Denver Counseling Solutions LLC
New Client Information Form

Client Information

Date: __________________

Last Name: __________________________________ First Name: __________________________________ MI: __________

Client is: __Self __Couple __Family __Minor Gender: ___________________

Marital Status: __Single __Married __Divorced __Separated __Widowed __Domestic Partnership

Date of Birth: ___________________ Age: ________

Address: ____

City, State, Zip Code: ____

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

Home or Alternate 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

Parent/Guardian Information (If client is under 18)

Last Name: _____________________________________ First Name: ___________________________________

Relationship to Client: ____

Address: ____

City, State, Zip: ____

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

Home or Alternate Phone: ______________________ May we contact you at this number? __Yes __No

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

Permission for Treatment

In presenting myself (or my child) 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 (or my child'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 Signature (or Parent/Guardian) **Date**

Self –Assessment

Client Name: ____ Date of Assessment: ____________________________

In filling out this form, you are encouraged to provide as much information as possible.

If you find a question that you desire to leave blank, you are welcome to do so for any reason.

Your therapist will review this form and if they have any questions regarding your answers, they will follow up with you in session.

Section A: Client Information

1. Are there cultural or heritage influences that are important to you, which your counselor should be aware? Yes or No

   If yes, please explain: ____

2. Ethnicity: ____

3. Are there religious or spiritual beliefs that are important to you, which your counselor should be aware? Yes or No

   If yes, please explain: ____

   ____

   ____

Section B: Presenting Problem

1. Briefly describe the problem or concern you're hoping to address?

   ____

   ____

   ____

2. How would you rate the intensity of the problem or concern that led you to seek professional services?

   (Please circle your selection)

   Extreme Moderate Mild

   5 4 3 2 1

3. Approximately how long have you had the current problem or concern? ______________________________

4. In what ways have you attempted to cope with this problem or concern?

   ____

   ____

   ____

Section C: Family Background

1. Please list the members of your family:

   a. Father Age: Occupation: Education:

   b. Mother Age: Occupation: Education:

   c. Sibling Age: Occupation: Education:

   d. Sibling Age: Occupation: Education:

   e. Sibling Age: Occupation: Education:

   f. Sibling Age: Occupation: Education:

2. Is your father deceased? Y or N Year? ______________________

   Mother deceased? Y or N Year? ______________________

3. What is/was your parents' marital status? ____

4. Please list your stepfamily members. (Please circle "step" or "half")

   a. Step-father Age: Occupation: Education:

   b. Step-mother Age: Occupation: Education:

   c. Step/half sib Age: Occupation: Education:

   d. Step/half sib Age: Occupation: Education:

   e. Step/half sib Age: Occupation: Education:

   f. Step/half sib Age: Occupation: Education:

5. In what city were you raised? ____

6. Please list all cities you have lived in: ____

   ____

7. What is your spouse's/partner's name? ___________________________ Age: _______________

   Occupation: ________________________________ Education: ________________________________

   How long have you been together/married? _________________________

   Deceased? Y or N Year: ___________________

8. Please list your children:

   a. Child Name_____________________ Age_______ Gender: M or F

      Circle: Biological Stepchild Adopted Foster

   b. Child Name_____________________ Age_______ Gender: M or F

      Circle: Biological Stepchild Adopted Foster

c. Child Name____________________ Age_______ Gender: M or F

Circle: Biological Stepchild Adopted Foster

d. Child Name____________________ Age_______ Gender: M or F

Circle: Biological Stepchild Adopted Foster

e. Child Name____________________ Age_______ Gender: M or F

Circle: Biological Stepchild Adopted Foster

9. Have you personally experienced significant abuse?

None Unsure Emotional Physical Sexual

10. In general, how happy or adjusted were you growing up?

Poor Unsatisfactory Average Substantial Completely

11. How much is your immediate family a source of emotional support for you?

None Little Somewhat Substantial Always

12. How much conflict in values do you currently experience with your parents?

None Little Somewhat Substantial Always

Who in your family do you currently feel closest to? ______________________________

Most distant from? ____________________ In most conflict with? ____________________

Section D: Education and Work Information

1. What is your highest education level? ______________________________
2. What was your major/minor area of concentration? ______________________________
3. Did you experience any learning problems in school?

