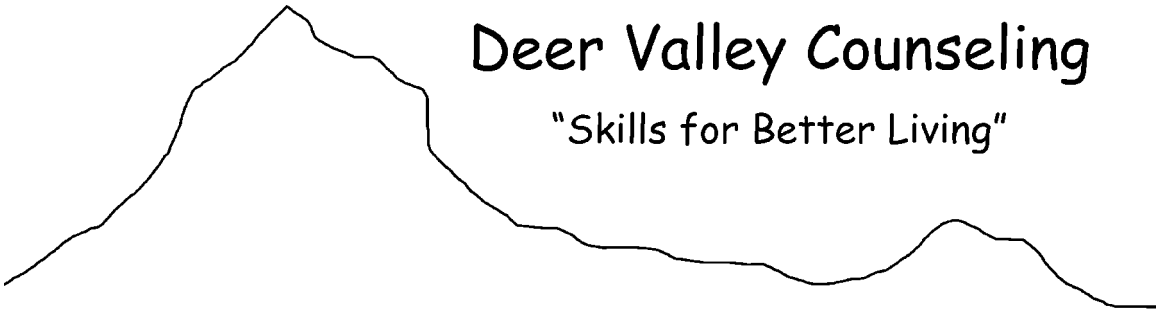

Client Information Sheet – Adult

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Mobile Phone: _____

Preferred Method for Courtesy Appointment Reminders:

☐ **Text Message to Mobile Phone** ☐ Call to Home Phone ☐ Call to Mobile Phone ☐ Do Not Remind

Note: You are responsible for appointments you schedule whether you receive a courtesy reminder or not.

Emergency Contact: _____ Phone: _____

Referral Source:

☐ Internet. Search Terms: _____

☐ Bing ☐ Yahoo ☐ Google ☐ Yelp ☐ Counsel-Search.com ☐ Family-Marriage-Counseling.com

☐ Psychology Today ☐ Theravive.com ☐ GoodTherapy.org ☐ Find-a-Therapist.com

☐ Verizon Superpages ☐ DEX Knows ☐ Other _____

☐ Phone Book: ☐ DEX ☐ Verizon ☐ Other: _____

☐ Another client: _____

☐ Friend, relative, or acquaintance: _____

☐ Doctor or other professional: _____

☐ Other: _____

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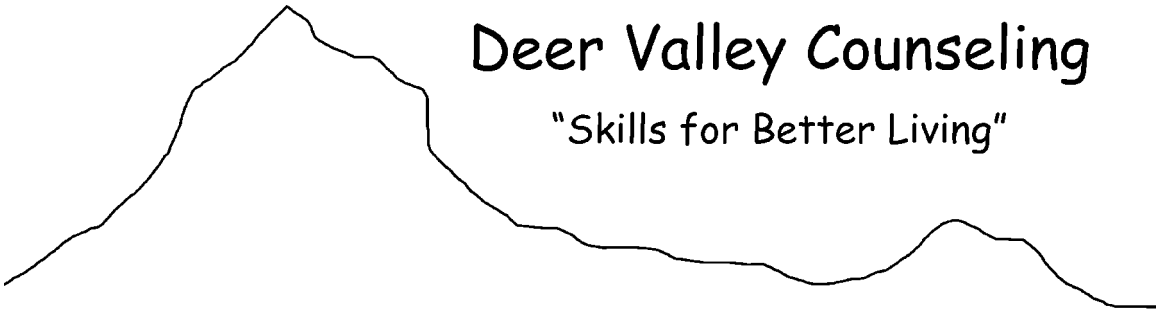

Acknowledgments, Permissions & Consents

Name: _____ DOB: _____

I hereby acknowledge that I have received and have been given an opportunity to read copies of Deer Valley Counseling's Payment Policy, Consent to Treat, Notice of Privacy Practices, Fee Schedule and Clinician's Notice. I understand that if I have any questions regarding privacy rights, I can contact James Nettles, Privacy Officer, Deer Valley Counseling, 2301 W Dunlap Ave, Suite 206, Phoenix, AZ 85021.

I hereby give my permission for Deer Valley Counseling to charge my credit card on file the full rate for any missed appointments not canceled or rescheduled 48 hours in advance, for late arrivals and for any other fees not paid at time of service.

