in the second degree when he/she intentionally stalks another person and makes an explicit or implicit threat with the intent to place that person in reasonable fear of sexual contact, physical injury or death.

Stalking in the second degree is a Class A misdemeanor, punishable by up to six months in prison and/or a fine up to $500.

Louisville Seminary Counseling Training Center
1044 Alta Vista Road, Louisville, KY 40205
502 / 894-2293

Telephone Intake

Intake Date: ____ Recorder's Initials: RGT Assigned Date: _____

Advised of student therapist experience:	Yes X / No _____
Advised of supervision & videotaping requirement:	Yes X / No _____
Advised of current wait list:	Yes X / No _____
Advised of sliding scale fee:	Yes X / No _____

Client Family:
Caller's Name & Age: _____
Spouse/Partner Name & Age: _____
Family Members & Ages: _____

Caller's Address: _____
Caller's Phones: Work: _____
Cell: _____ Home: _____
Preferred #: _____ Permitted to leave message: yes ☒ no ☐

Referred by: _____

Concern/issue bringing caller for counseling: _____

Prior medical care or hospitalization for the presenting issue: Yes _____ / No _____
If yes, for whom, name of provider & how recently: _____

Any current mental health diagnosis: Yes _____ / No _____; If yes, please list family member name & diagnosis: _____

Currently on a prescription medication for mental health concerns?
Name & Medication: _____

Is family currently involved in any court action? Describe. _____

Any questions or comments? _____

**** For the safety of the client and yourself, coverage is required during all sessions at the Counseling Ministry.**

Assigned Date: _____ Intern Assigned: _____

Welcome to LOUISVILLE SEMINARY COUNSELING TRAINING CENTER

This center is sponsored by the Louisville Presbyterian Theological Seminary for the purpose of providing pastoral therapy to individuals, couples, and families. We are committed to family therapy methods and to matters of faith. Our client fees are based on a sliding scale. Our counseling services are intended to enhance your family relations.

There are a number of things you should know about our services:

1. Counseling sessions are 50 minutes in length.
2. Fee payment is expected at the time of services. LSCTC accepts checks or cash as payment. Any returned check fee incurred by LSCTC must be reimbursed by the client.
3. Counseling sessions are kept confidential within the Louisville Seminary Counseling Training Center except under the following situations:
   a. suicidal or homicidal intentions;
   b. reports of suspected abuse, neglect, or exploitation of children;
   c. reports of spouse abuse;
   d. reports of elder abuse;
   e. reports of sexual exploitation by a therapist;
   f. issuance of a court order;
   g. with your permission.

Our professional staff members are interns who are earning their Masters of Arts degree in Marriage and Family Therapy, MFT Associates, and licensed therapists. This program is accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) of the American Association of Marriage and Family Therapy (AAMFT), and by the American Association of Pastoral Counselors (AAPC). Each therapist utilizes a team of colleagues for consultation. Interns and Associates are supervised by an AAMFT Approved Supervisor.

You will be required to sign a "Video Recording Release" form. Videotaping counseling sessions is a necessary practice in a clinical setting that uses team consultation. Team consultation incorporates a systemic perspective that is fundamental to marital and family therapy. The videotape will be viewed by your intern and her/his consulting team and clinical supervisor.

In addition, there may be an occasion where your intern, with your permission, will utilize live team consultation during the course of your work together. This is also a normal procedure in a clinical setting where the luxury of having team consultation can enhance the therapeutic process.

Your therapist will want to understand how the problem you are presenting fits within the context of your life. Some time in the initial sessions and future sessions will be spent collecting and processing information about your life experience. At any point in the process, if your therapist feels your needs would be best served by resources from additional or other professionals, he/she will make referrals for you.

If you have any further questions, please discuss them with your therapist. Thank you for choosing the Louisville Seminary Counseling Training Center.

(Rev. 8/27/13)

LOUISVILLE SEMINARY COUNSELING TRAINING CENTER

CLIENT'S BILL OF RIGHTS

You, the client, have the right to:

- receive respectful treatment that will be helpful to you
- receive a particular type of treatment or end treatment without obligation or harassment
- a safe environment, free from sexual, physical, and emotional abuse
- report unethical and illegal behavior by a therapist
- ask questions about your therapy
- request and receive full information about your therapist's professional capabilities, including licensure, education, training, experience, professional association membership, specialization, and limitations.
- have written information about fees, methods of payment, insurance reimbursement, number of sessions, substitutions (in cases of vacation and emergencies), and cancellation policies *before* beginning therapy
- refuse electronic recording thereby indicating a desire to end sessions at LSCTC (a referral to another agency will be provided)
- refuse to answer any questions or disclose any information you choose not to reveal
- know the limits of confidentiality and the circumstances in which your therapist is legally required to disclose information to others
- know if there are supervisors, consultants, students, or others with whom your therapist will discuss your case
- request, and in most cases receive, a summary or full copy of your file
- receive a second opinion at any time about your therapy or therapist's methods
- request that your therapist inform you of your progress

 Rev. 07/31/13

Louisville Seminary Counseling Training Center

Informed Consent

1. The therapist has reviewed the following seven articles of informed consent with me:
   a. The specific procedures to be used in therapy and their purposes.
   b. The role of the therapist in treatment.
   c. Specific discomforts or risks to be expected.
   d. Benefits **reasonably** to be expected.
   e. Alternative methods of treatment for the same problem that may produce similar results.
   f. The client's right to ask questions about the nature and process of therapy at any time.
   g. The client's right to end therapy at any time.

2. It is agreed that through interns or other staff, the Louisville Seminary Counseling Training Center will provide counseling dealing with individual, couple, and family issues, including matters of religious concern.

3. It is agreed that the therapist in collaboration with the client, will mobilize the assistance of other professional resource persons as indicated for the welfare of the client.

4. It is agreed that my fee will be _____ for each session. I understand that payment is expected at the time of service. It is agreed that appointments may be changed or canceled without charge, provided a 24-hour advance notice is given. If a 24-hour advance notice is not given, the appointment will be charged to my (the client's) account.

5. The Louisville Seminary Counseling Training Center is not an emergency crisis center. If you are unable to contact your counselor in an emergency, it is suggested that you call the Seven Counties Crisis and Information Center (589-4313) or go the Emergency Room of the University of Louisville Hospital. I understand LSCTC accepts checks or cash as payment and that I am responsible for reimbursing any returned check fee incurred.

6. It is agreed that all information about the counseling relationship will be used responsibly by the staff of the Louisville Seminary Counseling Training Center. When ending my connection with the Center, only official documentation and progress notes will be retained. All other documentation will be destroyed. I have read and signed the Limits of Confidentiality form.

7. I understand that if my therapist feels at any point that my needs would best be served by additional or other professionals, she/he will make the needed referrals.

8. I have received and read the Client's Bill of Rights.

9. I understand videotaping is a required part of each session. I have read and signed the Tape/Observe Release form.

My signature below indicates I understand this Informed Consent. I have been informed about the Counseling Training Center policies. I may ask questions regarding the policies at any time. Furthermore, my signature validates my consent for myself (and if family therapy, for individuals under my guardianship) to receive treatment at the Louisville Seminary Counseling Training Center as deemed appropriate by the staff.

_____ _____

Date Client's Signature (One signature needed for each adult in treatment)

_____ _____

Date Therapist

LOUISVILLE SEMINARY COUNSELING TRAINING CENTER
Application for Financial Assistance

Client Name: _____ Date of Application: _____

Client Contact Number: _____

Assistance Applicant Name (if not the client): _____

Relationship to Client: _____ Applicant's Contact Number: _____

The following to be completed by Applicant

Service provided to Client: ☐ Group Therapy ☐ Individual/Couple/Family Therapy

Current fee, if established: _____ ☐ Fee not established

Assistance request: ☐ Partial Assistance – Amount Requested: $ _____
☐ Full Assistance

Please state reason for requested assistance: _____

_____

Applicant's Personal and Financial Information:

Marital Status: ☐ Single ☐ Married/Partner ☐ Divorced ☐ Separated

Members in Household: _____

Are you employed? ☐ Yes; Please list current annual salary – $_____

☐ No; How long have you been unemployed? _____

Do you receive disability payments? ☐ Yes ☐ No

Do you receive other income?

☐ Yes; Please list other income: _____

☐ No

---------- For Office Use Only ----------

☐ Application for financial assistance approved.

Amount of assistance: _____ Number of sessions assisted: _____

☐ Application for financial assistance denied.

LOUISVILLE SEMINARY COUNSELING TRAINING CENTER
LIMITS OF CONFIDENTIALITY

Information discussed in the therapy setting is held confidential and will not be shared without written permission except under the following conditions:

1. The client threatens suicide.
2. The client threatens harm to another person(s), including murder, assault, or other physical harm.
3. The client reports suspected abuse or neglect, including but not limited to, physical and/or sexual abuse of a child, of the elderly, or of a spouse.
4. The client reports sexual exploitation by a therapist.
5. There is issuance of an order by a court.
6. The client has granted permission.

State law mandates that mental health professionals may need to report these situations to the appropriate persons and/or agencies.

Further, MFT interns receive supervision and participate in team consultation which is an additional benefit of receiving services in an educational institution. Therapy sessions are discussed as deemed necessary with supervisors and other staff at the Louisville Seminary Counseling Training Center and with faculty and professional colleagues at the Louisville Presbyterian Theological Seminary.

Communications between the clinician and client will otherwise be deemed confidential as stated under the laws of this state.

HAVING READ AND UNDERSTOOD THE ABOVE, I AGREE TO THESE LIMITS OF CONFIDENTIALITY.

