

New Client Information

Client Information:

Name: _____ SSN: _____

Date of Birth: _____ Age: _____ Gender: _____

Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Work phone: _____ Cell: _____

In case of emergency, please notify:

Name: _____ Phone: _____ Relationship: _____

Insurance:

Policy holder's name: _____ SSN: _____

Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Work phone: _____ Cell: _____

Primary insurance:

Company: _____

Authorization #: _____ Number of sessions: _____

Co-pay: _____

Employer: _____ Job title: _____

Relationship to the policy holder: _____

Secondary insurance:

Company: _____

Authorization #: _____ Number of sessions: _____

Co-pay: _____

Employer: _____ Job title: _____

Relationship to the policy holder: _____

90 S. Kyrene Road #4
Chandler, Arizona 85226

602-686-3723 480-775-6423
Fax 480-775-6425
Dalena@dalenawatson.com
www.dalenawatson.com

Informed Consent for Counseling

Purpose of Counseling

The purpose of counseling/therapy is to assist you on your path to greater personal growth and healing. The holistic focus of Dalena Watson Counseling is the integration of the mind, body, and spirit.

Treatment

Dalena Watson is a Master-level, Licensed Professional Counselor (LPC) in the state of Arizona. She is also a board-certified music therapist (MT-BC) and her post-master training is as a Fellow of the Association for Music & Imagery (FAMI). Your therapist may use a variety of methods including: cognitive/behavioral, which addresses how your thoughts affect your emotions and how together they influence your behavior; psycho-dynamic, which addresses how your past experiences may be influencing your present emotional health (and the way you see the world); and experiential, which allows direct and symbolic expression of emotions and deeper self insight.

The results you obtain from this counseling will largely depend on your commitment to your own growth process. Therefore, homework may be given to continue your growth process between sessions. During the counseling process, uncomfortable feelings may arise. This is a normal part of counseling and your therapist will assist you in processing and managing these emotions. As you grow and change, people in your life/significant relationships may be affected as others adapt to the new you. This is normal, and should be discussed with your therapist.

With your therapist, you will develop an understanding of the areas you wish to address and the techniques that will best serve you, as well as a treatment plan to guide the direction of your therapy. This plan is reviewed and revised periodically (approximately every 90 days). You have the right to refuse any treatment services or modalities. Your therapist will advise you of any potential consequences of such refusal.

If you are in need of medical attention, you should call 911 or your doctor depending on your need. If you are having a counseling emergency, please call your therapist. If your therapist is not available, please leave a message requesting an emergency call back. If you do not receive a call back within 15 minutes, please call the local crisis line at 1-800-631-1314 or 480-784-1500.

Client Signature

Date

Confidentiality

Your sessions are confidential as well as the therapist's notes. Your therapist may use case consultation with other professional therapists in order to serve you better. These therapists will keep any information confidential as well. If you desire specific information to be released to a specific person or agency, you may sign a release of information.

You have the right to request to review your records. You also have the right to request copies of your records. Requests must be made in writing. For copies over 10 pages, you will be charged a fee, 10 cents a page and \$10 per hour for copying time. The therapist has a right to deny the request to various items in the record if it is deemed psychologically harmful to you (ie: raw testing data, personality assessments, etc).

The therapist may be legally bound to disclose information if you disclose committing a crime, aiding another in criminal activity, are involved in abuse/neglect/exploitation against a minor or elder, are a danger to yourself or others, or by court-order.

Limitations of Technology

While technology (ie: computers, Internet, cell phone, email, faxes) are used in the normal course of business at Dalena Watson Counseling, there are limitations to the confidentiality of such technology. Every reasonable effort is made to secure your information.

Your therapist will print and file in your records any email correspondence that you send. However, emails will not be electronically archived.

Notice of Privacy Practices and Client’s Rights

Please sign below that you have read and received copies of the Privacy Practices and Client’s Rights documents.

Client Signature

Date

Payment/Fees

Payment will be arranged with your therapist, and is due at the time of services. In telephone counseling, payment must be pre-paid. Cancellation fees of \$50 per session apply if you do not notify the therapist 24 hours before your scheduled session.

