VALLEY CHRISTIAN COUNSELING

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The Staff of Valley Christian Counseling Welcomes You

We appreciate your selecting us and having confidence in our staff. We want you to feel comfortable coming to Valley Christian Counseling and to accomplish this we have prepared this introduction. Although this document can seem long and complex, it is very important that you read it carefully and complete all sections before our first session. We can discuss any questions you may have at that time. Please continue to ask any questions or voice concerns throughout the course of treatment so that our professional relationship will be open and satisfying for all. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time.

Appointments

Psychotherapy appointments are normally 50 minutes in duration, however longer sessions are also available. After your intake appointment, future appointments will be scheduled as determined between you and your clinician. Clients are seen by appointment only. To change or cancel an appointment, we require at least a 48-business hour notice to our office for any cancellations. This will help us to schedule those waiting for appointments and for you to avoid being charged for the time that was reserved for you. **Clients who cancel without a 48-hour notice or do not attend their appointment will incur a cancellation/no show fee.** If your appointment is on a Monday, and you leave a message on the machine over the weekend, then that does not constitute 48-hour notice. Insurance does not pay for late cancellations or missed appointments. Confirmation calls are done as a courtesy to patients; however, there are times we cannot make them. Please do not rely on our call.

Emergencies

If you experience an emergency during or after hours, you should seek immediate help by calling 911, Helpline (539-1000 or 539-3424), the mental health center (533-1970), your primary care physician, or one of the hospital emergency rooms for assistance as needed and then alert your clinician at your earliest convenience.

Financial Agreement

Office policy is full payment at the time services are rendered. We accept cash, checks, and credit cards. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require the disclosure of otherwise confidential information. In most collection situations, the only information released regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

***I am looking for a clinician to assist me in court related issues: NO _____ YES_____**

- If a letter or other special correspondence is requested/required, preparation time for processing the request may be billed at the clinician's usual hourly rate.
- Review of past therapeutic documentation (i.e. treatment, history, discharge summaries, etc.) letters, journals, or personal writings forwarded to the clinician for reading and telephone correspondence to and from authorized sources may be subject to billing at the usual hourly rate and is regarded as the client's personal financial responsibility (not covered by insurance).
- During the course of treatment, off-site consultation is sometimes requested. School consultations, team meetings, and hospital consultations are billed at the usual hourly rate, including travel time.
- **Clients are discouraged from having their clinician subpoenaed.** All court related work is billed at $220/hour. This is a non-insurance charge. The client will be responsible for payment which includes: phone calls, filing documents with the court, pre-court record review, pre-court case formulation, depositions, consultations with attorneys, court appearances, in court (testimony) time, and time for travel and "waiting," and total time out of the office (departure until return). The minimum charge for a court appearance is $1500. A retainer of $1500 is due in advance. If a subpoena or notice to meet attorney(s) is received without a minimum of 48-hour notice there will be an additional $250 "express" charge. Also, if the case is reset with less than 72 business hours notice, then the client will be charged $500 (in addition to the retainer of $1500). Even though you are responsible for the testimony fee, it does not mean that the clinician's testimony will be solely in your favor. The clinician can only testify to the facts of the case and to their professional opinion. Patients will be asked to sign a release of information and agreement for court appearances, if these services are required.

I, (your name) _____ understand that my clinician is not in network for any private insurance providers. Valley Christian Counseling does not file insurance. We cannot determine if or what you will be reimbursed for mental health services. That is between you and your insurance provider. If you plan to file an insurance claim on psychological services, please contact your insurance provider before your first visit to verify your mental health benefits as pre-certification or authorization may be required. You will be provided a complete itemized statement that contains all necessary information needed so that you can bill your insurance directly.

I have been given the opportunity to discuss these policies and to ask for clarification. I have read and agree with all of the above information. I understand that I will be responsible for charges and will pay for services as rendered regardless of amounts, if any, reimbursed to me by my insurance company. My signature below constitutes an understanding of and agreement to the terms and conditions above.

