Denver Counseling Solutions LLC

Child and Adolescent Information Form

Client Information

Initial Date of Service: _____ Date of Birth: _____

Age: _____ Gender: _____

Client Name: _____

Parent/Legal Guardian: _____

Address: _____

City, State, Zip Code: _____

Cell Phone: _____ May we contact you at this number? __Yes __No

Home Phone: _____ May we contact you at this number? __Yes __No

Email address: _____ May we contact you by email? __Yes __ No

Will you be filing a claim with your insurance (if yes, then you must provide an email address)?

__Yes __ No

Primary Care Physician/Pediatrician: _____

Address: _____

Telephone/Fax: _____

Allergies: _____

Specific Health Conditions (we should be aware of): _____

_____

Psychiatrist: _____

Address: _____

Telephone/Fax: _____

Current Medications and Dosage: _____

_____

Past Medications: _____

Has your child/adolescent had previous counseling or psychotherapy? ___ Yes ___ No

If yes, please specify the following:

Reason for counseling: _____

_____

Counseling location: _____

Counseling dates: _____

Counseling duration: _____

Has your child/adolescent ever been hospitalized for psychiatric reasons? ___ Yes ___ No

If yes, please specify the following:

Reason for hospitalization: _____

_____

_____

Hospital location: _____

Dates of hospitalization: _____

Duration of hospitalization: _____

Permission for Treatment:

In presenting my child/adolescent for diagnosis and treatment, I voluntarily consent to the rendering of counseling services provided by Denver Counseling Solutions LLC. I acknowledge no guarantees have been made to me as to the effect of treatment on my child/adolescent's condition. I acknowledge I am responsible for all reasonable charges in connection with care and treatment. I have read this statement and acknowledge that I understand it.

_____ _____

Client Name and Parent/Guardian Signature Date

Strengths and Difficulties Questionnaire

For each item, please mark the box for Not True, Somewhat True, or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of your child's behavior over the last six months.

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings			
Restless, overactive, cannot stay still for long			
Often complains of headaches, stomach-aches, or sickness			
Shares readily with other children, for example toys, treats, pencils			
Often loses temper			
Rather solitary, prefers to play alone			
Generally well behaved, usually does what adults request			
Many worries or often seems worried			
Helpful if someone is hurt, upset, or feeling ill			
Constantly fidgeting or squirming			
Has at least one good friend			
Often fights with other children or bullies them			
Often unhappy, depressed, or tearful			
Generally liked by other children			
Easily distracted, concentration wanders			
Nervous or clingy in new situations, easily loses confidence			
Kind to younger children			
Often lies or cheats			
Picked on or bullied by other children			
Often offers to help others (parents, teachers, other children)			
Thinks things out before acting			
Steals from home, school, or elsewhere			
Gets along better with adults than with other children			
Many fears, easily scared			
Good attention span, sees chores or homework through to the end			

For the following questions, please put a check next to the most accurate answer for your child/adolescent.

Overall, do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behavior, or being able to get along with other people?

No ____ Yes: minor difficulties ____ Yes: definite difficulties ____ Yes: severe difficulties ____

If you answered "Yes," please answer the following questions about these difficulties:

1. How long have these difficulties been present?

   Less than a month ____ 1-5 months ____ 6-12 months ____ Over a year ____

2. Do the difficulties upset or distress your child?

   Not at all ____ Only a little ____ Quite a lot ____ A great deal ____

3. Do the difficulties interfere with your child's everyday life in the following areas?

HOME LIFE	Not at all ___ Only a little ___ Quite a lot ___ A great deal ___
FRIENDSHIPS	Not at all ___ Only a little ___ Quite a lot ___ A great deal ___
CLASSROOM LEARNING	Not at all ___ Only a little ___ Quite a lot ___ A great deal ___
LEISURE ACTIVITIES	Not at all ___ Only a little ___ Quite a lot ___ A great deal ___

4. Do the difficulties put a burden on you or the family as a whole?

   Not at all ____ Only a little ____ Quite a lot ____ A great deal ____

5. Do you have any other concerns?

_____

_____

_____

_____

_____

Child/Adolescent Diagnostic Assessment

Part 1: Please provide the following information in preparation for your interview with your mental health clinician.

Reason for Referral:

Living Situation:

Primary Household					
Household member name	Relationship to child	Age	Occupation/School	Highest level of education	Quality of relationship
Does the client live in more than one household? No _____ Yes _____ (If yes, complete the secondary household information below.)					

