Linda Carroll-Barraud, MS, LMFT, BCC

Board Certified Life Coach

Board Certified COACH™

CLIENT INFORMATION

CLIENT FULL NAME		DATE OF BIRTH	SSN
ADDRESS		CITY/STATE/ZIP	
HOME PHONE	CELL PHONE	WORK PHONE	INDICATE BEST # TO LEAVE MESSAGE ☐ HOME ☐ CELL ☐ WORK
EMAIL ADDRESS If you do NOT wish to be included on our mailing list, check here ☐		OK TO DISCUSS SCHEDULING VIA EMAIL? ☐ YES ☐ NO OK TO SEND RECEIPTS OR STATEMENTS VIA EMAIL? ☐ YES ☐ NO	

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED ☐ OTHER

EMPLOYMENT STATUS ☐ FULL-TIME ☐ PART-TIME ☐ SELF-EMPLOYED ☐ RETIRED ☐ ACTIVE MILITARY

GENDER ☐ MALE ☐ FEMALE ☐ TRANS

EMERGENCY CONTACT

EMERGENCY CONTACT NAME	EMERGENCY CONTACT PHONE	RELATIONSHIP TO CLIENT

RESPONSIBLE PARTY (if different than client)

BILLING FULL NAME		RELATIONSHIP TO CLIENT
BILLING ADDRESS		CITY/STATE/ZIP
BILLING PHONE	LEAVE MSG? ☐ YES ☐ NO	EMAIL ADDRESS

FEES FOR SERVICES – **PLEASE CHECK ONE**

☐ One Session (45 minutes)	$200
☐ 5-Session Package (save $50)	$950
☐ 11-Session Package (for the price of 10)	$1,900
☐ 20-Session Package (save $500)	$3,500

Note: If necessary, travel expenditures will be charged separately

SERVICES VALID FOR ONE YEAR FROM DATE OF PURCHASE

CANCELLATION POLICY

ALL SESSIONS ARE NON-TRANSFERABLE.

If you fail to cancel a scheduled appointment, this time cannot be used for another client and you will be billed for the entire cost of your missed appointment. A full session is charged for missed appointments or cancellations with less than 24 hour notice unless due to illness or emergency. Thank you for your cooperation in this matter.

FULL PAYMENT IS DUE IN FULL AT THE BEGINNING OF SESSION PLAN

	EXP DATE	CVV CODE	
CARD NUMBER			If you would prefer to be billed via Paypal or iSquare, please provide credit card and check this box: ☐
CARDHOLDER NAME			
I hereby give consent to charge my credit card listed above for any outstanding balance such as deductibles, co-payments, fees or other amounts my carrier determines as payable by me.			
CARDHOLDER SIGNATURE		DATE	

1242 NW Hillcrest Drive ▪ Corvallis, Oregon 97330 ▪ 541.758.4118 ▪ fax 541.758.3214 ▪ www.lindaacarroll.com

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AUTHORIZATION FOR RELEASE OF INFORMATION

To Our Clients
We can help you better if we are able to work with other professionals that know you and your family. By signing this form, you are giving permission for those listed to share information about your situation.

Name _____ Date of birth _____

I authorize the following individuals or agencies to exchange information with Linda Carroll-Barraud, MS, LMFT, BCC:

_____

_____

Purpose
The information received will be used to better serve in helping in planning and coordinating services for me and my family, or for other purposes, as specified:

_____

_____

Only information necessary to assist in the process of my care will be exchanged. This permission is good for one year, or until

_____. I can cancel this at any time, but I understand that the cancellation will not affect any information that was already released before the cancellation. I understand that information about my case is confidential and protected by state and federal law. I approve the release of this information. I understand what this agreement means. I am signing on my own and have not been pressured to do so.

Client Signature _____ Date _____

Life Coach Signature _____ Date _____

To those Receiving Information Under this Authorization
This information disclosed to you is protected by state and federal law. You are not authorized to release it to any agency or person not listed on this form without specific written consent of the person to whom it pertains unless authorized by other laws.

LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect / when a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. N cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults / if a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances / mental health care professional are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship / parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

Client Signature _____ Date _____
(client's parent/guardian if under 18)

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INTAKE FORM

Please provide the following information and answer the questions below. Please note: Information you provide here is protected as confidential information.

