# HEALING JOURNEY COUNSELING SERVICES, LLC

***Help on the journey to healing, wholeness, and tranquility.***

1122 O.G. Skinner Drive
West Point, Ga 31833

Phone: 404-800-4048
Fax: (334)-209-2722

## Comprehensive Psychosocial History

Date: _____Referred by:_____ May we thank them: Y/N

Last Name: _____First Name: _____Middle Initial: _____SSN:_____

Address:_____City:_____State_____Zip_____

Occupation: _____ Work Phone_____

Date of Birth: _____Age:_____Male____Female____Married_____Single_____Divorced_____Widowed____Partner____

If minor child-Parents name_____

Home/Mobile Phone:_____Is it ok to leave message for you at this number? Y/N

Email_____Is it ok to email you at this address? Y/N

Racial/Ethnic Identity:_____Religious/denominational Preference:_____

Person to notify in case of emergency: Name_____Phone#_____

If you are using your EAP provide the name and contact information of your EAP company. Your regular insurance should be listed under secondary insurance.

Person to notify in case of emergency: Name:_____Phone # _____

Name of EAP Company_____Authorization Number: _____

Number of sessions authorized: _____

Secondary Insurance: Circle one: HMO PPO MEDICARE MEDICAID TRICARE: STANDARD OR PRIME

Name of Insurance Company_____ Group #_____Authorizations required: Y/N

Policyholder Name: _____ID#_____Policyholder SSN_____

Policyholder Date of Birth _____

Insured's relationship with client: Self_____Spouse_____Child_____Authorization #_____# of sessions authorized_____.

# HEALING JOURNEY COUNSELING SERVICES, LLC

**Client Authorization**

___I authorize the release of any medical or other information necessary to process my insurance claim.

___ I authorize payment of medical benefits to the provider for services. I fully understand that, regardless of insurance coverage, I am legally responsible for all fees due for counseling.

Signature_____Date_____

**Client information**

Reason for seeking counseling: Personal Choice Referral by a physician _____

Court Mandate Terms of Probation Terms of Parole

If court mandated, by which judge_____ Date of order: _____

If for terms of probation or parole, name(s) of P.O. (s): _____

**Section 1**

**Current concerns:**

Presenting Concern: _____

_____

_____

_____

When did this concern begin (give dates)? _____

Have you been in counseling before or received any prior professional assistance for your concerns? If so, please give dates of treatment and results_____

_____

What do you hope to accomplish in counseling? _____

_____

What kind of obstacles could get in the way? _____

_____

Please list any counseling or mental health treatment that you have had in the past (give dates and reasons) _____

Do you have a family history of mental illness, psychiatric hospitalizations, addictions, or nervous breakdowns?

**Section 2**

**Relationship Status:**

Are you currently in a romantic relationship? N / Y If yes, for how long? _____

Current relationship satisfaction Poor 1 2 3 4 5 6 7 8 9 10 Excellent

Describe any problems you are experiencing in the relationship_____

Do you have prior marriages? Y N If yes, how many_____How long were you married? _____
Do you have children? Y N If yes, gender, how many, and ages_____

Describe any problems you are having with your children_____

Describe any problems with family members or friends_____

**Employment Status:**

Employed: Full-time Part-time Self-Employed Unemployed Occupation_____Years on current job_____

Current employment satisfaction Poor 1 2 3 4 5 6 7 8 9 10 Excellent

**Circle Level of Education:** Some High School High School Some College College Degree Technical School

**Section 3 Medical/Health: In the past year have you experienced or are you experiencing any of the following:**

- Head injury or seizures ○ Epilepsy –what type? _____
- Black outs or dizziness ○ Delirium Tremens ○ Exposure to a toxin or poison ○ Chills or

persistent fever ○ Circulatory Problems ○ Poor Circulation ○ Varicose Veins

- Anemia
- Internal bleeding, spitting up blood
- Other blood system disorders_____
- High Blood Pressure ○ Low Blood Pressure
- Heart Problems_____
- Endocrine Problems
- Thyroid
- Diabetes
- Tumors, cyst: benign_____: malignant_____
- Liver or pancreas malfunction
- Kidney or bladder problems (i.e., infections)
- Gastro-intestinal; stomach__: appetite____: esophageal hernia____
- GI Tract: chronic diarrhea: hemorrhoids
- Ulcers
- Irregular menstrual period____; Menopause_____
- Dental Problems
- Glaucoma
- Other uncorrectable visual problems
- Persistent Cough
- Frequent drowsiness
- Frequent periods of breathlessness
- Frequent nervousness
- Frequent headaches
- Frequent nausea
- Nose bleeds
- Asthma
- Allergies_____

- Tuberculosis

Describe any medical problems not mentioned up to this point.

