

{Simplified} Life Solutions
Hannah Rinehart, MA, LAPC
Informed Consent

Counseling is a cooperative venture with responsibility resting on both the counselor and the client. In order to enable you and Hannah to work most effectively together, please carefully read the information below. If you have any questions, Hannah will be happy to discuss them with you.

Hannah Rinehart is a Master's level counselor who is a Licensed Associate Professional Counselor approved by the Georgia Board of Professional Counselors, Social Workers and Marriage and Family Therapists. The counselor is receiving supervision from Terry Freeman, a Licensed Professional Counselor and Direction from Emily Shupert, a Licensed Professional Counselor. Hannah has been working with women, adolescents and their families for over 4 years in the State of Georgia.

Confidentiality: The Health Insurance Portability and Accountability Act (HIPPA) has created new patient protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law," HIPPA provides patient protections related to the electronic transmission of data, the keeping and use of patient records, and storage and access to health care records. HIPPA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide patients a notification of their privacy rights as it relates to their health care records. An explanation of those rights is attached to this document.

Communications between client and counselor are confidential and will not be revealed unless required by law such as in situations of

- 1.) child abuse, elder abuse, or threats of physical harm to self or others,
- 2.) for clinical supervision purposes,
- 3.) if subpoenaed by a court of law,
- 4.) If a guardian ad litem (GAL) is appointed in a custody case involving adolescent clients I have seen for counseling services and she/he is ordered by the court to have access to mental health practitioners and records therein, I am required to provide that information as it is court ordered.
- 5.) The Patriot Act of 2001 requires me in certain circumstances, to provide federal law agents with records, papers and documents upon request and prohibits me from disclosing to my client that the FBI sought or obtained the items under the Act.
- 6.) I am happy to provide paperwork for you to file with your insurance company; however, in doing so, there will be a diagnosis required with the paperwork and there may be a violation of your confidentiality, as insurance companies do not always observe the same strict confidentiality policies that I do as a Licensed Associate Professional Counselor. I am also willing to share information about our counseling sessions with any other professional or agency that you wish, provided you sign a Release-of-information form.
- 7.) In **working with adolescents**, though legally the parent(s) or legal guardian(s) of adolescent clients are the client and confidentiality lies with the client, in order to establish and preserve the essential relationship and setting for a adolescent's therapy, I honor what the adolescent does or says in our sessions as confidential while providing parents and/or legal guardians summaries of treatment goals, plan and progress as well as recommendations.
- 8.) In **working with couples and families**, the couple as an entity and the family as an entity is my client and I am not providing individual therapy for either half of the couple or for any one member of the family although sessions with individuals in the couple/family may be a part of the couples/family therapy. I ***will not be a "secret keeper" nor will I facilitate secret keeping.*** If anything significant is revealed in an individual session that I feel the other party needs to be told, I will require it be brought up in the next session together so we can work through it or I may have to terminate the therapeutic relationship and refer you to another therapist.

Counseling Fees: The normal fee for a 50-55 minute session is \$100 (includes time for handling administrative details such as scheduling the next appointment, etc). We ask that you keep your account current and pay by **cash, check or credit card (make checks out to Simplified Life Solutions)** at the beginning of the session. We do not accept insurance, but are happy to provide you with a receipt at the end of the month if you wish to file your own insurance claim. If you are experiencing financial hardship, please speak to your counselor about this, so she can work with you. In the event of lack of payments received for over 2 sessions, no further sessions will be made until the balance is paid in full.

Hours and Dates: See Online Scheduling Program for Openings and Specifics

Tuesdays: 10am-7pm, Thursdays: 10am-7pm, Fridays: 10 am- 6pm, Saturdays: check scheduling program for availability

Other Fees:

Phone calls: (longer than 10 minutes) \$5.00 a minute after first 10 minutes (first 10 minutes at no charge)

Non-session time \$80 an hour (Ex.: consultations with others at your request)

Paperwork time: \$80 an hour (Ex.: writing reports related to you at your request)

Other Charges: \$20 for a check returned for "insufficient funds"

Please be aware that I charge for and expect payment for phone time (time after the first 10 minutes) and for non-session time related to you. Payment is due at your next session following the rendering of these services. I will provide a statement for you upon request.

