



**Patient Information**  
(Please print clearly)

PATIENT'S NAME \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ Last First Middle

Minor  Unmarried  Married  Separated  Divorced  Widowed

Address \_\_\_\_\_ Cell # \_\_\_\_\_

\_\_\_\_\_ Number & Street City State Zip

Occupation \_\_\_\_\_ Work # \_\_\_\_\_

Patient's Employer \_\_\_\_\_ Email \_\_\_\_\_

\_\_\_\_\_ Name

\_\_\_\_\_ Employer Address

SPOUSE OR PARENT'S NAME \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Spouse or Parent's Employer \_\_\_\_\_ Cell # \_\_\_\_\_

\_\_\_\_\_ Name

\_\_\_\_\_ Employer Address

\_\_\_\_\_ Work # \_\_\_\_\_ Email \_\_\_\_\_

\_\_\_\_\_ Occupation

CLOSEST FRIEND OR RELATIVE NOT LIVING AT YOUR HOME, TO CONTACT IN EVENT OF EMERGENCY

Name \_\_\_\_\_ Phone # \_\_\_\_\_

\_\_\_\_\_ Last First Middle Relationship

Address \_\_\_\_\_

\_\_\_\_\_ Number & Street City State Zip

REFERRED BY \_\_\_\_\_ Phone # \_\_\_\_\_

\_\_\_\_\_ Name Address Relationship

Have you or any member of your family ever been treated by Building Bridges CC?  No  Yes When (approximately) \_\_\_\_\_

**INSURANCE**  
Building Bridges Christian Counseling's policy is that **all fees for counseling are to be paid in full at the time of each session.** Any exceptions must be made in writing. We are willing to assist in your efforts to bill your insurance carrier. If you are seeing a pre-licensed counselor it is very likely that your insurance carrier will not cover services rendered by the pre-licensed counselor.

**FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT**  
I authorize treatment for the person(s) named above and agree to pay all fees and charges for such treatment at the time of service. I agree to pay all charges for me and members of my family shown by statements, promptly upon presentment, unless credit arrangements are agreed upon in writing. I agree to pay a \$20 charge for each returned check.

I give my permission to **allow referring person or agency to be thanked** for referring me to Building Bridges Christian Counseling. I further give permission to **place my name on the mailing list** so that I may be informed of upcoming events, services, or resources. **Building Bridges CC's** mailing list will not be given or sold to any other individual or agency.

I understand that all CANCELLATIONS MUST BE MADE 24 HOURS IN ADVANCE OTHERWISE A CHARGE OF \$45 WILL BE MADE. I will be fully responsible for such charges.

Signature(s) \_\_\_\_\_ Date \_\_\_\_\_

Signature(s) \_\_\_\_\_ Date \_\_\_\_\_



### BISCHOF ADULT SYMPTOM INVENTORY

NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

DATE OF TEST \_\_\_\_\_

CIRCLE THE NUMBER THAT BEST DESCRIBES THE DEGREE OF DIFFICULTY YOU HAVE BEEN EXPERIENCING IN EACH AREA RECENTLY.

0 = No Difficulty    1 = A Little    2 = Moderate    3 = Quite a Bit    4 = Extreme

|    |  |   |   |   |   |   |
|----|--|---|---|---|---|---|
| 1  | Depressed mood, hopelessness.  | 0 | 1 | 2 | 3 | 4 |
| 2  | Fatigue, loss of energy, drive, or motivation.   | 0 | 1 | 2 | 3 | 4 |
| 3  | Suicidal thoughts or behavior.   | 0 | 1 | 2 | 3 | 4 |
| 4  | Poor concentration, difficulty making decisions.   | 0 | 1 | 2 | 3 | 4 |
| 5  | Loss of appetite.  | 0 | 1 | 2 | 3 | 4 |
| 6  | Sleep disturbance.   | 0 | 1 | 2 | 3 | 4 |
| 7  | Body aches and pains, dizziness.   | 0 | 1 | 2 | 3 | 4 |
| 8  | Restlessness or feeling keyed-up, on edge.   | 0 | 1 | 2 | 3 | 4 |
| 9  | Fearful or anxious about upcoming situations or events.  | 0 | 1 | 2 | 3 | 4 |
| 10 | Managing life transitions (e.g., the loss of primary relationship, changes in family, job, health or school, death). | 0 | 1 | 2 | 3 | 4 |
| 11 | Episodes of terror or panic.   | 0 | 1 | 2 | 3 | 4 |
| 12 | Unwanted persistent and intrusive thoughts.  | 0 | 1 | 2 | 3 | 4 |
| 13 | Hearing voices, seeing things.   | 0 | 1 | 2 | 3 | 4 |
| 14 | Socially isolated because of thoughts or beliefs that are not acceptable.  | 0 | 1 | 2 | 3 | 4 |
| 15 | Behavior considered eccentric or "different".  | 0 | 1 | 2 | 3 | 4 |
| 16 | Feelings of worthlessness.   | 0 | 1 | 2 | 3 | 4 |
| 17 | Feeling you are in control of your own life.   | 0 | 1 | 2 | 3 | 4 |
| 18 | Being yourself, expressing your feelings.  | 0 | 1 | 2 | 3 | 4 |
| 19 | Lack of self-confidence, feeling critical of yourself.   | 0 | 1 | 2 | 3 | 4 |

CIRCLE THE NUMBER THAT BEST DESCRIBES THE DEGREE OF DIFFICULTY YOU HAVE BEEN EXPERIENCING IN EACH AREA RECENTLY.

