The Counseling Center

## REGISTRATION FORMS

***Please have these forms COMPLETED prior to your first office visit or we will have to reschedule your appointment. USE BLACK INK ONLY.***

**Intake Questionnaire**
**Patient Information**
**No Show/Late Cancellation Policy**
**Minor Policy**
**Notice of Privacy Practice**
**Consent for Treatment**
**Release of Information**
****Any other paperwork specifically included**

We at **The Counseling Center** wish to take a moment to welcome you to our office.

Thank you for selecting us as your mental health service centered home and we look forward to serving you. Our goal is to provide you with the best coordinated, highest quality care as well as a safe place for change and growth.

### CLIENT INFORMATION

The Counseling Center employs Psychologists and Professional Counselors to provide behavioral health services to clients.

Discussions between you and your therapist are confidential. No information will be released without your signed consent, unless mandated by law. If you have questions regarding confidentiality, please feel free to discuss them with your therapist. If you are not comfortable bringing these issues directly to your therapist, you can speak with the Business Manager or the Clinical Supervisor.

### APPOINTMENTS, CHARGES AND MESSAGES

You can make appointments by calling our office, Monday thru Thursday between 7am-5pm & Friday between 7am-3pm @ 541-928-2710. After hours, you may leave a confidential voice mail for business and non-urgent matters. Please call to **cancel** or **reschedule** your appointment and avoid a missed appointment charge (Refer to NO SHOW POLICY). Insurance companies **DO NOT** cover these charges; therefore, they're your responsibility.

**IN THE CASE OF AN URGENT MATTER, YOU MAY GO TO YOUR HOSPITAL EMERGENCY ROOM OR CALL THE LOCAL CRISIS LINE @ 800-560-5535.**

936 8th Avenue SW Albany, Oregon 97321
Phone: 541-928-2710 Fax: 541-928-4301
www.albanycounselors.com

The Counseling Center

## PATIENT INFORMATION

**Name** _____ ☐ M ☐ F **Birthday** / / **Age:**
*Last First Middle Month Day Year*

**Address:** _____ **Social Security #:** _____
*Street / PO Box City State Zip Code*

Home Phone: ( ) - Cell Phone: ( ) - Work Phone: ( ) -

Parent's Name (for Minors only): _____ Email: _____
*Name Phone Number*

Employer: _____ ( ) -
*Name Address Phone*

Emergency Contact: _____
*Name Phone Number Relationship*

### INSURANCE INFORMATION

PRIMARY INSURANCE: _____
*Name ID Number Group Number*

Subscriber: _____
*Name Phone Number Relationship to Patient*

Address: _____
*(If different than Patient's) City State Zip Code Social Security #*

Birthday / / Employer: _____
*Month Day Year*

Primary Care Doctor: _____

SECONDARY INSURANCE: _____
*Name ID Number Group Number*

Subscriber: _____
*Name Phone Number Relationship to Patient*

Birthday: / / Employer: _____
*Month Day Year*

**Are you using an EMPLOYEE ASSISTANCE PROGRAM (EAP) benefit?** **Yes** ☐ **No** ☐

EAP Company _____
*Name Authorization Number # of Sessions Approved*

Our services are billed to your insurance as a courtesy, provided **ALL ACCURATE** information is given to us at the time of your appointment. No oral or written info given by an employee of The Counseling Center will create a warranty of any kind. Any outstanding accounts sent to collection will be assessed a **$60 fee**; returned checks will be assessed a **$25 fee**. Payment arrangements can be made with the business office. **ALL NO SHOW and LATE CANCELLATION** fees can be up to **$155** and are billed directly to the responsible party, **NOT** the insurance company. Accounts not paid within 30 days may be subject to a $15 service charge. Cancellations **must be made no later than 5:00 pm the BUSINESS DAY prior to the appointment.**

PRINT NAME: _____ DATE: _____

SIGNATURE: _____
*Patient/Parent/Guardian/Responsible Party*

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# Release of Information

## This is NOT a Records Release

Please complete sign and date this form if you would like to authorize anyone other than yourself for scheduling, billing or verbal communications with The Counseling Center or your Counselor.