Cancellation of Appointments: If you must cancel your appointment for any reason, please phone Hannah at 770.880.3167 at least **24 business hours in advance** of your scheduled appointment. If you miss your appointment, you will be billed at the full rate.

Late Appointments: Each appointment begins at the scheduled time and lasts for 50 to 55 minutes. If you should arrive late for an appointment, the appointment will begin shortly after your arrival and end at the normal time.

Telephone Calls/Emails: The purpose of email, telephone, or other electronic correspondence is to assist in our communication regarding scheduling, appointment information, homework assignments, and information regarding payment status. This type of communication is not a way to communicate therapeutic information regarding your counseling care and treatment as these matters are saved for your counseling session time. While I will take reasonable, precautions to protect your confidential information, as with any electronic communication, there is no way to completely secure communication. Should you need to contact Hannah, you may leave a message at 770.880.3617. Please leave your name, telephone number, and a brief message. Your call will be returned as soon as possible, usually within 24 business hours.

Public Contact: In the event that you see me outside of the counseling office, my policy is to not acknowledge you until or unless you respond first. If you would like to acknowledge me or not, I will not be offended as it is completely dependent upon your level of comfort and desire for discretion.

Please initial that you have read the above statements and agree with them: _____

Nature of Counseling: You have the right to choose alternatives and to participate in designing your treatment plan. The therapeutic relationship, which we establish, will be characterized by respect and cooperation. Through therapeutic techniques and methods, I will offer you ways in which you can reach your counseling goals and objectives. My services will be practiced in a professional manner that is consistent with the Georgia State Board of Examiners of Professional Counselors qualifications for ethical standards. You are entitled to an explanation of your condition and the treatment that will be provided as well as the probable duration and adverse risk involved. Please know that it is impossible to guarantee any specific results regarding your counseling goals for the counseling process, however, together we can work to achieve the best possible results for you.

Emergency Procedures: This practice is not staffed with a receptionist or paging system, therefore we are not equipped to handle emergency situations. In the case of an emergency, we recommend you contact either a hospital emergency room or the police depending on the situation. You can also call the Georgia Crisis Line at: (800) 715-4225).

Divorce/Custody Disputes: If you are ever become involved in a divorce or custody dispute, I am not able to provide evaluations or expert testimony in court. You should hire a different mental professional for evaluations or testimony that you may require. My position is based on two reasons: 1) my statements will be seen as biased in your favor because we have a therapeutic relationship and 2) the testimony might affect our therapeutic relationship and I must put this relationship first. By signing this informed consent document, you are acknowledging your full understanding of and agreement on my position concerning this matter.

Dual Relationships: Counseling is a professional service I am providing to you. Because of the nature of counseling, our relationship has to be different from other relationships. Dual relationships set up conflicts between therapeutic interests and your best interest. In order to offer my clients the best care, my judgment needs to be professional at all times. Because I am your counselor, dual relationships like these are improper:

- I cannot be your supervisor, teacher or evaluator.
- I cannot be a counselor to my own relatives, friends (or the relatives of friends), people I know socially, etc.
- I cannot provide counseling to people I used to know socially.
- I cannot have any other kind of business relationship with you besides counseling.
- I cannot give you legal, medical, financial or any other type of professional advice.

I, _____, fully understand what I have just read and voluntarily request counseling services at {Simplified} Life Solutions and I agree to these terms and conditions.

