



# Deer Valley Counseling

"Skills for Better Living"

## 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 \_\_\_\_\_

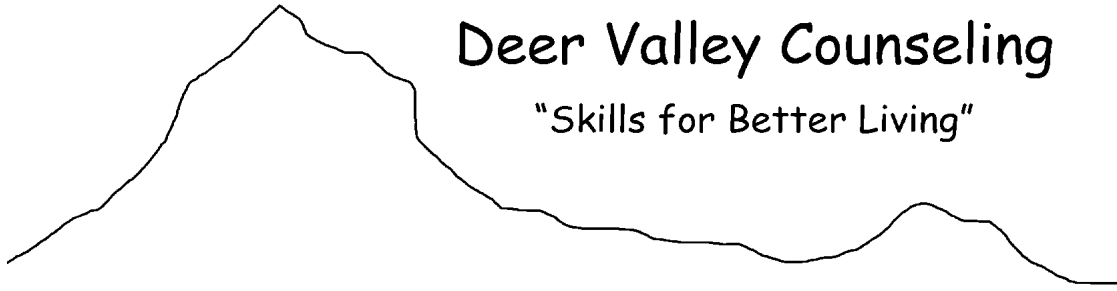
Phone Book:  DEX  Verizon  Other: \_\_\_\_\_

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, 8611 N Black Canyon Hwy, Suite 104, Phoenix, AZ 85021.

I authorize Deer Valley Counseling to bill my insurance company and for my insurance company to pay Deer Valley Counseling directly.

I understand that insurance companies do not reimburse for missed appointments or appointments where I arrive late and that I will be financially responsible for missed appointments or late arrivals.

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 copay, coinsurance, deductible or 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.

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**Signature of Client**

**Date**

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**Signature of Therapist**

**Date**



**Deer Valley Counseling**  
"Skills for Better Living"

**Primary Care Practitioner (PCP)**

**Authorization for Release of Confidential Information**

***Coordination of Care can improve treatment outcomes.***

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

- Client has no PCP.
- Client declines to authorize release of confidential information because: \_\_\_\_\_

I hereby authorize Deer Valley Counseling to release information to the client's Primary Care Practitioner (PCP) or other medical professional and for the PCP or medical professional to release information to Deer Valley Counseling.

**Required:** Medical Professional's Name: \_\_\_\_\_  
**And One of the Following:** Telephone Number: \_\_\_\_\_  
Fax Number: \_\_\_\_\_  
Address: \_\_\_\_\_  
Clinic Name: \_\_\_\_\_

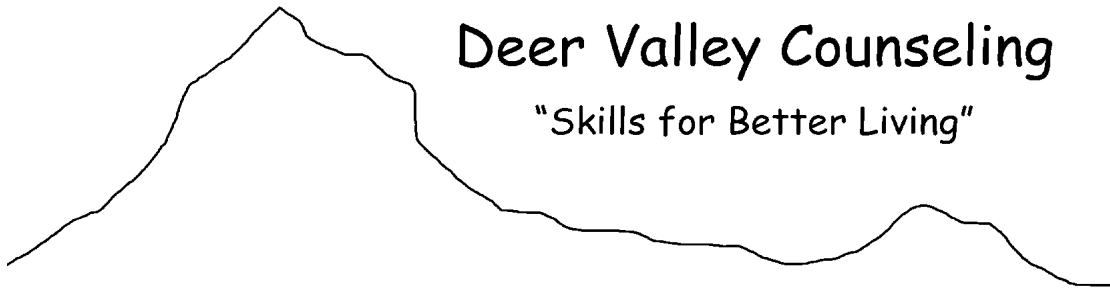
I understand that the purpose of these disclosures is to coordinate treatment.

Information to be disclosed includes evaluations, recommendations, test results, diagnosis, treatment plan, progress, progress notes as well as any alcohol and drug abuse evaluation and treatment information.

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: \_\_\_\_\_



# Deer Valley Counseling

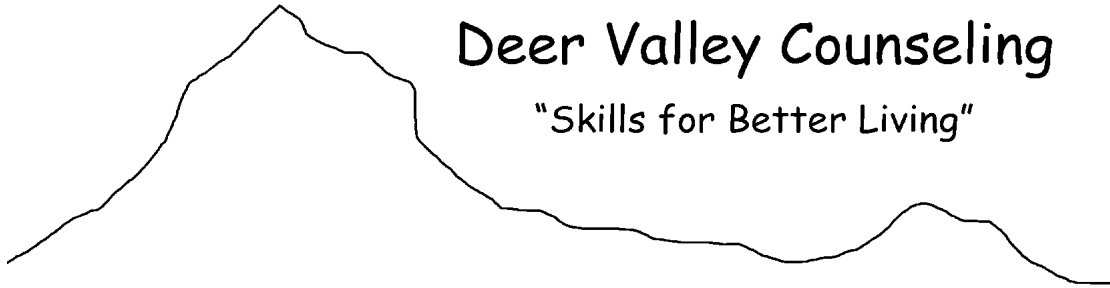
"Skills for Better Living"

## 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					



# Deer Valley Counseling

"Skills for Better Living"

## Treatment Plan, Original or Revised Client Fills Out This Page

Name: \_\_\_\_\_

Client Statement of Problems: \_\_\_\_\_

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Goal 1: \_\_\_\_\_

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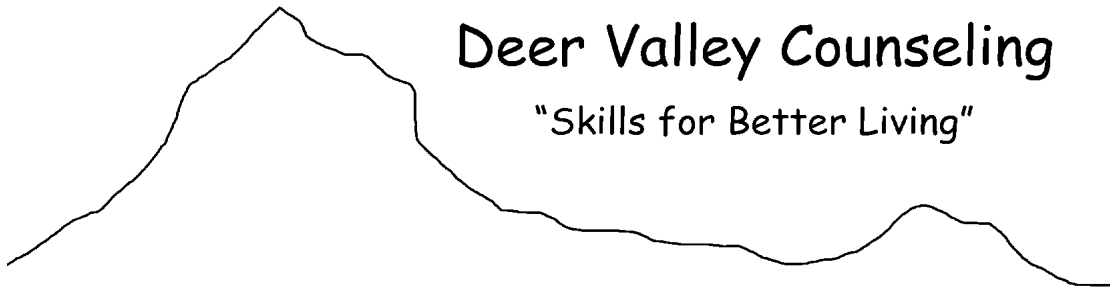
Goal 2: \_\_\_\_\_

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Goal 3: \_\_\_\_\_

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*Attach additional sheets if necessary.*



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## Treatment Plan, Original or Revised Therapist Fills Out This Page

Name: \_\_\_\_\_

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