_____
_____

Do you smoke cigarettes/cigars/pipe? _____ How many a day? _____

Are you in recovery from substance abuse or addiction? _____

How much alcohol do you drink in a week? _____

Do you use street drugs? (i.e., pot, heroin, cocaine, methamphetamine, etc.) _____

How often do you use street drugs? _____

Date of your last physical examination: _____

Is your physician aware of the medical problems you described? _____

Physician(s): _____

_____

_____

Medications:

_____for_____Prescribing Physician_____

_____for_____Prescribing Physician_____

_____for_____Prescribing Physician_____

_____for_____Prescribing Physician_____

Adverse reactions to medications

_____

_____

_____

**Do you take all medications as prescribed? Yes No Do you take vitamins and/or herbal remedies? Yes No If yes, what, and how often? _____**

**How many times per week do you exercise for at least 20 minutes? One or less ☐ Two to Four ☐**

**Five or more ☐**

**How is your physical health at present? Poor Unsatisfactory Good Excellent**

**Have you ever had any head injuries or loss of consciousness? Y N**

**Female Clients please complete this section.**

Menstrual History: How old were you when you got your first period?_____Is your period regular? Y N

Do your periods affect your mood? Y N Duration? _____ Date of last period? _____
Any relevant information about abortions or miscarriages? If yes, please describe_____

_____

Which category best describes your diet? **Please circle a category.**

Very Healthy (lots of fresh fruits/vegetables/whole grains and few sweets/fatty foods).

Moderately Healthy (Some fresh fruits/vegetables/whole grains, and some sweets/fatty foods).

Unhealthy (Few fresh fruits/vegetables/whole grains, and lots of sweets/fatty foods).

Between Unhealthy and Moderately Healthy

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**Section 4 Please Check All That Apply**

| Difficulty with | Now | Past | Difficulty with | Now | Past | Difficulty with | Now | Past |
|---|---|---|---|---|---|---|---|---|
| Suicidal thoughts | | | Homicidal thoughts | | | Hallucinations | | |
| Physical Abuse | | | Sexual abuse | | | Domestic violence | | |
| Verbal Abuse | | | Depression | | | Mood changes | | |
| Self-mutilation | | | Panic | | | Trauma | | |
| Anxiety | | | Stress | | | Friends | | |
| Alcohol abuse | | | Drug Abuse | | | Gambling | | |
| Anger | | | Irritability | | | Other addiction | | |
| Fears | | | Children | | | Parents | | |
| Employer | | | Co workers | | | Spouse | | |
| People in general | | | Loss of memory | | | Feeling manic | | |
| Trusting others | | | Communicating | | | Eating problems | | |
| Sleeping problems | | | Severe weight loss | | | Severe weight gain | | |
| Blackouts | | | Finances | | | Sexual problems | | |
| Legal Problems | | | Nightmares | | | Nausea | | |
| Dizziness | | | Fainting spells | | | Chest pain | | |
| Heart Palpitations | | | Muscle tension | | | Careless mistakes | | |
| Attention | | | Fidget frequently | | | Obsessive thoughts | | |
| Easily Distracted | | | Waiting your turn | | | Completing tasks | | |
| Flashbacks | | | Authority | | | Discipline | | |
| Headaches | | | Hyperactivity | | | Learning Disability | | |
| Speaking without thinking | | | Failure to follow rules | | | Grades | | |

**Strengths: Please review the list and check those qualities you feel you possess.**

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Integrity** | | Courage/Bravery | | Persistence | | Gratitude | | Love | |
| **Creativity** | | Vitality | | Forgiveness | | Spirituality | | Opportunistic | |
| **Openmindedness** | | Kindness | | Prudence | | Humor/Witty | | Patient | |
| **Love of learning** | | Loyalty | | Self-Control | | Hope | | Confident | |
| **Perspective** | | Fairness | | Leadership | | Love of beauty | | Rational | |
| **Charming** | | Polite | | Attractive | | Assertive | | Adaptable | |
| **Serious** | | Relaxed | | Healthy | | Intellectual | | Tactful | |
| **Resourceful** | | Organized | | Serious | | Logical | | Strong-minded | |