_____ _____

Client or Legal Guardian's signature Date

Clinical Record

Professional laws and standards require that a clinical record of psychotherapy services be maintained for all treatment provided. The client record remains the property of the clinician. Patients have the right to request that a record is amended; to request restrictions on what information from your clinical record is disclosed to others; to request an accounting of disclosures that you have neither consented to nor authorized; to determine the location to which protected information disclosures are sent; and to have any complaints you make about these policies and procedures recorded in your records. Valley Christian Counseling is not a HIPAA covered entity. I am happy to discuss any of these rights with you.

Confidentiality and Disclosure Statement

The confidentiality of psychotherapy services provided by Valley Christian Counseling is protected by professional ethics and law. Unless you grant written permission, we will neither inform anyone that you are receiving services, nor will we disclose personal information provided. Legal and ethical exceptions exist. If you would like for information from your clinical record to be sent to a third party (i.e., physician, therapist, attorney, etc.) you must *first* sign a Release of Authorization form provided by our office. A fee may be required before records are forwarded.

Limits On Confidentiality

The law protects the privacy of all communications between a patient and a clinician. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements. There are other situations that require that you provide written advance consent. Your signature on this Agreement provides consent for those activities, as follows:

1. I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I believe that it is important to our work together. I will note all consultations in your Clinical Record.

2. You should be aware that I practice with other mental health professionals and that I employ administrative staff. In most cases, I need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling and billing. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

3. I also may have contracts with other businesses such as an accounting firm or attorney. I have a formal business associate contract with these businesses, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, I can provide you with the names of these organizations and/or a blank copy of this contract.

4. If a patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

1. If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the therapist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

2. If a government agency is requesting the information for health oversight activities, I am required to provide it for them.

3. If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.

4. If a patient files a worker's compensation claim, I may disclose information relevant to that claim to the patient's employer or the insurer.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about a patient's treatment.

1. If I know or suspect that a child under the age of 18 has been abused or neglected, the law requires that I file a report with the appropriate governmental agency, usually the Alabama Department of Human Resources. Once such a report is filed, I may be required to provide additional information.

2. If I know that an elderly or disabled adult has been abused, neglected, exploited, sexually or emotionally abused, the law requires that I file a report with the appropriate governmental agency, usually the Alabama Department of Human Resources. Once such a report is filed, I may be required to provide additional information.

3. If a clear and immediate threat of serious physical harm to an identifiable victim is communicated by a patient then I am required to communicate confidential information to a potential victim, the family of a potential victim, law enforcement authorities, or other appropriate authorities.

I hereby acknowledge that these limitations on confidentiality have been read by me and/or explained to me and I agree to abide by them. I have been given the opportunity to discuss these concepts and conditions and to ask for clarification. I understand that my consent to treatment may be withdrawn by me at any time without prejudice.

_____ _____

Client or Legal Guardian's Signature Date

Client's Rights

You, the client, have the right to:

- Receive respectful treatment that will be helpful to you without discrimination
- Be informed about techniques, intervention strategies and procedures, or any aspect that might not be clear or understood regarding treatment
- Be informed and inquire about diagnosis, methods of assessment, and the goals of treatment
- Accept or decline treatment (except in emergency situations or when ordered by a judge or Federal/State authority)
- Seek alternative psychotherapy services and be provided with an appropriate referral

- Discuss, question, and participate in hospital, residential placement, half-way or quarter-way treatment decisions
- Ask for and receive information about the clinician's qualifications, including license, education, training, experience, membership in professional groups, special areas of practice, and limits of practice
- Refuse to answer any question or give any information you choose not to answer or give
- Know if your clinician will discuss your case with others
- Ask that the clinician inform you of your progress
- A safe treatment setting, free from sexual, physical, and emotional abuse. In a professional relationship, sexual intimacy between a therapist and a client is never appropriate
- Report suspected immoral or illegal behavior

Other Considerations

Smoking is not allowed inside the facilities. Possession of illegal substances, alcohol, firearms, or weapons is prohibited on our premises. Being under the influence of drugs or alcohol is prohibited. If we suspect that you are in violation of these rules, or any other laws, you will be asked to leave, and /or appropriate authorities will be notified.

