



# Joyful Hearts Counseling

Leslie Pechkurow, LPC, RYT, RPT-S

Welcome! Thank you for choosing Joyful Hearts Counseling. My name is Leslie Pechkurow, and Joyful Hearts Counseling is my private practice. I am pleased to offer counseling services to children, adolescents, and adults who are hoping to live with less stress and more peace in their lives. Whether you are healing from a past trauma, looking to improve relationships, or would simply like to live a more fulfilling life, I would be honored to accompany you through this journey.

A little about my experience...I am a Licensed Professional Counselor (LPC-14134), independently licensed in the state of Arizona to practice psychotherapy. I have been working in the behavioral health field since 2004, and I have worked in a variety of setting with a variety of populations. The type of therapy I use is a mixture of the experiences I have found most helpful in working with clients. When working with children I utilize a lot of play therapy techniques because this is the language that children can relate to. I am also trained as a Registered Yoga Teacher (RYT), and so I bring in mindfulness, meditation, and breathwork into my sessions with children, adolescents, and adults alike. Most important, I look to you as the expert in your life as my guide to what will make therapy a positive experience.

I believe that we all come to a point in our lives when we could benefit from the support and encouragement to help us overcome obstacles. Sometimes you will be on the helping end, and sometimes you will be on the receiving end. My passion is to help those who are ready to make changes and are open to someone walking with them to live a more joyful life.

Thank you,  
Leslie



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## Client Information/Assessment Form

Client Name: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Last) (First) (M.I.)

Client Address: \_\_\_\_\_

City-State-Zip: \_\_\_\_\_

Telephone: (home) \_\_\_\_\_ (cell) \_\_\_\_\_ May we leave a message? Yes No

E-mail address: \_\_\_\_\_ May we use to communicate? Yes No

Best method of contact for appointment reminders? text e-mail phone call other \_\_\_\_\_

Marital Status:  Never Married  Domestic Partnership  Married  Separated  Divorced  Widowed

Place of Employment: \_\_\_\_\_ Telephone: \_\_\_\_\_

**In case of an Emergency:** Contact Person: \_\_\_\_\_ Telephone: \_\_\_\_\_

### Treatment History

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?  No  Yes, previous therapist/practitioner:

When and how long?  
\_\_\_\_\_

Have you ever been hospitalized for a psychiatric condition?  No  Yes

If yes, describe date(s) and circumstances:  
\_\_\_\_\_  
\_\_\_\_\_

Are you currently taking any prescription medication?  No  Yes Please list:  
\_\_\_\_\_

If yes, who is your prescriber: \_\_\_\_\_

Have you ever been prescribed psychiatric medication?  No  Yes

Please list and provide dates, along with the prescriber names:  
\_\_\_\_\_  
\_\_\_\_\_



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## General Health

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

Poor      Unsatisfactory      Satisfactory      Good      Very good

Please list any specific health problems you are currently experiencing:

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

Poor      Unsatisfactory      Satisfactory      Good      Very good

Please list any specific sleep problems you are currently experiencing:

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

What types of exercise do you participate in:

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

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5. Are you currently experiencing overwhelming sadness, grief or depression?  No  Yes

If yes, for approximately how long? \_\_\_\_\_

6. Are you currently experiencing anxiety, panic attacks or have any phobias?  No  Yes

If yes, when did you begin experiencing this, and what symptoms do you have?

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7. Are you currently experiencing any chronic pain?  No  Yes

If yes, please describe?

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8. How often do you drink alcoholic beverages? \_\_\_\_\_ How many drinks at a time \_\_\_\_\_

9. How often do you engage recreational drug use?  Daily  Weekly  Monthly

Infrequently  Never

10. Are you currently in a romantic relationship?  No  Yes If yes, for how long? \_\_\_\_\_

On a scale of 1-10, how would you rate your relationship? \_\_\_\_\_



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## Presenting Concerns

Below is a list of concerns commonly reported by people seeking counseling. To facilitate the best assessment of your current situation, please check the number indicating the degree to which each item is *presently a concern for you*.