_____ _____
Printed Name of Client or Guardian Date

_____
Signature of Client or Guardian

_____ _____
Signature of Intern Date

LOUISVILLE SEMINARY COUNSELING TRAINING CENTER
VIDEO RECORDING RELEASE

I understand any assessment and/or treatment session in which I and/or individuals under my guardianship participate will be electronically recorded as required by this agency. I understand sessions may also receive direct live supervision/observation.

I understand the confidentiality of my counseling sessions and any recordings thereof will be maintained and will be used for educational purposes by Louisville Presbyterian Theological Seminary, its staff, students, and representatives and for assuring quality care by Louisville Seminary Counseling Training Center. I understand all electronic recordings of my counseling sessions will be destroyed upon termination of sessions with this agency.

I hereby release the Louisville Seminary Counseling Training Center and the Louisville Presbyterian Theological Seminary, its staff, students, and representatives from any and all claims or demands arising out of the observation, recording, and educational use of these sessions.

(Family member or legal guardian must sign for a counselee who is unable to sign, is a minor, or is mentally disabled. Each adult participating in therapy must sign.)

_____ _____
Date Family Member

_____ _____
Date Family Member

_____ _____
Date Family Member

_____ _____
Date Therapist

_____ _____
Date Therapist

Revised 08/26/2013

Louisville Seminary

CLIENT CONFIDENTIAL INFORMATION FORM (Adult)

INSTRUCTIONS: The information provided on this form is for use by your counselor. Your honest and complete answers will help us in helping you. If more than one person is coming for counseling, each should fill out a form. Please be sure to complete each question.

PLEASE PRINT ALL INFORMATION

CLIENT NAME: _____
First M.I. Last

PLEASE CHECK ONE: ( ) Mr. ( ) Mrs. ( ) Ms. ( ) Miss ( ) Dr. ( ) Rev.

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

BIRTH DATE (mm/dd/yyyy): _____/_____/_____

RELIGIOUS AFFILIATION/DENOMINATION: _____

PHONES: HOME - ( ) _____ CELL - ( ) _____

WORK - ( ) _____

NO. PREFERRED FOR CONTACT? _____ LEAVE MESSAGE? (Y) (N)

OCCUPATION: _____ EMPLOYER: _____

EMERGENCY CONTACT: _____ PHONE: _____

REFERRAL SOURCE: I was referred to the Louisville Seminary Counseling Training Center by:

_____

FAMILY AND PERSONAL INFORMATION

1. FAMILY INFORMATION:

RELATIONSHIP STATUS: (Please check all that apply.)

( ) Single ( ) Married ( ) Partnered ( ) Separated ( ) Divorced ( ) Widowed

(a) INFORMATION ON SPOUSE/PARTNER

NAME OF SPOUSE/PARTNER: _____

BIRTH DATE (mm/dd/yyyy): _____/_____/_____

RELIGIOUS AFFILIATION/DENOMINATION: _____

OCCUPATION _____ OFFICE TELEPHONE: _____

DATE OF MARRIAGE/COMMITMENT CEREMONY (mm/dd/yyyy): _____/_____/_____

(b) INFORMATION ABOUT YOUR CHILDREN (Please list each child's name, birth-date and relation)

_____

_____

_____

WITH WHOM DO ANY MINOR CHILDREN RESIDE: _____

_____

2. PERSONAL INFORMATION:

ETHNICITY (Please check)

( ) African-American ( ) Arab ( ) Asian ( ) Caucasian ( ) Jewish ( ) Latina(o)
( ) Native American/Indigenous ( ) Other: _____

FAITH INFORMATION

Church membership or faith community affiliation: _____

Religious denomination (if any): _____

Religious upbringing (please describe): _____

_____

Role of faith in your life (please check):
( ) None ( ) Important
( ) Minor role ( ) Very Important

EDUCATIONAL BACKGROUND

Circle last year completed: Elementary/Middle School: 1 2 3 4 5 6 7 8

High School: 9 10 11 12

College: 1 2 3 4 5 6+

Other training (list type and number of years): _____

_____

Military (list branch of service and years): _____

_____

HEALTH INFORMATION

Rate your physical health: ( ) Very Good ( ) Good ( ) Average ( ) Declining

Your approximate weight: _____ lbs. Approximate Height: _____

Have you had any significant weight changes lately? Lost _____ Gained _____

List all important present or past illnesses or injuries:
_____

_____

Your physician: _____ Office Phone: _____

Physician's Address: _____

_____

Are you presently taking any prescription medication(s)? Yes _____ No _____
If Yes, please list and briefly explain:

_____

_____

Drug and Alcohol Use

Please list your use of caffeine, tobacco, alcohol, marijuana and other drugs over the last month:

_____

_____

Please check your response to the following questions:

1. Have you ever felt a need to cut down on your drinking or drug use? ( ) yes ( ) no
2. Have people ever annoyed you by criticizing your drinking or drug use? ( ) yes ( ) no
3. Have you ever felt bad or guilty about your drinking or drug use? ( ) yes ( ) no
4. Have you ever had a drink or used drugs in the morning to steady your nerves or get rid of a hangover? ( ) yes ( ) no

CLIENT SELF-ASSESSMENT

Please circle the description that is most appropriate for you:

YOUR MOOD?

Extreme Depression Down, Low Content Happy Extremely Happy

YOUR SENSE OF PLEASURE AND INTEREST IN ACTIVITIES?

None Poor Average Good Excellent

FEELINGS OF GUILT?

Excessive Some Little Rare None

YOUR ENERGY LEVEL?

None Poor Average Good Excessive

YOUR CONCENTRATION?

Extremely Poor Poor Average Good Excellent

YOUR SLEEP?

Extremely Poor Poor Average Good Excessive

YOUR APPETITE?

None Poor Average Good Excessive

Have you ever experienced thoughts of hurting yourself or others? (please check your response) ( ) yes ( ) no

If yes, please explain:

_____

_____

_____

_____

_____

_____

STRESSORS

Instructions: Please place a (√) in one of the boxes (Not Present, Mild, Moderate, Severe, or Extreme) for each of the stressors in the following list. Use the check list to indicate how much stress you have been under during the past year. Be sure to check one of the boxes for every one of the stressors. Use the "Not Present" column if you have not experienced a specific type of stress during the past year.

List of Stressors	Not Present	Mild	Moderate	Severe	Extreme
1. Beginning/Ending Employment					
2. Job problems					
3. Conflict with boss or co-worker					
4. Retirement					
5. Move					
6. Couple/Partner					
7. Infertility					
8. Birth or adoption of child					
9. Separation or divorce					
10. Death of loved one					
11. Physical illness					
12. Caregiver issues					
13. Financial problems					
14. Conflict with family member					
15. Sexual problems or infidelity					
16. School problems					
17. Legal problems					
18. Addictions					
19. Other:					

Are you currently impacted from any past stressor or trauma that we should be aware of?
( ) yes ( ) no

If yes, please explain: _____

_____

If yes, how does this past stressor or trauma currently impact your life?

_____

_____

PAYMENT INFORMATION

Who will be responsible for charges incurred?

Name: _____

Address: _____

_____

Phone: _____

The Louisville Seminary Counseling Training Center (LSCTC) initial session fee is $20.00. Counseling session fees range from $10.00 to $65.00 as negotiated with your counselor. In the event that you are in need of financial assistance with your fee, please discuss this with your counselor.

LSCTC accepts checks or cash as payment. Any returned check fee incurred by LSCTC must be reimbursed by the client.

Please list your monthly income: _____ or your annual income _____

I HEREBY CERTIFY THAT, TO THE BEST OF MY KNOWLEDGE, THE INFORMATION PROVIDED ON THIS INTAKE FORM IS COMPLETE AND CORRECT.

_____ _____

SIGNATURE OF CLIENT **DATE**

Louisville Seminary

CLIENT NAME: _____
First M.I. Last

INITIAL SESSION INFORMATION

INSTRUCTIONS: This section is to be completed by the therapist in conversation with the client during the initial session. Please be sure to complete each question as appropriate.

Mood and Behavior Assessment

☐ withdrawal or social isolation	☐ loss of energy	☐ hopeless
☐ diminished interest in activities	☐ difficulty concentrating	☐ worthless
☐ hyperactive	☐ happy	☐ sad
☐ fearful/anxious	☐ irritable/angry	☐ stressed
☐ mood swings	☐ critical of others/judgmental	☐ lying

Anxiety: ☐ panic attacks – how often: _____
☐ phobias: _____
☐ obsessive-compulsive symptoms :_____

Comments: _____

_____

Eating/appetite: ☐ well ☐ increase ☐ decrease ☐ refusal to eat
☐ weight gain ☐ weight loss
☐ binging/purging – how often: _____

Sleep: ☐ well ☐ trouble falling ☐ trouble staying ☐ nightmares
☐ Other: _____

Therapist Observation/Mental Status Assessment

Appearance: ☐ Neat/Well-groomed ☐ Disheveled ☐ Unclean ☐ Other: _____
Affect: ☐ Appropriate ☐ Flat ☐ Labile ☐ Incongruent with reason for coming
Mood: ☐ Happy ☐ Hyper ☐ Angry ☐ Sad ☐ Fearful/anxious
Speech: ☐ Normal ☐ Loud ☐ Rapid/pressured ☐ Slowed
☐ Soft ☐ Slurred
Insight: ☐ Good ☐ Fair ☐ Poor
Orientation: ☐ Person ☐ Place ☐ Time
Psychosis: Hallucinations: ☐ N ☐ Y: Visual Auditory Tactile Olfactory
Delusions: ☐ N ☐ Y
Paranoia: ☐ N ☐ Y

Risk Assessment

Current: ☐ Suicidal thoughts ☐ Homicidal thoughts ☐ Cutting ☐ Violence ☐ None

History of: ☐ Suicidal attempts/thoughts ☐ Homicidal thoughts ☐ Cutting

☐ Violent behavior ☐ Legal problems ☐ Educational problems ☐ None

Safety plan necessary: ☐ N ☐ Y _____

Have you ever been arrested because of anger issues? ☐ N ☐ Y
Has your education been impacted or suspended because of anger issues? ☐ N ☐ Y

PARENTAL/FAMILY HISTORY/GENOGRAM:

(Create a beginning genogram in the space at the bottom of the page while gathering the following information.)