Our psychologist, therapists and psychiatrist are experienced, independently licensed and certified in their respective specialty areas. Each practitioner operates as the sole proprietor of his or her practice. My signature below acknowledges my understanding and acceptance that each practitioner here operates as the sole proprietor of his or her practice. I agree to hold harmless all other practitioners at this site from the actions of my psychologist or therapist.

_____ _____

Client or Legal Guardian's signature Date

Client Contact Information

Client's Name_____ Date _____
Client Age_____ Sex_____ Ethnicity _____ Date of Birth _____
Home Address _____
City_____ State _____
Email _____ Cell Phone _____
Home Phone _____ Work Phone _____ (Circle preferred contact #)
*OK to leave a voicemail at preferred contact # regarding appointments? Y N
How did you hear about us:_____
Other family members seen here:_____
In case of an emergency please contact:_____
Relationship:_____ Telephone: _____

Background Information

Reason for Seeking Treatment:_____
_____
_____
Approximately how long have you had the current problem or concern? _____
How was the decision made to come in now? _____
_____
In what ways have you attempted to cope with this problem or concern? _____
_____
What do you hope to accomplish through psychotherapy? _____
_____
Are you currently receiving psychiatric services, counseling or therapy elsewhere? Y N
Have you ever seen a therapist, counselor, psychologist, or psychiatrist prior to this? Y N
*If yes, please list names of providers, dates, reasons for treatment and outcomes of treatment:
_____
_____
_____
_____
_____
Have you ever been hospitalized for psychological problems? Y N
Have you ever received psychological testing in the past? Y N
*If yes, by whom, when, where and for what reason?
_____
_____
_____
Have you ever heard unusual noises or voices that other people nearby were not able to hear? Y N
Have you ever had visions of people or things that seemed real? Y N
Have you ever smelled odors that others nearby did not smell? Y N
Have you thought that someone else might be controlling your mind or putting thoughts into your head? Y N
Have you personally experienced any abuse: ( ) None ( ) Emotional ( ) Physical ( ) Sexual
Do you currently have thoughts of harming yourself? Y N
Do you currently have thoughts of wishing you were dead? Y N
Do you currently have urges to hurt, harm, or kill someone else? Y N If yes, whom? _____
Have you ever attempted suicide or intentionally harmed yourself? Y N

Have you ever seriously considered suicide or felt like harming someone else? Y N
If yes, please explain: _____
_____
Have you lost or gained an unusual amount of weight lately Y N Lost or Gained ____ lbs

Family History

Marital Status_____ Spouse/ Partner's Name_____
How long have you been married? _____ Previous marriages? _____
Is the marriage in trouble? Y N Areas of concern: _____
Do you have any problems with relatives or in-laws? Y N
Are there any issues about your marriage you wish to discuss? _____
Is your spouse willing to participate in psychotherapy? _____
If never married, are you now involved in a serious relationship with anyone? _____
Are you now living alone or with somebody who is not your spouse? Y N

Where were you born/raised? _____
In general, how happy or adjusted were you growing up? ( ) Poor ( ) Average ( ) Completely
Were you ever raised by someone other than your biological parents? Who: _____
Did you have an unhappy childhood? Y N
Were you ever abused or mistreated as a child or teenager? Y N
Were you often in poor health as a child or teenager? Y N
Were you very poor when growing up? Y N
Did you have a poor relationship with your mother or father? Y N
Choose three words to describe your father: _____
Choose three words to describe your mother: _____
What important expectations were held for children growing up in your family of origin?
_____
Were you especially close to any adults other than your parents? Who _____
How was affection expressed in the home where you grew up? _____
How was anger expressed in the home where you grew up? _____
Were there any unusual or disturbing experiences in your childhood? Y N
Do you feel your current problems may be directly related to the way you were raised? Y N
At what age ( ) and under what circumstances did you leave home? _____

How much is your immediate family a source of emotional support for you?
( ) None ( ) Little ( ) Somewhat ( ) Substantial ( ) Always
Who in your family do you currently feel closest to? _____
Most distant from? _____ In most conflict with? _____
Do you have inadequate social support (family/friends)? Y N
Religious affiliation: _____ Was religion a major part of your upbringing Y N
Is religion a major part of your life now? Y N
Would you like your therapist to pray with you? Y N

Is there a familial history of any of the following concerns with any biologic relatives (please include immediate family members and extended relatives)?