Secondary Household					
Household member name	Relationship to child	Age	Occupation/School	Highest level of education	Quality of relationship
Street address: (If different from child's address listed on Client Information form.)					

Family members who live in both households: ___ Only child ___ Child and (list):
Additional family members: ___ No, parents or sibling other than those listed in primary or secondary households ___ Yes, list family members:
Custody and parenting plan: ___ Lives with both parents (biological or adoptive) in some household ___ Single parent ___ Shared custody – parents in different households ___ Other (describe):

Developmental Issues:

Have you ever had concerns about the following issues with this child?

Pregnancy	Yes	No	Unknown
Had bleeding during first three (3) months			
Had bleeding during second three (3) months			
Had bleeding during last (3) months			
Had toxemia			
Had to take medications Specify any medication:			
Got injured or hurt			
Gained less than 15 lbs. (7 kgs.) Specify:			
Took narcotic drugs			
Drank alcohol			
Had an infection			
Smoked during pregnancy			
Length of pregnancy: months			
Other pregnancy problems/illnesses Specify:			

Birth/Early Infancy	Yes	No	Unknown
Born prematurely			
Born with cord around neck			
Injured during birth			
Had trouble breathing			
Turned blue (cyanosis)			
Was a twin or triplet			
Had an infection			
Had seizures (fits, convulsions)			
Needed oxygen			
Was very jittery			

Childhood Health Issues	Yes	No	Unknown	If yes, age first noted	If yes, still occurring?
Seizures (convulsions) or spells					
High fevers (over 103° F. or 39° C.)					
Head injury					
Asthma					
Trouble with hearing					
Trouble with vision					
Lead poisoning					
Other poisoning or overdose					
Other serious illness					
Other hospitalizations					

Functioning	Yes	No	Unknown	If yes, age first noted	If yes, still occurring?
Poor appetite					
Constipation					
Stomach aches					
Trouble falling asleep					
Trouble staying asleep					
Overactivity					
Head banging					
Rocking in bed					
Temper tantrums					
Self-destructive behavior					
Difficulty in being comforted or consoled					
Stiffness or rigidity					
Looseness or floppiness					
Crying often and easily					
Shyness with strangers					
Irritability					
Extreme reaction to noise or sudden movement					

Attention Problems	Yes	No	Unknown	If yes, age first noted	If yes, still occurring?
Can concentrate for only a short time unless things are very interesting					
Understand the main ideas of things but misses important details					
Does work or performs many tasks carelessly without thinking					
Learns a new skill well one day and then can't seem to do it a few days later					
Receives very unpredictable (inconsistent) grades or test scores in school					
Can work well only on things he/she really enjoys doing or thinking about					
Often doesn't notice when he/she makes mistakes					
Seems to not realize when he/she is disturbing someone					
Doesn't do much better after punishment or correction					
Makes comments about or is distracted by background noises or unimportant things					
Seems to want things right away and/or is hard to satisfy					
Annoys or bothers other children					
Behavior is variable and hard to predict					
Is a troublemaker; bullies others					

Behaviors	Yes	No	Unknown	If yes, age first noted	If yes, still occurring?
Has bad dreams					
Is often very quiet or withdrawn					
Is often "down" on himself/herself					
Is often tired					
Speaks unclearly, stutters, or stammers					
Wets bed or pants often					
Soils underwear or has accidents with bowel movements					
Is often too neat or orderly					
Is often too concerned about cleanliness					
Often plays with matches					
Destroys objects at home					
Destroys objects away from home					
Is fearless					
Is cruel to animals					
Is not liked by other children					
Feels ill on school mornings					
Has eating problems (either overeats or undereats)					
Is preoccupied with food or diet					
Is part of a clique or gang that causes trouble					
Other behaviors not noted above					
Have you ever had concerns about your child's early development (i.e. walking, talking, learning)?					
Have you ever had concerns about your child's sexual development or behaviors?					
Please list any other concerns regarding behavioral problems:					

Child/Adolescent's School Functioning:

Education Classification	
Does your child receive special education services? ___ Yes ___ No	
If no, has your child ever been tested and determined not to need services? ___ Yes ___ No	
Regular education classroom, no special services ___ Yes ___ No	
If no, check all that apply below:	
___ Early Childhood Spec. Ed./Developmental Delay	___ Special Learning Disability
___ Special Learning Disability	___ Autism Spectrum Disorder
___ Hearing Impaired	___ Traumatic Brain Injury
___ Visually Impaired	___ Other Health Impaired
___ Speech or Language Impaired	___ Unsure
___ Physically Impaired	___ Current 504 plan
___ Emotional/Behavioral Disorder	___ Other:
___ Developmental/Cognitive Disability	
Comments on Educational Classification:	

