YOUTH CONFIDENTIAL CLIENT INFORMATION FORM

CHILD'S/TEENAGER'S INFORMATION

Date:_____. Referred by: □Internet □Friend □Doctor

Full Name: _____

Name you prefer: _____ Pronouns:_____ Age:_____ Date of Birth:_____

Current School Attending:_____Grade in School:_____

PARENT/GUARDIAN INFORMATION

Full Name:_____

Name you prefer: _____Age:_____Date of Birth:_____

Employer:_____Length of Employment:_____

Occupation: _____

Salary (Monthly or Annual):_____

Highest Level of School Completed: □9 □10 □11 □12 □GED College: □1 □2 □3 □4 □Other:_____

Address:_____

City: _____State: _____Zip Code: _____

May we send mail here: □ Yes □ No

Cell Phone: (_____) _____-_____ May we leave a message here: □ Yes □ No

Email Address: _____May we send a message here: □ Yes □ No

*Please be aware of the limits of security with electronic communication

Current Marital Status: □ Single □ Engaged □ Married □ Separated □ Divorced □ Widowed

If married, how long? _____Number of previous marriages for you: _____

If separated or divorced, how long? _____

If widowed, how long?_____

Please list family members and other household members (continue on back if necessary):

Name:	In home or Out of home?	Age:	Gender:	Relationship:

PARENT/GUARDIAN INFORMATION

Full Name:_____

Name you prefer: _____Age:_____Date of Birth:_____

Employer:_____Length of Employment:_____

Occupation: _____

Salary (Monthly or Annual):_____

Highest Level of School Completed: □9 □10 □11 □12 □GED College: □1 □2 □3 □4 □Other:_____

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If married, how long? _____Number of previous marriages? _____

If separated or divorced, how long? _____

If widowed, how long?_____

IF PARENTS ARE SEPARATED OR DIVORCED, THE PARENT INITIATING TREATMENT IS RESPONSIBLE FOR CONTACTING THE NON-INITIATING PARENT WITH FULL CONTACT INFORMATION OF THE COUNSELOR. COUNSELING CANNOT CONTINUE UNTIL BOTH PARENTS OR LEGAL GUARDIANS HAVE GIVEN CONSENT FOR COUNSELING.

By signing, you agree that you understand that both parents/ legal guardians must give consent for counseling services and will contact the non-initiating parent/ guardian immediately.

Signature _____ Date_____

Reasons for Counseling and Goals of Child/Teenager:

LEVEL OF DISTRESS OF CHILD/TEENAGER

Indicate how distressed you are by circling on the scale below

(1= Very Little Distress; 10=Extreme Distress):

1 2 3 4 5 6 7 8 9 10

Are you currently experiencing any suicidal thoughts? □ Yes □ No.

Have you in the past? □ Yes □ No

Have you ever attempted suicide? □ Yes □ No

If yes, please explain:_____

PREVIOUS COUNSELING OF CHILD/TEENAGER

Please list any previous counseling, psychiatric treatment, or residential/in-patient care you have received:

Location	Therapist	Dates	Reason

CURRENT STATUS OF CHILD/TEENAGER

Please check any of the following physiological symptoms that apply to you presently or in the recent past:

Headaches	□ Past □ Present	Visual Trouble	□ Past □ Present	Weakness	□ Past □ Present
Insomnia	□ Past □ Present	Change in Appetite	□ Past □ Present	Hearing Voices	□ Past □ Present
Dizziness	□ Past □ Present	Sleep Trouble	□ Past □ Present	Tension	□ Past □ Present
Intestinal Trouble	□ Past □ Present	Tiredness	□ Past □ Present	Seeing Things	□ Past □ Present
Stomach Trouble	□ Past □ Present	Trouble Relaxing	□ Past □ Present	Rapid Heart Rate	□ Past □ Present
Hearing Noises	□ Past □ Present	Pain	□ Past □ Present	Other	□ Past □ Present

How has your weight changed in the last 2-3 months? (If so, how?) _____

Please check any of the following problems that apply to you and/or your family.

