Parkdale Therapy Group, LLC

Megan A. Jankord, MA, LMFT
1000 Shelard Parkway, Ste 520
St. Louis Park, MN 55426-1053

E-Mail: megan.jankord@parkdaletherapy.org
Tel # 952-224-0399 (extension 114)
Fax # 952-224-0396

CLIENT INFORMATION PACKET

This booklet will help acquaint you with my office procedures, as well as provide information about your rights and responsibilities with regard to therapy. You will also find updated information about your rights pursuant to the Health Insurance Portability and Accountability Act (HIPAA). If you have any questions about this information, please discuss them with me at any time.

DIRECTIONS

From the North take 169 south to Shelard Pkwy/ Betty Crocker Drive. Take Shelard Parkway to 1000 Shelard Parkway. Turn right into the parking lot, and if you park on ground level, use the main entrance to the elevators up to the fifth floor. Turn right and continue down to suite 520.

From the South take 169 north to Shelard Pkwy/ Betty Crocker Drive. Take Shelard Parkway to 1000 Shelard Parkway. Turn right into the parking lot, and if you park on ground level, use the main entrance to the elevators up to the fifth floor. Turn right and continue down the hall to suite 520.

From the East take 394 west to 169 North and then exit on Shelard Pkwy/ Betty Crocker Drive. Take Shelard Parkway to 1000 Shelard Parkway. Turn right into the parking lot, and if you park on ground level, use the main entrance to the elevators up to the fifth floor. Turn right and continue down the hall to suite 520.

From the West take 394 east to Hopkins Crossroads exit and turn left to cross over 394, then take the first right (East) on N. Wayzata Blvd (frontage road) approximately six blocks to the six-story blue glass building with FOCUS FINANCIAL in white letters. Turn into the ramp and park, then take the walkway to the second floor elevators up to the fifth floor. Turn right and continue down the hall to suite 520.

PROFESSIONAL RELATIONSHIP

The professional relationship is not easily described in general statements. It varies depending on the personalities of the consultant and client, and the concerns you are experiencing. There are many different methods we may employ to attend to the concerns that you hope to address. The relationship is not like a medical doctor and calls for a very active role on your part. It might even include other important people in your life.

Therapy can have benefits and some risks. Since consultation may involve discussing challenging experiences of your life, you may experience sadness, guilt, anger, frustration, loneliness, etc. On the other hand, therapy may have many benefits. Successful therapy can lead to increased satisfaction in relationships, new possibilities for addressing specific concerns, and/or reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will focus on understanding your needs, goals, and presenting concerns. After these first few sessions, we will be able to discuss your first impressions of what our work could include and then co-create a potential plan to follow if we decide to continue with therapy. It is important to evaluate this information along with your own opinions of whether you feel comfortable working together. Since therapy involves a commitment of time, money, and energy, it is important to be selective about the therapist you select. If you have questions about my procedures, we can discuss these whenever they arise. While we co-create possible solutions, you maintain the right to implement them, or decide against implementing any or all of them.

MEETINGS & PROFESSIONAL FEES

I conduct an initial session of 55 – 75 minutes at a cost of $250. Following the initial session is an evaluation period of 2 to 3 sessions, during which we all determine if I am the best person to provide the services you need to meet your goals. The fee for these 55-minute sessions is $180. I usually suggest one 55-minute session per week at a time, but we work together to determine how often and for what length of time we meet. Once an appointment hour is scheduled, you will be financially responsible if you were to cancel with at least a 24-hour notice. If were unable to attend due to circumstances beyond your control, such as an unforeseen emergency, sudden illness, etc., the fee is waived. Periodically we are faced with the issue of raising our rates. While this is not an annual change, there have been times when the hourly rate has increased $10.00/hour. In the event of a change, we will post these changes in our individual offices at least 90 days in advance and make every effort to verbally apprise you of the changes.

ADDITIONAL PROFESSIONAL FEES

In addition to weekly appointments, I charge $180 per 55 minutes for other professional services you may need, though I will break down the hourly cost if I work for periods of less than 55 minutes. Other services may include report writing, telephone conversations lasting longer than 10 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and time spent performing other services you may request.

If you become involved in any legal proceedings that require my participation, you will be expected to pay for all my professional time, including preparation and transportation costs, and any legal fees that I might incur, even if I am called to testify for another party. I charge $180 per hour for preparation and attendance, and in addition, mileage to and from any location.

Relational and Couple Therapy may not covered by the insurance panels to which I belong, as such the fees for the session are due at the beginning of each session. Fees can be paid for using debit/credit cards, checks, or cash.

CONTACTING ME

You may leave me a message on my confidential voicemail or e-mail me. Email or text is used to make or change appointments, or for general questions not requiring an immediate response. For more detailed and sensitive information, please leave a voicemail. I will make every effort to return your call or e-mail within 24 hours, except for weekends and holidays. If it might be difficult to reach you, please leave times when you might be available by phone.

