



Face Sheet

Boyd D. Brooks PsyD, LPC
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Date of call _____

Caller's Name _____

Client Name _____

Address _____

City _____ State _____ Zip _____

Telephone: Home _____

Work _____ Cell _____

Email _____

Date of Birth _____

Marital Status _____

of Dependents _____ Religion _____

List Name and Age of Children (even if married):

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

Education _____

Employer _____

Occupation _____

Legal Issues _____

Spouse/Other/Parent _____

Address _____

City _____ State _____ Zip _____

Telephone: Home _____

Work _____ Cell _____

Email _____

Date of Birth _____

Marital Status _____

of Dependents _____ Religion _____

List Name and Age of Children (even if married):

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

Education _____

Employer _____

Occupation _____

Legal Issues _____

Emergency Contact Name _____

Emergency Contact Name _____

Relationship _____ Phone _____

Relationship _____ Phone _____

Primary Physician _____ Telephone _____

Address _____ City _____ State _____ Zip _____

Previous Counselor _____ Telephone _____

Address _____ City _____ State _____ Zip _____

When _____ Last Visit _____

Presenting Problem _____



Psychosocial Assessment

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Client's Name _____ Age _____ Male Female

Ethnicity _____ Lives with _____

Presenting Problems _____

Areas of Difficulty (Check all that apply. If not checked, we will assume there is no problem.)

- | | |
|---------------------------------------------------------------------------------------|-------------------------------------------------------------|
| <input type="checkbox"/> Marriage/Relationships/Family | <input type="checkbox"/> Ability to Concentrate |
| <input type="checkbox"/> Job/School Performance | <input type="checkbox"/> Ability to Control Temper |
| <input type="checkbox"/> Disability Leave | <input type="checkbox"/> Hobbies/Interests/Play Activities |
| <input type="checkbox"/> Job/School Jeopardy | <input type="checkbox"/> Eating Habits |
| <input type="checkbox"/> Sleeping Habits | <input type="checkbox"/> Weight Gain in past 6 months _____ |
| <input type="checkbox"/> Difficulty Falling Asleep | <input type="checkbox"/> Weight Loss in past 6 months _____ |
| <input type="checkbox"/> Difficulty Staying Asleep | <input type="checkbox"/> Current Weight _____ Height _____ |
| <input type="checkbox"/> Early Morning Awakening | <input type="checkbox"/> Friendship/Peer Relationships |
| <input type="checkbox"/> Financial Problems | <input type="checkbox"/> Sexual Function |
| <input type="checkbox"/> Activities of Daily Living (personal hygiene, bathing, etc.) | <input type="checkbox"/> Other _____ |

Symptoms (Check all that apply. If not checked, we will assume there is no problem.)

- | | | |
|-----------------------------------------------------------------------|-----------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Depressed Mood | <input type="checkbox"/> Irritability | <input type="checkbox"/> Stealing |
| <input type="checkbox"/> Decreased Energy | <input type="checkbox"/> Impulsiveness | <input type="checkbox"/> Bedwetting/Pooping |
| <input type="checkbox"/> Grief | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Setting Fires |
| <input type="checkbox"/> Intellectual Deficit | <input type="checkbox"/> Disruption of Thoughts | <input type="checkbox"/> Running Away |
| <input type="checkbox"/> Guilt/Low Self-Esteem | <input type="checkbox"/> Delusions | <input type="checkbox"/> Learning Disability |
| <input type="checkbox"/> Lying | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> School Problems _____ |
| <input type="checkbox"/> Hopelessness/Helplessness | <input type="checkbox"/> Memory Problems | _____ |
| <input type="checkbox"/> Anxiousness | <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Medical Conditions _____ |
| <input type="checkbox"/> Obsessions/Compulsions | <input type="checkbox"/> Defiance | _____ |
| <input type="checkbox"/> Trauma: Emotional/Verbal/
Physical/Sexual | <input type="checkbox"/> Physical Complaints: _____ | <input type="checkbox"/> Other _____ |

Victim _____ Interested in Losing Weight

Perpetrator _____ Interested in Quitting Smoking



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Treatment History No Previous Treatment

	Outpatient	Inpatient past year	One prior admission	Multiple admissions
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Substance Abuse History

Type	Amount	Frequency/Pattern	Method of Use	Last Use	Age of 1 st Use
Alcohol					
Marijuana					
Heroin/Narcotics					
Amphetamines					
Cocaine/Crack					
Hallucinogens					
Nicotine					
Barbiturates					
Other					
Addictions (gambling/sex)					

Comments _____



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Medications

Is the client on any prescribed medications, over-the-counter medications, or herbal or vitamin supplements?

No Yes (please complete medication information below)

Name of Medication	Purpose	Dosage	How Long on the Medication	Prescriber	Is it helpful?

Do you have a good understanding of your medications and how they work? Yes No

Social History (check all that apply)

Current Marital Status:

- Married
- Divorced
- Separated
- Living Together
- Widowed
- Single

Employment Status:

- Full-Time
- Part-Time
- Self-Employed
- Disabled
- Unemployed
- Retired
- Student

Number of Marriages _____

Number of Dependents _____

Highest Educational Level _____

What school are you attending?

What kind of work do you do?