_____ (signature of client) _____ (date)

_____ (signature of Parent or Guardian) _____ (date)

**{Simplified} Life Solutions
Hannah Rinehart, MA, LPC
Patient Notification of Privacy Rights**

The Health Insurance Portability and Accountability Act (HIPAA) has created new patient protections surrounding the use of protected health information. Commonly referred to as the “medical records privacy law,” HIPAA provides patient protections related to the electronic transmission of data (“the transaction rules”), the keeping and use of patient records (“privacy rules”), and storage and access to health care records (“security rules”). HIPAA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide patients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you don’t have formal legal training. This Patient Notification of Privacy Rights is our attempt to inform you of your rights in a simple yet comprehensive fashion. Please read this document, as it is important you know what patient protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of therapeutic relationship, and as such, you will find we make every effort to do all we can to protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask for further clarification.

By law, {Simplified} Life Solutions is required to secure your signature indicating you have received a copy of the Patient Notification of Privacy Rights document.

{Simplified} Life Solutions
HIPAA Compliance Officer

Patient Name (print) _____

I have received a copy of {Simplified} Life Solutions Patient Notification of Privacy Rights document, which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand that I have the right to review this document and I may at any time, not or later, as any questions about or seek clarification of the matters discussed in this document. Signing below indicates only that I have received a copy of the Patient Notification of Privacy Rights document.

Patient Signature

Date

Parent Signature if patient is a minor

Date

Guardian Signature if patient is legal charge

Date

Consent to Correspond Electronically

While {Simplified} Life Solutions takes reasonable precautions to protect your confidential information, e-mail, texting & social networking is not a completely secure method of communication.

I acknowledge that if I use electronic mail to initiate contact with a {Simplified} Life Solutions Staff member regarding my therapeutic care, the {Simplified} Life Solutions and/or his/her representative has my permission to correspond via that email address and other forms of electronic communications.

I give permission for a clinical staff member to email me regarding my therapeutic care at

_____ @ _____

The purpose of e-mail and other forms of electronic communication is to communicate with the client regarding scheduling appointments, reminding clients regarding their appointments, homework assignments, follow-up care according to staff or information regarding the clients' business account. Electronic communication is not a way of communicating new information regarding care or of communicating emergency treatment. You must call and talked to your individual therapist regarding any information towards your treatment at {Simplified} Life Solutions

In Case of Emergency:

If you are in an emergency situation and need to contact someone immediately to help you, you may call the following numbers:

Georgia Crisis Line: 1-800-715-4225

Atlanta Emergency Mental Health Services: 404-730-1600

Emergency Services: 911

____ I give {Simplified} Life Solutions my permission to add my e-mail address for the purpose of sending me notices of future events and other pertinent information through my e-mail.

{Simplified} Life Solutions

Payment Information

Payments are required at the date of services. You may pay through cash, check or credit cards. If you wish to pay by credit card, please complete the following:

Creditcard: MasterCard VISA

Number: _____

Expiration Month _____ Year _____

Address where bill is sent:

Street _____

City _____ State _____ Zip _____

Name as it appears on the card: _____

{Simplified} does not accept insurance as payment for services, although we will make every effort to provide the information necessary for you to file for reimbursement. You are responsible for payment at the time services are rendered.

By signing below you are indicating that you have read and agree to the above contract and that you also give authorization to {Simplified} to release any information necessary for you to secure insurance reimbursement for fees you have paid to restoration:

Client's Signature

Date

Counselor's Signature

Date

{Simplified} Life Solutions

Patient Notification of Privacy Rights

THIS FORM DESCRIBES THE CONFIDENTIALITY OF YOUR MEDICAL RECORDS, HOW THE INFORMATION IS USED, YOUR RIGHTS, AND HOW YOU MAY OBTAIN THIS INFORMATION. (EFFECTIVE 4-14-03)

LEGAL DUTIES: State and Federal laws require that we keep your medical records private. Such laws require that we provide you with this notice informing you of our privacy of information policies, your rights, and our duties. We are required to abide these policies until replaced or revised. We have the right to revise our privacy policies for all medical records, including records kept before policy changes were made. Any changes in this notice will be made available upon request before changes take place.

The contents of material disclosed to us in an evaluation, intake, or counseling session are covered by the law as private information. We respect the privacy of the information you provide us and we abide by ethical and legal requirements of confidentiality and privacy of records.