			Relationship to Patient
Autism Spectrum	Y	N	_____

Suicide	Y	N	_____
Eating Disorder	Y	N	_____
Depression	Y	N	_____
Bipolar Disorder/Manic-Depression	Y	N	_____
Anxiety Disorder	Y	N	_____
Obsessive-Compulsive Disorder	Y	N	_____
ADD/ADHD	Y	N	_____
Schizophrenia or Psychotic Disorder	Y	N	_____
Alcohol/Drug Problems	Y	N	_____
Legal Problems	Y	N	_____
Other (please specify)	Y	N	_____

Education Information and Work History

Highest education level completed: _____ History of learning problems Y N
Were you generally a below average student?____Were you generally an above average student?_____
Were you a behavior problem in school or when growing up? Y N
Were you ever in trouble with the law or juvenile authorities while growing up? Y N

Employment status (Check all that apply):
( ) Employed ( ) Homemaker ( ) Retired ( ) Disabled ( ) Student ( ) Unemployed
If/When employed, what type of work do you do? _____
Current Employer: _____ Years on Current Job: _____
Are you unsatisfied with your present work? Y N

Previous Jobs Held	*How Long*	*Why Left*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you been in trouble with the law as an adult? Y N
History of Military Service: Y N Currently in military? Y N Branch: _____
If you served in combat, when did you serve? _____
Type of discharge: _____ Reason for discharge: _____

What are your ambitions in life? _____
Please list any leisure activities (such as sports, clubs, religious organizations, etc.) that you are involved in currently: _____
_____

Medical History

Your present state of health is: ( ) Excellent ( ) Good ( ) Fair ( ) Poor
Describe any current medical problems (including allergies, asthma, injuries, etc.)
_____
_____
_____
Name of medical provider by whom you were last seen:_____Date_____

Address:_____Phone # _____
How many times a week do you exercise?_____ For how long? _____
Please describe all past major hospitalizations or illnesses (i.e. when, where, how long, for what problem, type of treatment received):

_____

_____

_____

Please list all currently prescribed medications and over-the-counter medications and supplements; the reason prescribed; the duration; and effect by completing the following table:

Name of medication	Reason prescribed	Date started	Date ended/ reason for stopping	Helpful? Yes/No Side effects?

What is your sexual orientation? ( ) Heterosexual ( ) Gay/Lesbian ( ) Bisexual ( ) Unsure

Are you currently sexually active?	Y	N
Is sex a problem area for you?	Y	N
Is your present sex life satisfactory to you?	Y	N
Has your sexual interest/behavior changed recently?	Y	N
Have you had any unusual or disturbing sexual experiences?	Y	N
Would you like to discuss sexual matters with your therapist?	Y	N

Substance Use History

Have you used any of the following?

	Current Use	Past Use	How much/often	Last time used?
Alcohol	_____	_____	_____	_____
Marijuana	_____	_____	_____	_____
Cocaine, including crack	_____	_____	_____	_____
Amphetamines, speed	_____	_____	_____	_____
Tranquilizers or sedatives	_____	_____	_____	_____
Caffeine (coffee, tea, cola)	_____	_____	_____	_____
Nicotine (cigarettes, tobacco	_____	_____	_____	_____
Appetite suppressants/diet pills	_____	_____	_____	_____
Hallucinogens, LSD	_____	_____	_____	_____
Inhalants	_____	_____	_____	_____
Opium/heroine	_____	_____	_____	_____
Medication abuse	_____	_____	_____	_____
Other medication abuse	_____	_____	_____	_____