Family History	Mental Health	Substance Abuse	Developmental Delay	Major Medical	Criminal	Specify
Grandparent						
Mother						
Father						
Siblings						
Other:						



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Family & Marriage Therapy

I specialize in family and marriage therapy. It is incredible what can happen when the whole family comes to counseling and talks to each other with the help of a counselor. Sometimes what we think is the problem is only the symptom of a bigger problem. Every family has challenges, but if we figure out what they are and talk them out, we can improve family relations.

Sometimes, without realizing it, couples emphasize their weaknesses while ignoring their strengths. I help them see what they have so they appreciate it more while assisting them in learning how to deal with those weaknesses more effectively. You can improve once you decide to work on the problem. I encourage anyone who wants to improve the quality of their family life to invest time and effort in counseling. What we learn about each other and ourselves is crucial in helping us change.

Benefits of Counseling & Approach

Counseling offers you the opportunity to make some critical changes. The success of those changes depends on your effort and participation in the process. Some benefits include conflict resolution, a greater sense of meaning and purpose in life, increased self-worth, and an awareness of one's choices. Learning to make decisions with a long-term perspective in mind produces much better decisions. In each counseling session, I aim to help you develop the needed skills to accomplish your goals. My approach to counseling is practical, in which I use techniques and principles that best fit each situation. I work to help you see the other perspective. Secondly, I concentrate on how we think and how our thoughts become patterns, ultimately influencing our behavior. Thirdly, I help the person design a strategy to implement appropriate behavior. Successful counseling helps marriages and families appreciate each other and enjoy their relationships.

Qualifications

I have been counseling families for many years. I have a Master's degree in counseling from Missouri Baptist University in St. Louis and a Doctorate in Psychology from California Southern University in Irvine, California. I am a Licensed Professional Counselor #2011014362 in Missouri and a National Certified Counselor #326853.

Appointments and Fees

The charge is \$160 to initiate counseling, individual or couple (reports and letters are additional). That gives you four sessions. If you need to cancel, you must do so within 24 hours; if not, I count that missed session as one of the four. We do not accept insurance but can give you an official receipt to submit to your insurance for reimbursement. To get started:

1. Download the forms and fill them out.
2. Sign the consent form and drop them off by the office or mail them to our office with your payment.
3. Make checks or money orders to People's Church, 1770 Missouri State Rd, Arnold, MO 63010.

Please call the office for more information. Office: 636-296-0400. Once we receive your forms and payment, I will contact you about an appointment.

Pastor Boyd D. Brooks PsyD, LPC, NCC.



Informed Consent for Counseling Services

Counseling of Minor Persons

Minor clients (persons under the age of 18 who are not legally emancipated) must have the permission of a parent or legal guardian to receive psychological services. Laws provide that the parent or legal guardian has a right to information obtained in the course of counseling or psychological assessment. At the onset of treatment, the counselor, the minor client, and parent or guardian will discuss the limits of confidentiality as it regards a minor client.

Special Disclosure Situations:

If the client presents a clear and present danger to themselves and refuses to accept appropriate treatment, the counselor is mandated to release relevant information to protect the client.

If the counselor has a reasonable basis to believe that there is a clear and present danger of physical violence against a clearly identified or reasonably identifiable victim(s), the counselor is mandated to release relevant information to protect the potential victim(s).

If there is a threat of imminently dangerous activity by the client against themselves or another person, the counselor is mandated to disclose client communication to place or retain the client in a psychiatric hospital.

If the client, or any party acting on behalf of a deceased client, introduces evidence of the client's mental condition as an element of claim or defense in a legal proceeding (except child custody or adoption), the judge may order the counselor to disclose confidential client communication.

In any case of child custody or adoption, a judge may order the counselor to disclose confidential client communication if the judge determines that the counselor has evidence bearing significantly on the client's ability to provide proper care or custody. It is more critical to the welfare of the child that the communication be disclosed than the relationship between client and counselor be protected.

If the client initiates legal action (for example, malpractice, criminal, or license revocation) against the counselor, the counselor may disclose confidential client communication if disclosure may be necessary or relevant to the counselor's defense.

The counselor may be required to provide diagnostic or treatment information to an insurance company or review board, non-profit hospital or medical service corporation, or health maintenance organization for administration or provision of benefits and expenses to compensate the client.

If the counselor has reasonable cause to believe that a child under the age of eighteen years is suffering from severe physical and or emotional injury, abuse, or neglect, the counselor is mandated to report that information to the appropriate agencies.

If the counselor has reasonable cause to believe that a person over the age of 60 or handicapped or disabled person is suffering abuse, the counselor is mandated to report this information to the appropriate agencies.

Information acquired by the counselor in the course of professional practice may be disclosed to another appropriate professional as part of a professional consultation.

In the case of a court order that compels the counselor to reveal confidential information.

My approach is the "no secrets" policy with marriage and couples counseling. Although I am usually able to convince the individual to share the secret, I reserve the right to do so if necessary. If you have any questions about confidentiality or this statement, please feel free to ask me.

Boyd D. Brooks, PsyD., LPC # 2011014362 at 636-296-0400.

Counseling Notes: Notes recorded by your clinician documenting the contents of a counseling session with you will be used only by your clinician and will not otherwise be used or disclosed without your written authorization.

Print/Type Name: _____ Telephone: () _____

Complete Address: _____

Signature _____ Date _____

Parent/Guardian's Signature _____ Date _____

Relationship: _____