

***Cheryl B. La Mastra, M.A.***  
*Licensed Professional Counselor*

**PATIENT INFORMATION**

If services are for a couple or family, please fill out according to whose first name you want on receipts.

Name: _____	Date: _____
Home address: _____	SS#: _____
City/State/Zip: _____	Date of birth: _____
Phone: Home: _____	Mobile: _____
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Living Together <input type="checkbox"/> Widowed Sex: <input type="checkbox"/> M <input type="checkbox"/> F Age: _____	
Employed by: _____	Occupation: _____
Bus. phone: _____	Extension: _____
Spouse: _____	Occupation: _____
Employed by: _____	Bus. phone: _____
Emergency contact name: _____	Contact's #: _____
Family MD/Psychiatrist: _____	Referred by: _____

**CHILD OR ADOLESCENT**

School name: _____	Grade: _____
Are parents divorced? <input type="checkbox"/> Yes <input type="checkbox"/> No Child lives with: _____	
Home phone: _____	Bus. phone: _____
According to the divorce decree, who is allowed to seek treatment on child's behalf? <input type="checkbox"/> Only mom <input type="checkbox"/> Only dad <input type="checkbox"/> Either <input type="checkbox"/> Other: _____	

**RESPONSIBLE PARTY**

Name: _____	Relationship to client: _____
Address: _____	Home phone: _____
City/State/Zip: _____	Bus. phone: _____
Employed by: _____	

**GUARANTOR AGREEMENT:** I certify the above is true and take full responsibility for the entire amount due for any and all services rendered by Cheryl La Mastra.

Guarantor Signature (Patient signature, if patient is guarantor) \_\_\_\_\_ Date \_\_\_\_\_

***Cheryl La Mastra, M.A.***  
*Licensed Professional Counsel*

### **Patient Information & Consent to Treatment**

Welcome to my practice. I look forward to working with you regarding the concerns that brought you here, and I hope that you find our work together beneficial. Please read carefully the following information concerning my professional services and business policies, and discuss with me any questions you may have. Your signature at the end of this document indicates you have read and understand this information, thus providing an agreement for proceeding with treatment.

**Qualifications:** I am licensed by the State of Texas as a Licensed Professional Counselor with a Master's degree in Counseling. I have extensive experience working with individuals (children, adolescents, and adults), couples, families, and groups. I am a member of the American Counseling Association (ACA), the American Association of Christian Counselors (AACC). Additionally I provide consulting services to various ministries and organizations and do adjunct teaching at a local college.

**Orientation:** I am trained in a variety of approaches to therapy, including cognitive-behavioral, family systems and family of origin approaches, and employ a variety of techniques to assist you in clarifying your goals for change and taking steps in the desired direction. My overall goal in therapy is to assist you in being as healthy as possible physically, mentally, emotionally, relationally, and spiritually. I believe all people are created with a need for purpose and meaning, a need for significant connection with others, and a capacity for growth. Thus I am committed to providing quality psychological care to assist you in achieving these goals.

**Nature of Psychological Services:** The purpose of psychological treatment may include relieving distress; decreasing symptoms of a mental or emotional disorder; improving one's mood, self-esteem, or overall well-being; working through trauma or loss; working to improve significant relationships; or learning better coping skills for life's challenges. As such, psychotherapy is not an exact science and it is not like a visit to a medical doctor, but rather requires your active participation in identifying problems and goals, and working to make changes. In order for therapy to be most successful, I will at times ask you to take specific steps to work on the issues we discuss, both during our sessions and in the time in between our appointments. I will work to create a safe setting in which you feel respected and accepted in order for you to openly discuss issues which may be at times personal and uncomfortable. I will be sensitive to the pacing and timing of these discussions to maximize a therapeutic result.

**Therapy Relationship:** Sessions are usually 45-50 minutes, on a weekly basis. Less frequent sessions will be scheduled as improvements occur, goals are met, and we near the end of treatment. Feel free to express your preferences for scheduling of sessions, as your needs will likely change over the course of therapy. Although our sessions may be very intimate psychologically, it is important for you to realize that we have a professional relationship rather than a social one. Our contact will be limited to sessions you schedule at my office. Emergency phone calls after hours will be handled as follows: if it is life-threatening, you will be directed to call 911 or go to your nearest emergency room. Crisis management calls will be brief and aimed at stabilizing the situation for processing at our next scheduled appointment.

**Effects of Therapy:** Psychotherapy can have benefits and risks. Therapy often leads to better relationships, solutions to specific problems, and significant reduction in feelings of distress.

