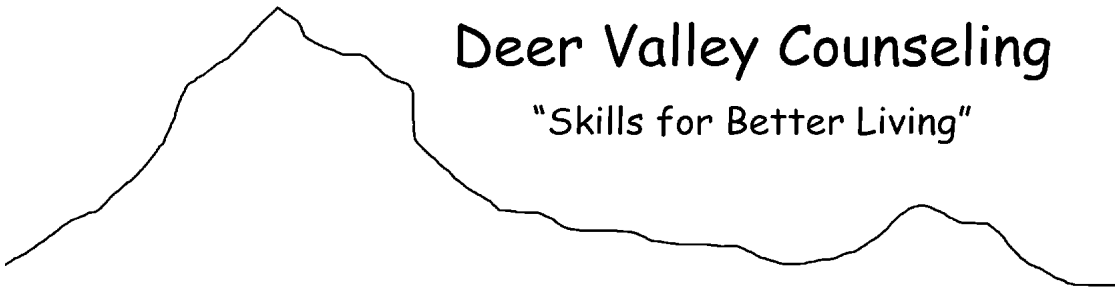

Client Information Sheet – Adult – UHC

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.

Employer: _____ Work Phone: _____

Emergency Contact: _____ Phone: _____

Referral Source:

☐ Searched Provider Directory on Insurance Company Website

☐ General Internet Search. 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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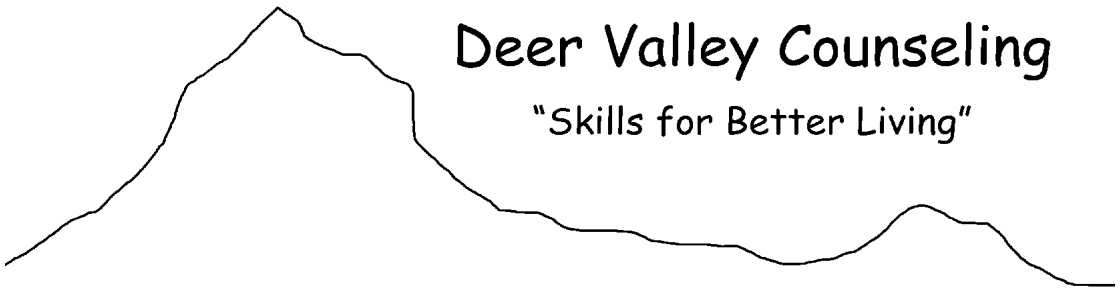

Acknowledgments, Permissions & Consents

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.

_____

Signature of Client **Date**

_____

Signature of Therapist **Date**

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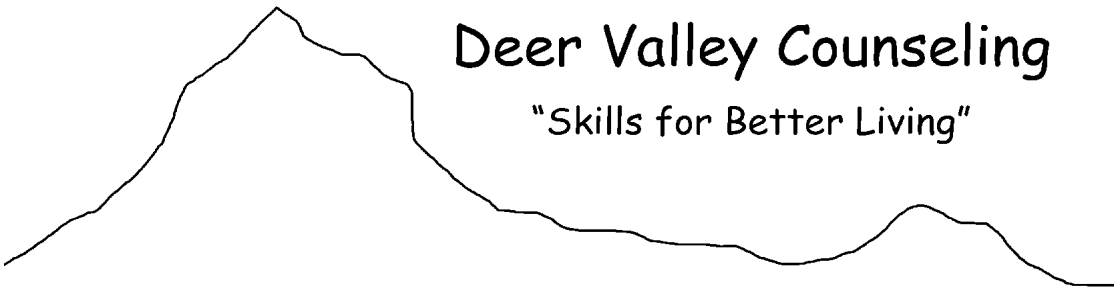

Primary Care Practitioner (PCP)

