CONSENT FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

Name (Adult) _____ Age _____ DOB _____

Address: _____ Phone: _____

Who is the client? _____ Relationship to Adult above: _____

Describe the problem you or the client is having: _____

Professional Disclosure: I am a Master's level mental health clinician, practicing with a License issued from the State of Arkansas. I am not a medical doctor, or a doctor of Psychology. My primary role is to provide professional counseling services. If you have questions, you are welcome to ask for clarification of my credentials, specializations, and training.

Risks and Benefits: I am aware that there are both risks and benefits to counseling. While most people experience some level of distress that leads them to seek counseling, it should be understood that when a counselor and client are working towards the goals of counseling, distress, problems in relationships, and other unforeseen circumstances may arise. It is also understood that a goal of counseling will be to alleviate or manage these potential stressors, but an exacerbation of problems may occur. The benefits of therapy may include, but are not limited to, the diminishing of symptoms, distress, relationship growth and a general sense of well-being. However, individual results are not predictable and may vary.

Confidentiality: In accordance with HIPAA and Arkansas state law, we are to keep your medical records confidential. The only exceptions to this are:

1. When the client gives directive/consent for the counselor to communicate with others.
2. When there is a threat to life either by homicide or suicide.
3. When there is a strong suspicion of abuse or neglect to children, elderly, or the handicapped.
4. When counseling records are subpoenaed by a court of law.

Fees: Individual and family counseling sessions last 45-50 minutes. The first session is a Diagnostic Interview. All other sessions are considered Ongoing Psychotherapy. We have established a *Standard Fee* for the Diagnostic Interview and also for the Ongoing Psychotherapy sessions. Additional fees may be assessed for work including special testing, court appearances, document creation, excessive phone calls, extra session time, or consultation with 3rd parties. Payment for services are expected at the end of each session. Concerns about payment will be discussed during the first session.

Emergency Notification:
My counselor can be called in the case of psychological emergencies. However he will not always be available by phone or in the evenings. If I cannot reach my counselor I can call 911 or go to the nearest emergency room.

Cancellation: Your appointment time is held for you alone; thus, we require 24 hours notice for appointment cancellations. Except in true emergencies, you will be charged full fee for a late cancellation or "no show".

I have read and understand the above information and agree to receive counseling for myself or for my child. I also give consent for my mental health clinician to leave a voicemail or text on my phone, or to contact me via email, as provided. If necessary, I give consent to my mental health clinician to file insurance claims regarding my payment and healthcare operations.

_____ _____ _____

Signature of Client (Adult, Legal Guardian) Print Name Date

_____ _____

Signature of Mental Health Clinician Date

CLIENT DEMOGRAPHICS

Client's Name _____ DOB _____ Social Security # _____

Address _____ City _____ State _____ Zip Code _____

Cell Phone _____ Alternate_____ (Cell) (Work) (Home)

Occupation _____ Emergency Contact Name/Phone _____

Referred by _____ May we send a note of appreciation to this person? Yes___ No____

(This note will not release any information other than the fact that you have initiated counseling.)

IF CLIENT IS A MINOR (complete this section)

Mother's Name _____ Phone _____ (Cell) (Work) (Home)

DOB _____ Social Security # _____

Address(if different than child) _____ City _____ State ___ Zip Code _____

Occupation _____Employer/Phone _____

Father's Name _____ Phone _____ (Cell) (Work) (Home)

DOB _____ Social Security # _____

Address(if different than child) _____ City _____ State ___ Zip Code _____

Occupation _____Employer/Phone _____

INSURANCE INFORMATION(please provide copy of insurance card with paperwork)

Primary Ins. _____ ID# _____ Group # _____

Name of Policy Holder _____ Phone # _____

Secondary Ins. _____ ID# _____ Group # _____

Name of Policy Holder _____ Phone # _____

Personal Information

Client Name_____**Date of Birth**_____ **Age**_____

Responsible Party _____**Date of Birth**_____ **Age**_____

Marital Status (indicate # of yrs): ❑ Married_____ ❑ Divorced_____ ❑ Widowed_____
❑ Separated_____ ❑ Engaged_____ ❑ Cohabitating_____ ❑ Single

Spouse's Name_____ **Date of Birth**_____ **Age**_____
Spouse's Place of Employment_____ **Work Phone**_____