EMERGENCIES

If you are experiencing an immediate crisis and are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist [psychiatrist] on call, the St. Paul Ramsey Crisis Intervention Center at (651) 266-7900, or your local emergency services at 911. Please see our website for additional resources. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

PAYMENTS

You will be expected to pay for each session at the time of the session. Our health insurance company contracts may not permit reimbursement for couple or relational therapy. As such all fees for sessions will be due at the time of session.

CONCERNS

I urge you to discuss with me any questions or concerns you may have with the consultation you receive. If you are not satisfied with the results of that discussion, and additional measures are necessary, a formal concern or complaint may be made with Ms. Michelle A. Craveiro, MA, LMFT whose number is 952-224-0399 ext 102. If the results of that consultation are not satisfactory, you may call the Board of Marriage and Family Therapy at 612-617-2220.

COUPLE THERAPY AGREEMENT

Couple or relationship therapy is a distinct form of therapy. The therapy unit is the relationship, not the individual. It is common in couple therapy that both partners experience different levels of agreement and disagreement with the therapist. The goal is to improve the relationship, not the individual, but individual change may occur. Since the couple is the therapy unit, all consent and confidentially resides with both members. Specifically, both partners are required to sign all releases of information and to mutually agree to the therapy. If one member of the couple chooses not to sign or give consent, information will not be released from the file except for when required by law.

As the focus of couple therapy is the relationship, we provide no recommendations on parenting time or parenting suitability, in the event of separation or divorce, nor will we render an opinion as to who may be at fault if a couple chooses to end their relationship. We neither make recommends for a couple remain together nor suggest they separate. The decision to end a relationship is a personal choice and the decision resides solely with the individuals in the relationship, and is a decision made with care and caution. We maintain a "no secrets" policy, which permits use of the information obtained by the therapist, to be used in a fashion that fosters the therapeutic process. In general, we do not believe secrets in couple therapy is helpful to the therapeutic process. The decision to share personal information resides with the individuals with the understanding the therapist is free to exchange this information with each individual member of the couple relationship.

Our health insurance company contracts do not permit reimbursement for couple or relational therapy. As such you are responsible for all fees related to your therapy. We are still required to perform an assessment covering a broad range of topics, typically more than may be covered in our initial session.

We will appear for court matters if subpoenaed, after having both parties consent to and sign a Release of Information, or if court ordered to release therapy information. If either member of the couple requires my legal appearance, my fee is $180.00 per hour with a minimum of four (4) hours; to be paid in full by cashier's check or credit card seventy-two hours prior to any court related appearance. This amount may be divided between the partners as they see fit, if the amount is paid in full prior to any legal proceeding. We will provide copies of your files at a cost of $1.25 per page plus $16.50 for administrative expenses. Under no circumstances will we release the private therapy notes of sessions, however, we will provide a written summary, if requested and authorized, by both members.

Our insurance company contracts do not reimburse me for relational or couple therapy. All fees for sessions are due at the time of session.

Your signatures indicate you understand and accept the terms contained within this agreement and have been offered a copy for your records.

Partner I Signature _____ Date _____

Partner II Signature _____ Date _____

CONTACT INFORMATION

Today's Date _____

Partner I Name _____ Date of Birth _____
Last, First, MI

Street Address _____ City _____

State _____ Zip Code _____ Sex: F ◯ M ◯ O ◯ Age ____ Partner Status: Sgl ◯ Mar ◯ Div ◯ Sep ◯ Other ◯

Cell Phone _____ Work Phone _____ Other Phone _____
May I leave a message? Yes ◯ No ◯ May I leave a message? Yes ◯ No ◯ May I leave a message? Yes ◯ No ◯

Confidential Email _____ May we send an encrypted message? Yes ◯ No ◯

Employer _____ Occupation _____

Primary Care Physician _____ Phone: _____ May I contact? Yes ◯ No ◯

Partner II Name _____ Date of Birth _____
Last, First, MI

Street Address _____ City _____

State _____ Zip Code _____ Sex: F ◯ M ◯ O ◯ Age ____ Partner Status: Sgl ◯ Mar ◯ Div ◯ Sep ◯ Other ◯

Cell Phone _____ Work Phone _____ Other Phone _____
May I leave a message? Yes ◯ No ◯ May I leave a message? Yes ◯ No ◯ May I leave a message? Yes ◯ No ◯

Confidential Email _____ May we send an encrypted message? Yes ◯ No ◯

Employer _____ Occupation _____

Primary Care Physician _____ Phone: _____ May I contact? Yes ◯ No ◯

EMERGENCY CONTACTS

My priority is maintaining the safety and privacy of those with whom I consult. If there comes a time when I am concerned with your safety or the safety of others in your life, I may need to contact them. I ask you provide two names of people I could call if I am concerned about your safety. If you are the parent of a client I am seeing, there may be times when I am unable to contact you immediately and need someone else to verify your child's safety. Please list these individuals below.