USE OF INFORMATION: Information about you may be used by the personnel associated with this clinic for diagnosis, treatment planning, treatment, and continuity of care. We may disclose it to health care providers who provide you with treatment, such as doctors, nurses, mental health professionals, and mental health students and mental health professionals or business associates affiliated with this clinic such as billing, quality enhancement, training, audits, and accreditation.

Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian or personal representative. It is the policy of this clinic not to release any information about a client without a signed release of information except in certain emergency situations or exceptions in which client information can be disclosed to others without written consent. Some of these situations are noted below, and there may be other provisions provided by legal requirements.

DUTY TO WARN AND PROTECT: When a client discloses intentions or a plan to harm another person or persons, the health care professional is required to warn the intended victim and report this information to legal authorities. 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.

PUBLIC SAFETY: Health records may be released for the public interest and safety for public health activities, judicial and administrative proceedings, law enforcement purposes, serious threats to public safety, essential government functions, military, and when complying with worker's compensation laws.

ABUSE: 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 health care professional is required to report this information to the appropriate social service and/or legal authorities. If a client is the victim of abuse, neglect, violence, or a crime victim, and their safety appears to be at risk, we may share this information with law enforcement officials to help prevent future occurrences and capture the perpetrator.

PRENATAL EXPOSURE TO CONTROLLED SUBSTANCES: Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

IN THE EVENT OF A CLIENT'S DEATH: In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records.

PROFESSIONAL MISCONDUCT: Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

JUDICIAL OR ADMINISTRATIVE PROCEEDINGS: Health care professionals are required to release records of clients when a court order has been placed.

MINORS/GUARDIANSHIP: Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

OTHER PROVISIONS: When payment for services are the responsibility of the client, or a person who has agreed to providing payment, and payment has not been made in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, progress notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the client's credit report may state the amount owed, the time-frame, and the name of the clinic or collection source.

Insurance companies, managed care, and other third-party payers are given information that they request regarding services to the client. Information which may be requested includes type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, and summaries.

Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed. Some progress notes and reports are dictated/typed within the clinic or by outside sources specializing in (and held accountable for) such procedures.

In the event in which the clinic or mental health professional must telephone the client for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please notify us in writing where we may reach you by phone and how you would like us to identify ourselves. For example, you might request that when we phone you at home or work, we do not say the name of the clinic or the nature of the call, but rather the mental health professional's first name only. If this information is not provided to us (below), we will adhere to the following procedure when making phone calls: First we will ask to speak to the client (or guardian) without identifying the name of the clinic. If the person answering the phone asks for more identifying information we will say that it is a personal call. We will not identify the clinic (to protect confidentiality). If we reach an answering machine or voice mail we will follow the same guidelines.

YOUR RIGHTS: You have the right to request to review or receive your medical files. The procedures for obtaining a copy of your medical information is as follows. You may request a copy of your records in writing with an original (not photocopied) signature. If your request is denied, you will receive a written explanation of the denial. Records for non-emancipated minors must be requested by their custodial parents or legal guardians. The charge for this service is \$1 per page, plus postage. You have the right to cancel a release of information by providing us a written notice. If you desire to have your information sent to a location different than our address on file, you must provide this information in writing. You have the right to restrict which information might be disclosed to others. However, if we do not agree with these restrictions, we are not bound to abide by them. You have the right to request that information about you be communicated by other means or to another location. This request must be made to us in writing. You have the right to disagree with the medical records in our files. You may request that this information be changed. Although we might deny changing the record, you have the right to make a statement of disagreement, which will be placed in your file. You have the right to know what information in your record has been provided to whom. Request this in writing. If you desire a written copy of this notice you may obtain it by requesting it from the Clinic Director at this location.

COMPLAINTS: If you have any complaints or questions regarding these procedures, please contact the clinic. We will get back to you in a timely manner. You may also submit a complaint to the U.S. Dept. of Health and Human Services and/or the Georgia Board of Counseling. If you file a complaint we will not retaliate in any way.