If you would like to utilize your insurance plan, Dalena Watson will submit billing to your insurance (through her contracted billing company) if Dalena Watson is in network with your insurance company.

If she is out of network with your plan, please self-pay and then file for reimbursement. It is advised that you investigate your insurance coverage prior to beginning treatment. You may need to inquire as to diagnoses covered, number of sessions, types of mental health services covered, and out of network provider coverage. Your therapist can provide you with a Superbill including the documentation necessary for insurance purposes.

I have read and received a copy of the fee schedule document.

Client Signature

Date

Referrals for Additional Services

At times, your therapist may give you suggestions and/or referrals for additional services. It is your responsibility to investigate these options and whether or not you enter into a professional arrangement for additional services. If you have a negative experience with a referral, please inform your therapist.

Telephone Counseling

This service is available to established adult clients only. Payment must be arranged in advance and is not covered by insurance. You will benefit more from this service when you arrange a comfortable environment for yourself, free from distractions or interruptions. Telephone counseling may not be appropriate for all. Please be advised that telephone counseling may not be entirely confidential if one or both parties are using a cell phone.

If during a telephone session, there is equipment failure, please attempt to reconnect immediately. If this is not possible, the session will be billed for time completed.

Some disadvantages may include: lack of visual cues (body language, facial expression for both the counselor and client), possible difficulty in assessing emergency or suicidal situations.

Client Signature

Date

Termination of Services

You or your therapist may choose to terminate the therapeutic relationship at any time. Optimally, this decision is made jointly during the session, and after you have met the treatment goals. If this decision is made outside of the session, whoever makes this decision must contact the other party in writing (email) or by phone. The counselor may also choose to terminate services if you are not progressing, you need other services the counselor cannot provide, if you or another person with whom you have a relationship are deemed to be a danger to (likely to harm) the therapist, or you do not pay your fees. Your therapist will recommend other providers when necessary.

Should your therapist be unable to provide therapeutic services, a plan has been developed to continue your counseling with a qualified professional.

Scheduling Sessions

Call 602-686-3723 or email dalena@dalenawatson.com to schedule appointments. By making arrangements to use the therapeutic services, you are agreeing to all of the conditions stated in this informed consent. If you have questions regarding this information, please ask.

Client Signature

Date

Therapist Signature

Date

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HIPAA NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS

THIS NOTICE DESCRIBES HOW MEDICAL/MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective date: April 14, 2003. Dalena Watson Counseling only releases information in accordance with state and federal laws and the ethics of the counseling profession. This notice describes the policies related to the use and disclosure of clients' healthcare information.

Use and disclosure of protected health information for the purposes of providing services. Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for these purposes.

Your healthcare information may be used and disclosed to appropriate sources for the following reasons:

Treatment:

- Provide, manage or coordinate care
- Consultants
- Referral sources

Payment:

- Verify insurance and coverage
- Process claims and collect fees

Healthcare operations:

- Review of treatment procedures
- Review of business activities
- Certification
- Staff training
- Compliance and licensing activities

Other uses and disclosures without your consent:

- Mandated reporting
- Emergencies
- Criminal damage
- Appointment scheduling
- Treatment alternatives
- As required by law

CLIENT RIGHTS: As a client of mental/behavioral health services you have the following rights (more detailed information of most of these categories is provided in your consent to treatment):

Right to request where we contact you:

- Home _____ yes no
- Work _____ yes no
- Cell phone _____ yes no
- Email _____ yes no
- If not, how may we contact you _____

Right to release your medical records:

- Written authorization to release records to others
- Right to revoke release in writing
- Revocation is not valid to the extent that the counselor has acted in reliance on such previous authorization

Right to inspect and copy your medical billing records:

- Right to inspect and receive a copy of your records
- Counselor may deny this request
- Charges for copying, mailing, etc. apply

Right to add information or amend your medical records:

- May request to amend your record
- Counselor has 30 days to decide
- Counselor may deny the request
- If denied, you have the right to file a disagreement statement
- Disagreement and the counselor's response will be filed in the record
- Amendment request must be in writing

Right to Accounting of disclosures:

- For a six year period beginning with date the counselor came in to compliance (no later than 4/14/03)
- Exceptions:
 - Disclosure for treatment, payment or healthcare operations
 - Disclosures pursuant to a signed release
 - Disclosure made to client
 - Disclosures for national security or law enforcement

Right to request restrictions on uses and disclosures of your healthcare information:

- Must be in writing
- Counselor is not obligated to agree

Right to complain:

- Please contact the counselor first in person or in writing
- If not satisfied, you have the right to complain to the U.S. Dept. of Health and Human Services
- To be free from retaliation

Right to receive changes in policy:

- You may request any future changes to these policies
- Submit your request to privacy officer

Client's signature

Date

Therapist's signature

Date

SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

1. **INSURANCE:** I request that payment of authorized insurance benefits be made on my behalf to Dalena Watson for services furnished to me by Dalena Watson. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Dalena Watson accepts the charge determination of the insurance carrier as the full charge, and I am responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductibles are based upon the charge determination of the insurance carrier.
2. **RELEASE OF INFORMATION:** Dalena Watson may disclose all or any part of my medical record and/or financial ledger, to any person or corporation which is or may be liable or under contract to Dalena Watson for reimbursement for services rendered, and any health care provider for continued patient care.
3. **OTHER INSURANCE:** I understand that Dalena Watson maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office and that Dalena Watson has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Dalena Watson if I belong to a plan that does not appear on the above-mentioned list.
4. **NON-COVERED SERVICES:** I understand that Dalena Watson contracts with health care service plans. (i.e., HMO's, PPO's) Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plan's not to be covered.

Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Dalena Watson to obtain necessary health care service plan authorizations.

5. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by Dalena Watson, I will pay my account at the time of service is rendered or will make financial arrangements satisfactory to Dalena Watson for payment. If an account is sent to collections, I agree to pay collection expenses and/or reasonable attorney's fees as established by the court. I understand and agree that if my account is delinquent, I may be charged a service fee. Any benefits of any type under any policy of insurance insuring the patient or any other party liable to the patient is hereby assigned to Dalena Watson. If my insurance company or health plan designs co-payments and/or deductibles, I agree to pay them to Dalena Watson. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of the bill. I also agree that if I have to miss a scheduled appointment without giving at least 24 hours notice. I can be charged a \$50.00 cancellation fee.
6. **PRIVACY PLAN:** I agree that I have been given the opportunity to read and receive a copy of the Dalena Watson agreement. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Beneficiary or Guardian Name (print)

Beneficiary or Guardian Signature**

Date

** If an authorization is signed by an individual's personal representative, the representative's authority is based on:

_____ (e.g., state law, court order, etc.)

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Service Agreements

Please initial each statement.

_____ I understand the information about insurance reimbursement, and authorize the release of my pertinent health information to my insurer, and the direct payment of my insurance benefits to Dalena Watson, LPC.

_____ I realize that I am responsible for paying all non-covered services, deductibles, copays, coinsurances, and fees for documentation or cancellation penalties.

_____ I understand that Dalena Watson, PLLC is a sole proprietor, and her practice is independent from the other clinicians who share the office in which I receive treatment.

Fees For Service

Service Code	Service	Fee
90791	Initial intake appointment	\$180
90834	30- 45 min. therapy session	\$120
90837	51-60 min. therapy session	\$150
90846	Family session w/out patient	\$150
90847	Family session w/ patient	\$150
--	No show or late cancellation	\$50
--	Returned check	\$35
--	Letters/paperwork	\$30/15 min.
--	Review of outside materials	\$30/15 min.
--	Court time, prep, travel	\$150/hour

Credit Card on File: VISA Mastercard Discover Amex Health Savings

Card number

Exp. Date

CVV Code

Zip Code

Name as it appears on card

I understand and agree to comply with the policies of Dalena M. Watson, PLLC. I am aware I can obtain copies of all paperwork I sign.

I *authorize the charge of my credit card* for all services, documentation and cancellation penalties, etc. incurred.

Signature

Date

Printed name

Date of birth

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PARENTAL/GUARDIAN CONSENT

To ensure a positive therapeutic relationship your child's session information will be confidential. We ask that you sign this Consent with regard to the treatment of your child.