1. By whom were you raised? _____

2. Was your childhood home affected by divorce or death of one or both of your parents?

   Yes – divorce / death No

3. Are your biological parents/primary caregivers still living? Father? ____ Mother? _____
   Other primary caregiver? _____

4. Rate your parents' marriage:

   ( ) Unhappy ( ) Average ( ) Happy ( ) Very Happy

5. As a child, did you feel closer to your father, mother, or other family member?

   _____

6. List your brother(s)' and/or sister(s)' names in birth order:

   _____

   _____

   _____

DIAGNOSTIC IMPRESSIONS:

_____

_____

_____

Source of Information: _____ Client report _____ Referral source

_____ Therapist impression _____ Other

COUNSELING EXPERIENCE:

Have you ever seen a counselor before? Yes _____ No _____ If Yes, what was your experience?

_____

Can you tell me why you are seeking counseling now: What has happened that told you you needed to come in now? How have you tried to resolve the issue/issues? How will you see our time together as being helpful? How will we know it when we are done, or you are able to say, "I have accomplished what I had hope to accomplish through therapy?"

_____

_____

_____

So, a good goal for us would be _____

_____

_____ _____

Therapist Date Supervisor Date

PASTORAL/SPIRITUAL ASSESSMENT: SWB Scale

For each of the following statements, circle the choice that best indicates the extent of your agreement or disagreement as it describes your personal experience:

SA = Strongly Agree	D = Disagree
MA = Moderately Agree	MD = Moderately Disagree
A = Agree	SD = Strongly Disagree

1.	I don't find much satisfaction in private prayer with God.	SA	MA	A	D	MD	SD
2.	I don't know who I am, where I came from, or where I'm going.	SA	MA	A	D	MD	SD
3.	I believe that God loves me and cares about me.	SA	MA	A	D	MD	SD
4.	I feel that life is a positive experience.	SA	MA	A	D	MD	SD
5.	I believe God is impersonal and not interested in my daily situation.	SA	MA	A	D	MD	SD
6.	I feel unsettled about my future.	SA	MA	A	D	MD	SD
7.	I have a personally meaningful relationship with God.	SA	MA	A	D	MD	SD
8.	I feel very fulfilled and satisfied with life.	SA	MA	A	D	MD	SD
9.	I don't get much personal strength and support from my God.	SA	MA	A	D	MD	SD
10.	I feel a sense of well-being about the direction my life is headed in.	SA	MA	A	D	MD	SD
11.	I believe God is concerned about my problems.	SA	MA	A	D	MD	SD
12.	I don't enjoy much about life.	SA	MA	A	D	MD	SD
13.	I don't have a personally satisfying relationship with God.	SA	MA	A	D	MD	SD
14.	I feel good about my future.	SA	MA	A	D	MD	SD
15.	My relationship with God helps me not to feel lonely.	SA	MA	A	D	MD	SD
16.	I feel that life is full of conflict and unhappiness.	SA	MA	A	D	MD	SD
17.	I feel most fulfilled when I'm in close communion with God.	SA	MA	A	D	MD	SD
18.	Life doesn't have much meaning.	SA	MA	A	D	MD	SD
19.	My relation with God contributes to my sense of well-being.	SA	MA	A	D	MD	SD
20.	I believe there is some real purpose for my life.	SA	MA	A	D	MD	SD

Hamilton Rating Scale For Depression

Patient's Name: _____ Date of Assessment: _____

This checklist is to assist the therapist in recording evaluations of each patient with respect to degree of depression and pathologic condition. The higher the score, the more severe the depression.

For each item, write enter the appropriate rating on the line next to the item (only one response per item).

Rating: 0 – None 1 – Mild 2 – Moderate 3 – Severe 4 - Extreme

Item	Rating
1. Depressed Mood **Sadness, hopelessness, gloomy, pessimistic, weeping, worthless. Behavior: Facies, postures, weeping voice.**	
2. Guilt Feelings **Pathologic guilt, not rationalizing, self-blame, feelings of self-reproach.**	
3. Suicide **Recurrent thoughts of death: life is empty, not worth living, isolation, suicide gestures, threats or attempts.**	
4. Initial Insomnia **Difficulty getting to sleep after going to bed.**	
5. Middle Insomnia **Difficulty staying asleep.**	
6. Delayed Insomnia **Early-morning awakening.**	
7. Work and Interest **Apathy, loss of pleasure and interest in work, hobbies, social activities, recreation, inability to obtain satisfaction, decreased performance at work and in home duties. (Do not rate fatigue or loss of energy.)**	
8. Retardation **Psychomotor: Slowing of thoughts speech, and movement.**	

Item	Rating
9. Agitation **Psychomotor fidgeting, restlessness or pacing, clenching fists, kicking feet, wringing hands, biting lips, pulling hair, gesturing with arms, picking at hands and clothes.**	
10. Anxiety **(Psychologic)** **Tense, unable to relax, irritable, easily startled, worrying over trivia. Phobic symptoms, apprehensive of impending doom, fear of loss of control, panic episodes.**	
11. Anxiety **(Somatic)** **Physiologic concomitants of anxiety: Effects of autonomic overactivity, "butterflies," indigestion, stomach cramps, belching, diarrhea, palpitations, hyperventilation, paresthesia, sweating, flushing, tremor, headache, urinary frequency.**	

12. Loss of Appetite	
13. Anergia **Fatigability, feels tired or exhausted, loss of energy, heavy or dragging feelings in arms or legs.**	
14. Loss of Libido **Impairment of sexual performance**	
15. Hypochondriasis **Morbid preoccupation with real or imagined bodily symptoms or functions**	

16. Weight Loss **Since onset of illness or since last visit.**	
17. Loss of Insight **Denial of "nervous" illness, attributes illness to virus, overwork, climate, or physical symptoms. Does not recognize symptoms are "nervous" in origin.**	
18. Diurnal Variation **Change in mood**	
19. Hypersomnia **(More Time Spent in Bed)** **Retires earlier and/or rises later than usual, not necessarily sleeping longer.**	
20. Hypersomnia **(Oversleeping)** **Sleeping more than usual.**	
21. Hypersomnia **(Napping)** **Naps, excessive daytime sleepiness**	
22. Increased Appetite **Change in appetite marked by increased food intake or excessive cravings.**	
23. Weight Gain **Since onset of illness or since last visit.**	
24. Psychic Retardation **Slowness of speech and thought process, inhibition of will or feeling as if thought processes are paralyzed.**	
25. Motor Retardation **Slowness of movement and affective expression.**	

25-ITEM TOTAL	

S**hort** M**ichigan** A**lcoholism** S**creening** Test **(**SMAST**)**[2]

Name: Date:

		Yes	No
1.	**Do you feel you are a normal drinker?**	□	□
2.	**Does your wife/husband, a parent, or other near relative ever worry or complain about your drinking?**	□	□
3.	**Do you ever feel guilty about your drinking?**	□	□
4.	**Do friends or relatives think you are a normal drinker?**	□	□
5.	**Are you able to stop drinking when you want?**	□	□
6.	**Have you ever attended a meeting of Alcoholics Anonymous?**	□	□
7.	**Has drinking ever created problems between you and your wife/husband, a parent, or other near relative?**	□	□
8.	**Have you ever gotten into trouble at work because of drinking?**	□	□
9.	**Have you ever neglected your obligations, your family, or your work for 2 or more days in a row because you were drinking?**	□	□
10.	**Have you ever gone to anyone for help about your drinking?**	□	□
11.	**Have you ever been in a hospital because of drinking?**	□	□
12.	**Have you ever been arrested for drunken driving, driving while intoxicated, or driving under the influence of alcoholic beverages?**	□	□
13.	**Have you ever been arrested, even for a few hours, because of other drunken behavior?**	□	□
Total number of shaded checks			

Scoring:	***0-1 shaded checks:***	***nonalcoholic***
	2 shaded checks:	***possibly alcoholic***
	3 or more shaded checks	***probably alcoholic***

For patients with two or more checks in the shaded areas, an alcoholism evaluation by a substance abuse professional is recommended.

References

1. **Ewing JA. Detecting alcoholism: the CAGE questionnaire. *JAMA*. 1984; 252:1905-1907.**
2. **Selzer ML, Vinokur A, Van Rooijen L. A self-administered short Michigan alcoholism screening test (SMAST). *Journal of Studies on Alcohol.* 36;1:117-126.**

Revised 09/05/2013

Louisville Seminary

CLIENT CONFIDENTIAL INFORMATION FORM
(Child/Adolescent under 18 yrs)

INSTRUCTIONS: The information provided on this form is for use by your counselor. Your honest and complete answers will help us in helping you. If more than one person is coming for counseling, each should fill out a form. Please be sure to complete each question.