{Simplified} Life Solutions

Waiver of Confidentiality

I, _____, whose address is _____ do hereby consent and authorize:

{Simplified} Life Solutions counselor and/or coaches

To release information specified below to/To receive information specified below from:

I authorize the release of this information _____ verbally or _____ in writing, by my signature below:

____ Personal identifying information

____ Education and school-related information

____ Employment and work-related information

____ Psycho-social history and related information

____ Drug and alcohol information (for the sole purpose of assessment and/or treatment)

____ Treatment recommendations

____ Other _____

The authorized information is released only to the person named above. The information will be released with a warning that any further use of this information is a violation of confidentiality. I understand that this consent is revocable except to the extent that the action has been taken in reliance thereon and that this consent will remain in force until _____.

Dated this _____ day of _____, 200__

_____ Signature of Client

_____ Signature of Parent or Guardian _____ Printed Name of Parent or Guardian

_____ Witness

NOTE TO RECIPIENT OF INFORMATION: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Unless the records of your program are also subject to Federal Law, federal regulations prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information is not sufficient for this purpose

Simplified} Life Solutions
Counseling Intake Form
Hannah Rinehart, MA, LAPC

The following form, which will become a part of your confidential record, will enable me to gain a quicker understanding of you. Please answer each question as completely and carefully as you can. You may use the back of any page for additional comments.

Name: _____ Date of Birth _____ Age _____ Sex _____

Present Address _____
Street _____

City _____ County _____ State _____ Zip Code _____

Home or Cell Phone: _____ Can we contact you at work? Work phone: _____

Email _____ Would you like to be added to our monthly email newsletter? Yes No

Ethnicity _____ Years of Education _____ Referred by: _____

Marital Status: Single _____ Married _____ (# of Years _____) Divorced _____ Separated _____

Presently Living With: Parents _____ Spouse _____ Roommate _____ Alone _____ Other _____

Occupation _____ Total Hours/Week _____

Employed by _____ Phone _____

Religious Affiliation _____ Church _____

Are you a member? Yes _____ No _____ Active _____ Inactive _____

Are you interested in having Christian principles incorporated into counseling? Yes No Maybe

Family member to notify in case of emergency: Name: _____

Address: _____ Phone: _____

Education: Circle last year completed:

GradeSchool- 1 2 3 4 5 6 7 8

HighSchool - 1 2 3 4

College - 1 2 3 4 5 6 + Other Training: _____

Family Members:

<u>Relationship</u>	<u>Name</u>	<u>Age</u>	<u>Grade in School Last Completed</u>	<u>Occupation if Out of School</u>
Spouse	_____	_____	_____	_____
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Brother(s)	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
Sister(s)	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
Children	_____	_____	_____	_____
	_____	_____	_____	_____

Any miscarriages or abortions? _____

General Family History:

Approximately how many times did you family move when you were young? _____

Parents

If separated or divorced, how old were you at the time? _____

Father deceased? _____ How old were you at the time? _____

Step-father deceased? _____ How old were you at the time? _____

Mother deceased? _____ How old were you at the time? _____

Step-mother deceased? _____ How old were you at the time? _____

Father remarried when you were age _____ You lived with whom? _____

Mother remarried when you were age _____ You lived with whom? _____

Until age 18 tell how long you lived with Mother _____ Father _____
Step-mother _____ Step-father _____ Other _____

How did the step-parent relate to you? (kindly, poorly, affectionately, little discipline, etc.)

Natural father's occupation _____

Natural mother's occupation _____

Step father's occupation _____

Step mother's occupation _____

How many times was your father married? _____

Your mother? _____

Rate your parent's marriage: Miserable _____ Unhappy _____ Average _____ Happy _____
Very Happy _____ Their marriage lasted _____ years

Describe the relationship you have with your siblings:

Past:

Present:

Does your spouse wish to come for counseling? Yes____ No____ Maybe____

Have either of you ever filed for divorce?