**Signature**_____**Date**_____

# HEALING JOURNEY COUNSELING SERVICES, LLC

## Mental Health History

**Have you ever been diagnosed with a mental illness?** (Please circle one) **Y / N**

If yes: Date (month/year) _____ Approximate Age _____

Diagnosis _____ Were you treated? **Y / N** (please circle one)

If yes, what form of treatment did you receive? _____
_____

**Has anyone in your family ever been diagnosed with a mental illness? Y / N** If yes, then

What family member _____Diagnosis _____

What family member _____Diagnosis _____

What family member _____Diagnosis _____

**Are you presently or have you previously participated in counseling or psychotherapy? ___**

If yes: Counselor(s) _____ Reason(s)_____

**Have you ever had thoughts or feelings to harm/kill yourself? Y /N** Another person? **Y / N**

If yes, have you attempted to harm yourself previously? **Y / N** Please respond to the following three questions by selecting a number between 1 and 10 (1 = not at all likely; 10 = very likely). Do you presently intend to harm yourself/someone? _____ Do you currently have a plan to harm yourself/someone? _____ Do you currently have the means and/or opportunity to harm yourself or another person? _____

**Are you presently or have you previously in the past year experienced:**

**_ Depression** – times when you feel sad, hopeless, or discouraged, and can't snap out of it?

- o Poor appetite/overeating
- o Low self-esteem
- o Poor concentration
- o Feelings of hopelessness

- Sleep disturbance (insomnia, hypersomnia) ○ Fatigue or low energy ○ Guilt feelings or worthlessness
- Lack of interest in things you used to enjoy

_ **Anxiety** – ongoing worry, periods when you feel that something bad is going to happen, or that you are in some sort of danger?

- Restless ○ Easily tired ○ Problems concentrating ○ Irritability ○ Tension in muscles
- Problems falling asleep or staying asleep ○ Periods of intense fear or discomfort

_ **Obsession/Compulsion** – thoughts, words, or worries that run through your mind that you wish you could get rid of, or do you struggle to keep yourself from repeating behaviors?

- Do you repeat things as if they were rituals (repeating hand washing, checking locks on doors, etc.)? ○ What do you think might happen if you did not repeat these behaviors?
- Other _____

_ **Mania/Hypomania** – are there times when you are so happy or energetic that you can get by on very little sleep, and even feel that you can get away with things that are dangerous? ○ Rapid speech (pressure to keep talking) or increased talkativeness ○ Racing thoughts or flight of ideas ○ Distractibility ○ Irritability
- Inflated self-esteem or grandiosity

_ **Delusions/Hallucinations** ○ Do you ever think of something so strongly that others can hear your thoughts**?**

- Is someone plotting to harm you?
- Has someone put thoughts in your head or taken thoughts out of your head? ○ Do you think you have done something terrible and deserve to be punished?
- Do you have ideas or beliefs that other people do not accept as true?
- Have you heard noises or sounds that others did not hear?
- Have you seen visions that others did not see? ○ Do you have strange sensations in your body or on your skin?
- Do you smell things that others don't notice, or have strange tastes in your mouth? ○ Do you ever feel that you are being controlled by some strange force or power?
- Depersonalization/Derealization: Do you feel that things around you are not real, that you are not real, or that you are detached from yourself or the things around you?

**Are you currently experiencing difficulty in any of the following areas:**

_ Primary support group?

_ Interpersonal/social?

_ Academic standing/education?

_ Occupational performance/employment?

_ Housing/living conditions?

_ Finances/economic?

_ Access to health care services?

_ Legal system/crime?