PLEASE PRINT ALL INFORMATION

CLIENT NAME: _____
First M.I. Last

CLIENT RESIDES WITH: ____ Both parents ____ Mother _____ Father

____ Other: _____

Is there a custodial agreement/decree in effect? _____ yes _____ no

If yes, please explain: _____

_____

CLIENT BIRTH DATE (mm/dd/yyyy): _____/_____/_____ AGE: _____ SEX: ___M ___F

FATHER'S NAME: _____ BIRTHDATE: _____/_____/_____

AGE: _____ ADDRESS _____

_____

PHONES: Cell – (_____)_____ Best number to call? _____ cell
_____ home
Home – (_____)_____ _____ work

Work – (_____)_____

MOTHER'S NAME: _____ BIRTHDATE: _____/_____/_____

AGE: _____ ADDRESS _____

PHONES: Cell – (_____)_____ Best number to call? _____ cell
_____ home
Home – (_____)_____ _____ work

Work – (_____)_____

ADDITIONAL FAMILY MEMBER:

NAME: _____ BIRTHDATE: _____/_____/_____

RELATIONSHIP: _____

ADDRESS _____

_____

PHONES: Cell – (_____)_____ Best number to call? _____ cell
_____ home
Home – (_____)_____ _____ work

Work – (_____)_____

EMERGENCY CONTACT

NAME: _____ RELATIONSHIP: _____

PHONES: Cell – (_____)_____ Best number to call? _____ cell
_____ home
Home – (_____)_____ _____ work

Work – (_____)_____

EDUCATIONAL INFORMATION

SCHOOL CURRENTLY ATTENDING: _____ GRADE: _____

NUMBER OF YEARS ATTENDING: _____

SCHOOL CONTACT - NAME: _____ PHONE: (_____) _____

Please indicate Contact's role: _____ teacher _____ counselor
_____ principal _____ other
List any school related concerns: _____

_____

Level of concern: _____ low _____ medium _____ high

ETHNICITY (Please check)

( ) African-American ( ) Arab ( ) Asian ( ) Caucasian ( ) Jewish ( ) Latina(o)
( ) Native American/Indigenous ( ) Other: _____

REFERRAL SOURCE – We were referred to Louisville Seminary Counseling Training Center by:

_____

FAITH INFORMATION

Church membership or faith community affiliation: _____

Religious denomination (if any): _____

Religious upbringing (please describe): _____

_____

Role of faith in your child's life (please check):
( ) None ( ) Important
( ) Minor role ( ) Very Important

HEALTH INFORMATION

Rate your child's physical health: ( ) Very Good ( ) Good ( ) Average ( ) Declining

Child's approximate weight: _____ lbs. Approximate Height: _____

Has there been any significant weight changes lately? Lost _____ Gained _____

List all important present or past illnesses or injuries:
_____

_____

Child's primary physician: _____ Office Phone: _____

Physician's Address: _____

_____

Is your child presently taking any prescription medication(s)? Yes _____ No _____
If Yes, please list and briefly explain:

_____

_____

Drug and Alcohol Use

Please list any concerns regarding your child's use of drugs or alcohol _____

_____

Counseling Experience

Has your child ever seen a counselor before? _____ Yes _____ No

If Yes, please list: _____

_____

_____

Please give a brief description of why you are seeking counseling for your child: _____

_____

_____

_____

ASSESSMENT OF CHILD ADOLESCENT

Form completed by: _____

____ Client
____ Parent/Guardian
____ Other _____

Please circle the description that is most appropriate:

MOOD?

Extreme Depression	Down, Low	Content	Happy	Extremely Happy

SENSE OF PLEASURE AND INTEREST IN ACTIVITIES?

None	Poor	Average	Good	Excellent

FEELINGS OF GUILT?

Excessive	Some	Little	Rare	None

ENERGY LEVEL?

None	Poor	Average	Good	Excessive

CONCENTRATION?

Extremely Poor	Poor	Average	Good	Excellent

SLEEP?

Extremely Poor	Poor	Average	Good	Excessive

APPETITE?

None	Poor	Average	Good	Excessive

SCHOOL PERFORMANCE?

None	Poor	Average	Good	Excessive

Has the child/adolescent ever experienced thoughts of self-harm or harm to others? (please check your response) ( ) yes ( ) no

If yes, please explain:

_____

_____

_____

_____

STRESSORS

Instructions: Please place a (√) in one of the boxes (Not Present, Mild, Moderate, Severe, or Extreme) for each of the stressors in the following list. Use the check list to indicate how much stress the child/adolescent or family has been under during the past year. Be sure to check one of the boxes for every one of the stressors. Use the "Not Present" column if a specific type of stress has not been experienced during the past year.

List of Stressors	Not Present	Mild	Moderate	Severe	Extreme
1. Birth or adoption of sibling					
2. Sibling rivalry					
3. Family employment issues					
4. Family financial problems					
5. Parent absence					
6. Separation or divorce of parents					
7. Conflict with family member					
8. Physical illness of child/adolescent or family members					
9. Death of loved one					
10. Move					
11. Change of school					
12. Conflict with peers					
13. Bullying					
14. School educational problems					
15. Truancy					
16. Dating Issues					
17. Legal problems					
18. Addictions					
19. Other:					

Is the child/adolescent or family currently impacted from any past stressor or trauma that we should be aware of?
( ) yes ( ) no

If yes, please explain: _____

_____

If yes, how does this past stressor or trauma currently impact the child's/adolescent's life?

_____

_____

PAYMENT INFORMATION

Who will be responsible for charges incurred?

Name: _____

Address: _____

_____

Phone: _____

The Louisville Seminary Counseling Training Center (LSCTC) initial session fee is $20.00. Counseling session fees range from $10.00 to $65.00 as negotiated with your counselor. In the event that you are in need of financial assistance with your fee, please discuss this with your counselor.

LSCTC accepts checks or cash as payment. Any returned check fee incurred by LSCTC must be reimbursed by the client.

Please list your monthly income: _____ or your annual income _____

I HEREBY GIVE MY PERMISSION FOR _____ TO BE SEEN IN THERPAY. I AM LEGALLY DESIGNATED TO GIVE THIS PERMISSION.

I HEREBY CERTIFY THAT, TO THE BEST OF MY KNOWLEDGE, THE INFORMATION PROVIDED ON THIS INTAKE FORM IS COMPLETE AND CORRECT.

_____ _____

SIGNATURE OF PARENT OR GUARDIAN **DATE**

_____

RELATIONSHIP TO CLIENT

Revised 09/17/2012

Louisville Seminary

PARTICIPANT CONFIDENTIAL INFORMATION FORM

INSTRUCTIONS: The information provided on this form is for use by the counselor. Please be sure to complete each question.

PLEASE PRINT ALL INFORMATION

PARTICIPANT NAME: _____
First M.I. Last

PLEASE CHECK ONE: ( ) Mr. ( ) Mrs. ( ) Ms. ( ) Miss ( ) Dr. ( ) Rev.

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

BIRTH DATE (mm/dd/yyyy): _____/_____/_____

RELIGIOUS AFFILIATION/DENOMINATION (if any): _____

PHONES: HOME - ( ) _____ CELL - ( ) _____

WORK - ( ) _____

NO. PREFERRED FOR CONTACT? _____ LEAVE MESSAGE? (Y) (N)

OCCUPATION: _____ EMPLOYER: _____

RELATION TO CLIENT: _____

I HEREBY CERTIFY THAT, TO THE BEST OF MY KNOWLEDGE, THE INFORMATION PROVIDED ON THIS INTAKE FORM IS COMPLETE AND CORRECT.

_____ _____
SIGNATURE OF PARTICIPANT **DATE**

Louisville Seminary

CLIENT NAME: _____
First M.I. Last

INITIAL SESSION INFORMATION

INSTRUCTIONS: This section is to be completed by the therapist in conversation with the client during the initial session. Please be sure to complete each question as appropriate.

Mood and Behavior Assessment

☐ withdrawal or social isolation	☐ loss of energy	☐ hopeless
☐ diminished interest in activities	☐ difficulty concentrating	☐ worthless
☐ hyperactive	☐ happy	☐ sad
☐ fearful/anxious	☐ irritable/angry	☐ stressed
☐ mood swings	☐ critical of others/judgmental	☐ lying

Anxiety: ☐ panic attacks – how often: _____
☐ phobias: _____
☐ obsessive-compulsive symptoms :_____

Comments: _____

_____

Eating/appetite: ☐ well ☐ increase ☐ decrease ☐ refusal to eat
☐ weight gain ☐ weight loss
☐ binging/purging – how often: _____

Sleep: ☐ well ☐ trouble falling ☐ trouble staying ☐ nightmares
☐ Other: _____

Therapist Observation/Mental Status Assessment

Appearance: ☐ Neat/Well-groomed ☐ Disheveled ☐ Unclean ☐ Other: _____
Affect: ☐ Appropriate ☐ Flat ☐ Labile ☐ Incongruent with reason for coming
Mood: ☐ Happy ☐ Hyper ☐ Angry ☐ Sad ☐ Fearful/anxious
Speech: ☐ Normal ☐ Loud ☐ Rapid/pressured ☐ Slowed
☐ Soft ☐ Slurred
Insight: ☐ Good ☐ Fair ☐ Poor
Orientation: ☐ Person ☐ Place ☐ Time
Psychosis: Hallucinations: ☐ N ☐ Y: Visual Auditory Tactile Olfactory
Delusions: ☐ N ☐ Y
Paranoia: ☐ N ☐ Y

Risk Assessment

Current: ☐ Suicidal thoughts ☐ Homicidal thoughts ☐ Cutting ☐ Violence ☐ None

History of: ☐ Suicidal attempts/thoughts ☐ Homicidal thoughts ☐ Cutting

☐ Violent behavior ☐ Legal problems ☐ Educational problems ☐ None

Safety plan necessary: ☐ N ☐ Y _____

Have you ever been arrested because of anger issues? ☐ N ☐ Y
Has your education been impacted or suspended because of anger issues? ☐ N ☐ Y

PARENTAL/FAMILY HISTORY/GENOGRAM:

(Create a beginning genogram in the space at the bottom of the page while gathering the following information.)