(Client) I, _____ authorize and give my consent to

NAME/RELATIONSHIP_____

NAME/RELATIONSHIP_____

NAME/RELATIONSHIP_____

(Circle)

| | | | |
|---|---|---|---|
| SCHEDULE | BILLING | VERBAL | OTHER: (specify) |

____**PLEASE CHECK IF THERE IS NO ONE YOU WISH TO AUTHORIZE**

I also understand that I may revoke this release orally or in writing at any time, except for action already taken. This release will expire in 12 months from date signed or (90) days after last face to face contact, whichever is later unless another date is specified.

**It is The Counseling Centers right and mandated responsibility to report at risk behavior for self-harm or harm to others.**

Time limitation of release:_____

Signed_____Date_____

Signed_____Date_____

(Legal guardian if client is a minor or 13 or under)

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# CONSENT FOR TREATMENT

I, _____ , voluntary agree to receive mental health
(CLIENT PRINTED NAME)
Services from any of the therapists at The Counseling Center to provide such care, treatment and/or services which are considered necessary and advisable.

I understand and agree that I will participate in the planning of treatment and/or services, and that I may stop treatment and/or services that I receive at any time.

In the event that my therapist is no longer practicing at your clinic I understand my records will remain at The Counseling Center until I authorize The Counseling Center in writing to deliver said records to a therapist of my choice.

By signing this consent form, I also acknowledge that I have read and I understand the terms contained herein.

I consent that The Counseling Center may communicate with me by mail, email, Internet Communication and /or by phone.

Client Signature: _____

Client Printed Name: _____

Parent/Guardian Signature: _____

Printed name of signee: _____

Date: _____

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Revised 04/29/2015

The Counseling Center

**NOTICE OF PRIVACY PRACTICE**
**CONSENT TO USE OR DISCLOSE CLINICAL INFORMATION**

I authorize the Counseling Center to use and disclose the health and clinical information of:

(Client Name:)_____ for the purpose of Treatment, Payment, and Health Care Operations. The Counseling Center is not liable for any internet security breaches for online counseling.

**Treatment:** The Counseling Center will use your health care information to provide you with clinical services. We may disclose your information to office staff or other personnel who are involved in your treatment.

**Payment:** The Counseling Center may disclose your health information for the purpose of determining eligibility, billing, and receiving payment from you, your insurance company or a third party.

**Health Care:** The Counseling Center may use your health information for administrative and business purposes.

**Internet Communications:** The Counseling Center provides counseling via internet communication in special situations. The Counseling Center will provide services in a closed room with only the counselor present unless otherwise disclosed in advance. The client is responsible for protecting the clients' privacy at the client's location. The Counseling Center is not responsible for the protection of privacy at the client's location.

You have the right to review The Counseling Center's Privacy Policy for additional information about the uses and disclosures of information described in this document prior to signing consent.

***I understand that I have the right to revoke this consent provided I do so in writing, except to the extent that The Counseling Center has already used or disclosed the information in reliance on this consent.***

_____

**Client Signature (or person authorized by law to act on behalf of the patient)**

_____ _____

**Printed Name** **Date**

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# NO SHOW/LATE CANCELLATION POLICY

Dear Client:

Any cancellation calls received after 5:00 pm the business day prior to your appointment will be considered a Late Cancellation. A **"No Show"** is someone who misses an appointment without cancelling it in an adequate manner. A failure to be present at the time of a scheduled appointment will be recorded in your record as a "No Show."

A charge of up to $155 may be assessed for each Late Cancellation or No Show of an appointment. This fee is billed directly to the responsible party, NOT the insurance company.

To cancel an appointment, call 541-928-2710. Please leave a voicemail if our office does not answer. All calls are confidential and time-stamped.

The No Show and Late Cancellation fees are the sole responsibility of the client and must be paid in full before the client's next appointment.

****Be aware that if we bill you for a Late Cancellation or a No Show fee, this may impact your ability to receive the care and service you require from your counselor.****

Thank you for helping The Counseling Center provide the quality care you deserve!