Have you ever been hospitalized or received treatment for substance abuse problems? Y N
Have you ever tried to cut down on the amount of alcohol you consume? Y N
Has anyone close to you ever been annoyed by your drinking or drug usage? Y N
Do you consider your alcohol consumption or drug usage to be a problem? Y N
In a typical month, how often do you have 4 or more drinks in a 24 hour period? _____
If substance abuse has occurred, please provide specific information including amounts of the substance, withdrawal symptoms, successful, and unsuccessful attempts to decrease or discontinue use.
_____
_____
_____

Personal Perception Circle any words which apply to you according to you:

Competent	Confident	Shy	Unloved
"A nobody"	Not Confident	Weak	Loving
Intelligent	Guilty	Strong	Kind
Stupid	Evil	Superstitious	Considerate
Attractive	Morally wrong	Outgoing	Quiet
Unattractive	Irritable	Friendly	Loud
Plain	Angry	Neat	Bored
Ugly	Aggressive	Messy	Restless
Repulsive	Timid	Disorganized	Regretful
A loner	Misunderstood	Confused	Others: _____
Nervous	Jumpy	Lonely	_____

Please complete the following sentences:

I am a person who_____
All my life_____
I am proud of _____
I regret_____
It's hard to admit that_____
I can't forgive_____
Life is_____
Mother_____
Father_____
I would like to change_____
My earliest memory is_____
My motto is_____
I like_____
My greatest fear_____
What makes me angry is_____
I can't _____
I am embarrassed_____
I secretly_____

Pre-treatment Checklist of Concerns

Please mark all of the items that apply, and add any others at the bottom.

- o I have no problems
- o Abortion, crises/ unexpected pregnancies, post-abortion issues
- o Academic Problems, Learning Disabilities
- o Adoption, infertility
- o Abuse: physical, sexual, emotional, neglect (of children or elderly), animal cruelty
- o Aggression, violence
- o Alcohol use
- o Anger
- o Anxiety, nervousness
- o Attention, concentration, distractibility
- o Autism Spectrum Disorder, developmental concerns
- o Bedwetting
- o Career concerns, goals, and choices
- o Child leaving home
- o Childhood issues (your own childhood)
- o Children, child management, childcare, parenting, child-parent relationships
- o Chronic illness
- o Codependence
- o Confusion
- o Compulsions
- o Crying spells
- o Custody of children, divorce litigation
- o Debilitating injuries/disabilities
- o Decision-making, indecision, mixed feelings, putting off decisions
- o Delusions (false ideas)
- o Dependence
- o Depression, low mood, sadness, crying
- o Divorce, separation
- o Dizziness
- o Drug use – prescription medications, over-the-counter medications, street drugs
- o Eating problems – over-eating, under-eating, changes in appetite, vomiting
- o Emptiness
- o Eviction/repossession
- o Failure
- o Fainting spells
- o Family concerns
- o Fatigue, low energy, constantly tired
- o Fears of specific things, phobias
- o Fear of losing my mind, going crazy
- o Financial or money troubles, debt, impulsive spending
- o Flashbacks
- o Friendships
- o Gambling
- o Gender identity problems
- o Grieving, mourning, deaths, losses, bereavement
- o Guilt
- o Hallucinations, psychosis (hearing or seeing things that others don't)
- o Health, illness, medical concerns, physical problems
- o Heart racing
- o Home life concerns
- o Homicidal thoughts (current or history of)
- o Identity (self-esteem, goals)
- o Inferiority feelings
- o Impulsiveness, loss of self-control
- o Irresponsibility
- o Irritability
- o Job related stress
- o Judgment problems, risk-taking
- o Learned about a "family secret"
- o Legal matters, charges, suits
- o Loneliness
- o Mania
- o Marital conflict, distance/coldness, infidelity/affairs, remarriage
- o Medical concerns
- o Memory problems, forgetfulness
- o Menstrual problems, PMS, menopause
- o Mood swings
- o Motivation, laziness
- o Nausea/vomiting
- o Nervousness, tension
- o Obsessions, compulsions (thought or actions that repeat themselves)
- o Others controlling your thoughts
- o Over-sensitivity to rejection
- o Overambitious
- o Panic or anxiety attacks
- o Perfectionism
- o Pessimism
- o Physical complaints, headaches, other pains