1. By whom were you raised? _____

2. Was your childhood home affected by divorce or death of one or both of your parents?

   Yes – divorce / death No

3. Are your biological parents/primary caregivers still living? Father? ____ Mother? _____
   Other primary caregiver? _____

4. Rate your parents' marriage:

   ( ) Unhappy ( ) Average ( ) Happy ( ) Very Happy

5. As a child, did you feel closer to your father, mother, or other family member?

   _____

6. List your brother(s)' and/or sister(s)' names in birth order:

   _____

   _____

   _____

DIAGNOSTIC IMPRESSIONS:

_____

_____

_____

Source of Information: _____ Client report _____ Referral source

_____ Therapist impression _____ Other

COUNSELING EXPERIENCE:

Have you ever seen a counselor before? Yes _____ No _____ If Yes, what was your experience?

_____

Can you tell me why you are seeking counseling now: What has happened that told you you needed to come in now? How have you tried to resolve the issue/issues? How will you see our time together as being helpful? How will we know it when we are done, or you are able to say, "I have accomplished what I had hope to accomplish through therapy?"

_____

_____

_____

So, a good goal for us would be _____

_____

_____ _____

Therapist Date Supervisor Date

PASTORAL/SPIRITUAL ASSESSMENT: SWB Scale

For each of the following statements, circle the choice that best indicates the extent of your agreement or disagreement as it describes your personal experience:

SA = Strongly Agree	D = Disagree
MA = Moderately Agree	MD = Moderately Disagree
A = Agree	SD = Strongly Disagree

1.	I don't find much satisfaction in private prayer with God.	SA	MA	A	D	MD	SD
2.	I don't know who I am, where I came from, or where I'm going.	SA	MA	A	D	MD	SD
3.	I believe that God loves me and cares about me.	SA	MA	A	D	MD	SD
4.	I feel that life is a positive experience.	SA	MA	A	D	MD	SD
5.	I believe God is impersonal and not interested in my daily situation.	SA	MA	A	D	MD	SD
6.	I feel unsettled about my future.	SA	MA	A	D	MD	SD
7.	I have a personally meaningful relationship with God.	SA	MA	A	D	MD	SD
8.	I feel very fulfilled and satisfied with life.	SA	MA	A	D	MD	SD
9.	I don't get much personal strength and support from my God.	SA	MA	A	D	MD	SD
10.	I feel a sense of well-being about the direction my life is headed in.	SA	MA	A	D	MD	SD
11.	I believe God is concerned about my problems.	SA	MA	A	D	MD	SD
12.	I don't enjoy much about life.	SA	MA	A	D	MD	SD
13.	I don't have a personally satisfying relationship with God.	SA	MA	A	D	MD	SD
14.	I feel good about my future.	SA	MA	A	D	MD	SD
15.	My relationship with God helps me not to feel lonely.	SA	MA	A	D	MD	SD
16.	I feel that life is full of conflict and unhappiness.	SA	MA	A	D	MD	SD
17.	I feel most fulfilled when I'm in close communion with God.	SA	MA	A	D	MD	SD
18.	Life doesn't have much meaning.	SA	MA	A	D	MD	SD
19.	My relation with God contributes to my sense of well-being.	SA	MA	A	D	MD	SD
20.	I believe there is some real purpose for my life.	SA	MA	A	D	MD	SD

Hamilton Rating Scale For Depression

Patient's Name: _____ Date of Assessment: _____

This checklist is to assist the therapist in recording evaluations of each patient with respect to degree of depression and pathologic condition. The higher the score, the more severe the depression.

For each item, write enter the appropriate rating on the line next to the item (only one response per item).

Rating: 0 – None 1 – Mild 2 – Moderate 3 – Severe 4 - Extreme

Item	Rating
1. Depressed Mood **Sadness, hopelessness, gloomy, pessimistic, weeping, worthless. Behavior: Facies, postures, weeping voice.**	
2. Guilt Feelings **Pathologic guilt, not rationalizing, self-blame, feelings of self-reproach.**	
3. Suicide **Recurrent thoughts of death: life is empty, not worth living, isolation, suicide gestures, threats or attempts.**	
4. Initial Insomnia **Difficulty getting to sleep after going to bed.**	
5. Middle Insomnia **Difficulty staying asleep.**	
6. Delayed Insomnia **Early-morning awakening.**	
7. Work and Interest **Apathy, loss of pleasure and interest in work, hobbies, social activities, recreation, inability to obtain satisfaction, decreased performance at work and in home duties. (Do not rate fatigue or loss of energy.)**	
8. Retardation **Psychomotor: Slowing of thoughts speech, and movement.**	

Item	Rating
9. Agitation **Psychomotor fidgeting, restlessness or pacing, clenching fists, kicking feet, wringing hands, biting lips, pulling hair, gesturing with arms, picking at hands and clothes.**	
10. Anxiety **(Psychologic)** **Tense, unable to relax, irritable, easily startled, worrying over trivia. Phobic symptoms, apprehensive of impending doom, fear of loss of control, panic episodes.**	
11. Anxiety **(Somatic)** **Physiologic concomitants of anxiety: Effects of autonomic overactivity, "butterflies," indigestion, stomach cramps, belching, diarrhea, palpitations, hyperventilation, paresthesia, sweating, flushing, tremor, headache, urinary frequency.**	

12. Loss of Appetite	
13. Anergia **Fatigability, feels tired or exhausted, loss of energy, heavy or dragging feelings in arms or legs.**	
14. Loss of Libido **Impairment of sexual performance**	
15. Hypochondriasis **Morbid preoccupation with real or imagined bodily symptoms or functions**	

16. Weight Loss **Since onset of illness or since last visit.**	
17. Loss of Insight **Denial of "nervous" illness, attributes illness to virus, overwork, climate, or physical symptoms. Does not recognize symptoms are "nervous" in origin.**	
18. Diurnal Variation **Change in mood**	
19. Hypersomnia **(More Time Spent in Bed)** **Retires earlier and/or rises later than usual, not necessarily sleeping longer.**	
20. Hypersomnia **(Oversleeping)** **Sleeping more than usual.**	
21. Hypersomnia **(Napping)** **Naps, excessive daytime sleepiness**	
22. Increased Appetite **Change in appetite marked by increased food intake or excessive cravings.**	
23. Weight Gain **Since onset of illness or since last visit.**	
24. Psychic Retardation **Slowness of speech and thought process, inhibition of will or feeling as if thought processes are paralyzed.**	
25. Motor Retardation **Slowness of movement and affective expression.**	

25-ITEM TOTAL	

S**hort** M**ichigan** A**lcoholism** S**creening** Test **(**SMAST**)**[2]

Name: Date:

		Yes	No
1.	**Do you feel you are a normal drinker?**	□	□
2.	**Does your wife/husband, a parent, or other near relative ever worry or complain about your drinking?**	□	□
3.	**Do you ever feel guilty about your drinking?**	□	□
4.	**Do friends or relatives think you are a normal drinker?**	□	□
5.	**Are you able to stop drinking when you want?**	□	□
6.	**Have you ever attended a meeting of Alcoholics Anonymous?**	□	□
7.	**Has drinking ever created problems between you and your wife/husband, a parent, or other near relative?**	□	□
8.	**Have you ever gotten into trouble at work because of drinking?**	□	□
9.	**Have you ever neglected your obligations, your family, or your work for 2 or more days in a row because you were drinking?**	□	□
10.	**Have you ever gone to anyone for help about your drinking?**	□	□
11.	**Have you ever been in a hospital because of drinking?**	□	□
12.	**Have you ever been arrested for drunken driving, driving while intoxicated, or driving under the influence of alcoholic beverages?**	□	□
13.	**Have you ever been arrested, even for a few hours, because of other drunken behavior?**	□	□
Total number of shaded checks			

Scoring: ***0-1 shaded checks:*** ***nonalcoholic***

2 shaded checks: ***possibly alcoholic***

3 or more shaded checks ***probably alcoholic***

For patients with two or more checks in the shaded areas, an alcoholism evaluation by a substance abuse professional is recommended.

References

1. **Ewing JA. Detecting alcoholism: the CAGE questionnaire. *JAMA*. 1984; 252:1905-1907.**
2. **Selzer ML, Vinokur A, Van Rooijen L. A self-administered short Michigan alcoholism screening test (SMAST). *Journal of Studies on Alcohol.* 36;1:117-126.**

Louisville Seminary Counseling Training Center
Permission to Counsel a Minor

Date _____

Minor Client: _____ Date of Birth: _____

Parent/Legal Guardian: _____

I give permission to Louisville Seminary Counseling Training Center to provide counseling services to my child, _____.

Limits of Confidentiality

I understand that all Counseling Center staff adhere to strict confidentiality standards according to Kentucky Law. I understand that while my child is a minor, I have rights to discuss my child's counseling with her/his counselor. Information discussed in the therapy setting is held confidential and will not be shared legal authorities without written permission from a parent except under the following conditions:

1. The client threatens suicide.
2. The client threatens harm to another person(s), including murder, assault, or other physical harm.
3. The client reports suspected abuse or neglect, including but not limited to, physical and/or sexual abuse of a child, of the elderly, or of a spouse.
4. The client reports sexual exploitation by a therapist.
5. There is issuance of an order by a court.
6. The client has granted permission.

Therapists at LSCTC receive supervision and participate in team consultation that is an additional benefit of receiving services in an educational institution. Therapy sessions are discussed as deemed necessary with supervisors and other staff at the Louisville Seminary Counseling Training Center and with faculty and professional colleagues at the Louisville Presbyterian Theological Seminary. Identifying client information is kept confidential during such consultation.

_____ _____

Parent/Guardian Name Parent/Guardian Signature

NOTE: This form **must** be notarized if not completed at Louisville Seminary Counseling Training Center. (See back of form.)

Notary Witness:

On this _____ day of _____, 20_____, before me, the undersigned notary public appeared _____, proved to me through satisfactory evidence of identification to be the person who signed the preceding or attached document in my presence.

_____ _____

Notary Public Date Commission expires

_____

Date

Seal

Seminary Witness:

Today, _____, parent/guardian of _____ proved to me through satisfactory evidence of identification to be the person who signed the preceding or attached document in my presence.