Signature _____

Print Name _____

Date _____

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# ACKNOWLEDGMENT OF
# OFFICE POLICY FOR MINORS 13 AND UNDER

For safety reasons, we always depend on parents/adults to properly supervise their child(ren) in our office.

All children 13 and under shall **not be left unattended** by their responsible parent, adult guardian or caregiver.

Adults who have brought in a child(ren) for counseling are required to remain **on the premises** and available to our staff while the child(ren) are in their counseling session.

Any other child/children not in session may not be left in our lobby unattended for any reason and should be attended to and adequately supervised by a parent, guardian or caregiver 18 years of age or older.

CLIENT NAME (please print): _____

Client Signature (Age 14 or older): _____

Parent/Guardian signature: _____
(If client is Age 13 or younger)

Parent/Guardian printed name: _____

Date: _____

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THE COUNSELING CENTER
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# CHILD INTAKE QUESTIONNAIRE

**INSTRUCTIONS:**

**Please fill out this form as completely as possible and answer all sections that apply.**
If you have any questions, please feel free to give our office a call.

**NOTICE:**
It is of utmost importance that you bring your paperwork **signed, dated, and completed** during your scheduled first visit to our office.

**Please be advised that without your new client paperwork we will need to reschedule your appointment at a later date and time.**

**Thank You.**

# THE COUNSELING CENTER

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## Child Assessment Questionnaire

Child's Name: _____ Today's Date: ___/___/____

Date of birth: ____/____/_____ Gender: _____ Age: _____

Your relationship to child: _____ Referred by: _____

**Main reason child is being seen today:**

Parent's Response: _____

_____

Child's Response: _____

_____

**When did this problem first begin?**

_____

_____

**What strengths do the child and the child's family have to help solve the problems?**

_____

_____

I. **Areas of Concern:**

- ☐ School grades, behavior
- ☐ Death in the family
- ☐ Parent or caregiver job change
- ☐ Family move
- ☐ Incarceration/Detention
- ☐ Other significant event
- ☐ Family accident or illness
- ☐ Death in a close relationship
- ☐ Child changes schools
- ☐ Family financial problems
- ☐ Child Protective Custody
- ☐ Describe:

**Child's interests and strengths: [what sports, other activities do they enjoy, personality traits]**

_____

_____

**II. ASSESSMENT OF RISK OF SELF-HARM OR HARM TO OTHERS**

**1.** Has the child been a danger to others? If yes, specify.

- ☐ assaultive toward others
- ☐ sexual assault, molestation or attempt towards other children
- ☐ other *(specify)*
- ☐ none of these

Comment:

**2.** Has the child been a danger to self? If yes, specify.

- ☐ Reckless, puts self in danger: If yes, explain:

☐ Suicide Ideation: Verbal or written
When? _____

Why? _____

Duration? _____

☐ Suicide Plan:
When? _____

Why? _____

What was the plan? _____

Courage to Carry Out? _____

Preparation to make attempt? _____

Available Means to carry out plan? _____

Giving away possessions? _____

☐ Suicide Gesture:
When? _____

Why? _____

☐ Suicide Attempt:
When? _____

Why? _____

How? _____

☐ Access to firearms: [ ] yes [ ] no

If yes please explain: _____

☐ Other *(specify)*
☐ None of these

**3.** Has the child recently experienced a significant loss *(relationship, death of family member/close friend, job, etc.)*?
☐ Unknown ☐ Yes ☐ No If yes, explain:

**4.** Does the child feel there is nothing to look forward to in the immediate future *(youth expressing helplessness and/or hopelessness)*? ☐ Yes ☐ No If yes, explain:

**5.** Is the child experiencing extreme stress, anxiety, sleep difficulties, or excessive sleep? ☐ Yes ☐ No If yes, explain:

**6.** Is the child using substances? ☐ Yes ☐ No If yes, explain:

**7.** Does the child have a current mental health diagnosis? ☐ Yes ☐ No If yes, explain:

**8.** Does the child show signs or withdrawal? ☐ Yes ☐ No If yes, explain:

9. Does the child have a history of impulsivity? ☐ Yes ☐ No If yes, explain:

10. Does the child show excessive anger, rage or feelings of revenge? ☐ Yes ☐ No If yes, explain:

11. Has the child shown recent dramatic mood changes? ☐ Yes ☐ No If yes, explain:

12. Does the child express self-hatred, low self-respect or no self-esteem? ☐ Yes ☐ No If yes, explain:

13. Has the child engaged in self-mutilation without the intent to die? ☐ Yes ☐ No If yes, explain:

**III. MENTAL HEALTH SERVICES**

1. Has the child received any mental health services to include the following *(select all that apply)*? Note provider, when occurred, duration, and outcome.