I understand that Deer Valley Counseling does not perform evaluations or make recommendations related to custody, divorce or other court cases. I agree to pay Deer Valley Counseling $2000 plus expenses for each day that a Deer Valley Counseling clinician or employee is required to be present at a legal proceeding, including but not limited to a deposition, hearing, or court, regardless of whether or not the clinician or employee is actually called to speak that day.

I hereby give my permission and consent to participate in the treatment provided by Deer Valley Counseling.

_____

Signature of Client **Date**

_____

Signature of Therapist **Date**

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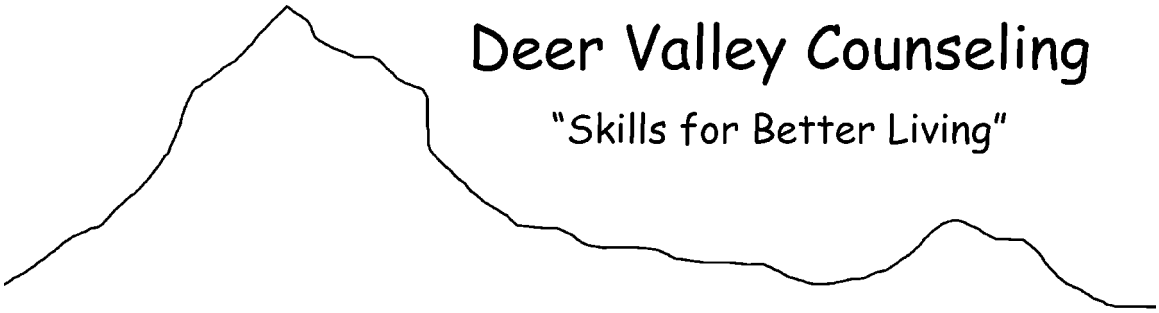

Authorization for Release of Confidential Information To Primary Care Physician

☐ Client declines to authorize release of confidential information to PCP or has no PCP.

I, _____ Date of Birth of Client: _____
(Client's Name or Person Authorized to Sign for Client)

hereby authorize Deer Valley Counseling to release information to the client's Primary Care Physician (PCP) and for the client's PCP to release information to Deer Valley Counseling.

Required: PCP Name: _____

And One of the Following: PCP Telephone Number: _____

PCP Fax Number: _____

PCP Address: _____

PCP Clinic Name: _____

I understand that the purpose of these disclosures is to coordinate treatment.

Information to be disclosed includes evaluations, recommendations, diagnosis, treatment plan, progress, progress notes as well as:

☐ Alcohol and drug abuse evaluation and treatment information **(if your file contains any substance abuse information, we will not release your record unless this box is checked).**

☐ Other: _____

I understand that I may revoke, in writing, this authorization at any time, except to the extent that action has already been taken in reliance on it. I understand that this information may be redisclosed by the recipient and at that time would no longer be protected by the originator. I understand that Deer Valley Counseling may not condition services upon my signing this authorization unless the services are provided to me for the purpose of creating health information for a third party. This authorization for release of information will expire on _____ (if left blank, one year from the date it was signed).

_____	_____	_____
Printed name of Client	Signature of Client	Date Signed
_____	_____	_____
Person Authorized to Sign for Client	Signature of Person Authorized to Sign	Date Signed

Reason person may sign for client: ☐ Parent ☐ Guardian ☐ Other: _____

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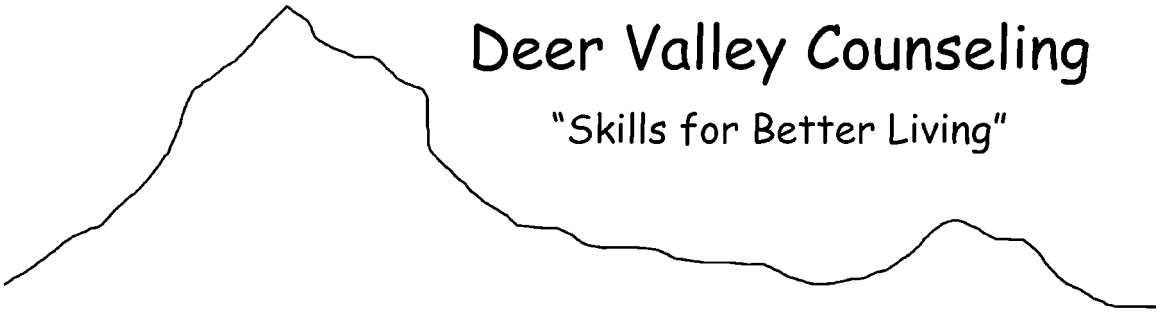

Symptoms

Name: _____

How often do you experience the following thoughts or behaviors?