Child/Adolescent's Legal History:

Does your child/adolescent have a history of legal charges? ___ No ___ Yes
If yes, describe charges:
Is your child/adolescent currently on probation? ___ No ___ Yes
Has your child/adolescent ever been on probation? ___ No ___ Yes
Has your child/adolescent ever been court-ordered into chemical health or mental health treatment? ___ No ___ Yes

Child/Adolescent's Trauma History:

Children's Protective Services (CPS) involvement with family ___ No ___ Yes
If yes, describe:
Name of CPS caseworker(s) assigned to family (if applicable): ___ None reported
Name of Guardian Ad Litem (GAL) or Court Appointed Special Advocate (CASA) assigned to family ___ None reported
Has your child/adolescent ever experienced any of the following? ___ Physical Abuse ___ Domestic Violence/Abuse ___ Physical Neglect ___ Emotional Abuse ___ Sexual Abuse ___ Community Violence ___ None of the Above

Child/Adolescent's Alcohol and Drug History:

Do you have any concerns about your child/adolescent's use of alcohol or drugs? ___ No ___ Yes
Comments:

Family Environment/Relationships:

Please indicate below the best descriptions of parent-child/adolescent relationships.

Parent-Child/Adolescent Relationship(s) **P** = Primary Household **S** = Secondary Household **B** = Both					
Parent-child/adolescent conflict	None – Mild	Moderate	Severe		
Issues with supervision and monitoring of child/adolescent	Always	Usually	Inconsistently	Rarely	
Cooperation between parents regarding child/adolescent rearing	Always	Usually	Inconsistently	Rarely	Not Pertinent
Parent positive activities with relationship	Frequent	Occasionally	Infrequent		
Parent satisfaction with relationship	Satisfied	Neutral	Dissatisfied		
Child/Adolescent satisfaction with relationship	Satisfied	Neutral	Dissatisfied		
Comment on parent-child/adolescent relationships (describe further if needed):					

Please indicate below the best descriptions of sibling-child/adolescent relationships.

Sibling-Child/Adolescent Relationship(s) **P** = Primary Household **S** = Secondary Household **B** = Both ___ No siblings			
Sibling-child/adolescent conflict	None – Mild	Moderate	Severe
Sibling(s) positive activities with relationship	Frequent	Occasionally	Infrequent
Sibling(s) satisfaction with relationship	Satisfied	Neutral	Dissatisfied
Child/Adolescent satisfaction with relationship	Satisfied	Neutral	Dissatisfied
Comment on sibling-child/adolescent relationships (describe further if needed):			

Please indicate below the best descriptions of parent marital or couple relationships.

Parent Marital or Couple Relationship(s) **P** = Primary Household **S** = Secondary Household **B** = Both ___ Not Applicable			
Marital or couples conflict	None – Mild	Moderate	Severe
Marital or couples satisfaction	Satisfied	Neutral	Dissatisfied
Comment on parent marital or couples relationships (describe further if needed):			

Other Family Concerns			If yes, indicate:		
	No	Yes	Parent	Sibling	Other
Family member health problems					
Family member disability					
Family member legal issues					
Family financial concerns					
Family member alcohol abuse					
Family member substance abuse					
Family member anxiety					
Family member depression					
Family member ADHD					
Family member mania					
Family member schizophrenia/other psychosis					
Significant family stressors (moves, deaths, divorce, loss of employment)					
Comment on other family concerns and information relating to financial status (specify problems that impact your child/adolescent's needs.):					

Denver Counseling Solutions LLC
Policy Statement

- The full cost of each session will be billed directly to the client.
- Payment is due at the end of each session. A receipt will be provided for the clients to make their own insurance claim.
- Patients will be charged $30 for returned checks. Upon the occurrence of a returned check the client will be required to pay by cash or credit card for future sessions.
- Sessions begin at your designated appointment time. Standard sessions are 60 minutes in length.
- Patients arriving late after their designated appointment time will still be charged the full fee.
- Cancellations must be made 48 hours prior to appointment. Any cancellations made less than 48 hours in advance will be charged the full fee.
- Missing an appointment without prior notice is considered a No Call / No Show. All No Call/ No Show's will be billed directly to the client for the full amount of the scheduled session.
- Patients that accumulate three late cancellations or No Call / No Show's in any combination may be referred out to another counseling service.
- Time spent preparing letters, misc. paperwork, court documents etc. on behalf of a client will be billed directly to the client at the rate of the clinician's current fee schedule.
- Time spent on the phone or in correspondence over 15 minutes will be billed according to the clinician's current fee schedule.
- Court time or consultations with third parties on behalf of a client may be billed directly to the client at the rate of the clinician's current fee schedule.