☐ Therapeutic foster placement

☐ Treatment home
☐ Inpatient care
☐ Basic skills training
☐ Crisis intervention
☐ Day treatment
☐ Emergency shelter
☐ Family support
☐ Peer support
☐ Psychosocial rehabilitation
☐ Outpatient treatment
☐ Other. Identify:

2. Has the child ever received a mental health diagnosis? ☐ Unknown ☐ No ☐ Yes
If yes, describe: _____
_____

3. Has the child had psychological testing in the past? ☐ Unknown ☐ No ☐ Yes
What tests, when, results/scores: _____
_____

4. Has the child any history of emotional, physical, or sexual abuse? ☐ Unknown ☐ No ☐ Yes
If yes, describe: _____
_____
_____

5. Has the child ever been exposed to violence? ☐ Unknown ☐ No ☐ Yes
If yes, describe: _____
_____
_____

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**541-928-2710**

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6. Has any relative had a mental health history involving any of the following conditions? Indicate the relationship to the child i.e. father, mother, brother, sister, etc. What were the results of treatment?

_____

_____

_____

| | Condition | Treatment Outcome |
|---|---|---|
| ☐ | Anxiety | |
| ☐ | PTSD | |
| ☐ | Bipolar Disorder | |
| ☐ | Dementia | |
| ☐ | Depression | |
| ☐ | Psychosis | |
| ☐ | Suicide | |
| ☐ | ADHD | |
| ☐ | Autism, PDD, Asperger's | |
| ☐ | Eating Disorder | |
| ☐ | Other: | |
| ☐ | No mental health history | |

| | Condition | Relation to Child | Treatment Outcome |
|---|---|---|---|
| ☐ | Anxiety | | |
| ☐ | PTSD | | |
| ☐ | Bipolar Disorder | | |
| ☐ | Dementia | | |
| ☐ | Depression | | |
| ☐ | Psychosis | | |
| ☐ | Suicide | | |
| ☐ | ADHD | | |
| ☐ | Autism, PDD, Asperger's | | |
| ☐ | Eating Disorder | | |
| ☐ | Other: | | |
| ☐ | None with mental health history | | |

**Current Symptoms:**

| | |
|---|---|
| [ ] excessive worrying | [ ] excessive need for reassurance |
| [ ] separation anxiety | [ ] persistent worries about 'doing well' |
| [ ] refusing to sleep alone | [ ] very self-conscious |
| [ ] unrealistic worries about future events | [ ] frequent 'stomach aches' or headaches |
| [ ] frequent nightmares or 'night terrors' | [ ] frequently refusing to go to school |
| [ ] frequently 'stressed' or agitated | [ ] panic or anxiety attacks |
| [ ] persistent worries they can't get rid of | [ ] distressing thoughts or impulses |
| [ ] driven to perform certain behaviors or rituals | [ ] irrational fear of _____ |
| [ ] other fears: | |
| [ ] distressed, unhappy much of the time | [ ] excessive guilt |
| [ ] often seems tired, low energy | [ ] problems with self-esteem |
| [ ] often feels hopeless, helpless, negative | [ ] problems with sleep |