	Never	Rarely	Sometimes	Frequently	Please Explain
Depression					
Feeling hopeless or helpless					
Restless or easily annoyed					
Uncontrolled crying					
Suicidal thoughts					
Suicide attempts					
Difficulty concentrating					
Lack of interest in old activities					
Anxiety					
Panic attacks					
Problems in family					
Questions about your gender					
Questions about orientation					
Verbally/physically aggressive					
Excessive anger					
Fatigue or difficulty sleeping					
Persistent thoughts/behaviors					
Racing thoughts					
Excessive energy or activity					
Excessive weight gain or loss					
Excessive alcohol use					
Illegal drug use					
Violence in family/work/other					
Sexual difficulties					
Learning difficulties					
Relationship problems					
I hear voices in my head					
Specific fears					

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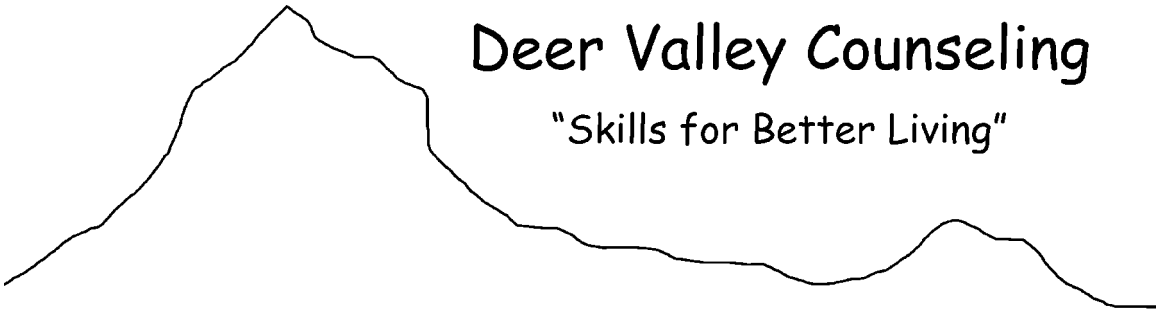

Deer Valley Counseling

"Skills for Better Living"

Treatment Plan, Original or Revised

Name: _____

Client Statement of Problems: _____

_____

_____

_____

_____

_____

_____

_____

_____

Goal 1: _____

_____

Goal 2: _____

_____

Goal 3: _____

_____

Attach additional sheets if necessary.

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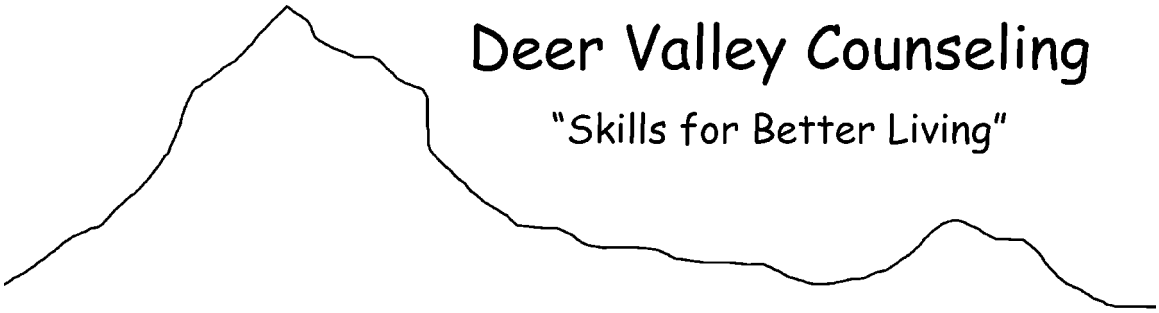

Deer Valley Counseling

"Skills for Better Living"

Name: _____

The therapist will fill out this portion.

Treatment Method: _____

_____

Treatment Method: _____

_____

Treatment Method: _____

_____

Treatment Method: _____

_____

Aftercare Requirements: _____

I have met with staff and participated in the planning process of this treatment plan. It has been explained to me in language that I understand. I understand the risks and benefits of these services. I agree and consent to receive services as outlined in this plan. This plan will be reviewed one year from the date it is signed or sooner if clinically indicated.

_____

Client's Signature Date

_____

Parent or Guardian's Signature Date

_____

Therapist's Signature Date

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