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.

Patient Information	**No Show/Late Cancellation Policy**
Release of Information	**Minor Policy**
Consent for Treatment	**Intake Questionnaire**
Notice of Privacy Practice	****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 7:30-5pm & Friday between 7:30am-4pm @ 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

PATIENT INFORMATION

Last Name: | First Name: | Middle Initial: | Nickname/AKA:

Date of Birth: | Social Security Number: | Pronoun: How would you like us to address you? ☐ She/ Her ☐ He/ Him Other: ________________

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Life Partner ☐ Separated ☐ Widowed ☐ Other | Language other than English

Address: | Apt #: | City: | State: | Zip Code:

Home Phone: | Cell Phone/Other:

Email Address:

Employer: | Employer Phone:

PHYSICIAN REFERRAL INFORMATION

Primary Care Physician: | Referring Physician:

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Relationship to Patient : ☐ Self (If self, skip to Insurance Information) ☐ Spouse ☐ Parent ☐ Other:

Last Name : | First Name: | Middle Initial:

Date of Birth: | Social Security Number:

Address: | Apt #: | City: | State: | Zip Code:

Home Phone: | Cell Phone/Other:

Employer: | Employer Phone:

INSURANCE INFORMATION

Primary Insurance Co: | Policy Number: | Group Number:

Policy Holder Last Name: | First Name: | Date of Birth: | Phone:

Address: | Apt#: | City: | State: | Zip Code:

Are you using an Employee Assistance Program? (EAP): | EAP Company: | Auth #: | # of Sessions Approved:

Secondary Insurance Co: | Policy Number: | Group Number:

Policy Holder Last Name: | First Name | Date of Birth: | Phone:

Address | Apt# | State | Zip Code

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EMERGENCY / NEXT OF KIN CONTACT INFORMATION

Last Name:	First Name:	Phone:

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 **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 **$160** 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.

PRINT NAME: ______________________________ DATE: ________________

SIGNATURE: ______________________________

Patient / Parent / Guardian / Responsible Party

The Counseling Center

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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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

Thank you again for choosing The Counseling Center for your Mental Health needs.

We understand that emergencies happen, or you get sick without any notice or warning. Please call the office to learn about your options if you have any questions.

Our office No Show/ Cancellation policy is:

1st No show/ Late Cancellation is forgiven

2nd No Show/ Late Cancellation- May result in a $25 fee and or schedule restrictions.

3rd No Show/ Late Cancellation- $75 fee and or Counseling Relationship Terminated.

1st Intake Appointment No Show without any contact: there maybe a 3-4-month delay getting you rescheduled again.

Our office will place a courtesy phone call reminder 2 days prior to your 1st appointment and sends text messages 1 day prior to your scheduled appointment day.

How to cancel your appointment:

To cancel or reschedule your appointment please call The Counseling Center at **541-928-2710**. If you have any problems getting through, you can leave a confidential message with your name, appointment date and time, and cancellation reason or request for a rescheduled appointment. Please leave your phone number and a good time to reach you.

______________________ Patient/Guardian Signature ____________ Date

______________________ Patient Printed Name ____________ Date

______________________ Office Staff Signature ____________ Date

Copy given to client ____________ (Client's Initials)

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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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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.

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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:

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

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):

____

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***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:

____

____

____

____

____

____