First Emergency contact _____ Relation to You? _____

Home Phone _____ Work Phone _____ Mobile Phone _____

Email _____

Second Emergency contact _____ Relation to You? _____

Home Phone _____ Work Phone _____ Mobile Phone _____

Email _____

Third Emergency contact _____ Relation to You? _____

Home Phone _____ Work Phone _____ Mobile Phone _____

Email _____

PAYMENT AUTHORIZATION FORM

Keeping your account up to date is effortless and worry free, simply authorize your charges to your Health Savings Account (HSA), credit card or debit card.

This form will authorize Megan A. Jankord or John L. Jankord, Parkdale Therapy Group CEO, to charge your HSA, credit or debit card for your sessions. Your personal information will be kept secure and confidential.

Payment is simple and secure whether using Health Savings account, Visa, MasterCard, American Express or Discover Card. Complete and sign this form to get started. A paid receipt will be sent to the mail, email, or Fax you prefer.

Please complete all the information below:

I _____ authorize Parkdale Therapy Group to charge my credit card as follows:

For, _____ the client(s)

Billing Address: _____

City, State, Zip: _____

Phone: _____ Email: _____

Credit Card

Visa ◯ MasterCard ◯ HSA ◯

Amex ◯ Discover ◯

Cardholder Name: _____

Account Number: _____

Exp. Date: _____

CVV (3-digit number on back of card) or (4-digit on the front if AmEx) _____

Zip: _____

Receipt to be sent by Email ◯ Mail ◯ Fax ◯

Partner I Signature _____ Date _____

Partner II Signature _____ Date _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Parkdale Therapy Group in writing of any changes to my account information. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card Company; so long as the transactions correspond to the terms indicated in this authorization form.

CONFIDENTIALITY AGREEMENT

Information about clients and their families is confidential with exception to the following:

1. Written authorization by the client and/or family (valid authorization form).
2. Therapist's duty to warn another in the case of potential suicide, homicide or threat of imminent, serious harm to another-individual.
3. Therapist's duty to report suspicion of abuse or neglect of children or vulnerable adults.
4. Therapist's duty to report prenatal exposure to cocaine, heroin, phencyclidine, methamphetamine, and amphetamine or their derivatives, THC, or excessive & habitual alcohol use. (253b.02; 2007).
5. Therapist's duty to report the misconduct of mental health or health care professionals.
6. Therapist's duty to provide a spouse or parent of a deceased client access to their child or spouse's records.
7. Therapist's duty to provide parents of minor children access to their child's records. Minor clients can request, in writing, that specific information not be disclosed to parents. Such a request should be discussed with the therapist.
8. Therapist's duty to release records if subpoenaed by the courts.
9. Therapist's obligations to contracts (e.g. to employer of client, to an insurance carrier or health plan.

Consultation Within The Parkdale Therapy Group

The Parkdale Therapy Group, LLC consists of a clinical team including: John L Jankord, MA, LMFT, LADC, LPCC; Michelle Craviero, MA, LMFT; Jessie Brown, Psy D, LP; Tyra Hughes, MA, LMFT; Randi Born, Psy D, LP, MA, LMFT; Annie Will, MA, LMFT; Jake Voelker MA, LMFT; Michelle Hunt-Graham, MA, LMFT, CDWF; Aysem Senyurekli, PhD, LMFT; Libby Marx, MA, LMFT; Megan A. Jankord, MA, LMFT; Kate Schmidt, MSW, LICSW, Maureen Trefethren, MS, LPCC; Meredith Hyduke Dehn, MA, LAMFT, Samantha Waldron, MA; Megan O'Brien, MSW, LICSW.

The purpose of consulting with colleagues is to obtain additional insight, further therapeutic skills, and ensure the highest possible service to the people we serve. During collegial consultation we will make every effort to provide only those details necessary to gain adequate feedback.

Communication: Email, Text & Other Non-Secure Means

It may become useful during our work to communicate by email, text message (e.g. "SMS") or other electronic methods of communication. Please know that these methods, in their typical form, are not confidential means of communication and may be susceptible to a third party may be able to intercept and eavesdrop on those messages, even though we offer encrypted email. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that youuse to read and write messages
- Your employer, if you use your work email to communicate with Parkdale Therapy Group, LLC
- Third parties on the Internet such as server administrators and others who monitor Internet traffic

If there are people in your life you don't want to access these communications, please talk to your Parkdale Therapy Group, LLC provider about ways to keep your communications safe and confidential.

I consent to Parkdale Therapy Group, LLC providers use of email and mobile phone text messaging when transmitting your protected health information, such as:

- Information related to the scheduling of meetings or other appointments
- Information related to billing and payment
- Non-emergency related correspondence

My signature indicates I have been informed of the risks, including but not limited to my confidentiality in therapy, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement to receive therapy. I also understand that I may terminate this consent at any time.

Partner I Signature _____ Date _____

Partner II Signature _____ Date _____

YOU HAVE THE RIGHT TO KNOW AND INQUIRE ABOUT:

1. The cost of counseling, time frame for payment, access to billing statements, billing procedure for missedappointments, and any issues related to insurance coverage.