Type of Verification: _____

_____ _____

LSCTC Witness Date

Approved for use: 10/10/11

Outcome Rating Scale (ORS)

Name _____Age (Yrs):____ Sex: M / F
Session # ____ Date: _____
Who is filling out this form? Please check one: Self_____ Other_____
If other, what is your relationship to this person? _____

Looking back over the last week, including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels. *If you are filling out this form for another person, please fill out according to how you think he or she is doing.*

Individually
(Personal well-being)

I----------I

Interpersonally
(Family, close relationships)

I----------I

Socially
(Work, school, friendships)

I----------I

Overall
(General sense of well-being)

I----------I

Institute for the Study of Therapeutic Change

www.talkingcure.com

Session Rating Scale (SRS V.3.0)

Name _____Age (Yrs):____
ID# _____ Sex: M / F
Session # ____ Date: _____

Please rate today's session by placing a mark on the line nearest to the description that best fits your experience.

Relationship

I did not feel heard, understood, and respected. ---------- I felt heard, understood, and respected.

Goals and Topics

We did *not* work on or talk about what I wanted to work on and talk about. I---------- We worked on and talked about what I wanted to work on and talk about.

Approach or Method

The therapist's approach is not a good fit for me. I---------- The therapist's approach is a good fit for me.

Overall

There was something missing in the session today. ---------- Overall, today's session was right for me.

Institute for the Study of Therapeutic Change

www.talkingcure.com

Louisville Seminary Counseling Training Center
Initial Case Write-Up

Therapist: Click here to enter text. Session Date: _____

Client Name(s): Click here to enter text.

I. Identifying Information: (A one paragraph description of client. Include ages, ethnic and gender information, vocational or educational information and any other important details that will help provide a picture of the context for treatment of this case.)

Click here to enter text.

II. Presenting Problem: (In their words, why did the client(s) come to therapy? Include perceptions provided by referral source or treating therapist.)

Click here to enter text.

III. Relevant History: (Briefly report personal and family events that illustrate the personal/family system. Include references to relevant social, marital, important school and vocational histories, etc. and identify areas of success and struggle, that aid in understanding the families' identified concerns evident at intake. Describe how the problem developed.)

Click here to enter text.

IV. Clinical/Pastoral Assessment: (Given what is known about the case ***at this point,***

- What theoretical approach seems appropriate to guide your assessment? What ***theoretical orientation*** appears most appropriate and why?
- From the "flag assessment questions," what formal assessment tools should be used?
- Include a brief clinical summary of your ***interview findings.***
- Include **a theological reflection/pastoral assessment** for this client)

Click here to enter text.

V. Genogram: (Include a brief initial Genogram below.)

_____ _____
Therapist Date

_____ _____
Supervisor Date

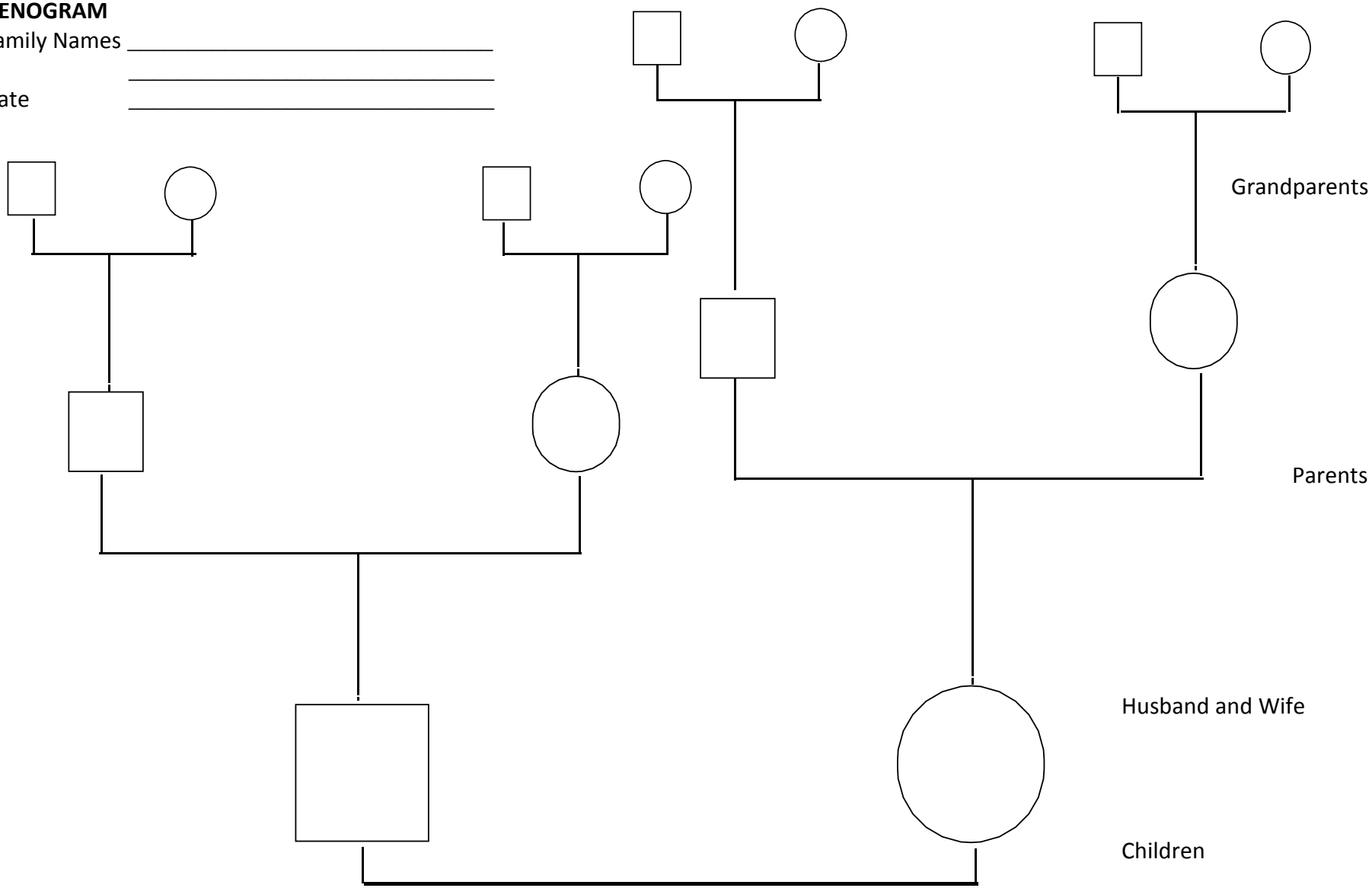
Revised 09/05/13

GENOGRAM

Family Names _____

_____

Date _____



LOUISVILLE SEMINARY COUNSELING TRAINING CENTER

TREATMENT PLAN

(To be completed at the end of the assessment phase)

Client: _____ Date: _____

Presenting Problem: _____

_____

_____

_____

_____

Assessment (Using systemic language): _____

_____

_____

_____

_____

_____

_____

Therapeutic Goals (usually in the words of the client): _____

_____

_____

_____

_____

Structure of Treatment (Who will be included in sessions, how frequently will sessions be scheduled, how long do you expect sessions to last?):

_____

_____

_____

DSM Diagnosis (If family, include DSM diagnosis for family members as applicable):

Name_____

No.	Description
Axis I:	_____
Axis II:	_____
Axis III:	_____
Axis IV:	_____
Axis V:	_____

Name_____

No.	Description
Axis I:	_____
Axis II:	_____
Axis III:	_____
Axis IV:	_____
Axis V:	_____

Name _____

No.	Description
Axis I:	_____
Axis II:	_____
Axis III:	_____
Axis IV:	_____
Axis V:	_____

Name _____

No.	Description
Axis I:	_____
Axis II:	_____
Axis III:	_____
Axis IV:	_____
Axis V:	_____

Treatment Plan (List specific therapeutic changes to be made that will enable client(s) to reach goals).

_____

_____

_____

_____

Plan for Assessing Progress: _____

_____

_____

_____

_____ _____

Therapist's Signature Date

_____ _____

Supervisor's Signature Date

PROGRESS NOTES

Client(s): _____

Session # ____ Date: _____ Time: Beginning - _____ Ending - _____

Persons present: _____

1. Observations/family status
2. Themes or problems considered
3. Clinical conceptualization
4. Types of interventions used
5. Theological, spiritual, pastoral assessment

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

6. Assessment of goal or problem: Improved Intensified Lessened Same

7. Goals for next session: _____

_____

8. End of session assignment: _____

_____

9. Date and time of next session: _____

_____ _____

Intern Date

_____ _____

Supervisor Date

CASE ACTIVITY NOTES

Client: _____

	Time		Activity	Intern & Supervisor Signatures
Date	**Start**	**End**	**Phone calls, research, collateral contact, message left, etc.**	
(All entries must have complete information, signatures.)				

LSCTC Safety Plan for Self-Harm

Client Name: _____ Date: _____

Therapist Name: _____

Self-Harm and suicidal thoughts can be overwhelming and seem like they will last forever. In reality these thoughts and feelings are often temporary. This safety plan can help you cope with difficult moments and can help keep you safe. This plan is developed jointly with your therapist at LSCTC. In general, a safety plan is designed so that you can start at step one and continue through the steps until you feel safe. You should keep your plan in a place where you can easily access it (your wallet, purse or cell phone) when you have thoughts of hurting yourself.

1. Recognize triggers and warning signs: List here the thoughts, images, feelings, moods, situations, and behaviors that signal to you that a crisis may be developing.

1. My Warning Thoughts:

2. My Feelings or moods:

3. Stressful Situations:

4. My at-risk behaviors:

2. Make use of your own coping strategies: What are some things that you can do on your own to help you to stay safe and not act on thoughts/urges to harm yourself?

1.