- Pornography, sexual addictions
- Premarital counseling, engagement
- Procrastination, work inhibitions, laziness
- Rebellion, oppositional behaviors
- Recent trauma (assault, burglary, accident, etc.)
- Relationship problems, difficulty making friends
- Retirement
- Seeing strange visions
- Self-centeredness
- Self-harm, cutting, burning
- Self-neglect, poor self-care
- Sexual issues, dysfunctions, conflicts, desire differences
- Shyness, over-sensitivity to criticism
- Significant property damage
- Sleep problems - too much, too little, insomnia, nightmares
- Smoking and tobacco use
- Spirituality, religious issues
- Stealing
- Stress, relaxation, stress management, stress disorders, tension
- Suspiciousness
- Suicidal thoughts (current or history of)
- Temper problems, outbursts, low frustration tolerance
- Thought disorganization and confusion
- Threats, violence
- Tics, motor or verbal
- Trust issues, mistrust of others, suspiciousness
- Uncontrolled behavior/feelings
- Unemployment
- Vandalism
- Verbal abuse
- Weight and diet issues
- Withdrawal, isolating
- Worries, excessive

Please indicate if the following symptoms are either a current or past problem. Please indicate the frequency using the following scale: Never (1); Sometimes (3); Almost Always (5)

Anxiety Symptoms	**When**	**Frequency**
Excessive worrying	Current / Past	1 2 3 4 5
Muscle stiffness	Current / Past	1 2 3 4 5
Panic attacks	Current / Past	1 2 3 4 5
Avoiding things	Current / Past	1 2 3 4 5
Unwanted fears	Current / Past	1 2 3 4 5
Unwanted rituals	Current / Past	1 2 3 4 5
Unwanted habits	Current / Past	1 2 3 4 5
Procrastination	Current / Past	1 2 3 4 5

In the last four weeks have you had an anxiety attack? (Suddenly feeling fear or panic) Y N
*If yes, has this ever happened before? Y N
Do these attacks bother you a lot or are you worried about having another attack? Y N
Do some of these attacks come suddenly out of the blue, or in situations where you don't expect to be nervous or uncomfortable? Y N

Think about your last bad anxiety attack:

Were you short of breath? Y N
Did your heart race, pound, or skip? Y N
Did you have chest pain or pressure? Y N
Did you sweat? Y N
Did you feel as if you were choking? Y N

Did you have hot flashes or chills? Y N
Did you have nausea or an upset stomach, or the feeling that you were going to have diarrhea? Y N
Did you feel dizzy, unsteady, or faint? Y N
Did you tremble or shake? Y N
Were you afraid you were dying? Y N

Mania Symptoms	When	Frequency
Increased energy	Current / Past	1 2 3 4 5
Racing thoughts	Current / Past	1 2 3 4 5
Rapid speech	Current / Past	1 2 3 4 5
Less than 4 hours sleep per night	Current / Past	1 2 3 4 5
Euphoria	Current / Past	1 2 3 4 5
Invincibility	Current / Past	1 2 3 4 5
Irritability	Current / Past	1 2 3 4 5
Anger	Current / Past	1 2 3 4 5
Violent outburst	Current / Past	1 2 3 4 5
Sexual impulsivity	Current / Past	1 2 3 4 5
Financial impulsivity	Current / Past	1 2 3 4 5
Mood swings	Current / Past	1 2 3 4 5

Other information you feel is important and wasn't asked about: _____

_____

_____

_____

Thank you for your time and effort in completing these forms prior to your intake. This form is intended to help your clinician become better acquainted with you and in turn, serve you better. You may omit any item, but try to be as thorough as possible. This will allow us to use our time more efficiently during the intake session.