CLIENT FULL NAME			DATE OF BIRTH	AGE
ADDRESS			CITY/STATE/ZIP	
HOME PHONE	CELL PHONE	WORK PHONE	INDICATE BEST # TO LEAVE MESSAGE ☐ HOME ☐ CELL ☐ WORK	
EMAIL ADDRESS			OK TO DISCUSS SCHEDULING VIA EMAIL? ☐ YES ☐ NO OK TO SEND RECEIPTS OR STATEMENTS VIA EMAIL? ☐ YES ☐ NO	

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
☐ NO
☐ YES, previous therapist/practitioner: _____

Are you currently taking any prescription medication? ☐ NO ☐ YES

If YES, please list _____

Have you ever been prescribed psychiatric medication? ☐ NO ☐ YES

If YES, please list and provide dates _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (Please circle)

POOR UNSATISFACTORY SATISFACTORY GOOD VERY GOOD

2. How would you rate your current sleeping habits? (Please circle)

POOR UNSATISFACTORY SATISFACTORY GOOD VERY GOOD

3. How many times per week do you generally exercise? _____

What types of exercise to you participate in? _____

4. Please list any difficulties you experience with your appetite or eating patterns: _____

_____

5. Are you currently experiencing overwhelming sadness, grief, or depression? ☐ NO ☐ YES

If yes, for how long? _____

6. Are you currently experiencing anxiety or panic attacks or have any phobias? ☐ NO ☐ YES

If yes, when did this begin? _____

7. Are you currently experiencing any chronic pain? ☐ NO ☐ YES

If yes, please describe _____

8. Do you drink alcohol more than once per week? ☐ NO ☐ YES

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9. Are you now, or have you any family members been concerned about your drug or alcohol intake? ☐ NO ☐ YES

If yes, please explain _____

10. How often do you engage in recreational drug use?
☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never

11. Are you currently in a romantic relationship? ☐ NO ☐ YES

If yes, for how long? _____ On a scale of 1-10, how would you rate your relationship?_____

12. What significant life changes or stressful events have you experienced recently?

_____

_____

_____

FAMILY MENTAL HEALTH HISTORY

	PLEASE CIRCLE		LIST FAMILY MEMBER
Alcohol/substance abuse	YES	NO	_____
Anxiety	YES	NO	_____
Depression	YES	NO	_____
Domestic violence	YES	NO	_____
Eating disorders	YES	NO	_____
Obesity	YES	NO	_____
Obsessive compulsive behavior	YES	NO	_____
Schizophrenia	YES	NO	_____
Suicide attempts	YES	NO	_____

ADDITIONAL INFORMATION

1. Are you currently employed? ☐ NO ☐ YES

If yes, what is your current employment situation? _____

_____

_____

Do you enjoy your work? Is there anything stressful about your current work? _____

_____

_____

2. Do you consider yourself to be spiritual or religious? ☐ NO ☐ YES

If yes, please describe your faith or belief: _____

_____

_____

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3. What do you consider to be some of your strengths?

4. What do you consider to be some of your weaknesses?

5. What would you like to accomplish out of your time in therapy?

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PROFESSIONAL DISCLOSURE STATEMENT

Philosophy and Approach to Counseling
My approach is eclectic and multi-disciplinary. It includes a strong base of clinical skills in a psychodynamic mode along with an emphasis in interpersonal communication, psychoeducation and transpersonal psychology. I work closely with the client – setting goals and expectations together and regularly reviewing them. When I see evidence of a biological basis for symptoms, I work with a physician or naturopath. I refer often to other community resources including education systems, support groups, spiritual resources and various healthcare professionals. My training has focused on couples counseling, and I have extensive training with PAIRS International, Inc., and am a Master PAIRS Teacher. I am a trained IMAGO therapist (the work of Harville Hendrix), and have studied extensively with Drs. Hal and Sidra Stone in couple's work.