| | |
|---|---|
| [ ] often seems unmotivated | [ ] suicidal thoughts |
| [ ] bored much of the time | [ ] often irritable |
| [ ] self-harm or mutilation [e.g. cutting] | [ ] often complains others don't like them |
| [ ] very self-critical | [ ] easily upset or emotional |
| [ ] other: | |
| [ ] often loses temper | [ ] often argues with adults |
| [ ] often defiant, refuses to obey rules | [ ] often annoys others |
| [ ] often blames others for own problems | [ ] easily annoyed by others' behavior |
| [ ] often angry or resentful | [ ] often spiteful or vindictive |
| [ ] often swears or uses obscene language | [ ] very upset when told 'no' or frustrated |
| [ ] has 'meltdowns' that last 30 min or more | [ ] breaks things when angry |
| [ ] can't handle minor frustrations | [ ] becomes upset 'for no reason' |
| [ ] can't be reasoned with when angry | [ ] often rigid and inflexible about things |
| [ ] family history of anger problems or bipolar | [ ] hears or sees things that aren't there |
| [ ] bullies, threatens, or intimidates others | [ ] often gets into fights |
| [ ] has been physically cruel to others | [ ] has been cruel to animals |
| [ ] frequently lies | [ ] often skips school or classes |
| [ ] run away from home at least twice | [ ] destruction of property |
| [ ] stolen things in the home | [ ] stolen things outside the home |
| [ ] in trouble with the law for : | [ ] has used a weapon in a fight |
| [ ] difficulty with concentration/focus | [ ] easily distracted |
| [ ] problems with short-term memory | [ ] often 'doesn't seem to listen' |
| [ ] often loses things | [ ] difficulty following instructions |
| [ ] gets lost in task and doesn't finish | |
| [ ] seems restless or fidgety | [ ] hyperactive, constantly in motion |
| [ ] difficulty staying seated | [ ] often 'talks out of turn' or interrupts |
| [ ] often talks excessively | [ ] often acts without thinking of consequence |
| [ ] underachieves relative to ability | [ ] forgets assignments or doesn't turn them in |
| [ ] works too quickly or too slow | [ ] avoids tasks requiring sustained attention |
| [ ] learning disabilities or problems | [ ] makes careless mistakes, sloppy work |
| [ ] poor social skills, odd social interactions | [ ] odd communication style |
| [ ] odd or repetitive gestures or behaviors | [ ] over-reacts to change, trouble with transitions |
| [ ] odd sensory issues [touch, smell, noise, etc.] | [ ] often rigid or inflexible about things |
| [ ] 'inappropriate' behavior or comments | [ ] very restricted or fixated interest in things |
| [ ] few friends, difficulty relating to other kids | |

**IV. SUBSTANCE ABUSE HISTORY**

1. Does the child have a current/past history of substance abuse?
   ☐ Unknown ☐ No ☐ Yes If yes, describe:

   _____

   _____

☐ Alcohol ☐ Barbiturates ☐ Tranquilizers
☐ Caffeine ☐ Benzodiazepine ☐ Amphetamines

| | | |
|---|---|---|
| ☐ Cocaine | ☐ Nicotine | ☐ Ecstasy |
| ☐ Heroin/Opium | ☐ Methamphetamine | ☐ Methadone |
| ☐ LSD | ☐ Morphine | ☐ PCP |
| ☐ Marijuana | ☐ Mescaline | ☐ Other: |
| | ☐ Hashish | |

2. Do the child's family/caregivers have a current/past history of alcohol or substance abuse?
☐ Unknown ☐ No ☐ Yes
Identify family member role(s) and details including treatment outcomes.

_____

_____

_____

3. Have there been any legal/other consequences of family/caregiver substance abuse?
☐ Unknown ☐ No ☐ Yes If yes, describe:

_____

_____

4. Has the child had any alcohol or substance abuse treatment, to include: *(select all that apply)*

☐ Medication management? Outcome?
☐ Alcoholics/narcotics anonymous? Outcome?
☐ Outpatient care? Outcome?
☐ Inpatient care? Outcome?
☐ Not applicable

**V. FAMILY AND HOME ENVIRONMENT**

1. With whom does the child live?

_____

_____

_____

2. As a family/caregiver, what strengths and positive influences do you find in your current living arrangement/relationships?

_____

_____

_____

3. What is the child's current living situation: physical arrangements, others living in the home? Names and ages of siblings?