2.

3.

3. Spend time with others who may offer support and distraction from the crisis: List people (with phone numbers) and social settings that help take your mind off things.

1.

2.

3.

4. Positive social settings:

4. Contact family members or friends who may help to resolve a crisis: Make a list of family members or friends (with phone numbers) who are supportive and who you feel you can talk to when under stress.

1.

2.

3.

5. Contact mental health professionals or agencies: List names, including your current therapist at LSCTC, phone numbers and/or locations of clinicians, local emergency rooms, crisis hotlines – carry these numbers with you. While LSCTC is not a crisis center, it will be helpful to inform your therapist of the concern you are experiencing and to plan to address these concerns at your next counseling session.

1. Name of LSCTC Therapist _____ at 894-2293

2. Local Emergency Room:

3. Other clinical help:

Crisis line numbers:

Hope Now Hotline: 589-4313

Suicide Prevention Lifeline: 1-800-273-TALK (8255)

Local Emergency Response: 911

6. Establish a safe environment: If you have thought of ways in which you might harm yourself, describe your plan to limit availability and access to these means.

1.

2.

3.

*Adapted from the Safety Plan Template developed by the National Suicide Prevention Lifeline.

Louisville Seminary Counseling Training Center

Report Form for CPS / APS / CACU

Under Kentucky law ANY person is obligated to report child abuse, child sexual abuse, and child neglect or dependency. This means that any therapist who becomes aware of abuse or neglect from any source – whether from a child, parent, another therapist, or any other person – no matter if the information is oral or in written form, is obligated to report the suspected abuse or neglect.

Non-Emergency: Child Abuse Report: (502) 595-4550
or https://prd.chfs.ky.gov/ReportAbuse
Crimes Against Children Unit (CACU): (502) 574-2465
Adult Protective Services (APS): (502) 595-4803

Emergency requiring immediate response:
CPS/APS 24 hr Hotline: (877) 597-2331

Therapist Name: _____ Date and Time of Call: _____

Agency Contacted: _____ Phone: _____

Person Receiving Call: _____ Report/Case #: _____
(if given)

Report Information:

Informant Name: _____

Status of Informant to person of concern: ____ teacher ____ parent ____ child ____ other - _____

Person of Concern (child or adult): _____

Date of Birth or Approximate Age: _____ Gender: ____ M ____ F

School and Grade (if applicable): _____

Resides With (include name and relationship): _____

Home Address: _____ Phone: _____

Type of Abuse/Neglect Suspected: ____ physical ____ mental/emotional ____ sexual ____neglect

Name of Person Suspected of causing abuse/neglect: _____

Description of Concern (what, when, where): _____

_____

_____

_____

Witnesses to Event/Concern: _____

List any disabilities of victim: _____

Information provided by agency representative: _____

Therapist Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

Read more at: http://chfs.ky.gov/dcbs/dpp/

DEFINITIONS OF CHILD ABUSE, NEGLECT AND DEPENDENCY

600.020 Definitions for KRS Chapters 600 to 645.

(1) "Abused or neglected child" means a child whose health or welfare is harmed or threatened with harm when: (a) His or her parent, guardian, person in a position of authority or special trust, as defined in KRS 532.045, or other person exercising custodial control or supervision of the child:

1. Inflicts or allows to be inflicted upon the child physical or emotional injury as defined in this section by other than accidental means;
2. Creates or allows to be created a risk of physical or emotional injury as defined in this section to the child by other than accidental means;
3. Engages in a pattern of conduct that renders the parent incapable of caring for the immediate and ongoing needs of the child including, but not limited to, parental incapacity due to alcohol and other drug abuse as defined in KRS 222.005;
4. Continuously or repeatedly fails or refuses to provide essential parental care and protection for the child, considering the age of the child;
5. Commits or allows to be committed an act of sexual abuse, sexual exploitation, or prostitution upon the child;
6. Creates or allows to be created a risk that an act of sexual abuse, sexual exploitation, or prostitution will be committed upon the child;
7. Abandons or exploits the child;
8. Does not provide the child with adequate care, supervision, food, clothing, shelter, and education or medical care necessary for the child's well-being. A parent or other person exercising custodial control or supervision of the child legitimately practicing the person's religious beliefs shall not be considered a negligent parent solely because of failure to provide specified medical treatment for a child for that reason alone. This exception shall not preclude a court from ordering necessary medical services for a child;
9. Fails to make sufficient progress toward identified goals as set forth in the court-approved case plan to allow for the safe return of the child to the parent that results in the child remaining committed to the cabinet and remaining in foster care for fifteen (15) of the most recent twenty-two (22) months; or

(b) A person twenty-one (21) years of age or older commits or allows to be committed an act of sexual abuse, sexual exploitation, or prostitution upon a child less than sixteen (16) years of age.

KRS 600.020(19) states: "Dependent child" means any child, other than an abused or neglected child, who is under improper care, custody, control, or guardianship that is not due to an intentional act of the parent, guardian, or person exercising custodial control
or supervision of the child;

There are numerous factors involved in defining child abuse and neglect. Cultural and ethnic backgrounds, attitudes concerning parenting and professional training all contribute to an individual's definition. In seeking commonly acceptable definitions, it is helpful to distinguish between abuse and neglect. In simplistic terms, ABUSE IS AN ACT OF COMMISSION. NEGLECT IS AN ACT OF OMISSION.

Kentucky law contains a definition of an abused or neglected child, which must be utilized in determining whether a situation is appropriate for investigation and services by the child protection program. It is important to note that, for the situation to be appropriate for the Department of Community Based Services to investigate, the person who is the perpetrator of abuse or neglect must be the parent or guardian or have some type of supervisory responsibility for the child. This can include a babysitter, school teacher or day care center personnel, for example. In order to intervene in the lives of families there must be a legal basis for such intervention. That basis is described below:

WHEN TO REPORT

When you have reason to believe a child is being abused, neglected or is dependent, call the child protection hotline or your county Department for Community Based Services. If in doubt, contact your clinical supervisor to talk over what has come to your attention. Your supervisor will help you sort things out, such as whether a specific incident must be reported and to whom.

If you feel the child is in imminent danger or is in need of immediate protection, call 91 or your local police department. For example, a very young child or handicapped child who is left alone with no adult supervision needs immediate help. Police officers can remove a minor from a threatening environment in order to protect the child if the child is in danger of imminent death or serious physical injury or is being sexually abused and the custodian is unable / unwilling to protect the child. (KRS 620.040(5)(c))

WHEN NOT TO REPORT

Concerned citizens need to know they have a duty to report suspected child abuse. The Department for Community Based Services has the authority and the obligation to assure that reports meet the statutory definition of abuse, neglect, or dependency before a formal child protection investigation is set in motion. In those cases where the referral is not clearly one of abuse, neglect, or dependency, but indicates services needs, the Department attempts to be responsive and find appropriate services. Criteria for refusing reports include a specific act of abuse, neglect or dependency is not alleged, such as a generalized concern for welfare of the child that does not state specific allegations reflecting child abuse or neglect. Examples are

a. A child who is improperly dressed, but the clothing deficiency does not result in harm to the child;
b. A child who is provided nutritious food irregularly or insufficiently, but the health of the child is not impaired;
c. Hygiene, that although not optimal, does not adversely affect the well-being of the child;
d. Life-style issues, such as single parent who has several boy/girl friends with no allegations of abuse or neglect to the child;
e. A small child who is ambulatory and who has minor marks in routine areas such as the knees and the reporter has no reason to believe the injuries were caused by abuse or neglect;
f. Corporal punishment appropriate to the age of the child, without injuries, marks, bruises, or substantial risk of harm; or
g. Reports that have insufficient information to locate the child.

The online KY Child/Adult Protective Services Reporting System is available to report non-emergency situations that do not require an immediate response from COS staff. The website is monitored from 8 a.m. to 4:30 p.m. Eastern time Monday through Friday.

URL: https://prd.chfs.ky.gov/ReportAbuse/home.aspx

Louisville Seminary Counseling Training Center

Authorization for Live Observation and Audio-Visual Recording

As you know, this is a training center for marriage and family therapists. Therapists here are masters and doctoral students who have completed considerable course work and are accumulating clinical experience. An important part of this clinical training involves having faculty and clinical supervisors observe students' work as well as having students observe each other's work. This is accomplished in two ways. Sometimes supervisors or students observe therapy sessions from behind the one way mirror. Other times sessions are recorded on video or audio tape for later playback in individual or group consultation sessions. The use of observation and tapes insures that the therapy you receive is of the absolute highest quality and it contributes to the fine national reputation of this training program.

There are several things we would like you to be aware of concerning the observation and taping. First, the profession of marriage and family therapy has very clear and strict ethical standards concerning the confidentiality and protection of privacy. Consequently, the Louisville Seminary Counseling Training Center has strict policies concerning the discussion of cases during individual and group consultation sessions. Your last name will not be associated with any of the recordings. Your case will not be discussed outside of the clinical settings. All students and faculty are prohibited from observing/watching sessions/tapes of anyone they know even remotely. Furthermore, tape recordings generally are erased after two weeks unless special permission has been obtained from you.

I understand fully the information regarding live observation and audiovisual recording and its use and my signature indicates my consent.

_____	_____
Date	Family Member
_____	_____
Date	Family Member
_____	_____
Date	Family Member
_____	_____
Date	Therapist

LOUISVILLE SEMINARY COUNSELING TRAINING CENTER

CONSENT FOR RELEASE OF INFORMATION

RE: _____ Birthdate: _____
(Print Client's Name)

I, _____ hereby authorize and request that
(Print Client's or Guardian's Name)

Louisville Seminary Counseling Training Center
1044 Alta Vista Road, Louisville, KY 40205-1798

may obtain / release confidential professional information pertaining to me (or my minor children) to / from

Name: _____ Fax: _____

Address: _____

I understand that I may revoke this consent at any time by informing the above parties in writing. In consideration of this consent, I hereby release the above parties from any legal liability for the release of this information.