	(1) Not at all	(2) A little bit	(3) Quite a bit	(4) Extremely
1. Dealing with stress or pressure	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
2. Feeling sad, depressed or down	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
3. Death or illness of a significant person	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
4. Difficulties related to sexual orientation/identity	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
5. Family relationships	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
6. Abuse in relationship with partner/family member	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
7. Feeling anxious, worried, or panicky	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
8. Feeling unmotivated, difficulty concentrating	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
9. Feeling irritable, tense, angry, or hostile	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
10. Money or finances	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
11. Feeling isolated and uncomfortable with others	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
12. Values, beliefs, or spirituality concerns	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
13. Sexual abuse in childhood	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
14. Physical or verbal abuse in childhood	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
15. Someone else's habits or behaviors	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
16. My own unwanted habits or behaviors	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
17. Rape, sexual assault, or sexual harassment	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
18. Eating concerns (i.e., bingeing, restricting, vomiting, laxative use, etc.)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
19. Weight or body image concerns	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
20. Problems with partner/spouse/family member	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
21. Sexual concerns (i.e., pregnancy, sexual functioning, sexually transmitted disease, etc.)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
22. Physical health problems	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
23. Urge to harm others	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
24. Concerns about my own drug or alcohol use	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
25. Thoughts of harming myself	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
26. Other (please explain):	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

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Do you consider yourself to be spiritual or religious?  No  Yes

If yes, describe your faith or belief:

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What do you consider to be some of your strengths?

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Who do you consider to be a part of your support system?

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

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Is there any other important information about you that would be helpful to know?

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# Joyful Hearts Counseling

## **Client Rights and Responsibilities**

The following is to inform you of your rights as a consumer of counseling services and to outline your responsibilities as a client. Please read the following carefully so that you may be as informed as possible in giving consent to treatment. Please initial next to each statement.

### **Treatment Engagement**

\_\_\_\_\_ Initial

You have the right and the obligation to participate in treatment decisions and in the development and review and of your treatment plan. You also have the right to refuse any recommended treatment or to withdraw consent to treat and to be advised of the consequences of such refusal or withdrawal. Clients are often given homework assignments between sessions in order to facilitate growth and progress. You have the right to refuse these assignments at any time with the understanding that this could prolong your time in therapy. As your therapist I will remain dedicated to your treatment and will provide quality care to the best of my abilities. I ask that you, as the client, also take responsibility for your progress in counseling by remaining engaged and committed to your treatment goals. Our collaboration together will yield the best results!

### **Treatment Frequency**

\_\_\_\_\_ Initial

As a client you have the right to schedule and attend counseling sessions at your own convenience. As your therapist I will recommend a frequency that will promote the best possible progress towards your counseling goals. You may choose to schedule/attend sessions that are not as frequent with the understanding that progress may be compromised and total time in therapy may be prolonged. After 60 days of inactivity between sessions (meaning over 60 days between sessions) Joyful Hearts Counseling reserves the right to place your file on "closed status." This means that you are no longer a client of Joyful Hearts. If you would like to seek therapy after this time period you can simply contact Joyful Hearts Counseling and set up a therapy appointment to begin your therapy journey once again.

### **Purpose, limitations, and risks of treatment**

\_\_\_\_\_ Initial

Counseling is a process in which an individual seeks professional help to find relief from a stressful situation, event, or issue. While the ultimate purpose of counseling is to reduce your distress through a process of personal change, there are no guarantees that the treatment provided will be effective or useful. Moreover, the process of counseling usually involves working through tough personal issues that can result in some emotional or psychological pain for the client. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing, relationships, or virtually any other aspect of your life. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. While my goal, as the therapist, is to accompany you through this process and to facilitate a meaningful experience, I cannot guarantee that psychotherapy will yield positive or intended results at all times.

### **Our Relationship**

\_\_\_\_\_ Initial

The client/counselor relationship is unique in that it is exclusively therapeutic. In other words, it is inappropriate for a client and a counselor to spend time together socially, to bestow gifts to one another, or to attend family or religious functions. The purpose of these boundaries is to ensure that you and I are clear in our roles for your treatment and I can remain an unbiased participant in your treatment. If there is ever a time when you believe that you have been treated unfairly or disrespectfully, please talk with me about it. It is never my intention to



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cause this to happen to my clients, but sometimes misunderstandings can inadvertently result in hurt feelings. I want to address any issues that might get in the way of the therapy as soon as possible.