Date of this marriage:

Age when married: You____ Spouse____

Give a brief description of any previous marriages: _____

Describe any physical problems you have that require medication or physical care: _____

Are you currently receiving medical treatment? Yes _____ No _____

List any prescription and over the counter drugs/vitamins, herbs, taken in the last 90 days.

_____	dosage _____	# of times per day _____	prescribed by _____
_____	dosage _____	# of times per day _____	prescribed by _____
_____	dosage _____	# of times per day _____	prescribed by _____

List medical providers you have seen in the last 90 days _____

List any allergies _____

Primary Physician Name and phone#: _____ Do you have a psychiatrist? Yes No

Circle other drugs you have used in the past 90 days: Alcohol Caffeine Nicotine Marijuana
Cocaine Heroin Pain Pills Inhalants Amphetamines/Speed Ecstasy LSD Other

Previous Counseling/Therapy Yes _____ No _____ If yes, when? _____

With whom? Name _____ Address: _____

What experiences did you like the most and least about your last counseling experience? _____

Have you ever been hospitalized for emotional or mental reasons, including substance abuse rehab? _____ yes _____ no

Year _____ Reason _____

Year _____ Reason _____

Is there a history of alcohol or drug use in your family? _____

Has a friend, family member or relative discussed concerns about your use? _____

Have you ever been concerned about your drinking or other drug use? _____

Briefly describe the problem which prompted you to seek counseling at this time: _____

Have there been times when the problem got better or disappeared? Yes _____ No _____

If yes, when? _____

What do you think helped?

Were there times when the problems were especially bad? Yes _____ No _____

If yes, when? _____

What made it bad? _____

What have you already done about the problem? _____

What are your goals in coming to counseling? _____

Are there other people who play a major role in causing your problems or in helping you cope with your problems?

Yes _____ No _____ Explain briefly _____

Is there anything else that you believe might be important for your counselor to know at this time? _____

Using the scale below, please choose a number that reflects the extent of your concern about each of the issues listed below. Please rate every item.

0	1	2	3	4	5	6	7	8	9	10		
No Concern					Moderate Concern					Extreme Concern		
_____	Anger/Temper										_____	Religious/Spiritual Concern
_____	Depression										_____	Sexual Concerns
_____	Education										_____	Thoughts of suicide
_____	Eating difficulties										_____	Trouble making decisions
_____	Fearfulness										_____	Unhappy most of the time
_____	Nervousness										_____	Use of alcohol
_____	Financial problems										_____	Use of alcohol by family member
_____	Marital problems										_____	Use of other drugs
_____	Physical problems/Headache										_____	Work
_____	Pornography										_____	Worry
_____	Problems with social relationships											
_____	Problems with children										_____	Other (specify) _____

I have read the Counseling Informed Consent and voluntarily request counseling services at **{Simplified} Life Solutions** in accord with terms described on the Informed Consent document.

Signature

Date

For clients age 17 and under, the signature of his/her guardian or custodial parent is required.

Parent/Guardian

Date

PLEASE SUBMIT PAYMENT WITH THIS FORM PRIOR TO FIRST SESSION

Please Complete the Following Sentences (For Adults):

- 1.) The most important thing to me is
- 2.) I worry about
- 3.) What I do best is
- 4.) I have sometimes felt guilty about
- 5.) What makes me angry is
- 6.) My biggest mistakes were
- 7.) My job
- 8.) What makes me nervous is
- 9.) My personality would be better if
- 10.) I often felt that mother
- 11.) Jesus Christ is
- 12.) My temper
- 13.) My childhood
- 14.) Prayer is
- 15.) My biggest disappointment
- 16.) To me, sex is
- 17.) I would be better liked if
- 18.) I often felt that father
- 19.) God to me is
- 20.) My children (child) (brothers and sisters)
- 21.) Women are
- 22.) What hurts me most is
- 23.) My biggest problem in life is
- 24.) Men are