2. When the therapist is available and where to call during off hours in case of emergency.

3. The way the therapist conducts sessions concerning intake, treatment, and termination. Clients take an active role in the process by asking questions about relevant therapy issues, specifying therapeutic goals, and renegotiatinggoals when necessary.

4. The nature and perspective of the therapist's work, including techniques used, and alternative methods of treatment.

5. The purpose and potential negative outcomes of treatment. Clients may refuse any treatment intervention or strategy.

6. The anticipated length and frequency of treatment and limitations that may arise due to difficulties in financing.

7. The liberty of clients to discuss any aspect of their therapy with others outside the therapy situation, including consultation with another therapist.

8. The status of the therapist, including the therapist's training, credentials, and years of experience.

9. The maintenance of records, including security and length of time they are kept, client's rights to access personal records, and release policies.

10. The right to request a referral and the right to require the current therapist to send a written report regarding services to the qualified referred therapist or organization upon the client's written authorization.

11. The procedure followed in the event of the therapist's death/illness.

12. The therapist has a professional will.

13. That an executor may take over your case or refer to another clinician in the case of my inability to continue therapy.

14. That by signing they waive the right to sue your estate for abandonment.

I consent to this consultation, have read and understand my rights listed above, and have reviewed the Client Bill of Rights posted in our waiting room.

Partner I Signature _____ Date _____

Partner II Signature _____ Date _____

AS A CLIENT YOU HAVE A RESPONSIBILITY TO:

1. Ask questions and get clarification regarding your diagnosis and suggested treatment plan.

2. Be willing to be an active and collaborative partner in the therapeutic relationship.

3. Inform your therapist of any changes in your behavior and/or physical or mental health status that could affect your care, including compliance with any prescribed medication.

4. If using insurance, inform your therapist of any changes in your health insurance plan.

5. Be on time for scheduled appointments. If running late, please inform me by leaving a voice message on the office line (952-224-0399, ext. 114). Please do not text or email and drive.

6. Cancel appointments if you are unable to keep them, so others may use the time slot. Please adhere to a minimum of a 24-hour notice to cancel your appointment. Thank you!

7. Limit email communications primarily to scheduling issues (making appointments, rescheduling or canceling appointments). Email is not monitored sufficiently for therapeutic or crisis correspondence

8. Understand that for your confidentiality and to minimize the possibility of dual relationships, your therapist will not accept invitations for any social media connections (i.e., Facebook, LinkedIn, etc.).

9. Inform your therapist if you would prefer to "opt out" of text message or email appointment reminders.

I have read and understand my responsibilities as a client listed above.

Partner I Signature _____ Date _____

Partner II Signature _____ Date _____

COLLABORATING IN THERAPY

Tell Me What Works and Has Worked for You
Each person, couple, and family is unique. You can help by sharing the style and questions I use that work best for you and your partner and your family. You are not expected to run the therapy. Therapists have expertise and good reasons for doing what they are doing, and a therapist should allow some room for flexibility. If you have been in counseling before and found some aspect or method particularly helpful, let me know more about those experiences.

Let Me Know When We Do Something That Was Useful/Helpful
Therapy can be a difficult and challenging and rewarding process. We see people when they are feeling stressed, feeling hopeless and sometimes feeling impatient. We often aren't aware of the things we do that have been helpful if people don't return or when change takes some time. So, most therapists appreciate hearing when we've done something that worked or you've found helpful. This can also make your therapy experience more productive, since your therapist will have your feedback to guide him or her in future sessions.

Tell Me Your Expectations
If you attend therapy hoping to go back to your childhood to find origins or contributions to the concerns that brought you into therapy and your therapist focuses on the present, someone is bound to be frustrated if that expectation isn't brought up and discussed before you proceed. Also, you might indicate how long you had anticipated you would attend therapy, and how often, to make sure you and the therapist are on the same track.

Tell Your Therapist What Doesn't Work
Like telling your therapist your expectations and letting him/her know what has worked or is helping, as well as letting him/her know when something isn't helping is important. This includes what is happening between as well as during your therapy sessions. This gives the opportunity for mid-course corrections in the therapy process.

Tell Your Therapist Your Objections
Some people think that they shouldn't speak up about their worries or objections to their therapist's suggestions, but a free and frank discussion about any misgiving helps your therapist attend to your concerns and make any adjustments to ensure a higher likelihood of success.

Ask Questions
About the therapy process, fees, any suggestions or methods, the therapist's training and qualifications, etc. Anything you are curious about. If it gets too personal or the therapist considers the questions intrusive or inappropriate, he/she will let you know.

CONFIDENTIAL QUESTIONNAIRE

Partner I

Single ○ Partnered ○ Married ○ Divorced ○ Total # of Marriages _____

Length of current marriage/relationship _____

Assessment of current relationship: Good ○ Fair ○ Poor ○

Religious Affiliation/Spirituality: _____

Ethnic/Cultural Identification: _____

EDUCATION

Years of Education _____

Completed: High School/GED ○ Vocational ○ College ○ Graduate School ○ Doctorate ○

Other Training _____

Special Circumstances

MILITARY

Do you have a history of serving in the military? Please explain.