I, _____, give my consent to and understanding that Dalena Watson will be conducting psychotherapy/music therapy with _____.

I am the _____ of the child. I understand that the holder of the privilege is Dalena Watson.

I have been notified of the limitations as to confidentiality and I understand that information from my child's session can be released only with the permission of the holder of the privilege. While I, as a parent or guardian, have a legal right to the information, I understand that the therapist will speak with me in general terms unless there is concern with regard to the safety of my child.

I will accept the judgment of Dalena Watson with regard to releasing or sharing information obtained during the course of therapy with my child.

Parental/Guardian Print Name

Signature

Date

Therapist Print Name

Signature

Date

Dalena Watson Counseling
For Healing, Transformation, and Wholeness

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Child/Adolescent Intake Information

Welcome. Please fill out all information as completely as possible. If available, all involved parents should complete together. Information given is confidential and will help in providing the best possible service. Feel free to ask questions, if needed. Dalena will discuss the information with you after reviewing the form.

Child's Name: _____ Date Today: _____
Child's Nickname (if applicable): _____
Completed by: _____ Relationship to Child: _____
Child's Full Address: _____
Child's Gender: Male Female Date of Birth: ___/___/___ Age: _____ SS#: _____
Child's primary Language: _____ Language spoken at home: _____
Child's Ethnicity: _____ Child's religious preference (optional): _____

(We respect individuals of any age, gender, ethnicity, race, religion and sexual preference. Gathering the above information can help ensure that your counselor is respectful of your family's background and beliefs.)

Child's Legal Guardian(s): _____
(If the child is not living with both natural parents, both adoptive parents, or only living parent, we require a photocopy of the legal document stating custody arrangements.) (Please attach to this form.)

In case of emergency, contact: _____
Full Name Relationship Phone #
Is your child presently receiving counseling or mental health services elsewhere? Yes No
(If yes, do not complete this form until you have talked with your counselor)

Family members receiving services at this agency: Yes No (Names/Dates of service) _____

Is your child currently on probation? Yes No If yes, Probation Officer: _____

School Child Attends: _____
Current School Address & Phone: _____
Grade Level (now): _____ Has your child ever been retained? Yes No If yes, what grade _____
Current Teacher(s): _____
Current School Counselor: _____
Is your child receiving special education or other services? Yes No If yes, please explain _____

Has your child ever seen a mental health professional (psychiatrist, psychologist, or counselor)? Yes No **(If so, we will need your permission if you would like us to communicate with that individual or agency.)**

Previous Mental Health Professional/Agency: _____
Address: _____
Phone: _____ Dates of Service: _____ (beginning-ending)

Has your child been hospitalized or confined for mental health concerns? Yes No
If yes: When _____ Where _____

How were you referred to the agency? _____

Are you seeking services because your child is a victim of a crime? Yes No
If yes, please provide a brief explanation _____

Did it result in legal action? Yes No If yes, please explain _____

If yes, is involvement with the legal or judicial system currently ongoing? Yes No
If yes, please list names of any lawyers, detectives, & other persons involved _____

(If involvement with the legal/justice system is current, please provide your counselor with the status of any current court orders involving counseling services, visitation or reunification plans)

Person responsible for financial arrangements with the agency: _____

*** INFORMATION ON CHILD'S MOTHER ***

Mother's Name: _____

I am: _____ biological mother _____ stepmother _____ adopted mother Other _____

Full Address: _____

Home Phone: _____ (May call: Yes No Leave Message: Yes No)
Work Phone: _____ (May call: Yes No Leave Message: Yes No)

Date of Birth: _____ Occupation: _____

Employer: _____ How Long: _____

Last year of education completed:
8th grade or below _____ Trade School _____ Master's Degree _____
High School _____ Some College _____ Ph.D. Degree _____
GED _____ College Graduate _____

History of learning, emotional, or behavioral problems: Yes No
(if yes, please explain) _____