_ Other? _____

**Current GAF**: _____

## Substance Use History

**Family Alcoholic/drug abuse history:**

☐ Father

☐ Mother

☐ Grandparent(s) maternal/paternal

☐ Sibling(s)

☐ Stepparent/Live in

☐ Uncle(s) Aunt(s)

☐ Children

**Substance use status:**

☐ No history of use

☐ Active abuse

☐ Early full remission

☐ Early partial remission

☐ Sustained full remission

☐ Sustained partial remission

☐

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Other_____

**Treatment History:**

☐ Outpatient-When_____
Where_____

Inpatient-When_____
Where_____

☐ 12-Step Program-Age(s)_____

☐ Stopped on own-Age(s)_____

☐ Other-Age(s)_____

_

**Consequences:**

Hangovers
Seizures
Blackouts
Injuries
Overdose
Drug induced psychosis
Withdrawal Symptoms
Medical Complications
Tolerance changes
Loss of control of amount used
Sleep disturbance
Assaults
Suicidal impulse
Relationship conflicts
Binges
Job Loss
Arrests/DUIs

**Substances used: Please circle substances used and complete each section**

| | Age First Used | Age Last Used | Current Use Y/N | Frequency (how often) | Amount (how much) |
|---|---|---|---|---|---|
| Alcohol | _____ | _____ | _____ | _____ | _____ |
| Amphetamines/Speed | _____ | _____ | _____ | _____ | _____ |
| Barbiturates/Downers | _____ | _____ | _____ | _____ | _____ |
| Caffeine | _____ | _____ | _____ | _____ | _____ |
| Cocaine | _____ | _____ | _____ | _____ | _____ |
| Crack | _____ | _____ | _____ | _____ | _____ |
| Hallucinogens (LSD) | _____ | _____ | _____ | _____ | _____ |
| Inhalants (glue,gas) | _____ | _____ | _____ | _____ | _____ |
| Marijuana or Hashish | _____ | _____ | _____ | _____ | _____ |
| Nicotine/Cigarettes | _____ | _____ | _____ | _____ | _____ |
| PCP | _____ | _____ | _____ | _____ | _____ |
| Prescription(s) | _____ | _____ | _____ | _____ | _____ |
| Other | _____ | _____ | _____ | _____ | _____ |

## Criminal and Violence History

**Have you ever been convicted of a family violence charge?** (Please circle one) **Y / N** If so, then:

Date of conviction: _____ Victim(s): _____

**Have you ever been the victim of family violence or other violence?** (Please circle one) **Y / N**

When: _____ How often: _____ The perpetrator(s)? _____

**In your lifetime have you ever been convicted of a misdemeanor?** (Please circle one) **Y / N**

What was the charge: _____ Date of conviction: _____

What was the charge: _____ Date of conviction: _____

What was the charge: _____ Date of conviction: _____

**In your lifetime have you ever been convicted of a felony?** (Please circle one) **Y / N** If so, then,

What was the charge: _____ Date of conviction: _____

What was the charge: _____ Date of conviction: _____

What was the charge: _____ Date of conviction: _____

**Have you ever physically assaulted another person in your family?** (Please circle one) **Y / N** If so; (i.e., mother, father, grandparent, sibling, spouse, child, etc.)

Which family member: _____ How often: _____ Last occurrence: _____

Which family member: _____ How often: _____ Last occurrence: _____

Which family member: _____ How often: _____ Last occurrence: _____

**Have you ever assaulted someone that is or was not in your family?** (Please circle one) **Y / N** If so;
(i.e., girlfriend, boyfriend, neighbor, friend, acquaintance, stranger, etc.)

Who: _____ How often: _____ Last occurrence: _____

Who: _____ How often: _____ Last occurrence: _____

Who: _____ How often: _____ Last occurrence: _____

## Education and Work History

**Highest grade completed** _____. **Total number of years of education** (GED = 12): _____

**Favorite subject(s) in school**: _____

**Least favorite subject(s):** _____

**Name(s) of elementary school(s):**_____

_____

**Name(s) of junior high or middle school(s):**_____

_____

**Name(s) of high school(s):** _____

_____

**Post-Secondary Degree(s):** (please circle) **BA / BS; MA / MS; EdS / PhD; Other** _____

**Area or Field of Study:** _____

**Technical Training Certificate(s):** _____

**If not able to complete or still actively pursuing a degree or certificate, what degree or certificate were you working toward?** _____, **and what how much longer will/would it take to complete the program?** (Please specify years or months) _____

**Current vocation or job title:** _____

**Name of Company:** _____**How long employed:** _____

**Armed Services: Y / N**; **Branch:** _____; **Highest Rank Achieved:** _____

**Length of service:** _____; **Type of work:** _____

**In the table below, please list your jobs for the past 10 years:**

**Type of work Company Reason for leaving Length/Time employed_____**

# Personality Styles

There are 15 personality styles or types listed here. Starting with the first type, read its description and then put an X in one of the three columns: "Mostly like me," or "Somewhat like me," or "Not like me." Do this with ALL 15 types.