Marriage Information:
Is your spouse willing to come to counseling? ❑ Yes ❑ No
Have you ever been separated? ❑ Yes ❑ No
Have either of you ever filed for divorce? ❑ Yes ❑ No
How long did you know your spouse before marriage? _____
How long did you date your spouse? _____
How long were you engaged? _____

List all others living in your home:

Name	Age	Birthday	Relationship (ex. son, daughter)	School or Place of Employment

History of the Presenting Problem or Complaint
State the nature of your problem: _____
What do you want to accomplish during your sessions? _____
_____
Why are you coming at this time? _____

Problem/Symptom Checklist

❑ Alcohol / Drugs	❑ Family	❑ Marriage	❑ Singleness
❑ Aging	❑ Fear	❑ Money/Budgeting	❑ Smoking
❑ Anger	❑ Finances	❑ Mood Swings	❑ Stress Management
❑ Anxiety	❑ God / Faith	❑ Other Addiction	❑ Trauma
❑ Co-Dependency	❑ Grief / Loss	❑ Parenting	❑ Violence
❑ Child Custody	❑ Guilt	❑ Past Hurts	❑ Weight Control
❑ Communication	❑ Hopelessness	❑ Premarital	❑ Work / Career
❑ Depression	❑ Intimacy	❑ School / Learning	❑ Other_____
❑ Disabled	❑ In-laws	❑ Self-Esteem	❑ Other_____
❑ Divorce/Separation	❑ Loneliness	❑ Sexual Issues	❑ Other_____

Medical History
Any hospitalizations within the last five (5) years;_____
Have you ever received psychiatric or psychological help or counseling of any kind before? ❑Yes ❑ No
Rate Your Physical Health: ❑ Very Good ❑ Good ❑ Average ❑ Declining ❑ Poor
Recent Weight Changes: *Gained*_____*Lost*_____
Check if Applicable: ❑ Difficulty Sleeping ❑ Difficulty Eating ❑ Headaches
How many hours of sleep do you average each night? _____

Medication(s): (taken for anxiety, nervousness, depression, or related types of problems.)

Name	**Dosage / How Often**	**Reason Taken**	**How Long Taken**	**Response / Side Effects**

Do any of your family members have a history of mental illness? ❑ Yes ❑ No If yes, please explain whom and the nature of the illness._____

Have any of your family members ever received psychiatric or psychological help or counseling of any kind before? ❑ Yes ❑ No

Have you ever experienced any of the following?
❑ Physical Abuse
❑ Emotional Abuse
❑ Spousal Abuse
❑ Sexual Abuse
❑ Rape
❑ Harsh Physical Punishment as a child
❑ Incest
❑ Sexual advances towards you as a child
❑ Other_____

If so, please explain_____

Crisis Information:
Any current suicidal thoughts, feelings, or actions? ❑ Yes ❑ No
Any current homicidal thoughts, feelings, or actions: ❑ Yes ❑ No
Do you have a history of anger of impulse control problems? ❑ Yes ❑ No
Have you experienced any significant losses and/or deaths within the last five (5) years? ❑ Yes ❑ No
If yes, please explain_____

Have you ever been arrested? ❑ Yes ❑ No If yes, please explain_____
Have you ever served time in jail? ❑ Yes ❑ No If yes, please explain_____
Do you currently use any drugs including marijuana? ❑ Yes ❑ No History of Use? ❑ Yes ❑ No
Do you smoke or use tobacco products? ❑ Yes ❑ No
Do you drink alcoholic beverages including beer, wine, or liquor? ❑ Yes ❑ No

Religious Background
Do you consider yourself a religious person? ❑ Yes ❑ No ❑ Uncertain
Do you believe in God? ❑ Yes ❑ No ❑ Uncertain
Do you pray to God? ❑ Often ❑ Never ❑ Occasionally
Are you saved? ❑ Yes ❑ No ❑ Not sure what you mean
Do you read the Bible? ❑ Often ❑ Sometimes ❑ Never
Meaningfulness of your faith/religion: ❑ High ❑ Medium ❑ Low
Church you attend _____

Primary Support Group:
Please tell us who else knows you are coming and is interested in your care:
(This list does not Authorize Release of Information)

Relationship to You	**Name**	**Contact #**	
Physician			
Attorney			
Pastor			
Spouse			
Supportive Friend			
(Other)			

CHILD-TEEN BEHAVIORAL CHECKLIST

Child's Name _____ Your Name _____Date_____

Child's Age _____ Grade ____ Sex ____ Your relationship to the child _____

Please read the following list of behaviors carefully and **mark a check** next to those statements that describe the child. Please put a **circle** around any items that you feel are exceptionally significant at the present time. You may **write** any additional problems the child may be having at the end of the form. Thank you.