History of alcohol/drug/substance abuse: Yes No
(if yes, please explain) _____

History of family violence: Yes No
(if yes, please explain) _____

History of criminal activity: Yes No
(if yes, please explain) _____

Current living arrangements:
Family of origin _____ Relatives _____ Single _____
Married _____ Roommate(s) _____ Single parent w/ children _____
Married w/ children _____ Significant other _____ Other _____

Marital Status (indicate all that apply and duration of each, ex: 1965-1985):

Never married _____
Married 1 _____ Separated 1 _____ Divorced 1 _____ Widowed 1 _____
Married 2 _____ Separated 2 _____ Divorced 2 _____ Widowed 2 _____
Married 3 _____ Separated 3 _____ Divorced 3 _____ Widowed 3 _____

*** INFORMATION ON CHILD'S FATHER ***

Father's Name: _____
I am: _____ biological father _____ stepfather _____ adopted father Other _____

Full Address: _____
Home Phone: _____ (May call: Yes No Leave Message: Yes No) Work Phone: _____ (May call: Yes No Leave Message: Yes No)

Date of Birth: _____ Occupation: _____
Employer: _____ How Long: _____

Last year of education completed:
8th grade or below _____ Trade School _____ Master's Degree _____
High School _____ Some College _____ Ph.D. Degree _____
GED _____ College Graduate _____

History of learning, emotional, or behavioral problems: Yes No
(if yes, please explain) _____

History of alcohol/drug/substance abuse: Yes No
(if yes, please explain) _____

History of family violence: Yes No
(if yes, please explain) _____

History of criminal activity: Yes No
(if yes, please explain) _____

Current living arrangements:
Family of origin _____ Relatives _____ Single _____
Married _____ Roommate(s) _____ Single parent w/ children _____
Married w/ children _____ Significant other _____ Other _____

Marital Status (indicate all that apply and duration of each, ex: 1965-1985):
Never married _____
Married 1 _____ Separated 1 _____ Divorced 1 _____ Widowed 1 _____
Married 2 _____ Separated 2 _____ Divorced 2 _____ Widowed 2 _____
Married 3 _____ Separated 3 _____ Divorced 3 _____ Widowed 3 _____

*** GENERAL INFORMATION ***

Child's current household:
Natural Parents _____ Blended family (both spouses with children) _____
Natural Father & Stepparent _____ Natural Mother & Stepparent _____
Mother only _____ Father only _____
Relatives _____ Adoptive parents _____
Foster family _____ Institution _____ Other _____

List by Household your child's current family, beginning with the oldest member and include the child:
Primary Household (anyone who currently lives with child)

How long in this current living situation:

Name	Age	Gender	Relationship to child (include step, half, etc.)

Child lives in: House _____ Apartment _____ Duplex _____ Other _____

Second Household (non-custodial or extended family – if applicable)

Name	Age	Gender	Relationship to child (include step, half, etc.)

Currently involved in a custody dispute: No Yes (If yes, explain)

If divorced, circle the number which best describes your relationship with your ex-spouse

Hostile		Frustrating		Friendly
1 _____	2 _____	3 _____	4 _____	5 _____

How often does client see non-custodial parent? _____

*** CHILD'S HEALTH ***

Child's Primary Care Physician: _____
Name Phone

Address _____

Has your child ever seen a psychiatrist? Yes No
Is child currently seeing a psychiatrist? Yes No (If yes, list name, address and phone):

Name Phone

Address _____

Date of LAST complete physical _____
Physical Disability: Yes No (If yes, explain) _____
Chronic Illness: Yes No (If yes, explain) _____
Terminal Illness: Yes No (If yes, explain) _____

Check the following items for a diagnosis or medication that your child is now receiving or has received:

Diagnosis	Current	Past	Date of Diagnosis	Name of Medication	Dosage
Depression	_____	_____	_____	_____	_____
ADHD	_____	_____	_____	_____	_____
ADD	_____	_____	_____	_____	_____
Conduct Disorder	_____	_____	_____	_____	_____
Learning Disability	_____	_____	_____	_____	_____
Anxiety/ Nervousness	_____	_____	_____	_____	_____
Panic Attack	_____	_____	_____	_____	_____
Bipolar	_____	_____	_____	_____	_____
Schizophrenia	_____	_____	_____	_____	_____
Oppositional Defiant Disorder	_____	_____	_____	_____	_____
Mood/Anger	_____	_____	_____	_____	_____
Tics	_____	_____	_____	_____	_____
Insomnia/ Sleeplessness	_____	_____	_____	_____	_____
Obsessive/ Compulsive	_____	_____	_____	_____	_____
Addictions	_____	_____	_____	_____	_____
Convulsions	_____	_____	_____	_____	_____
Post-Traumatic Stress Disorder	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____

(If you do not know the name and dosage of current medication, please bring the medication to your next session)

If your child has been diagnosed, who gave the diagnosis?