However I cannot guarantee your specific results. Progress depends on many factors including motivation, effort, and how well we work as a team. Additionally, therapy at times involves unpleasant feelings and addressing issues that initially may be difficult, even painful. The changes you make may impact your relationships, your functioning on the job or at home, or your understanding of yourself. Some of these changes may be temporarily distressing. Whenever possible, we will anticipate these risks and discuss them throughout the course of therapy. Together we will work to achieve the best possible results for you.

**Patient Rights:** Some individuals only need a few sessions to achieve their goals; others may require months or even longer. Our first 1-3 sessions will involve an evaluation of your needs and goals. I will then offer you some initial impressions of what our work will include and make recommendations regarding a treatment plan. Your active involvement in this plan, along with your opinion of what you need and whether you feel comfortable working with me are crucial to your success in therapy. You have the right to discontinue our professional relationship at any time, though I recommend a termination session for reaching closure. You also have the right to refuse any recommendations I make. If your refusal, in my professional opinion, compromises my ability to render services in an ethical or beneficial manner (e.g. refusal to make a safety contract when feeling suicidal), I may determine to discontinue treatment. In such cases, I will provide you with referrals to another competent mental health professional, if you desire.

My services will be rendered in a professional manner consistent with the legal and ethical standards established by the licensing board for professional counselors. If at any time or for any reason you are dissatisfied with my services, please let me know. If I am not able to resolve your concerns to your satisfaction, you may report your complaints to the Texas State Board of Examiners of Professional Counselors at 1-800-942-5540.

**Referrals:** If at any time you and/or I believe a referral is needed (e.g. medication evaluation), I will provide recommendations for other providers or programs to assist you. Alternatives to therapy may also be discussed at your request (eg. support groups, community services). You will be responsible for contacting and evaluating those referrals or alternatives.

**Fees and Payment:** Initial evaluations are billed at \$120 per hour (50-60 min.). Follow-up therapy visits are \$115 per 45-50 minute clinical hour. Sessions may be scheduled for less than 45 minutes and will be billed as a portion of the hourly rate. Payment is expected at the time services are rendered. I do not accept any insurance but will provide you with all the necessary paperwork for you to file with your insurance company. For your convenience, I accept Visa, MasterCard, and American Express, as well as personal checks and cash. I do not file any insurance claims but will provide you a receipt so that you can file for insurance reimbursement. Insurance benefits usually cover only “medically necessary” treatment, requiring a diagnosis. I will inform you of the diagnosis I will be submitting; any diagnosis made will become part of your permanent insurance records. If payment becomes a hardship for you, please discuss this with me so we can arrange a suitable payment plan.

Other services for which additional fees may apply that are not covered by insurance include: telephone calls (>5-10 min.), clinical consultations with other providers to coordinate treatment (with your permission); preparation of treatment summaries or treatment plans; letters or documents for employment, disability, or legal purposes; and photocopying and/or mailing of medical records to other provider, attorneys, or insurance companies. For legal proceedings that require my participation, I bill \$220 per hour (includes depositions, time spent waiting to testify, driving time to the court, etc.).

**Cancellation Policy:** If you are unable to keep a scheduled appointment or need to change an appointment, please notify my office as soon as possible. Appointments not kept or cancelled less than 24 hours in advance will be billed for the time scheduled. Insurance will not pay for missed appointments or late cancellations.

**Records and Confidentiality:** All of our communication becomes part of the clinical record. Adult records are disposed of seven years after the file is closed. Records for minors are disposed of seven years after the child's 18th birthday.

Trust and openness are essential for effective therapy. You can expect our communications to remain private and your files to be kept secure and confidential. The staff in my office who may need to access your file for any administrative purposes are also bound by confidentiality. However, you should be aware of the following **exceptions to confidentiality:**

1. You are at risk of imminent serious harm to yourself or others;
2. You disclose abuse, neglect, or exploitation of a child, elderly, or disabled person;
3. You disclose sexual misconduct of a physician or therapist;
4. Information is requested by your insurance company;
5. I am ordered by a court to disclose information (e.g. child custody suits);
6. You direct me to release your records or to share information regarding your treatment.

When seeing couples or families, I will treat as confidential (within the limits cited above) information you disclose to me that you specifically request not be shared with your partner or family member. However, I encourage open communication between couples and families, and I reserve the right to terminate treatment if I judge a secret to be detrimental to the therapeutic process.