By signing below, I signify that I have read and fully understand this Policy Statement, and that I agree to pay any charges that may be applied to my account as a result of these policies.

Signed: _____ Date: _____

Denver Counseling Solutions LLC
Credit Card Authorization Form

I, _____, hereby authorize Denver Counseling Solutions LLC to charge my credit card account according to the following fee schedule:

Licensed Therapist Rate: $120 ($150 Initial Session)
MFTC/LPCC/Registered Psychotherapist Rate: $90 ($110 Initial Session)
Sliding Scale Rate: _____
Group Rate: _____
EAP
Supervision: $75

( ) VISA ( ) MasterCard ( ) American Express ( ) Discover

Credit Card Number: _____

Expiration Date: ____ / ____ Security Code: _____

Credit Card Billing Address:

Name as it appears on card: _____

Street: _____

City: _____ State: _____

Zip Code _____ - _____ Telephone: (_____) _____ - _____

Email: _____

By signing below, I authorize the charges specified above.

_____ _____/ _____/ _____
Cardholder's Signature Date

Your completion of this authorization form helps us to protect you from credit card fraud. Denver Counseling Solutions LLC will keep all information entered on this form strictly confidential and in a secure location.

DISCLOSURE STATEMENT

The Colorado Department of Regulatory Agencies has the general responsibility of regulating the practice of licensed psychologists, licensed social workers, licensed professional counselors, licensed marriage and family therapists, licensed school psychologists practicing outside the school setting, licensed or certified addiction counselors, and unlicensed individuals who practice psychotherapy. The agency within the Department that has responsibility specifically for licensed and registered Psychotherapists is the Department of Regulatory Agencies, Mental Health Section, 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7766.

Client Rights and Important Information:

1. You are entitled to receive information from me about my methods of therapy, the techniques I use, the duration of your therapy (if I can determine it), and my fee structure. Please ask if you would like to receive this information.
2. You can seek a second opinion from another therapist or terminate therapy at any time.
3. In a professional relationship (such as ours), sexual intimacy between a therapist and a client is never appropriate. If sexual intimacy occurs, it should be reported to the Department of Regulatory Agencies, Mental Health Section.
4. Generally speaking, the information provided by and to a client during therapy sessions is legally confidential if the therapist is a licensed psychologist, licensed social worker, licensed professional counselor, licensed marriage and family therapist, licensed or certified addiction counselor, or a Registered Psychotherapist. If the information is legally confidential, the therapist cannot be forced to disclose the information without the client's consent. Information disclosed to a licensed psychologist, licensed social worker, licensed professional counselor, licensed marriage and family therapist, licensed or certified addiction counselor, or an Registered Psychotherapist is privileged communication and cannot be disclosed in any court of competent jurisdiction in the State of Colorado without the consent of the person to whom the testimony sought relates. There are exceptions to the general rule of legal confidentiality. These exceptions are listed in the Colorado statutes (C.R.S. 12-43-218). You should be aware that provisions concerning disclosure of confidential communications shall not apply to any delinquency or criminal proceedings, except as provided in C.R.S. 13-90-107. There are exceptions that I will identify to you as the situations arise during therapy.
5. I understand that my therapist cannot guarantee confidentiality when using tools of technology such as phone, e-mail, text messaging, Skype, FaceTime, etc…
6. The use of recording devices is strictly prohibited without written consent. Neither the client nor the therapist can audio-record or video record sessions unless agreed upon beforehand with written permission.
7. I understand that my therapist provides non-emergency therapeutic services by scheduled appointment. Should a crisis arise, I take the responsibility to notify proper authorities, call 911, or take myself to an emergency room for immediate support. I understand that if my therapeutic needs are outside of the skill set of my therapist, he or she is required to refer, terminate, or consult regarding my case.
8. If I am involved in divorce or custody litigation, I understand that my therapist's role is not to make recommendations to the court concerning parenting or custody matters.
9. I agree not to subpoena my therapist for testimony or for disclosure of treatment information.
10. I understand that in the course of couples and family work it is sometimes necessary to utilize work done in individual sessions in joint sessions. I give permission for my therapist to use his or her discretion in discussing information from my individual sessions with partner and/or my family and myself. I understand that my therapist does not hold secrets in therapy or keep information from family members that may hinder therapeutic progress/treatment.
11. In the state of Colorado, minors over the age of 12 years old are entitled to the right of confidentiality. Minors over the age of 15 are allowed to seek counseling services without the permission of their parents/guardians. I give my therapist permission to use their discretion when treating minors as to when and what information is necessary to disclose in an effort to uphold the therapeutic ethical standard of confidentiality and maintain the relationship between the child and parent/guardian.
12. I may use or disclose protected health information (PHI) without your consent or authorization in the following circumstances:
    a. *Child Abuse*: If I have reasonable cause to know or suspect that a child has been subjected to abuse or neglect, I must immediately report this to the appropriate authorities.
    b. *Adult and Domestic Abuse*: If I have reasonable cause to believe that an at-risk adult has been mistreated, self-neglected, or financially exploited and is at imminent risk of mistreatment, self-neglect, or financial exploitation, then I must report this belief to the appropriate authorities.