YOUR REASON FOR SEEKING THERAPY TODAY

Who referred you to Megan A. Jankord, MA, LMFT? _____

May I acknowledge this referral? _____

Their email or phone number with which to acknowledge the referral _____

Briefly describe the problem or concern for which you, your child or adolescent would like addressed in counseling.

Who is the Person/Issue you are most concerned about and why?

Why do you think these challenges are present for you or your relationship? How long have they been present?

What is the main goal(s) for today's session?

What are your ideas on how that goal might be accomplished?

What attempts have you made in the past to challenge these concerns?

If the work that we did together was helpful or successful, how would you know? What would be different in your life?

If the work that we did together was helpful or successful, what might be different in your life and the lives of others close to you?

LIST OF CURRENT CHALLENGES & SYMPTOMS

Listed below are possible challenges you might be experiencing. Please rate each according to the degree you might be experiencing any of these. Click the scaling number to indicate the current intensity and explain briefly, what specifically makes any of these a concern?

Depression? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Thoughts/Actions of Self-Injury or Self-Harm? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Worry/Anxiety? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Family/Relational Conflict? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Verbal Harm/Behavior/Threat? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Sexual Harm/Behavior/Threat? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Physical Harm/Behavior/Threat? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Legal Challenge(s)? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Internet Usage Challenges? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Alcohol/Chemical Health Challenges? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Gambling Challenges? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Spiritual/Faith Concerns? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Other Concerns? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

COUNSELING & MEDICAL HISTORY

Have you previously worked with a counselor or therapist? Yes ○ No ○
If so, where and with whom:

Approximate dates of prior counseling?

For what reason(s) did you seek counseling?

Were you given a diagnosis? If so, what?

What did you find most helpful in counseling?

What did you find least helpful in counseling?

Name _____ Date: _____ Date of Birth: _____

0 Never or normal **1** Sometimes or mild **2** Often or moderate **3** Usually or severe

P in the past, not now **N/A** Not Applicable Some questions require a **YES** or **NO** response or **Frequency numbers**

Please ask for clarification if you are unclear about what the question is asking. Some questions are repeated.

To what extent do you consider each of the following a problem for yourself?

Decreased or irritable mood		History of Trauma	
Weight loss or gain		Nightmares (about):	
Appetite disorder		Intrusive Memories	
Fatigue, low energy level		Flashbacks	
Low self esteem		Body memories	
Feelings of hopelessness		Intense distress when reminded of trauma	
Feelings of worthlessness		Avoidance of reminders of trauma	
Poor concentration		Partial amnesia about trauma	
Indecisiveness		Developmental regressions	
Loss of interest/pleasure		Loss of sense of future	
Observable agitation		Feeling estranged from others	
Slowing down of physical and/or emotional response		Difficulty falling asleep	
Excessive guilt		Anger outburst	
Suicide threats, wishes, plans		Hypervigilance	
Self-harming urged, behaviors:		Exaggerated startle response	
		Unexpected panic attack, not triggered by social focus	
		Frequency:	
Excessive worrying about 2 or more life circumstances		Persistent fear of having another attack	
		Shortness of breath or smothering sensations	
Examples: school, job, finances, marriage, kids, etc.		Trembling or shaking	
Content of worries:		Sweating	
Trembling, twitching, or feeling shaky		Choking	
Muscle tension, aches, or soreness		Nausea or abdominal distress	
Restlessness		Depersonalization or derealization (feeling of	
Easy fatigability		being outside your body, surreal)	
Shortness of breath or smothering sensations		Numbness or tingling sensations	
Palpitations or accelerated heart rate		Flushes (hot flashes) or chills	
Sweating, or cold clammy hands		Chest pain or discomfort	
Dry mouth		Fear of dying	
Dizziness or lightheadedness		Fear of going crazy or doing something uncontrolled	
Nausea, diarrhea, or other abdominal distress		Fear of or severe difficulty leaving your house	
Flushes (hot flashes) or chills		Unusually high mood, expansive	
Frequent urination		Unusually irritable mood	
Trouble swallowing or "lump in throat"		Decreased need for sleep	
Feeling keyed up or on edge		Hypertalkative, feel pressured to keep talking	
Exaggerated startle response		Feel like thoughts are racing	
Difficulty concentrating or "mind going blank"		Easily distracted	
Trouble falling or staying asleep		Observable agitation	
Irritability		Unusually high activity level	
Any unusual stressors within the past 3 months		Out-of-character behavior	
List:		Examples: buying sprees, sexual indiscretion, etc.	
Impairment in school, work or social performance		Occupational functioning impaired by high mood	
Symptoms in excess of expected reaction to stressor			