Abortion	□ You □ Family	Eating Problems	□ You □ Family	Trouble with Job	□ You □ Family
Ambition	□ You □ Family	Being a Parent	□ You □ Family	Disaster	□ You □ Family
Anxiety	□ You □ Family	Depression	□ You □ Family	Terminal Illness	□ You □ Family
Bad Dreams	□ You □ Family	Unwanted Thoughts	□ You □ Family	Impulsive Behavior	□ You □ Family
Career Choices	□ You □ Family	Children	□ You □ Family	Recent Loss	□ You □ Family
Communication	□ You □ Family	Verbal Abuse	□ You □ Family	Anger	□ You □ Family
Concentration	□ You □ Family	Memory	□ You □ Family	Self-Control	□ You □ Family
Grief	□ You □ Family	Alcoholism	□ You □ Family	Fears	□ You □ Family
Hopelessness	□ You □ Family	Loneliness	□ You □ Family	Friends	□ You □ Family
Making Decisions	□ You □ Family	Finances	□ You □ Family	Other	□ You □ Family
Marriage	□ You □ Family	Emotional Abuse	□ You □ Family	Temper	□ You □ Family
Nervousness	□ You □ Family	Unhappiness	□ You □ Family	Apathy	□ You □ Family
Physical Abuse	□ You □ Family	Sexual Abuse	□ You □ Family	Aggressiveness	□ You □ Family
Pregnancy	□ You □ Family	Trauma	□ You □ Family	Alcohol Use	□ You □ Family
Racing Thoughts	□ You □ Family	Loss of Control	□ You □ Family	Compulsive	□ You □ Family
Recent Death	□ You □ Family	Inferiority Feelings	□ You □ Family	Shyness	□ You □ Family
Sexual Problems	□ You □ Family	Legal Matters	□ You □ Family		
Drug Use	□ You □ Family				
Stress	□ You □ Family	Panic	□ You □ Family		
Guilt	□ You □ Family				

FAMILY HISTORY

Has anyone in the Child/Teenager's immediate family ever had any of the following:

Mental illness requiring hospitalization Yes or No Who? _____

Counseling for any reason Yes or No Who? _____

Addiction to Alcohol/Drugs Yes or No Who? _____

Suicidal Thoughts Yes or No Who? _____

LEGAL HISTORY

Is any family member facing any pending civil or criminal litigation? □ Yes □ No

Has any family member been subject to a restraining order in the last 10 years? □ Yes □ No

Has any family member filed for a restraining order in the last 10 years? □ Yes □ No

Has any family member experienced any litigation relating to divorce or child custody in the last 10 years? □ Yes □ No

Does any family member anticipate the possibility of litigation relating to divorce or child custody in the next 5 years? □ Yes □ No

MEDICAL INFORMATION OF CHILD/TEENAGER

Primary Physician: _____City:_____ Zip:_____

Phone number: (_____) _____-_____FAX number: (_____) _____-_____

Are you currently receiving medical treatment? □ Yes □ No. If yes, please specify:_____

List all current medications you are taking, including those you seldom use or take only as needed.

Medication	Dosage	Purpose for Medication

Are you taking these medication(s) according to your doctor's recommendations. □ Yes □ No. If no, briefly explain:

_____

List significant conditions, illnesses, surgeries, hospitalizations, traumas, or treatments you've had.

_____

VOLUNTARY MEDICAL RELEASE OF INFORMATION

I authorize Ormond-By-The-Sea Counseling to release and or obtain medication records and relevant medical information from_____ (*doctor's name and office name*) for the purpose of providing continuity of quality mental health services.

I understand that I do not have to sign this authorization and my refusal to sign will not affect my ability to obtain treatment.

I understand that I may revoke this authorization at any time by written request to Ormond-by-the-Sea Counseling.

Print Name: _____Date: _____

Client Signature: _____ Date:_____

Parent/ Guardian Signature: _____Date:_____

TRAUMA/ABUSE HISTORY OF CHILD/TEENAGER

Have you ever experienced a severe trauma? □ Yes □ No □ Maybe

Have you ever been physically abused? □ Yes □ No □ Maybe

Have you ever been sexually abused? □ Yes □ No □ Maybe

Have you ever been emotionally abused? □ Yes □ No □ Maybe

RELIGIOUS/SPIRITUAL INFORMATION OF CHILD/TEENAGER

Is Faith, Religion or Spirituality important to you? □ Yes □ No □ Maybe. If yes or maybe, please explain:_____

Would you like to include prayer as part of your counseling experience? □ Yes □ No

WHAT ELSE DO WE NEED TO KNOW ABOUT YOUR SITUATION:

_____

FEE

Whatever fee you choose is paid at the time of service. If you fail to show for a scheduled appointment or do not call to cancel 24 hours before a scheduled appointment, we require that you pay the full amount of the agreed upon fee.