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## Payment policy

Initial

Payment is due at the beginning of each counseling session. You may pay with credit card, cash, check or through Paypal. An extra 2.5% + \$0.10 charge will be added to a credit card transaction for processing fees, and an extra 2.9% + \$0.30 will be added for Paypal fees. The payment scale is as follows:

Initial intake session	\$120
50 minute Individual/Family session	\$100
90 minute Individual/Family session	\$130
Late cancellation/no show	\$100

Because the scheduled session time is set aside specifically for you and cannot be used by others, a minimum of 24 hours is required for rescheduling or cancellation of an appointment to avoid payment.

Clients who use insurance to pay directly for counseling sessions should come to the first appointment with their insurance card and knowledge of what the payment responsibility is. Clients who are not prepared with this information may have to use part of the session to call and verify the insurance plan or will need to pay the full amount of the session until copay responsibility can be confirmed. The responsibility lies on the client to verify whether or not he/she is covered and how much he/she will need to pay at each visit.

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## Telephone calls between sessions

Initial

Brief telephone calls regarding a schedule change or asking for a specific piece of information are encouraged. Please allow 24 hours for non-emergency phone calls to be returned. Established clients with an urgent need may call, but an immediate response is not guaranteed. If the concern is regarding something significant, you may want to schedule an appointment. More extensive phone conversations may be charged as a regular office visit, but please note that Joyful Hearts Counseling does not conduct therapy over the telephone on a regular basis.

**I do not have the capability to respond immediately to a counseling emergency, and so if you experience a crisis in between counseling sessions, please call 911 or one of the crisis lines:**

**Impact Suicide Prevention Center/24 Hour Crisis Hotline – 480-784-1500**

**Teen Lifeline 1-800-631-1314**

**Maricopa 24 Hour Crisis Hotline 602-222-9444**

**Across Arizona 1-800-252-6465**

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## Requests for Written Documentation and Review of Chart

Initial

Requests for any type of written documentation will be considered and addressed as it pertains to the overall treatment goals of therapy. Requests may include but not limited to a summary of client’s progress, a summary of therapy notes, and/or other paperwork that may pertain to client’s well-being. Joyful Hearts Counseling reserves the right to fulfill or deny any request based on the appropriateness to therapeutic process. Requests that require more than 20 minutes to complete will be charged at \$40 per half hour.







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## Confidentiality Policy

Joyful Hearts Counseling regards confidentiality with the utmost importance, therefore it is essential that clients understand the limits and boundaries of confidentiality. In general, all information disclosed within a psychotherapy session, whether written or spoken, is confidential and legally privileged. Your therapist is the only individual who has access to your file, unless you direct your therapist, in writing, to disclose information to specific entities. However, there are a few circumstances under which a therapist is legally and ethically bound to disclose information:

### **Duty to Warn and Protect**

1. When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities.
2. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.
3. Abuse of children and vulnerable adults: If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.
4. Prenatal Exposure to Controlled Substances. Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

**Other circumstances that allow for disclosure include the following:**

### **Legal Proceedings:**

A court may require disclosure of confidential information in a legal proceeding in which your condition or treatment is a relevant concern. This may include, but is not limited to, legal proceedings such as a child custody hearing, board complaint, or criminal action.

### **Professional Consultation:**

As an independently licensed therapist I am not required to receive clinical supervision, however, in an effort to provide services that reflect best practices I belong to a group of therapists that meets regularly to discuss client care. When a client is discussed identifying information is kept confidential to the extent necessary.

### **Confidentiality in Group/Family Counseling**

Members of a counseling group are not bound to the same ethical and legal mandates that therapists are, however, if you do participate in a group or family counseling all members are asked to respect and maintain the confidentiality of what is disclosed during the course of treatment.



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## **Secrets Policy**

Secrets, when held from a family or significant other, can be destructive to the relationships of the individuals involved, including the holder of the secrets. When working with families the therapist reserves the right, when asked to maintain a secret, to work towards its disclosure as the therapist and individual together determine the appropriate time.