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: _____

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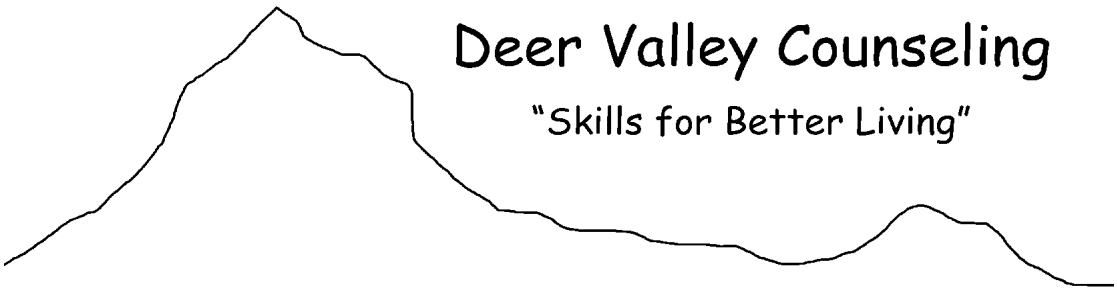

Mental Health Practitioner (MHP)

Authorization for Release of Confidential Information

Coordination of Care can improve treatment outcomes.

Client Name: _____ Date of Birth: _____

☐ Client has no other MHP.

☐ Client declines to authorize release of confidential information because: _____

I hereby authorize Deer Valley Counseling to release information to the client's other Mental Health Professional (MHP) and for the other MHP 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: _____

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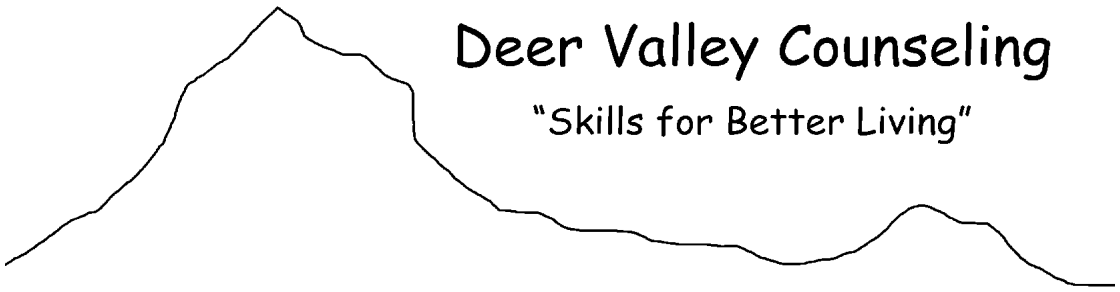

Client History – Adult – UHC

Name: _____

Education: _____

Occupation: _____

Relationship Status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widow/Widower

Number of Marriages/Partnerships: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ Other: _____

Child's First Name	Gender F M	Age	Child's First Name	Gender F M	Age
	☐ ☐			☐ ☐	
	☐ ☐			☐ ☐	
	☐ ☐			☐ ☐	
	☐ ☐			☐ ☐	
	☐ ☐			☐ ☐	

Parent's Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Never Married ☐ Deceased

Number of Sisters: _____ Number of Brothers: _____

Your Birth Order in Family: ☐ Eldest ☐ Middle ☐ Youngest ☐ Only

Previous counseling, inpatient mental health treatment or drug/alcohol treatment –

Who or Where	Problem Addressed	How Many Sessions	Result

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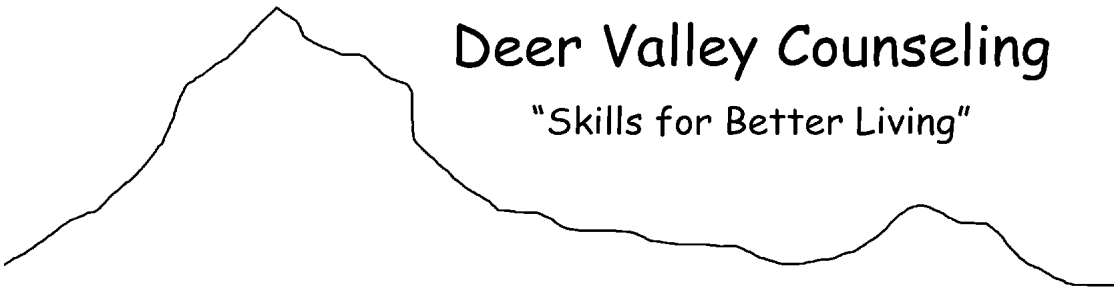