FEELINGS

( ) Is too neat
( ) Is suspicious
( ) Acts overly mature
( ) Worries about getting sick
( ) Sees or hears things others do not see or hear
( ) Seems overly serious
( ) Finds it hard to relax
( ) Has frequent and extreme mood swings
( ) Is jealous of peers
( ) Repeats certain behaviors over and over
( ) Often talks about death or getting hurt
( ) Seems afraid to show anger
( ) Seems overly afraid
( ) Is easily embarrassed
( ) Is afraid of many things
( ) Is uncomfortable in new or strange situations
( ) Is easily upset
( ) Seems withdrawn
( ) Does not enjoy affection
( ) Needs frequent reassurance
( ) Needs large amounts of affection
( ) Feels inferior to peers
( ) Feels guilty often or easily
( ) Often seems sad or depressed
( ) Worries a great deal
( ) Feelings easily hurt
( ) Overly dependent

SELF-ESTEEM

( ) Criticizes self
( ) Overreacts to small errors
( ) Is too humble
( ) Is not curious
( ) Always gives in to peers
( ) Gives up easily
( ) Is s pessimist
( ) Worries about mistakes
( ) Has little self-confidence
( ) Rarely disagrees
( ) Does not give best effort
( ) Always tries to please
( ) Is not interested in learning
( ) Acts inferior
( ) Always a follower
( ) Afraid to initiate play with peers

PERSONALITY

( ) Is not friendly
( ) Bullies other children
( ) Hurts or teases peers
( ) Argues a lot with peers
( ) Is not liked by peers
( ) Has problems making friends
( ) Friends get in a lot of trouble
( ) Competes too hard to win
( ) Is shy
( ) Is teased by peers
( ) Does not share
( ) Has few friends
( ) Is poor loser
( ) Has more opposite sex friends
( ) Does not compromise
( ) Is immature in social situations

MUSCULAR

( ) Lacks coordination
( ) Is always running or climbing
( ) Has trouble sitting still
( ) Has trouble throwing or catching a ball
( ) Has unexpected leg or arm twitches
( ) Has trouble with balance
( ) Has a lot of accidents
( ) Often drops or breaks things
( ) Is clumsy
( ) Lacks energy
( ) Runs into things
( ) Is overly active
( ) Is restless
( ) Has tics
( ) Is often injured
( ) Cannot skip

LEARNING/COGNITIVE

( ) Has trouble following rules
( ) Has trouble spelling or writing
( ) Has trouble finishing tasks
( ) Has trouble understanding tasks
( ) Has trouble with date and time
( ) Loses interest quickly
( ) Overactive imagination
( ) Inadequate common sense
( ) Stutters or stammers
( ) Difficulty knowing right from left
( ) Too involved with fantasies
( ) Poor organizational skills
( ) Poor sense of direction
( ) Inattentive
( ) Easily distracted
( ) Talks too fast
( ) Is impulsive
( ) Often changes mind
( ) Misnames things
( ) Refuses to talk
( ) Has trouble reading
( ) Uses baby talk
( ) Often daydreams
( ) Easily confused
( ) Often forgets
( ) Trouble manipulating objects
( ) Poor Planner

MORAL DEVELOPMENT

( ) Unaware of others' feelings
( ) Does not feel guilty
( ) Takes or uses others' things
( ) Blames others
( ) Takes advantage of others
( ) Does not know right from wrong
( ) Disrespectful of authority
( ) Does not keep agreements
( ) Ignores rules
( ) Disloyal
( ) Often lies
( ) Steals
( ) Cheats on tests
( ) Cheats at games
( ) Unappreciative