None Little Some Substantial Always

Please explain: ______________________________

____

4. How satisfied are you with your academic progress so far? (Please circle a number)

5 4 3 2 1

5. What barriers, if any, are impeding your academic progress? ______________________________
6. What is your current job and/or occupation? ______________________________
7. Where are you currently employed? ______________________________
8. How satisfied are you with you current job and/or occupation? (Please circle)

Very Satisfied Satisfied Dissatisfied Very Dissatisfied

9. Please list past significant employment history:

____

____

Section E: Health and Social Issues

1. How is your physical health at present?

   Poor   Fair   Satisfactory   Good   Excellent

2. Please list any persistent physical symptoms or health concerns (e.g., chronic pain, headaches, diabetes, etc.)

   ____

   ____

3. Please list any prescribed medications you are presently taking, including dosage and frequency

   ____

   ____

4. Are you having any problems with your sleep habits?   Yes or No

   If yes, circle where applicable:

   Sleeping too little   Sleeping too much   Poor quality of sleep

   Disturbing dreams   Other: ______________________________

5. How many times per week do you exercise? ____________   For how long? ______________________

6. Are you having any difficulty with appetite or eating habits?   Yes or No

   If yes, circle where applicable: Eating less   Eating more   Binge eating   Restricting calories

7. Have you had a significant weight change in the past two months?   Yes or No

8. Do you regularly use alcohol?   Yes or No

   In a typical month, how often do you have four or more drinks in a 24-hour period? ______________________

9. Have you ever tried to cut down on the amount of alcohol you consume?   Yes or No

10. Has anyone close to you ever been annoyed by your drinking?   Yes or No

11. Do you consider your alcohol consumption to be a problem?   Yes or No

12. How often do you engage in recreational drug use? ______________________________________

13. Do you consider this drug use to be a problem?   Yes or No

14. Have you ever experienced any legal problems?   Yes or No

    Nature of problem: ____

    ____

15. In the past, how would you rate the quality of your peer relationships?

    Very Poor   Unsatisfactory   Average   Good   Excellent

16. Approximately how many significant intimate relationships, lasting six months or more, have you had? ________________

    Are you currently in one? Yes or No

17. Have you been married previously? Yes or No   When? ____________________   Duration: ____________________

18. Do you have any problems or worries about sexual functioning? Yes or No

    If yes, circle where applicable:

    Performance Problem   Sexual Impulsiveness   Lack of Desire

    Difficulty Maintaining Arousal   Worry about STD(s)

19. What is your sexual orientation? Heterosexual   Gay/Lesbian   Bisexual   Transgender   Unsure

20. Besides family members, who are the people you can really count on currently for emotional support?

    ____

    ____

Section F: Mental Health History

1. Are you currently receiving psychiatric services, professional counseling or therapy elsewhere? Yes or No

   If yes, by whom? ______________________________________

2. Have you ever had previous counseling or psychotherapy? Yes or No   If yes, please specify the following:

   Reason for counseling: ____

   ____

   ____

   Counseling location: ____

   Counseling dates: ____

   Counseling duration: ____

3. Have you ever been hospitalized for psychiatric reasons? Yes or No   If yes, please specify the following:

   Reason for hospitalization: ____

   ____

   ____

   Hospital location: ____

   Dates of hospitalization: ____

   Duration of hospitalization: ____

4. Have you ever been prescribed medication for psychiatric reasons? Yes or No If yes, please specify the following:

Name/dose of medication: ____

Date of prescription: ____________________

Duration of medication: __________________

Prescribing doctor: ____________________

5. Is there a family history of mental illness? Yes or No

If yes, please specify relation and diagnosis: ______________________________________

____

6. Have you had suicidal thoughts recently? Yes or No If yes, how often? ____________________

Have you had them in the past? Yes or No If yes, how often? ____________________

7. Have you ever intentionally inflicted harm upon yourself? Yes or No

If yes, how often? ____________________ Nature of harm: ______________________________

____

8. Have you ever intentionally hurt someone else? Yes or No

If yes, when? ____________________ Nature of experience: __________________________

____

9. Have you ever experienced any form of traumatic experience? Yes or No

If yes, when? ____________________ Nature of experience: __________________________

____

Please circle any past, present, or impending problems/issues in your family:

a. physical/sexual abuse b. deaths c. financial/unemployment

d. frequent relocations e. divorce f. legal problems

g. injuries/disabilities

Please specify family member(s), which problem/issue, and approximate year of occurrence:

____

____

____

10. Have you ever experienced sexual assault, unwanted sex or uncomfortable touching?

Frequently A Few Times Once Never Unsure

11. How does the future look to you? Poor Fair Neutral Good Excellent

12. Please describe your future plans.

____

____

____

13. What do you hope to accomplish through counseling?

____

____

____

14. Is there anything else you would like your counselor to know about you?

____

____

____

~Thank you for your valuable time and effort~

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**