|    |  |   |   |   |   |   |
|----|--|---|---|---|---|---|
| 20 | Able to pursue and enjoy personal interests and activities.  | 0 | 1 | 2 | 3 | 4 |
| 21 | Relationship with family.  | 0 | 1 | 2 | 3 | 4 |
| 22 | Being able to get along with others.   | 0 | 1 | 2 | 3 | 4 |
| 23 | Feeling lonely even when you are with people.  | 0 | 1 | 2 | 3 | 4 |
| 24 | Feeling misunderstood or mistreated by others.   | 0 | 1 | 2 | 3 | 4 |
| 25 | Function on your job or at school to your full potential.  | 0 | 1 | 2 | 3 | 4 |
| 26 | Able to maintain focus on task get things accomplished.  | 0 | 1 | 2 | 3 | 4 |
| 27 | Job/career not going well (e.g., wrong job, no progress, difficulty with co-worker or boss).                 | 0 | 1 | 2 | 3 | 4 |
| 28 | Maintaining good work/school evaluations (e.g., attendance, evaluations, performance statistics, standards). |   |   |   |   |   |
| 29 | Volatile, aggressive, violent behavior.  | 0 | 1 | 2 | 3 | 4 |
| 30 | Moody, emotional, driven by your feelings.   | 0 | 1 | 2 | 3 | 4 |
| 31 | Overly sensitive, easily hurt or upset.  | 0 | 1 | 2 | 3 | 4 |
| 32 | Feeling easily annoyed or irritated.   | 0 | 1 | 2 | 3 | 4 |
| 33 | Temper outbursts that you cannot control.  | 0 | 1 | 2 | 3 | 4 |
| 34 | Pains in heart or chest.   | 0 | 1 | 2 | 3 | 4 |
| 35 | Nausea, upset stomach.   | 0 | 1 | 2 | 3 | 4 |
| 36 | Trouble getting your breath.   | 0 | 1 | 2 | 3 | 4 |
| 37 | Feeling weakness in part of your body.   | 0 | 1 | 2 | 3 | 4 |

RATE DIFFICULTY OVER THE PREVIOUS SIX MONTHS.

|    |  |   |   |   |   |   |
|----|--|---|---|---|---|---|
| 38 | Recurrent misuse of prescription or illegal drugs.   | 0 | 1 | 2 | 3 | 4 |
| 39 | Diminished effectiveness in major life roles (work, school, or home) resulting from use of drugs or alcohol. | 0 | 1 | 2 | 3 | 4 |
| 40 | Recurrent use of substances in situations that are hazardous or potentially self-defeating.                  | 0 | 1 | 2 | 3 | 4 |
| 41 | Recurrent hangovers or withdrawal symptoms when attempting to cut back or stop the use of alcohol or drugs.  | 0 | 1 | 2 | 3 | 4 |



## **Confidentiality Policy**

Confidentiality and privileged communication remain the rights of all clients of professional counselors according to law. However, there are limits such as communication some of which are mandated by state law. It is very important that you and those seeking counseling with you carefully read and understand the following limits of confidentiality.

### **Duty to Warn**

Some courts have held that if an individual intends to take harmful, dangerous, or criminal action against another human being, or against themselves, it is the counselor's duty to warn appropriate individuals of such intentions. Those warned may include a variety of persons such as:

1. The person or the family of the person who is likely to suffer the results of harmful behavior.
2. The family of the client who intends to harm him/herself or someone else.
3. Associates or friends of those threatened or making threats.
4. Law enforcement and medical emergency officials.

### **Child Abuse**

California State Law mandates the reporting of incidence or *suspected* incidence of child abuse including physical abuse, sexual abuse, unlawful sexual intercourse, neglect, emotional and psychological abuse. All actual or suspected acts of child abuse will need to be reported to the appropriate agencies. (Article 2.5 Penal Code 11165 and 11166)

### **“Dependent Adult” and Elder Abuse**

California law requires the incidence of “dependent adult” or elder physical abuse reported to your counselor must also be reported to California authorities. (Welfare and Institutional Code, Sec. 15630)

### **Therapeutic Criminal Involvement**

The State Law in the Evidence Code 1018 reads that “There is no privilege (confidentiality) under this article if the services of the psychotherapist were sought or obtained to enable or aid anyone to commit or plan to commit a crime or a tort or to escape detection or apprehension after the commission of a crime or a tort.” (Evidence Code 1024, 1965. Chp. 299)

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## **Family and Couple Therapy**

Family members and couples may be seen at times individually or conjointly. Information shared during these sessions or in related settings (e.g., telephone calls) is considered part of the overall family or couple therapy process and is not confidential from the other participating family members or partners. Your therapist will use his or her discretion in handling these matters. This is simply our “no secrets” policy. It is important that you understand this policy before treatment begins. It supports our belief that healthy relationships are built on openness and truth.

## **Case Evaluation**

In order to ensure the best treatment possible for each client, your counselor may consult with other professional counselors regarding cases. This is traditional in both out-patient and in-patient counseling facilities and is referred to as “case conference” or “peer review”. If you have any concerns regarding this practice, please notify your therapist.

## **Neglect of Outstanding Debt**

In the event a client fails to honor, after reasonable efforts to collect his/her debt, we may place the account in the hands of an agency or attorney for collection or legal action. This will necessitate the release of pertinent demographic information as accounting information.  
**NO THERAPEUTIC INFORMATION WILL BE RELEASED.**

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Please be sure that you have read the above very carefully. If you are not sure that you fully understand any of the above areas of confidentiality limitations, please ask your counselor before you sign below.

I/We the undersigned, have read and fully understand the limits of my/our confidentiality. I/We further agree to abide by the policy set out above. I/We have had a chance to ask my/our counselor for additional clarification regarding the limits of confidentiality.

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|           |      |           |      |
|-----------|------|-----------|------|
| Signature | Date | Signature | Date |
|-----------|------|-----------|------|

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| Signature | Date | Signature | Date |
|-----------|------|-----------|------|