The rate I choose (based on sliding scale): $_____

TERMS OF SERVICE: *I understand that it is customary to pay for professional services when rendered. I accept full responsibility for payment of any balance incurred for services. I further understand that without 24-hour notice of cancellation, I will be charged the full fee for professional service.*

PAYMENT: *All accounts are requested to have a credit card on file to reserve appointments. This information will be kept confidential and will only be used to process payments at your request or to bill for late cancellations and missed appointments.*

Credit Card Number: _____

Exp Date: _____ Type of Card: □ AMEX □ VISA □ MC

Code on the back of card: _____ Name on card: _____

Billing Zip Code: _____

Parent's Signature :_____ Date:_____

Therapist Signature: _____ Date:_____

CLIENT RIGHTS AND RESPONSIBILITIES

Ormond-By-The-Sea Counseling is committed to providing service to you, the client, without regard to race, sex, color, religion, handicapping condition, or national origin.
AS A CLIENT YOU HAVE THE RIGHT TO:
INDIVIDUAL DIGNITY, to be treated in a respectful and confidential manner.
QUALITY SERVICES, suited to your needs, administered skillfully, safely, humanely, with full respect for your dignity and personal integrity, and in accordance with all statutory and regulatory requirements.
WITHDRAW YOUR CONSENT for any specific activity.
CONFIDENTIALITY OF CLIENT RECORDS, Ormond-By-The-Sea Counseling has the obligation to obtain your written consent prior to any exchange of confidential information. There are a few exceptions to confidentiality listed below:
If you present a danger to yourself or others, we are legally, ethically and morally required to protect the safety of threatened persons. If abuse or neglect of a child, elder or disabled person is known or suspected, we are required by law to report it to the Florida Abuse Hotline. If Ormond-By-The-Sea Counseling receives a court order for client records, deposition or court testimony, we are required to comply. We are also required to report attendance compliance by court ordered clients. In the event that group or family services are provided, it is acknowledged that Ormond-By-The-Sea Counseling or its counselors/therapists cannot be held responsible for a breach of confidentiality on the part of a family member.

AS A CLIENT YOUR RESPONSIBILITIES INCLUDE:
Appointments: Regular attendance is very important to ensure progress with the concerns and issues that have been presented. If there is an emergency and you need to cancel or reschedule an appointment, please call as soon as you know. *Participation:* Your honest and accurate reporting of dilemmas and concerns is vital to your progress. To the best of your ability you must be open and honest in your sessions. *Safety:* It is important that you and your children exercise appropriate caution, control and safe behavior on the premises. *Termination*: Services may be discontinued for repeatedly missed appointments, if you come to appointments intoxicated and/or under the influence of substances, or if you show evidence of inappropriate behavior. *Transfer Plan:* Files/Records are the responsibility of the owner of Ormond By The Sea Counseling. *Weapons*: No weapons, including handguns are allowed on the counseling property.

THERAPY INFORMED CONSENT
SERVICES: We provide many different types of therapy and counseling. Counseling services can vary in length depending on the collaborative effort between therapist and client. The goals for counseling are developed with the therapist and are based on the client's needs and concerns, and are reviewed on a regular basis to monitor progress. Our counseling services are voluntary. If the client has court documentation for counseling a copy of this documentation must be provided by the next counseling session. *When bringing children for counseling services, the adult providing transportation is required to stay on the premises during the session.* STAFF: Counselors providing services are Licensed or Registered Clinical Social Workers, Marriage and Family Therapists, Mental Health Counselors, or they are Master Degree Student Interns in these fields supervised by Licensed Therapists. FEES: Counseling session fees are based on the client's agreed upon rate, set at the first counseling session. All fees are due at the beginning of each session. AUDIO/VIDEO TAPES: *Videotapes are used to assist with supervision, consultation and training of counselors working with their clients*. These tapes are not considered part of client files and will be used only to assist the progress of the client's case. The tapes are the destroyed on a regular basis. TERMINATION: The client is expected to inform the therapist if the client plans to discontinue counseling for any reason. If a client fails to show up or

cancel two appointments, their file will be closed. Counselors may have to discontinue therapy if the client is currently involved in domestic violence, substance abuse, or has shown violent or threatening behavior. The client may be given a referral to other more appropriate services for issues of substance abuse, violence, or severe mental health issues. BENEFITS/RISKS: The majority of individuals and families that obtain counseling, benefit from the process. Self- exploration, gaining insight, exploring options, for dealing with problem behavior, learning new skills, or venting difficult feelings and experiences are generally quite useful. But, some risks do exist. As counseling is begun some individuals experience unwanted feelings. Examining ones life can produce unhappiness, anger, guilt or frustration. These unwanted feelings are a natural part of the psychotherapeutic process and often provide the basis for change. Also, sometimes a decision that is positive for one family member will be viewed quite negatively by another. QUESTIONS: Do not hesitate to discuss counseling goals, procedures, concerns, or your impression of services provided. If there is something you do not understand, please ask for a clarification.

I have read and understand the nature and limits of therapeutic services provided by Ormond-By-The-Sea Counseling. I have read and agree to the terms of the HIPPA notice form provided at intake.

Client: _____ Date:_____

Parent/Guardian: _____ Date:_____

Counselor/Therapist:_____Date:_____