BEHAVIOR

( ) Does not respond to punishment
( ) Often interrupts
( ) Manipulative of others
( ) Talks back
( ) Often disagrees or argues
( ) Uncooperative
( ) Purposely breaks things
( ) Disobeys often
( ) Threatens to leave room
( ) Has a bad temper
( ) Threatens to hurt others
( ) Often sulks
( ) Threatens to hurt self
( ) Uses bad language
( ) Smokes, drinks, or uses drugs
( ) Acts secretively
( ) Is defiant
( ) Acts irresponsibly
( ) Refuses to listen
( ) Is stubborn
( ) Too interested in sex
( ) Is resentful
( ) Is too aggressive
( ) Shows off, brags
( ) Always has to have own way
( ) Is demanding

HEALTH/HYGIENE

( ) Not concerned with appearance
( ) Often vomits
( ) Spends much time in bathroom
( ) Has asthma
( ) Often has headaches
( ) Has allergies
( ) Often has stomachaches
( ) Is often ill
( ) Uses sickness to avoid tasks
( ) Is often tired
( ) Is unkempt or has poor hygiene
( ) Is overweight
( ) Eats dirt or other non-foods
( ) Is underweight
( ) Eats only a few specific foods
( ) Is a messy eater
( ) Seems to enjoy being sick
( ) Has poor manners
( ) Falls asleep while working or in school
( ) Often complains of feeling ill

Who is the child's physician?_____

Is he/she on any medication? If so, what and what dosage and for how long? _____
_____

What health problems does your child have?_____
_____

Do you have any other medical or mental health concerns for the child?_____
_____

These questions might prompt you to think about behaviors or attitudes that normally you would not. Please feel free to write down the things that you think are important for us to know about your child. Thank you for helping us gain this information.

_____

_____

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_____

_____ _____

Your signature Date

Adolescent Intake Questionnaire

Please complete this questionnaire as it will be helpful to me in planning counseling services for you. Answer each item as carefully as you can. Feel free to ask for any assistance if you have trouble with the question.

Full Name: _____ Date: _____

Date of Birth: _____ School Grade: _____

School Attending: _____ City: _____

What are your favorite subjects in school? _____

_____

Do you have hobbies? Yes No What are they? _____

_____

What extracurricular activities are you involved in: _____

_____

Who is/are your best friends and why? _____

_____

What is your religious preference? _____ Do you consider yourself

_____ Anti-religious _____ Not religious _____ Moderately religious _____ Strongly religious

Who suggested you come to my office? _____

Why do you think this person(s) suggested you come here? _____

_____

From your perspective, why do you think you are here? _____

_____

From your perspective, how do you think counseling might help you? _____

_____

Continued on back

Do you think there is anyone else in your family that could benefit from counseling?_____Who? And Why? _____

Have you ever seen a professional counselor before? YES NO If YES, who, why and when?

_____

Who is your Physician? _____ Have you seen him/her recently? _____

List any Illnesses that you have: _____

Medications that you take: _____

Do you smoke? YES NO if YES, how much? _____

Check all that apply:

❑ Health Problems	❑ Parents	❑ Legal Matters	❑ Suicidal thoughts
❑ Asthma	❑ Friends	❑ Assertiveness	❑ Nervousness
❑ Bedwetting	❑ Nightmares	❑ Decision Making	❑ Inferiority
❑ Drug Use	❑ Step Family	❑ Career Choice	❑ Sadness
❑ Appetite	❑ Divorce	❑ My Appearance	❑ Relaxation
❑ Sexual Problems	❑ Dating	❑ Ambition	❑ Depression
❑ Ulcers	❑ Family	❑ Finances	❑ Concentration
❑ Headaches	❑ Trust	❑ Work	❑ My thoughts
❑ Sleep	❑ Insomnia	❑ Abuse	❑ School
❑ Breakup	❑ Energy	❑ Shyness	❑ My Past
❑ Tiredness	❑ Loneliness	❑ Communication	❑ Self-Concept
❑ Stomach Problems	❑ Unhappiness	❑ Temper	❑ Stress
❑ Food	❑ Premarital	❑ Religion	❑ Memory
❑ Alcohol Use	❑ Siblings	❑ Self-Control	❑ Fears
❑ Hyperactivity	❑ Fighting	❑ Confusion	❑ Guilt

Have you ever considered suicide? YES NO Do you feel suicidal now?_____

Have you ever attempted suicide? YES NO If YES, when and how? _____

_____

Are you or anyone in your family involved currently with and community agency/institution or persons such as police, law, JDC, DHS, Attorney, etc. YES NO If YES, please list who, why and what the problem is. _____

_____

Is there any additional information that you are willing to share that might help me in working with you?

_____