**Phone Messages, Fax Transmissions, and Email:** Please initial the following. I authorize that messages may be left for me regarding appointments or returned calls...(initial all that apply)

On my home answering machine  With a family member  On my cell phone  
 On my voicemail at work

I acknowledge that telephone calls from Cheryl La Mastra may be returned by cellular phone.

I acknowledge that medical records, insurance information, or other information concerning my treatment may be sent by fax transmission when a release of information has been authorized.

I acknowledge that emails sent to Cheryl La Mastra may be received by the office manager. Emails are checked only during business hours (not on weekends), and thus should not be used for conveying urgent or highly sensitive information.

I hereby give my consent for psychological treatment by Cheryl La Mastra. I understand that, should I require services when Cheryl La Mastra is on vacation, this consent is transferable to the covering professional as designated by Cheryl La Mastra. I have read and understand this document regarding consent and Cheryl La Mastra's services and policies, and any questions I had were discussed and answered to my satisfaction. I have been furnished a copy of this statement.

**Patient Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

**Parent/Legal Guardian** \_\_\_\_\_

**Date** \_\_\_\_\_

**(If patient is under age 18)**

**Cheryl La Mastra, M.A., LPC** \_\_\_\_\_

**Date** \_\_\_\_\_

**LA MASTRA COUNSELING**  
5425 Spring Creek Parkway, Suite 200  
Plano, Texas 75024  
PHONE: 972-400-7422

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you have access to it.

Protected health information, about you, is obtained as a record of your contacts or visits for healthcare services with LA MASTRA COUNSELING. This information is called protected health information. Specifically, "Protected Health Information" is information about you, including demographic information (i.e., name, address, phone, etc.) that may identify you and relates to your past, present or future physical or mental health condition and related health care services.

LA MASTRA COUNSELING is required to follow specific rules on maintaining the confidentiality of your protected health information, how our staff uses your information, and how we disclose or share this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your protected health information. It also describes how we follow those rules and use and disclose your protected health information to provide your treatment, obtain payment for services you receive, manage our health care operations and for other purposes that are permitted or required by law.

**Your Rights Under The Privacy Rule**

Following is a statement of your rights, under the Privacy Rule, in reference to your protected health information. Please feel free to discuss any questions you may have.

*You have the right to receive and we are required to provide you with a copy of this Notice of Privacy Practices -*

We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. If needed, new versions of this notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment.

*You have the right to authorize other use and disclosure -* This means you have the right to authorize or deny any other use or disclosure of protected health information not specified in this notice. You may revoke an authorization, at any time, in writing, except to the extent that your physician or our office has taken an action in reliance on the use or disclosure indicated in the authorization.

*You have the right to designate a personal representative -* This means you may designate a person with the delegated authority to consent to, or authorize the use or disclosure of protected health information.

*You have the right to inspect and copy your protected health information -* This means you may inspect and obtain a copy of protected health information about you that is contained in your patient record. In certain cases we may deny your request.

*You have the right to request a restriction of your protected health information* - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. In certain cases we may deny your request for a restriction.

*You may have the right to have us amend your protected health information* - This means you may request an amendment of your protected health information for as long as we maintain this information. In certain cases, we may deny your request for an amendment.

### **How We May Use or Disclose Protected Health Information**

Following are examples of use and disclosures of your protected health care information that we are permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

*For Treatment* - We may use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that is involved in your care and treatment. For example, we would disclose your protected health information, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose protected health information to other physicians who may be involved in your care and treatment. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

*For Payment* -Your protected health information will be used, as needed, to obtain payment for our health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

*For Healthcare Operations* - We may use or disclose, as needed, your protected health information in order to support the business activities of our practices. This includes, but is not limited to business planning and development, quality assessment and improvement medical review, legal services, and auditing functions. It also includes education, provider credentialing, certification, underwriting, rating, or other insurance related activities. Additionally it includes business administrative activities such as customer service, compliance with privacy requirements, internal grievance procedures, due diligence in connection with the sale or transfer of assets, and creating de-identified information.

### **Other Permitted and Required Uses and Disclosures**

We may also use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information.

*To others Involved in Your Healthcare* - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or

disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, general condition or death. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

*As Required by Law* - We may use or disclose your protected health information to the extent that the law requires the use or disclosure.

*For Health Oversight* - We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.

*In Cases of Abuse or Neglect* - We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, file disclosure will be made consistent with the requirements of applicable federal and state laws.

*For Legal Proceedings* - We may disclose protected health information in the course of any judicial or administrative proceedings, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

*Required Uses and Disclosures* - Under the law, we must make disclosures about you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Privacy Rule.