Formal Education and Training
- Bachelor of Science in Community Service & Public Affairs, University of Oregon, 1977
- Master of Science in Counseling, Oregon State University, 1983
- Three-year post-graduate training in Counseling, Oregon State University, 1983
- Completed 90 hours of credit toward doctoral degree
- Completed one-year program with Institute of Transpersonal Psychology receiving a Certificate in Transpersonal Psychology, 1987
- Licensed Marriage and Family Therapist #T0380 – this carries continuing education requirements of 20 hours each year
- National Certified Clinical Mental Health Counselor #04133 by the National Board of Certified Counselors – this carries continuing education requirements of 100 hours in a five-year period
- Certified counseling supervisor since 1992
- Board certified Life Coach

Code of Ethics
As a licensee of the Oregon State Board of Licensed Professional Counselors and Therapists, I abide by its Code of Ethics.

Continuing Education/Supervision
To maintain my license I am required to participate in 20 hours of annual continuing education. I seek training to improve both the art and science of my work. I consult with a Clinical Supervisor on a regular basis, as well as consulting with other professionals as needed.

Client Rights
As a client of an Oregon licensee you have the following rights:
1. To expect that the licensee has met minimal qualifications of training and experience as required by state law.
2. To examine public records maintained by the Board and to have the Board confirm credentials of a licensee.
3. To obtain a copy of the Code of Ethics.
4. To report complaints to the Board
5. To be informed of the cost of professional services before receiving the services.
6. To be assured of privacy and confidentiality while receiving services as defined by rule and law, including the following exceptions:
   + Reporting suspected child abuse
   + Reporting imminent danger to client or others
   + Reporting information required in court proceedings or by client's insurance company or to other relevant agencies.
   + Providing information concerning licensee case consultation or supervision
   + Defending claims brought by client against licensee
7. To be free from being the object of discrimination on the basis of race, religion, gender, or other unlawful category while receiving services.

Board of Licensed Professional Counselors & Therapists / 3218 Pringle St SE, #50, Salem OR 97302
National Board for Certified Counselors / 3D Terrace Way, Greensboro NC 27403

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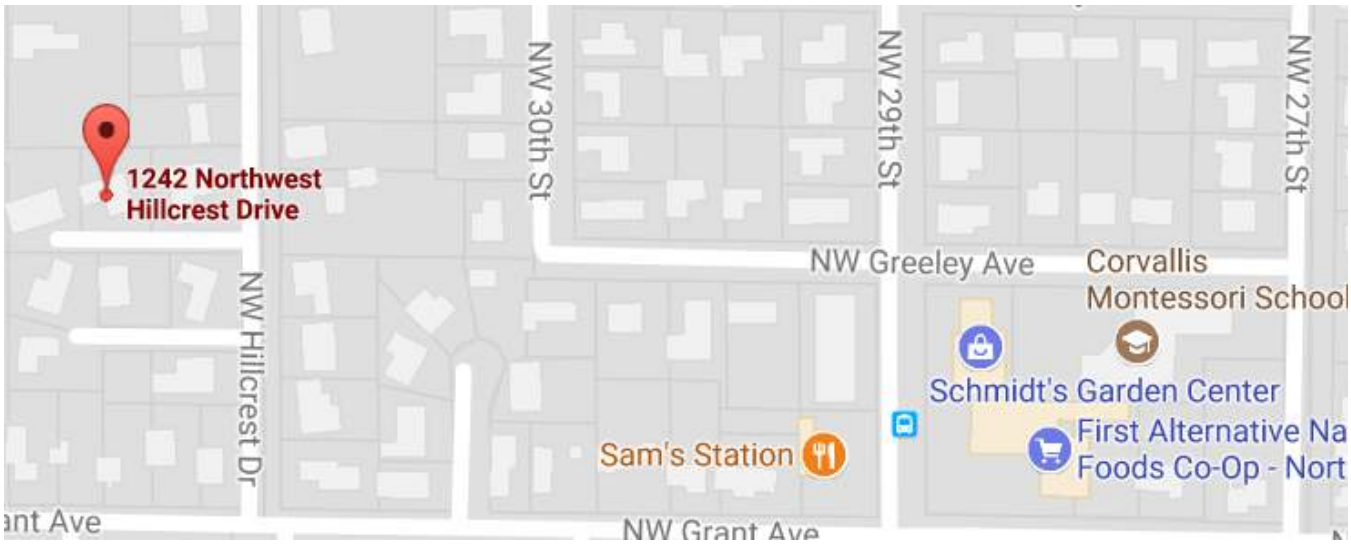

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