| | MOSTLY LIKE ME | SOMEWHAT LIKE ME | NOT LIKE ME |
|---|---|---|---|
| **1**.I am the type who gets good marks or promotions, has one or two very close friends, and follows the rules of society (PD) | | | |
| **2.** I am the type who lives and feels like an emotional Yo-Yo. Sometimes my feelings are up very high, and I am highly charged and sometimes my feelings | | | |
| are flat and I feel hopeless (BiP) | | | |
| **3.** I am the type who makes friends easily and who knows how to charm or lie to get others to give me things I want. I take what I want when I want it and I do not feel too sorry for them (CON) | | | |
| **4.** I am the type who feels inside like I am really a female, not a male and I want to dress like a girl and wear make-up, and I want to live my life as a girl (GI) | | | |
| **5.** I am the type who avoids other people for fear they will laugh or embarrass me. I am shy about making friends even though I would like to because I do not thing I am as good as other people (AVD) | | | |
| **6.** I am the type who needs someone to make decisions for me and take care of me. I do not ever want someone to get mad at me and I am afraid of being | | | |

| | | | |
|---|---|---|---|
| left alone to take care of myself (DEP) | | | |
| **7.** I am the type who likes to do just the opposite of what other people want me to do; the faster someone tries to make me go, the slower I move. I like to annoy others, especially most adults and I feel I have the right to make others suffer because they want to blame me for everything (OD) | | | |
| **8.** I am the type who would rather work hard than play but I have trouble finishing what I am working on because I worry it is not quite right or perfect. I like rules, and I try to live a perfect life and I expect others to do the same (OC) | | | |
| **9.** I am the type who believes most everyone is dishonest and threatening and that they are out to hurt me. I feel I must protect myself from them and I will not forgive people who try to hurt me (PA) | | | |
| **10.** I am the type who does not feel close to anyone including my family. I do not want to be near others and I try to go off by myself whenever I can (Sc) | | | |
| **11.** I am the type who was always getting into trouble because of my fighting, stealing, runaway, school conduct, lying, wrecking things and using alcohol and drugs. I may have been arrested a couple of times, but my friends thought that was cool (CD) | | | |
| **12.** I am the type who wants to be the center of attention and for others to think I am great and give me a lot of attention. I can get easily | | | |

| | | | |
|---|---|---|---|
| excited one minute and the next I am angry or bored. I love to show off (HIS) | | | |
| **13.** I am the type who does not listen or pay much attention and I jump from one thing to another. I am always losing things and I cannot sit still or be quiet. I butt in when others are talking or playing because I cannot wait my turn. I never finish hat I am supposed to and others get mad at me because I am always getting up and running around. (ADHD) | | | |
| **14.** I am the type who seems to be a loser at everything I do. I cannot do anything right and I feel helpless when I am asked to do something I am always made fun of and teased by others. I am awkward and clumsy and I feel like a failure and a fool. (Inadequacy) | | | |
| **15.** I am the type who is very superior to others because of my looks, the things I can do and my being very important. I expect people to treat me very special | | | |
| because of who I am and I only associate with the few other people who are as important as I am (NAR) | | | |

Sometimes people are not like any of the 15 types and mark an X in all of the "Not Like Me" column for all types. That is expected and is OK. However, we still want to know how you see yourself so please describe yourself. (Use extra paper if you need to)

## Parental and Family History

Father's Name: _____ His occupation while you were growing up

_____

His age now: _____ If he is not alive, how old were you when he died? _____

How did he die? _____

Mother's Name: _____ Her occupation while you were growing up _____

Her age now: _____ If she is not alive, how old were you when she died? _____ How did she die? _____

Siblings (brothers or sisters) if any. List by birth order & identify if they are a Whole, Half, or Step sibling

1st Name: _____ Age: _____ Gender: M / F W / H / S

1st Name: _____ Age: _____ Gender: M / F W / H / S

1st Name: _____ Age: _____ Gender: M / F W / H / S

1st Name: _____ Age: _____ Gender: M / F W / H / S

1st Name: _____ Age: _____ Gender: M / F W / H / S

1st Name: _____ Age: _____ Gender: M / F W / H / S

1st Name: _____ Age: _____ Gender: M / F W / H / S

1st Name: _____ Age: _____ Gender: M / F W / H / S

1st Name: _____ Age: _____ Gender: M / F W / H / S

1st Name: _____ Age: _____ Gender: M / F W / H / S

**PLEASE FINISH THE FOLLOWING:**

In my growing up years my parents argued_____.