Name _____ Date: _____

- Any concerns about your use of prescription drugs ☐
- Any concerns about your use of street drugs ☐
- Any concerns about your use of alcohol ☐
- Have you tried to quit/cut down ☐
- Frequency of intoxication ☐
- Any withdrawal symptoms ☐
- Any losses due to use (license, jobs, money, etc.) ☐
- Developed any tolerance symptoms ☐
- Repetitive intrusive thoughts or impulses ☐
- Efforts to suppress them
- Content:
- Feel driven to repeat behavior to avoid something bad ☐
- Behavior feels excessive, unreasonable ☐
- Delusions-firmly holding beliefs that others typically do not and in spite of contradictory information ☐
- Hallucinations-sensory experiences that others in the same environment are not experiencing ☐
- Difficulty making sense of your own thoughts ☐

_____

- Spirituality concerns: ☐

- Concerns about connecting with faith community ☐
- Concerns centered around the meaning of life ☐
- Difficulty with sense of purpose, passion ☐
- Major life transition; (birth, death, job change, retirement, graduation, medical diagnosis, move) ☐

- Persistent fear of scrutiny by others ☐
- Fear of publically doing something humiliating/ embarrassing ☐
- Feared situation is avoided, or endured with intense anxiety ☐
- Avoidant behavior interferes with normal functioning ☐
- Persistent fears of other specific objects or situations ☐
- List:
- Listed fear is avoided, or endured with intense anxiety ☐
- Avoidant behavior interferes with normal functioning ☐
- Difficulty adhering to medication regiment ☐
- Side effects from medication ☐
- Low sexual desire ☐
- Impairment in sexual functioning ☐
- Orgasm difficulty ☐
- Preoccupation with sex ☐
- Sexual compulsivity ☐
- Hormonal fluctuations ☐
- Premenstrual symptoms: ☐

- Post-partum symptoms: ☐

- Financial concerns ☐
- Legal concerns ☐
- Other concerns not covered: ☐

Have you utilized psychiatric services? Yes ◯ No ◯ Was it helpful? Yes ◯ No ◯

Have you taken medication for any psychological health concerns? Yes ◯ No ◯ If so, please list below:

Name of medication	Dosage	Dates Taken	Is it helping? Yes or No

Other medical concerns requiring surgery, treatment, or hospitalization? Please describe:

Your signature below indicates that you have read the entire Confidential Questionnaire, understand the content, and agree to abide by its terms during our professional relationship. Your signature also indicates you have had an opportunity to ask questions about this material and how it applies to my situation, and that you have been offered the HIPAA MN Notice Form (see below)

Partner I Signature _____ Date _____

CONFIDENTIAL QUESTIONNAIRE

Partner II

Single ◯ Partnered ◯ Married ◯ Divorced ◯ Total # of Marriages

Length of current marriage/relationship

Assessment of current relationship: Good ◯ Fair ◯ Poor ◯

Religious Affiliation/Spirituality:

Ethnic/Cultural Identification:

EDUCATION

Years of Education

Completed: High School/GED ◯ Vocational ◯ College ◯ Graduate School ◯ Doctorate ◯

Other Training

Special Circumstances

MILITARY

Do you have a history of serving in the military? Please explain.

YOUR REASON FOR SEEKING THERAPY TODAY

Who referred you to Megan A. Jankord, MA, LMFT?

May I acknowledge this referral?

Their email or phone number with which to acknowledge the referral

Briefly describe the problem or concern for which you, your child or adolescent would like addressed in counseling.

Who is the Person/Issue you are most concerned about and why?

Why do you think these challenges are present for you or your relationship? How long have they been present?

What is the main goal(s) for today's session?

What are your ideas on how that goal might be accomplished?

What attempts have you made in the past to challenge these concerns?

If the work that we did together was helpful or successful, how would you know? What would be different in your life?

If the work that we did together was helpful or successful, what might be different in your life and the lives of others close to you?

LIST OF CURRENT CHALLENGES & SYMPTOMS

Listed below are possible challenges you might be experiencing. Please rate each according to the degree you might be experiencing any of these. Click the scaling number to indicate the current intensity and explain briefly, what specifically makes any of these a concern?

(Low) 1 2 3 4 5 6 7 8 9 10 (High)

Depression?

Thoughts/Actions of Self-Injury or Self-Harm? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Worry/Anxiety? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Family/Relational Conflict? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Verbal Harm/Behavior/Threat? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Sexual Harm/Behavior/Threat? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Physical Harm/Behavior/Threat? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Legal Challenge(s)? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Internet Usage Challenges? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Alcohol/Chemical Health Challenges? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Gambling Challenges? (Low) ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 (High)

Spiritual/Faith Concerns? (Low) ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 (High)

Other Concerns? (Low) ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 (High)

COUNSELING & MEDICAL HISTORY

Have you previously worked with a counselor or therapist? Yes ○ No ○
If so, where and with whom:

Approximate dates of prior counseling?

For what reason(s) did you seek counseling?

Were you given a diagnosis? If so, what?

What did you find most helpful in counseling?

What did you find least helpful in counseling?

Name _____ Date: _____ Date of Birth: _____

0 Never or normal **1** Sometimes or mild **2** Often or moderate **3** Usually or severe

P in the past, not now **N/A** Not Applicable Some questions require a **YES** or **NO** response or **Frequency numbers**

Please ask for clarification if you are unclear about what the question is asking. Some questions are repeated.