#### *Complaints*

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may also file a complaint with us by notifying Cheryl La Mastra of your complaint.

By signing below, you confirm that you have read the above information regarding your Private Healthcare Information.

\_\_\_\_\_  
(Signature of client, or in the case of a minor, their legal guardian)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Printed name of client)

***Cheryl La Mastra, M.A.***  
*Licensed Professional Counselor*

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**Comprehensive Assessment Questionnaire**

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

What are the main problems or symptoms that caused you to seek help now? \_\_\_\_\_

\_\_\_\_\_

Describe any stresses in your life that may have contributed to the problem: \_\_\_\_\_

\_\_\_\_\_

Describe the history of the problem from its onset until now: \_\_\_\_\_

\_\_\_\_\_

Have you had a similar problem in the past?  Yes  No If so, please describe the episodes and the dates they occurred. \_\_\_\_\_

\_\_\_\_\_

Were you treated for this problem?  Yes  No If so, please describe the treatment you received.

\_\_\_\_\_

Has this problem caused you to experience any decrease in your ability to function in the following areas?

If so, please describe:

School performance: \_\_\_\_\_

Work performance: \_\_\_\_\_

Relationship with spouse/significant other: \_\_\_\_\_

Functioning as a parent: \_\_\_\_\_

Social life: \_\_\_\_\_

Ability to manage chores at home: \_\_\_\_\_

**Medical History**

Please list all medications you are currently taking:

Prescription Medication	Dose	Start Date (MMYY)
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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list any health problems: \_\_\_\_\_

\_\_\_\_\_

**Mental Health History**

Please list any Psychiatrist/Psychologist/Therapist you have seen previously:

Name	Dates Seen	Reason	Medications Prescribed
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever attempted suicide?  Yes  No If yes, please describe the nature of the event and the date(s) of occurrence. \_\_\_\_\_

Please list any blood relatives who have any history of mental or emotional problems (e.g. depression, manic depression, alcoholism, drug abuse, suicide, schizophrenia, anxiety problems, eating disorders, Attention Deficit Disorder, etc.)

Relative	Problem
_____	_____
_____	_____

**Substance Use:**

Do you use any of the following?

Substance	Yes	No	Amount	Frequency: Daily	Weekly	Date last used
Tobacco	___	___	_____	___	___	_____
Caffeine	___	___	_____	___	___	_____
Alcohol	___	___	_____	___	___	_____
Marijuana	___	___	_____	___	___	_____
Cocaine	___	___	_____	___	___	_____
Amphetamines	___	___	_____	___	___	_____
LSD	___	___	_____	___	___	_____
Heroin	___	___	_____	___	___	_____
Pain killers	___	___	_____	___	___	_____
IV Drug Use	___	___	_____	___	___	_____

Have you ever felt that you were abusing drugs or alcohol?  Yes  No If so, please describe when and the nature of the problem. \_\_\_\_\_

Have you tried to stop drinking?  Yes  No If yes, what was the outcome? \_\_\_\_\_

Have you ever attended AA?  Past  Current If yes, do you have a sponsor and how often do you attend meetings? \_\_\_\_\_

Have you ever attended NA?  Past  Current If yes, do you have a sponsor and how often do you attend meetings? \_\_\_\_\_

**Family/Social History**

Where were you born and raised? \_\_\_\_\_

What was your birth order? \_\_\_\_\_ of \_\_\_\_\_ children.

Please list your siblings and their current ages: \_\_\_\_\_

Are you close to your siblings? \_\_\_\_\_

How would you describe your relationship with your father? \_\_\_\_\_

How would you describe your relationship with your mother? \_\_\_\_\_

Describe your childhood: \_\_\_\_\_

Were your parents divorced?  Yes  No If yes, how old were you? \_\_\_\_\_

With whom did you live after the divorce? \_\_\_\_\_

Did your mother remarry?  Yes  No Did your father remarry?  Yes  No

What was your relationship like with the stepparent(s)? \_\_\_\_\_

Were you ever subjected to any type of abuse (emotional, physical, sexual)?  Yes  No

If yes, please describe the events and ages the abuse occurred. \_\_\_\_\_

Have you ever been the perpetrator of abuse, neglect, or violence towards another person?  Yes  No  
If yes, please explain \_\_\_\_\_

Have you lost a close family member or friend?  Yes  No Who? \_\_\_\_\_ When? \_\_\_\_\_