## **Treatment Records**

The therapist is required to maintain treatment notes, which include but are not limited to: dates of treatment, diagnosis, treatment interventions, and goals. The client (or parent/guardian in case of a minor) has a right to request records, however if examination of any part of these records would have an adverse effect on the client (or parent/guardian), the therapist is permitted to withhold that information and will provide justification for doing so.

## **Use of electronic and phone communication**

Although Joyful Hearts Counseling utilizes firewall and password protection for computer use, e-mail is not an encrypted form of professional exchange, therefore confidentiality cannot be guaranteed in this form of communication. When a client chooses to communicate using e-mail the client assumes the risk that the exchange may be intercepted. Joyful Hearts also employs the use of a password to protect any voicemail or text messages. If a client chooses to text the therapist and/or gives permission for the therapist to leave voicemails, the client again assumes responsibility that these messages could be viewed by another party.

\_\_\_\_\_ (initial) **I give permission to Joyful Hearts Counseling to leave a voicemail/text on this number \_\_\_\_\_.**

\_\_\_\_\_ (initial) **I give permission to Joyful Hearts Counseling to correspond through e-mail using this e-mail address \_\_\_\_\_.**

**I understand that only necessary information will be conveyed in any message left for me/my child.**

## **Insurance Claims**

In the event that an insurance company requests information other than on the claim form, this office will provide only a summary, with your written permission. Copies of progress notes from your confidential file will not be released. Most insurance companies require a diagnosis in order to pay for services.





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## Limits and Risks Associated with Telepractice/Email Use in Therapy

Although I use firewall, and my computer and files are password protected, I cannot guarantee absolute confidentiality in the use of telepractice/email exchange. I utilize a conference service through doxy.me that is an encrypted video service and HIPPA compliant, however my e-mail, phone calls, and text messages are not encrypted forms of professional exchange. If you choose to communicate with me via technology in any way, I will assume that you have made an informed decision, and I will view it as your agreement to take the risk that the exchange may be intercepted or interrupted.

Specific to telepractice exchange (phone or video), the client will identify him or herself by stating name, birthdate, residence zip code, and current location (address and phone number). The client will verify s/he is alone and in a confidential location. If client is not alone s/he will need to complete the necessary forms for additional people to be present during the counseling session.

It is possible that during our telepractice exchange the Internet connection may be disconnected or paused due to circumstances beyond either of our control. If this happens we will wait 2 minutes and try to connect again. If we are unable to reconnect at or near our scheduled time, we will call or e-mail with alternative times to resume or reschedule our exchange.

My secure appointment waiting room for teletherapy can be found at: <https://doxy.me/JoyfulHearts> Please note that this link will not work on Windows Edge browsers. You must use either Google Chrome or Firefox on Windows devices such as a PC, laptop or tablet. For iPad users, Safari will work as well. You should also be able to use your smart phone, especially if you don't have a web camera capability on your computer. You may also be able to reach me at my office number: (480)-420-8426 or via email at: [Leslie@joyfulheartscounseling.com](mailto:Leslie@joyfulheartscounseling.com)

**If I choose to communicate via phone call for counseling sessions, please use the following number/s:**

1. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ home/cell/work/other \_\_\_\_\_
2. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ home/cell/work/other \_\_\_\_\_
3. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ home/cell/work/other \_\_\_\_\_

**If there is no answer, I authorize that you can leave a message identifying who you are and a call back number**

Yes \_\_\_\_\_ No \_\_\_\_\_ (initial)

**If someone answers the call, and it is not you, I am authorized to leave a message with my name and phone number.**

Yes \_\_\_\_\_ No \_\_\_\_\_ (initial)

**I understand that telepractice will be a secondary support in my treatment, and that face-to-face will be the primary form.**

Yes \_\_\_\_\_ No \_\_\_\_\_ (initial)

**My signature indicates my understanding of the limitations and confirms my agreement to include this method of communication in my contact with Leslie Pechkurow, LPC. My signature also reflects that I have had an opportunity to ask questions regarding Leslie's use of telepractice and my questions have been answered.**

\_\_\_\_\_  
Client name

\_\_\_\_\_  
client signature

\_\_\_\_\_  
date