To what extent do you consider each of the following a problem for yourself?

Decreased or irritable mood		History of Trauma	
Weight loss or gain		Nightmares (about):	
Appetite disorder		Intrusive Memories	
Fatigue, low energy level		Flashbacks	
Low self esteem		Body memories	
Feelings of hopelessness		Intense distress when reminded of trauma	
Feelings of worthlessness		Avoidance of reminders of trauma	
Poor concentration		Partial amnesia about trauma	
Indecisiveness		Developmental regressions	
Loss of interest/pleasure		Loss of sense of future	
Observable agitation		Feeling estranged from others	
Slowing down of physical and/or emotional response		Difficulty falling asleep	
Excessive guilt		Anger outburst	
Suicide threats, wishes, plans		Hypervigilance	
Self-harming urged, behaviors:		Exaggerated startle response	
		Unexpected panic attack, not triggered by social focus	
		Frequency:	
Excessive worrying about 2 or more life circumstances		Persistent fear of having another attack	
		Shortness of breath or smothering sensations	
Examples: school, job, finances, marriage, kids, etc.		Trembling or shaking	
Content of worries:		Sweating	
Trembling, twitching, or feeling shaky		Choking	
Muscle tension, aches, or soreness		Nausea or abdominal distress	
Restlessness		Depersonalization or derealization (feeling of	
Easy fatigability		being outside your body, surreal)	
Shortness of breath or smothering sensations		Numbness or tingling sensations	
Palpitations or accelerated heart rate		Flushes (hot flashes) or chills	
Sweating, or cold clammy hands		Chest pain or discomfort	
Dry mouth		Fear of dying	
Dizziness or lightheadedness		Fear of going crazy or doing something uncontrolled	
Nausea, diarrhea, or other abdominal distress		Fear of or severe difficulty leaving your house	
Flushes (hot flashes) or chills		Unusually high mood, expansive	
Frequent urination		Unusually irritable mood	
Trouble swallowing or "lump in throat"		Decreased need for sleep	
Feeling keyed up or on edge		Hypertalkative, feel pressured to keep talking	
Exaggerated startle response		Feel like thoughts are racing	
Difficulty concentrating or "mind going blank"		Easily distracted	
Trouble falling or staying asleep		Observable agitation	
Irritability		Unusually high activity level	
Any unusual stressors within the past 3 months		Out-of-character behavior	
List:		Examples: buying sprees, sexual indiscretion, etc.	
Impairment in school, work or social performance		Occupational functioning impaired by high mood	
Symptoms in excess of expected reaction to stressor			

Name _____ Date: _____

- Any concerns about your use of prescription drugs
- Any concerns about your use of street drugs
- Any concerns about your use of alcohol
- Have you tried to quit/cut down
- Frequency of intoxication
- Any withdrawal symptoms
- Any losses due to use (license, jobs, money, etc.)
- Developed any tolerance symptoms
- Repetitive intrusive thoughts or impulses
- Efforts to suppress them
- Content:
- Feel driven to repeat behavior to avoid something bad
- Behavior feels excessive, unreasonable
- Delusions-firmly holding beliefs that others typically do not and in spite of contradictory information
- Hallucinations-sensory experiences that others in the same environment are not experiencing
- Difficulty making sense of your own thoughts

- Spirituality concerns:

- Concerns about connecting with faith community
- Concerns centered around the meaning of life
- Difficulty with sense of purpose, passion
- Major life transition; (birth, death, job change, retirement, graduation, medical diagnosis, move)

- Persistent fear of scrutiny by others
- Fear of publically doing something humiliating/ embarrassing
- Feared situation is avoided, or endured with intense anxiety
- Avoidant behavior interferes with normal functioning
- Persistent fears of other specific objects or situations
- List:
- Listed fear is avoided, or endured with intense anxiety
- Avoidant behavior interferes with normal functioning
- Difficulty adhering to medication regiment
- Side effects from medication
- Low sexual desire
- Impairment in sexual functioning
- Orgasm difficulty
- Preoccupation with sex
- Sexual compulsivity
- Hormonal fluctuations
- Premenstrual symptoms:

- Post-partum symptoms:

- Financial concerns
- Legal concerns
- Other concerns not covered:

Have you utilized psychiatric services? Yes No Was it helpful? Yes No

Have you taken medication for any psychological health concerns? Yes No If so, please list below:

Name of medication	Dosage	Dates Taken	Is it helping? Yes No

Other medical concerns requiring surgery, treatment, or hospitalization? Please describe:

Your signature below indicates that you have read the entire Confidential Questionnaire, understand the content, and agree to abide by its terms during our professional relationship. Your signature also indicates you have had an opportunity to ask questions about this material and how it applies to my situation, and that you have been offered the HIPAA MN Notice Form (see below)