c. *Health Oversight Activities:* If the Grievance Board for Unlicensed Psychotherapists or an authorized professional review committee is reviewing my services, I may disclose PHI to that board or committee.
d. *Judicial and Administrative Proceedings:* If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and I will not release information without your written authorization or a court order. The privilege does not apply when a third party is evaluating you or where the evaluation is court ordered. You will be informed in advance if this is the case.
e. *Serious Threat to Health or Safety*: If you communicate to me a serious threat of imminent physical violence against a specific person or persons, I have a duty to notify any person or persons specifically threatened, as well as a duty to notify an appropriate law enforcement agency or by taking other appropriate action. If I believe that you are at imminent risk of inflicting serious harm on yourself, I may disclose information necessary to protect you. In either case, I may disclose information in order to initiate hospitalization.
f. *Worker's Compensation:* I may disclose PHI as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law that provided benefits for work-related injuries or illness without regard to fault.

13. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. Updates will be posted on www.denvercounselingsolutions.com and provided to clients at their next appointment date.
14. Supervision and Consultation Disclosure**:** To assure the quality of care**,** I understand my therapist may regularly consult with individual and group supervisors regarding treatment. Supervisors and other mental health professionals are bound by the legal confidentiality standards outlined in this disclosure statement and explained in the Colorado statutes concerning the information you disclose in therapy. If your therapist consults with supervisors**,** colleagues or field experts regarding issues pertinent to your therapy**,** your circumstances will be generalized and all identifying information will be concealed. Client consent is required for release of any identifying information.
Supervisor's Name/Credentials/License #: _____
15. Registered psychotherapist is a psychotherapist listed in the State's database and is authorized by law to practice psychotherapy in Colorado but is not licensed by the state and is not required to satisfy any standardized educational or testing requirements to obtain a registration from the state.
16. Denver Counseling Solutions contracts with clinicians under various licensures. Below is an explanation of many of the different licensure requirements.
    a. Registered Psychotherapist is a psychotherapist listed in the state's database and is authorized by law to practice psychotherapy in Colorado. However, they not licensed by the state and are not required to satisfy any standardized educational or testing requirements to obtain a registration from the state.
    b. Certified Addiction Counselor I (CAC I) must be a high school graduate, complete required training hours and 1,000 hours of supervised experience.
    c. Certified Addiction Counselor II (CAC II) must complete additional required training hours and 2,000 hours of supervised experience.
    d. Certified Addiction Counselor III (CAC III) must have a bachelor's degree in behavioral health, complete additional required training hours and 2,000 hours of supervised experience.
    e. Licensed Addiction Counselor must have a clinical master's degree and meet the CAC III requirements.
    f. Licensed Social Worker must hold a master's degree in social work.
    g. Psychologist Candidate, Marriage and Family Therapist Candidate (MFTC) and a Licensed Professional Counselor Candidate (LPCC) must hold the necessary licensing degree and be in the process of completing the required supervision for licensure.
    h. Licensed Clinical Social Worker (LCSW), a Licensed Marriage and Family Therapist (LMFT), and a Licensed Professional Counselor (LPC) must hold a master's degree in their profession and have two years of post-masters supervision.
    i. Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision.

If you have any questions or would like additional information, please feel free to ask.

Client Signature

I have read the above terms and understand them as stated. I have been informed of my therapist's policies and practices to protect the privacy of my health information and understand my rights as a client/patient.

Client Name (PRINT)	**Client Signature**	**Date**
Parent / Guardian Name (PRINT)	**Parent / Guardian Signature**	**Date**
Therapist Name/Credentials (PRINT)	**Therapist Signature**	**Date**