In my growing up years my parents showed their affection for each other by_____.

During your growing up years did either of your parents hit the other? _____ Describe_____
_____
In your growing up years did either of our parents suffer from alcoholism, violence, criminal behavior, sexual problems or mental disturbance? _____ Who? _____

Explain_____

Did your parents stay married during the time you were growing up? _____ If they divorced, how old were you at the time? _____ How did you feel about the divorce? _____
_____

What was your father like when you were growing up? _____

How do you think he would have described you when you were growing up? _____

How did he discipline you? _____

How did he show concern and affection for you? _____

What was your mother like when you were growing up? _____

How did you feel about her when you were growing up? _____

How do you think she would have described you when you were growing up? _____

How did she discipline you? _____

Did you need disciplining often? _____ For what kinds of things? _____

Do you consider yourself to have been abused as a child? _____ Describe: _____
_____

When growing up I was closest to: _____

When I was growing up, I was able to confide in _____

Did your parents treat you differently than your brothers and sisters? _____ Explain _____
_____

Who do you feel has positively influenced you the most in life? _____Why? _____

Who do you hold as most at fault for the problems you have in life? _____ Why? _____

# HEALING JOURNEY COUNSELING SERVICES, LLC


## Ph: 404-800-4048
## Fax: 334-209-2722


To Our Patients:

In general, the HIPPA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their Protected Health Information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means, such as sending correspondence to an address other than one's home address.

The Therapists and staff of Healing Journey Counseling Services, LLC respect client privacy and wish to make all reasonable attempts to respect client wishes regarding confidential information. With that in mind, please indicate your preferences in the areas noted below.

**I wish to be contacted in the following manner (Check all that applies).**

Home Telephone: _____

Ok to leave message with detailed information: YES_____NO_____

Leave message with call back number only: YES_____NO_____

Work Telephone: _____Cell:_____

OK to leave message with detailed information: YES_____NO_____

Leave message with call back number only: YES_____NO_____

Written communications-including your account with our office:

OK to mail to my home: YES_____NO_____

OK to mail to my work/office: YES_____NO_____

OK to fax to this number: YES_____NUMBER_____NO_____

Other individuals, (family, friends, etc.) that we may speak to regarding your care and or bills.

Name: _____Relationship: _____

Name: _____Relationship: _____

Name: _____Relationship: _____

PRINT NAME: _____DATE OF BIRTH_____

SIGNATURE: _____DATE: _____

**HEALING JOURNEY COUNSELING SERVICES, LLC**

**1122 O.G. Skinner Drive**
**West Point, Ga 31833**
**Office: 404-800-4048**
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## CANCELLATION POLICY

If you are unable to keep an appointment, you must notify our office at least 24 hours in advance. If such advance notice is not received, you will be financially responsible for the session that you missed.

**$100.00 for the first missed appointment, $150.00 for the second missed appointment and $200.00 for the third missed appointment.**

Please note that insurances DO NOT PAY for your missed appointments/sessions.

Please print, date, and sign your name below indicating you have read and understand Healing Journey's cancellation policy.

_____ _____
Client Name (Please Print) Date

If Applicable:

_____ _____
Parents or Legal Guardians Name (Please Print) Date

_____ _____
Parents or Legal Guardians Signature Date

# HEALING JOURNEY COUNSELING SERVICES, LLC

**1122 O.G. Skinner Drive**
**West Point, GA 31833**
**Office: 404-800-4048**

## CONSENT FOR TREATMENT OF MINORS

Client's Name: _____

Date of Birth: _____

Counselor(s): _____

This is to certify that I give permission for Healing Journey Counseling Services, LLC and the counselor(s) listed for treatment of my child.

This treatment may also include referrals to other appropriate state and county professional agencies for further counseling.

_____
Signature of Parent/Guardian

_____
Printed Name of Parent/Guardian

_____
Street Address

_____
City/State/Zip

_____
Phone

Date: _____Witness/Title_____