The information to be disclosed is:

_____ Summary Social/Family History
_____ Summary Psychiatric History
_____ Results Psychiatric Evaluation
_____ Result of Medical Exam
_____ Termination/Discharge Summary
_____ Psychological Testing
_____ Treatment History

_____ Other (specify) _____

For the purpose of _____

_____ _____
Client or Guardian Signature Date Signed

_____ _____
Relation to Client Witness Signature

The Louisville Seminary Counseling Training Center is prohibited by law from re-release of information provided to us by other agencies/sources.
This authorization expires 90 days from the date it was originally signed.

LOUISVILLE SEMINARY COUNSELING TRAINING CENTER

TERMINATION SUMMARY

Client(s): _____

Relationship and Age of Family Members Attending Therapy Sessions:

_____

_____

DSM-IV-TR: _____

Intern: _____ Supervisor(s): _____

Referral Source: _____

Presenting Problem: _____

_____

_____

Timespan of Treatment: _____ Total Number of Sessions _____
(Including beginning and ending dates)

Summary of Relevant Test Data (Continue on separate sheet, if necessary):

_____

_____

_____

_____

Goals of Treatment:

_____

_____

_____

_____

Course of Therapy (including reason for termination):

_____

_____

_____

_____

_____

_____

_____

_____

Treatment outcome:

_____

_____

_____

_____

_____

_____

_____

Reason for Termination (check all that apply):

_____ completion of therapy goals
_____ referral of client to another therapist
_____ premature termination
_____ other (explain) _____

_____ _____
Therapist's Signature Date

_____ _____
Supervisor's Signature Date

Louisville Seminary Counseling Training Center

Attendance Register and Payment Log

	CLIENT INFORMATION		SESSION INFORMATION						
Therapist's Last Name(s)	Client's First Initial & Last Name	Ethnicity C / AA / AS/H/O	Today's Date	Attendance Status I / P / C / NS	Session Type I / C / F	Today's Charge	Amount Paid Today	Cash / Check #	Receipt #
Totals:									

Key: **Ethnicity** = C – Caucasian; AA – African American; AS – Asian; H – Hispanic; O – Other
Attendance Status = I – Intake; P – Present; C – Cancelled; NS – No Show
Session Type = I – Individual; C – Couple; F - Family

LOUISVILLE SEMINARY COUNSELING TRAINING CENTER
Client Record Release

File Identification

Client Name: _____ DOB: _____

Client Name: _____ DOB: _____

Other Participants: _____

Documentation to be Released

( ) Letter/Confirmation of attendance
( ) Contents of Client Record with LSCTC forms and documentation from other agencies removed

Purpose of Release of Information

Contents of client record released upon the request of the client, _____.

Records Release (***To be completed on day of release***)

Recipient: _____ Date Released: _____

Relationship to Client: ( ) Self ( ) Other - _____

( ) Received at LSCTC – Proof of Identification for Recipient _____

( ) Mailed per client request – Date of mailing _____

Mailing Address - _____

_____

_____ _____
Signature of Client, Parent or Guardian Date

_____ _____
Signature of Person Releasing Information Date

LSCTC Client Contact Letter Form

Date: _____

Client: _____

Address: _____

City/State/Zip: _____

Dear _____:

I have been unable to **(circle one: contact / schedule an appointment with)** you and would like to know your plans regarding the **(circle one: continuation of / beginning)** your counseling sessions. If you would like to (circle one: continue / begin), please notify me before **(date: _____)** by calling 894-2293. If I haven't heard from you by this date, I will understand that you (circle one: do not wish to begin counseling sessions / wish to terminate your sessions) and will take steps to close your account.

I look forward to hearing from you whatever your decision may be.

Sincerely,

Intern: _____
Marriage and Family Therapy Intern

LSCTC Termination Letter Form

Date: _____

Client Name: _____
Address: _____
City / State / Zip: _____

Dear _____:

INTRODUCTORY PARAGRAPH: (Select one of the following introductions)

____ This letter is to confirm that you have currently chosen not to continue therapy with the Louisville Seminary Counseling Training Center. If we can be of service to you in the future, please do not hesitate to call.

_____ This letter is to confirm we are no longer able to provide therapy for you at LSCTC. You have been referred to _____ for _____.

THERAPIST COMMENTS, if desired: _____
_____
_____

ACCOUNTING: (Select the appropriate comment)

_____Our records show your account with us has a balance of $_____. Feel free to use the enclosed envelope for your remittance or contact Becky Timerding at 992-9363 to make arrangements for payment.

_____Our records show your account is paid in full. Thank you for attending to this matter.

_____Our records show your account has a credit of $_____. We will have a check sent to you at the above address for this amount.

Enclosed is an evaluation form of our services. Your feedback will help us continue to provide quality service. Please take a minute to fill it out and mail it back to us in the envelope enclosed.

Sincerely,

THERAPIST NAME
Marriage and Family Therapy Intern

Enclosures

LOUISVILLE SEMINARY COUNSELING TRAINING CENTER

1044 Alta Vista Road
Louisville, Kentucky 40205-1798

CLIENT'S EVALUATION OF TREATMENT

Dear Client,

Recently you used our services to assist you in some way. I would appreciate you giving me five minutes of your time to complete this form and return it to me at your earliest convenience. Your candid honest opinions will allow me to continue to improve the services we provide. Your evaluations will be carefully considered.

Sincerely,
Jennifer A. Schiller, LMFT, JD
Director of Clinical Training, Louisville Seminary Counseling Training Center

---

Therapist's Name: _____ Date of last session: _____

1. Overall satisfaction with services:

   1 ---------- 2 ---------- 3 ---------- 4
   very dissatisfied dissatisfied satisfied very satisfied

2. Please rate the following, "Poor" to "Very Good"

		Poor	Fair	Good	Very Good
a)	First contact with agency	1	2	3	4
b)	Available service times	1	2	3	4
c)	Directions given	1	2	3	4
d)	Facility Accessibility	1	2	3	4
e)	Comfort in Setting	1	2	3	4
f)	Fees	1	2	3	4
g)	Service Provider	1	2	3	4

3. How well did you get along with your therapist?

   1 ---------- 2 ---------- 3 ---------- 4
   not well at all not so well fairly well very well

   Comments:_____

   _____

(Please continue on other side. Thank you.)

4. Professionalism of therapist (kept appointments, collected fee for sessions, dressed appropriately, etc.)

   1 ---------- 2 ---------- 3 ---------- 4
   inadequate/dissatisfied marginal adequate above average

   Comments: _____

   _____

5. Is the presenting concern which brought you to therapy:

   1 ---------- 2 ---------- 3 ---------- 4
   worse about the same better, but not resolved completely resolved

6. I would use this service again:

   1 ---------- 2 ---------- 3 ---------- 4
   never probably not probably so without a doubt

7. I would refer friends and family to Louisville Seminary Counseling Training Center

   1 ---------- 2 ---------- 3 ---------- 4
   never probably not probably so without a doubt

Comments: _____

_____

_____

_____

_____

_____

Please return this form in the envelope enclosed.
Thank you for your time.

Louisville Presbyterian Seminary
Incident/Accident Form

THIS FORM MUST BE FILLED OUT COMPLETELY AND IN DETAIL.

Date:_____ Time of incident:_____ a.m. p.m.

Person Filling Out This Form (please print):_____

PERSON

Name of person involved:_____

Home address:_____ Telephone:_____

Was an injury involved: ☐YES ☐ NO If yes, fill out this section completely.

Where did the accident/incident occur? _____

Explain in detail what happened: _____

_____

_____

DESCRIPTION

Was medical help called? ☐ YES ☐ NO

If yes, who provided care at the scene? (EMS, other) _____

Was the person taken to the hospital? ☐ YES ☐ NO

Was there any property damage? ☐YES ☐ NO If yes, please explain in detail.

_____

WITNESS

Please list anyone who witnessed the accident/incident:

_____
(name) (address) (telephone)

_____
(name) (address) (telephone)

_____
(name) (address) (telephone)

Name of person filling out this form: _____ Date: _____
(signature)

Please retain a copy of this form for your records.
Send the original form in its entirety immediately to Tim Williams, Director of Campus Facilities.

Louisville Seminary Counseling Training Center
Clinical Emergency Incident Report

Although Louisville Seminary Counseling Training Center is not an emergency facility, at times clinical emergencies do happen. The following procedure should be followed when client emergency events take place:

Actions to be Taken	Completion Date	Initials
1. The student will immediately notify his/her clinical supervisor and the Director of Clinical Training.		
2. The Director will notify MAMFT professors, clinical supervisors, Seminary Dean, and Dean of Students, as appropriate, within 24 hrs. of receiving information of a client death or other emergency event. The Director will consult with the Seminary Dean regarding possible legal/ethical issues to be considered/addressed.		
3. The Director will contact the student, the student's clinical supervisor, the student's academic advisor, and the Program's Administrative Assistant within 24 hrs of receiving emergency information to schedule a meeting. **Meeting Date: _____**		
4. The Program Administrative Assistant will help coordinate the flow of information and guide the student in the closing of the client's file.		
5. An assessment will be made collaboratively by the Director of Clinical Training and the clinical supervisor, in consultation with the student, and a "wellness" plan will be set in place for the student therapist and "others" immediately impacted by the event. **Plan: _____** **_____**		
6. The student's clinical supervisor will continue to assess and consult with the student therapist regarding her/his emotional, spiritual, and physical well-being and explore other appropriate resources, i.e., referral to counselor or spiritual director for student, material resources available, continued assessment of student's self-care. The supervisor will submit a report to the Director if further assistance is needed.		

Policy Accepted: March 14, 2011