Counselor/Psychologist _____ Family Physician _____ Psychiatrist _____

School Psychologist _____ Other _____

Name: _____ Phone #: _____

What other medication is your child currently taking?

Medication	Dosage	Taken for what reason?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

*** CURRENT CONCERNS ***

Indicate severity of up to 10 items that currently apply to your child. (1-mild; 2-moderate; 3-severe) Circle the item that you see as the most significant issue

- _____ Abuse (physical, emotional, sexual)
- _____ Adjustment to life changes (changing schools, parents divorcing, moving, getting married or divorced, aging, etc.)
- _____ Bed wetting daytime wetting, soiling or related problems
- _____ Career Decisions
- _____ Disturbing memories (past abuse, neglect or other traumatic experience)
- _____ Drug or alcohol use (both legal and illegal drugs)
- _____ Eating problem (purging, bingeing, overeating, hoarding, severely restricting diet)
- _____ Family or Stepfamily relationship problems
- _____ Feeling angry or irritable
- _____ Feeling anxious (nervous, clingy, fearful, worried, panicky, obsessive-compulsive, lacking trust, etc.)
- _____ Feeling guilty or shameful
- _____ Feeling sadness or depression NOT related to grief
- _____ Feeling sadness or depression related to grief
- _____ Gang related concerns (explain) _____
- _____ Gender identity concern
- _____ Health concerns (physical complaints and/or medical problems)
- _____ Illegal behaviors (runaway, stealing, fire setting, truancy, etc.)
- _____ Learning/Academic difficulties
- _____ Non-family relationship problems (teachers, peers, etc.)
- _____ Parent-Child relationship (discipline, adoption, single parent. etc.)
- _____ Personal Growth (no specific problem)
- _____ Religious or Spiritual concerns
- _____ Sexual concerns (excessive masturbation, inappropriate acting out)
- _____ Sexual identity concern
- _____ Sleep problems (nightmares, sleeping too much or too little, etc.)
- _____ Speech problem (not talking, stuttering, etc.)
- _____ Suicidal Ideation (thoughts of death, wanting to die)
- _____ Unusual behavior (bizarre actions, speech, compulsive behavior, tics, motor behavior problems, etc.)
- _____ Unusual experiences (loss of periods of time, sensing unreal things, etc.)
- _____ Other (explain)

** Remember to circle the most significant issue.*

When did you first become concerned about this issue? _____

How have you attempted before now to deal with this issue? _____

Other treatment your child has received to address any of the concerns indicated above:

None _____ Individual Counseling _____ Family Counseling _____
Group Counseling _____ Hospitalization _____ Other _____

What do you enjoy most about this child? _____

What do you find most difficult about this child? _____

Anything else you think we need to know _____

What is the one thing I need to know to help your child today? _____

*** FAMILY HISTORY EXPERIENCES ***

(For each of the following items that apply, write in your child's approximate age at the time it occurred):

Raised by:

Natural parents _____ Single natural parent _____ Natural & step-parent _____
Adoptive parent(s) _____ Relatives _____ Foster parents _____
Grandparents _____ Institution _____ Other _____

Stressors in the Family:

Chronic illness of family member _____ Death of significant person _____
Domestic Violence _____
Family member absent (explain) _____
Family member's disability/major accident/illness _____
Family member emotional problems (explain) _____
Family member suicide (explain) _____
Financial problems _____ Moved a lot _____ Parents arguing frequently _____
Parents divorced _____ Other _____

History of your child having learning, emotional, behavioral problems: Yes No
(If yes, please explain) _____