Have you had an abortion?  Yes  No

### **Educational History**

Did you complete high school?  Yes  No

What kind of grades did you receive in school? \_\_\_\_\_

How did you get along with your peers? \_\_\_\_\_

How did you get along with your teachers? \_\_\_\_\_

Did you attend college?  Yes  No

Where? \_\_\_\_\_ Degree? \_\_\_\_\_

### **Occupational History**

Are you currently working?  Yes  No What is your occupation? \_\_\_\_\_

What is your current position? \_\_\_\_\_

Where do you work? \_\_\_\_\_ How long have you been there? \_\_\_\_\_

Are you satisfied with your job?  Yes  No If no, explain: \_\_\_\_\_

Describe any current job stresses you may be experiencing: \_\_\_\_\_

How well do you get along with your co-workers? \_\_\_\_\_

How well do you get along with your supervisors? \_\_\_\_\_

List your last two jobs and how long you worked there: \_\_\_\_\_

**Relationship History**

Are you currently  Single  Married  Divorced  Widowed  Living Together

How long? \_\_\_\_\_ What is your sexual orientation? \_\_\_\_\_

Describe your relationship with your spouse or significant other: \_\_\_\_\_

List any stresses or problems in your relationship: \_\_\_\_\_

If married, what is your spouse's occupation? \_\_\_\_\_

Have you been married before (or in a long-term committed relationship)?  Yes  No

How many times? \_\_\_\_\_ How long did these relationships last? \_\_\_\_\_

Please describe the reason for the break-up or divorce: \_\_\_\_\_

If you have children, what are their names and ages? \_\_\_\_\_

Describe any problems you may be experiencing with your children: \_\_\_\_\_

Do you believe in God?  Yes  No

What is your religious preference? \_\_\_\_\_

How often do you attend religious services? \_\_\_\_\_ Where? \_\_\_\_\_

How important is it to you that your faith be incorporated into your therapy and your recovery? \_\_\_\_\_

Any hobbies?: \_\_\_\_\_

Is there any other important information about you that has not been covered, which you feel the therapist should know? \_\_\_\_\_

What would you like to accomplish during your treatment? \_\_\_\_\_

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Read and Reviewed by** \_\_\_\_\_, **Clinician, on** \_\_\_\_\_

**\*\*\*Please complete the attached symptom checklist\*\*\***

**Cheryl B. La Mastra, M.A.**  
*Licensed Professional Counselor*

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**Symptom Checklist**

*Check all that apply. Then circle up to 10 items that are especially bothersome to you.*

**Recent Past**

1. Please check any of the following which may have been particularly stressful to you:

- Job related stress
- Marital conflict
- Death or loss of loved one
- Move to a new place and losing contact with friends or family
- Conflict with children
- Children with behavior problems
- Conflict with parents or extended family
- Feeling stress due to recalling memories of trauma or stress in my life
- Family member with an alcohol or drug problem
- Being abused by someone
- Financial pressure

2. Any of the following symptoms for most of the day, nearly every day, for periods longer than several days at a time:

- Depressed or sad mood
- Loss of interest or pleasure in things I'm normally interested in
- Difficulty falling asleep
- Difficulty staying asleep or waking up too early  
(average number of hours you are sleeping per night? \_\_\_\_\_)
- Sleeping too much
- Increased appetite/weight gain (lbs. \_\_\_\_\_)
- Decreased appetite/weight loss (lbs. \_\_\_\_\_)
- Fatigue/Poor energy level
- Decreased activity (work, social, physical, sexual)
- Poor concentration or slowed thinking
- Thoughts of suicide
- Excessive feelings of guilt or worthlessness
- Decreased sex drive or interest

3. Any of the following symptoms, more days than not, for months at a time:

- Excessive anxiety or worry for no good reason
- Trembling, twitching or feeling "shaky"
- Muscle tension or muscle aches
- Easily fatigued
- Dry mouth
  
- Dizziness or lightheadedness
- Nausea, diarrhea or other stomach problems
- Frequent urination
- Feeling keyed up or on edge
- Irritability
- Trouble falling or staying asleep

**Recent Past**

4. Panic attacks (any period of extreme, increased anxiety lasting from a few minutes up to several hours) with any

of the following symptoms:

- Panic attacks/anxiety attacks
- Persistent worry that I will have a panic attack
- Heart pounding or racing heart
- Trembling or shaking
- Sweating
- Choking
- Nausea or stomach problems
- Feelings of unreality
- Numbness or tingling sensations
- Feeling of smothering or shortness of breathe
- Fear of dying
- Fear of going crazy or doing something uncontrolled
- Chest pain or discomfort
- Dizziness, unsteady feelings or faintness
- Flushes, hot flashes or chills
- Avoiding situations or places that may cause panic or severe anxiety