_____

_____

_____

_____

4. How would you characterize the child's relationships and interactions with the family/caregivers, siblings, and/or others living in the home:

5. What stressors can you identify in your current family's living arrangement/relationships?

6. Do you have any personal, religious, spiritual or cultural practices or beliefs that you want taken into account when working with you and your child?

**VI. CHILD'S EDUCATIONAL INFORMATION**

1. Describe the child's educational strengths and resources:

2. List daycare, preschools, schools attended:

3. Child's current grade level: _____

4. Describe how the child is currently functioning academically:

5. Describe the child's behaviors in school and abilities/difficulties in getting along with teachers, principals, classmates:

## VII. CHILD'S DEVELOPMENTAL HISTORY

Any problems with pregnancy?

_____

Pregnancy was [ ] full term [ ] premature [ ] late birth weight:

Any health complications following birth?

_____

As infant, child was [ ] Easy [ ] Difficult?

How would you describe their temperament when they were little?

_____

Developmental milestones?

walking, [ ] on time [ ] late [ ] early
talking, [ ] on time [ ] late [ ] early
toileting, [ ] on time [ ] late [ ] early
sleep patterns:

_____
_____

## VIII. CHILD'S SEXUAL DEVELOPMENTAL HISTORY

1. Has the child reached puberty? ☐ Unknown ☐ No ☐ Yes

2. What is the child's sexual orientation?
_____ ☐ Unknown

3. Is the child sexually active? ☐ Unknown ☐ No ☐ Yes
If yes, describe, including health safety issues:

_____
_____

4. Has the child received sex education? ☐ Unknown ☐ No ☐ Yes
If yes, describe:

_____

5. Has the child ever engaged in any inappropriate sexual behavior? ☐ Unknown ☐ No ☐ Yes
If yes, describe:

_____
_____

6. Describe any history of sexual victimization: ☐ Unknown

_____

_____

_____

**IX. CHILD'S LEGAL HISTORY**

1. Has the child ever: *(select all that apply)*

☐ Been detained or arrested by any law enforcement agency?
☐ Gone to court or appeared before Juvenile Master for legal infractions?
☐ Been on probation or under court supervision?
☐ Been remanded to Detention Center or County/State Training Schools?
☐ None applicable

2. Does your family have current or past involvement with the Child Welfare System?
☐ No ☐ Yes If yes, describe:

_____

_____

**X. CHILD'S MEDICAL HISTORY**

*1. How would you characterize the child's general medical condition?

_____

_____

*2. Does the child have: *(select all that apply)*

☐ Asthma?
☐ Allergies?
☐ Diabetes?
☐ Heart problems?
☐ Obesity?
☐ Seizures?
☐ Other chronic health problems? If yes, describe:

☐ No chronic health problems

3. When was the child's last physical examination? Date: _____ ☐ Unknown

4. Are the child's immunizations current? ☐ Unknown ☐ No ☐ Yes

5. Does the child see a doctor regularly? ☐ Unknown ☐ No ☐ Yes
If yes, describe and provide name of doctor(s):

_____

*6. Has the child ever been hospitalized for a medical condition? ☐ Unknown ☐ No ☐ Yes
If yes, how often, for what condition(s), duration, and outcome(s)? Describe and include any previous surgeries: _____

_____

_____

7. Has the child a history of accidents or repeated accidents? ☐ Unknown ☐ No ☐ Yes
If yes, describe: _____

_____

_____

8. Has the child ever had an accident or injury resulting in: *(select all that apply)*

☐ Unknown
☐ Headaches?
☐ Head trauma?
☐ Blurred vision?
☐ Loss of consciousness?
☐ Not applicable

9. Does the child experience any sleeping problems: *(select all that apply)*

☐ Falling asleep?
Note: If yes, where does the child fall asleep and what is used to help sleep *(TV, parent, video, radio, bottle, pacifier, other)* _____

_____

☐ Staying asleep?
☐ Early awakening?
☐ Loss of consciousness?
☐ Nightmares?
☐ Night terrors?
☐ Sleep walking?

**Additional Information about your child that you would like to share:**

_____

_____

_____

_____

_____

_____