History of your child having alcohol/drug/substance abuse: Yes No
(If yes, please explain) _____

History of family violence: Yes No
(If yes, please explain) _____

History of criminal activity in the family: Yes No
(If yes, please explain) _____

Has your child been abused (check all that apply): Physically ___ Emotionally ___ Sexually ___
Has your child been neglected (check all that apply): Physically ___ Emotionally ___

School Problems (check all that apply):
Academic problems _____ Discipline problems _____ Severely teased _____
Unpopular _____ Other _____

Early Language/Speech Problems (explain) _____

History of emotional concerns including recent changes in any of the following: (check all that apply)
Appetite change _____ Heard voices _____ Suicidal thoughts _____
Emotional problems _____ Loss of energy or fatigue _____ Suicide attempts _____
Gained weight _____ Lost weight _____ Other _____

History of behavior problems including recent changes in any of the following: (check all that apply)
Accident-prone _____ Aggressive Behavior (explain) _____
Alcohol/drug use _____ Attention problems _____ Frequent arguments _____
Hyperactive _____ Impulsive _____ Loner _____
Misbehaved a lot _____ Ran away _____ Taken advantage of _____
Temper outbursts _____ Trouble with the law _____ Other _____

History of anxiety symptoms including recent changes in any of the following: (check all that apply)
 Irritable _____ Obsessive worrying _____ Easily Startled _____ Phobias _____
 Keyed up, on edge _____ Physical Symptoms (below) _____ Other _____

History of health/physical problems including recent changes in any of the following: (check all that apply)
 Asthma _____ Disability _____ Nervous stomach _____
 Bedwetting _____ Dizziness _____ Neurological problems/exam _____
 Bone/joint/muscle _____ Headache (kind) _____ PMS _____
 Chest pain _____ Heart Palpitations _____ Serious overeating/undereating _____
 Chronic illness _____ Hospitalization _____ Shortness of breath without exertion _____
 Major accident _____ Sleep problem _____ Developmental delay(s) _____
 Diarrhea _____ Major illness _____ Surgeries _____
 Other _____

History of trauma/stressor includes: (check all that apply, even if not recent)
 Child separated from parent (how long, when, under what circumstances) _____

Death of a pet _____ Death of a significant person _____ Incarcerated family member _____
 Medical _____ Natural disaster _____ Sexual Assault _____
 Witnessed violence or death _____ Victim of trauma (unusual, terrifying experience) _____
 Other _____

History of interpersonal problems includes: (check all that apply)
 Aggressive behavior (explain) _____
 Bullied _____ Taken advantage of _____ Frequent arguments _____
 Temper outbursts _____ Loner _____ Other _____

Family Atmosphere (circle the number that best describes how you view your child's current family atmosphere)

Very lenient	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	Very strict
Very non-religious	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	Very religious
Chaotic	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	Highly structured
Few expectations	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	High expectations
Inconsistent	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	Consistent

Family Support System (such as church, friends, relatives, school)
 Hardly any support 1 2 3 4 5 Considerable support

Your child's current use of computer/video games and television/DVD (circle the number of hours that best describes use)

Computer/Video Games (circle approximate hours spent each week)
0-2 3-5 6-8 9-11 12+

Television/DVD (circle approximate hours spent each week)
0-2 3-5 6-8 9-11 12+

What are your child's interests (include general interests, specific toys they like to play with, etc.)

What are your and your child's goals to accomplish in counseling?

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Dalena@dalenawatson.com
www.dalenawatson.com

Release of Information

Client's name _____ D.O.B. _____

For the purposes of providing comprehensive care, the following information is to be released to or exchanged with:

Name _____

Address _____

Phone _____ Fax _____

Information to be released or exchanged:

- Progress Notes
- Discharge Summary
- Treatment plans
- Testing/Assessment results
- Verbal and written consultation/communication
- Other _____

I consent also for information to be released from _____ to Dalena Watson.

To be effective from _____ through _____ (not to exceed 1 year).

I, _____ authorize this release of information and understand its purpose. I understand that I may revoke this release in writing at any time.

Client's signature

Date

Therapist's signature

Date