5. Any of the following symptoms for most of the day, nearly every day, for more than four days at a time:

- Euphoric or “high” mood
- Irritable mood
- Decreased need for sleep without feeling tired
- Increased energy level
- Increased activity (work, social, physical, sexual)
- Thoughts speeded up or racing thoughts
- Increased talkativeness or being much more socially outgoing
- Making decisions too impulsively
- Going on spending sprees

6. Check any of the following relating to your alcohol or drug use:

- I’ve felt alcohol or drugs were causing a problem for me
- I have felt guilty about my use
- Others have annoyed me about my use
- I have had a desire (or made unsuccessful efforts) to cut down or control my use
- I’ve tried unsuccessfully to control my use
- I’ve used alcohol or drugs more often or in larger amounts than I intended
- I’ve had to increase my use of alcohol or drugs to get the desired effect
- I’ve had problems with withdrawal (shakes, nervousness, insomnia, etc.) when I’ve cut down or stopped using alcohol or drugs
- I’ve been to a meeting of Alcoholics Anonymous or Narcotics Anonymous

7. Any of the following disturbances in eating or maintaining normal weight:

- Insistence on maintaining body weight below expected for age and height
- Intense fear of gaining weight or becoming fat even though underweight
- I feel “fat” even when others see me as underweight
- Eating binges
- Feeling of lack of control of eating during eating binges
- Vomiting or using laxatives to prevent weight gain
- Being over-concerned about body weight and shape

**Recent Past**

8. Check any of the following that apply:

- I tend to do things on impulse which end up being damaging to me or others
- I have mood swings (depression, irritability, anger) lasting up to several hours
- I have tried to commit suicide
- I have made cuts, burns or other injuries to myself without wanting to kill myself
- My relationships always seem to work out wrong
- My mood often shifts from being either overconfident to having low self esteem
- I have a hard time sympathizing with other's pain
- I often feel others do not understand me
- I tend to get very hurt or angry when I am criticized or rejected by someone
- I tend to need a lot of reassurance or approval from others
- I am very concerned about my appearance
- Others often expect too much of me

9. Any of the following at any time:

- Hearing voices that sound real even though they are not actually there
- Vivid voices in my head that do not seem like my ideas
- Feeling that others might be putting thought in my head
- Feeling others might be able to read my thoughts
- Others feel I am too suspicious or paranoid
- Feeling others might be talking about me

10. Any of the following problems relating to a past severe trauma or stress:

- I have had an experience that was so traumatic that nearly anyone would have been seriously stressed by it
- History of relatives hurting me physically or touching me in sexual areas
- History of unwanted sexual contact
- I have memories or dreams of a stressful event that I have trouble putting out of my head
- I sometimes have flashbacks of past events; or I act or feel as though I am re-living a stressful event from the past
- I try to avoid situations or people that remind me of a stressful event in the past

11. Any of the following obsessions or compulsions:

- Excessive doubting; or repeated, forced unreasonable thoughts, images, or sounds that I cannot get out of my mind
- Urges to check thing, wash things, or count repeatedly
- Excessive concern about coming into contact with germs or dirt
- Excessive concern with right/wrong or morality
- Excessive need for things to be exact or symmetrical

***Thank you!***

**La Mastra Counseling**  
**2800 North Dallas Parkway, Suite 220**  
**Plano, Texas 75093**  
**972-400-7422**

**No-Show and Cancellation Agreement**

In an effort to provide excellent client service to all of our clients, and to provide the best possible therapeutic environment, it is our policy to require a fee for no-show appointments and cancellations made less than 24 hours in advance of the scheduled appointment. \*

The fee of \$115.00 will be charged to the following credit card:

\_\_\_ **Visa** \_\_\_ **MasterCard** \_\_\_ **American Express**

Credit Card #: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Name as it appears on Card: \_\_\_\_\_

I, \_\_\_\_\_, understand and agree that if I do not show up for my scheduled appointment or if I cancel my scheduled appointment with less than 24 hours notice, the above named credit card will be charged in the amount of \$\_\_\_\_\_. \_\_\_\_\_.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Printed Name \_\_\_\_\_

Address: \_\_\_\_\_ Daytime Ph.: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

\*Exceptions for emergencies are determined by your counselor.