Partner II Signature_____ Date _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half of the days	Nearly every day
1. Little interest or pleasure in doing things	○ 0	○ 1	○ 2	○ 3
2. Feeling down, depressed, or hopeless	○ 0	○ 1	○ 2	○ 3
3. Trouble falling or staying asleep, or sleeping too much	○ 0	○ 1	○ 2	○ 3
4. Feeling tired or having little energy	○ 0	○ 1	○ 2	○ 3
5. Poor appetite or overeating	○ 0	○ 1	○ 2	○ 3
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	○ 0	○ 1	○ 2	○ 3
7. Trouble concentrating on things, such as reading the newspaper or watching television	○ 0	○ 1	○ 2	○ 3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	○ 0	○ 1	○ 2	○ 3
9. Thoughts that you would be better off dead, or of hurting yourself	○ 0	○ 1	○ 2	○ 3
Column Totals		+	+	=
	Add totals together			

10. If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people	Not difficult	Some difficulty	Very difficult	Extremely difficult
	○	○	○	○

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half of the days	Nearly every day
1. Feeling nervous, anxious, or on edge	○ 0	○ 1	○ 2	○ 3
2. Not being able to stop or control worrying	○ 0	○ 1	○ 2	○ 3
3. Worrying too much about ifferent things	○ 0	○ 1	○ 2	○ 3
4. Trouble relaxing	○ 0	○ 1	○ 2	○ 3
5. Being so restless that it is hard to sit still	○ 0	○ 1	○ 2	○ 3
6. Becoming easily annoyed or irritable	○ 0	○ 1	○ 2	○ 3
7. Feeling afraid as if something awful might happen	○ 0	○ 1	○ 2	○ 3
Column Totals		+	+	=
		Add totals together		

8. If you have checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people	Not difficult	Some difficulty	Very difficult	Extremely difficult

When thinking about drug use, including illegal drug use and perscription drug use other thanprescribed (in the last 12 months):	Yes	No
1. Have you ever felt that you ought to cut down on your drinking or drug use?		
2. Have people annoyed you by criticizing your drinking or drug use?		
3. Have you felt bad or guilty about your drinking or drug use?		
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?		

HIP**AA MINNESOTA NOTICE FORM**
Notice of Parkdale Therapy Group, LLC
Policies and Practices to Protect the Privacy of Client Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes withyour consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment, Payment, and Health Care Operations"
  - Treatment is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or a psychologist.
  - Payment is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters, such as audits and administrative services, and case management and care coordination.
- "Use" applies only to activities within my [office, clinic, practice group, etc.], such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. "Psychotherapy notes" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given different protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If I know or have reason to believe a child is being neglected or physically or sexually abused or has been neglected or physically or sexually abused within the preceding three years, I must immediately report the information to the local welfare agency, police or sheriff's department.

- **Adult and Domestic Abuse:** If I have reason to believe that a vulnerable adult is being or has been maltreated, or if I have knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained, I must

- Immediately report the information to the appropriate agency in this county. I may also report the information to a law enforcement agency.

"Vulnerable adult" means a person who, regardless of residence or whether any type of service is received, possesses a physical or mental infirmity or other physical, mental, or emotional dysfunction:

(i) that impairs the individual's ability to provide adequately for the individual's own care without assistance, including the provision of food, shelter, clothing, health care, or supervision; and
(ii) because of the dysfunction or infirmity and the need for assistance, the individual has an impaired ability to protect the individual from maltreatment.

- **Health Oversight Activities:** The Minnesota Board of Marriage and Family Therapy or Board of Behavioral Health may subpoena records from me if they are relevant to an investigation it is conducting.

- **Judicial and Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about the professional services that I have provided you and/or the records thereof, such information is privileged under state law and I must not release this information without written authorization from you or your legally appointed representative, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. I will inform you in advance if this is the case.

- **Serious Threat to Health or Safety:** If you communicate a specific, serious threat of physical violence against a specific,clearly identified or identifiable potential victim, I must make reasonable efforts to communicate this threat to the potential victim or to a law enforcement agency. I must also do so if a member of your family or someone who knows you well has reason to believe you are capable of and will carry out the threat. I also may disclose information about you necessary to protect you from a threat to commit suicide.

- **Worker's Compensation:** If you file a worker's compensation claim, a release of information from me to your employer, insurer, the Department of Labor and Industry or you will not need your prior approval.

IV. Client's Rights and Clinician's Duties

Client's Rights:

- *Right to Request Restrictions* –You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)

- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI (and psychotherapy notes) in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.

- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Clinician's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

- If I revise my policies and procedures, I will send you a copy by mail or give you a copy in session.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact **Ms. Michelle A. Craveiro, MA @ 952-224-0399 ext 102.**

If you believe that your privacy rights have been violated and wish to file a complaint with me/my office, you may send your written complaint to:

Parkdale Therapy Group, LLC
1000 Shelard Parkway, Ste 520
St. Louis Park, MN 55426-1053
952-224-0399 ext 114 Fax 952-224-0396

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice became effective 4/14/03

We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by mail or in session.