Name: _____

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					
Thoughts of harming self					
Lack of interest in old activities					
Anxiety					
Panic attacks					
Problems in family					
Questions about your gender					
Questions about orientation					
Excessive anger					
Verbally/physically aggressive					
Thoughts of harming others					
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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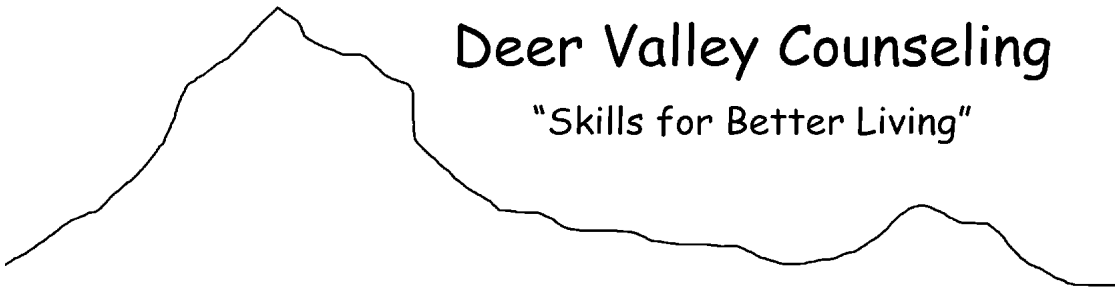

Deer Valley Counseling

"Skills for Better Living"

Name: _____

Have you experienced any of the following, recently or while growing up?

□ Neglect, physical or sexual abuse: _____

□ Trauma or assault (to self or another): _____

□ Death of a loved one: _____

□ Illness in self or family: _____

□ Difficult family situation: _____

□ Arrest or other legal issues: _____

□ Work problems: _____

□ Loss of a long-term relationship: _____

□ Difficulty cutting back on sex, gambling, drugs or alcohol: _____

□ Head trauma or injury: _____

Family History of:

□ Depression or anxiety: _____

□ Suicide or suicide attempts: _____

□ Chronic physical or mental illness: _____

□ Alcohol or drug abuse: _____

□ Violence or sexual abuse: _____

Mother: □ Alive □ Deceased Age at Death: _____ Cause of Death: _____

Father: □ Alive □ Deceased Age at Death: _____ Cause of Death: _____

Sibling: □ Alive □ Deceased Age at Death: _____ Cause of Death: _____

Sibling: □ Alive □ Deceased Age at Death: _____ Cause of Death: _____

Sibling: □ Alive □ Deceased Age at Death: _____ Cause of Death: _____

Sibling: □ Alive □ Deceased Age at Death: _____ Cause of Death: _____

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ALERT® Wellness Assessment - Adult

Completing this brief questionnaire will help us provide services that meet your needs. Answer each question as best you can and then review your responses with your clinician. Please shade circles like this●

Client Name | Date of Birth

Subscriber ID | Authorization #

Clinician Name: Nettles, Sandra | Today's Date (mm/dd/yy)

Clinician ID/Tax ID: 000378803002 | Clinician Phone: (602) 750-8051 | State: AZ | MRef ☐

Visit #: ◉ 1 or 2 ○ 3 to 5 ○ Other

For questions 1-16, please think about your experience in the past week.

How much did the following problems bother you?	*Not at All*	*A Little*	*Somewhat*	*A Lot*
1. Nervousness or shakiness	○	○	○	○
2. Feeling sad or blue	○	○	○	○
3. Feeling hopeless about the future	○	○	○	○
4. Feeling everything is an effort	○	○	○	○
5. Feeling no interest in things	○	○	○	○
6. Your heart pounding or racing	○	○	○	○
7. Trouble sleeping	○	○	○	○
8. Feeling fearful or afraid	○	○	○	○
9. Difficulty at home	○	○	○	○
10. Difficulty socially	○	○	○	○
11. Difficulty at work or school	○	○	○	○

How much do you agree with the following?	*Strongly Agree*	*Agree*	*Disagree*	*Strongly Disagree*
12. I feel good about myself	○	○	○	○
13. I can deal with my problems	○	○	○	○
14. I am able to accomplish the things I want	○	○	○	○
15. I have friends or family that I can count on for help	○	○	○	○

16. In the past week, approximately how many drinks of alcohol did you have? ☐☐ Drinks

Please answer the following questions only if this is your first time completing this questionnaire.

17. In general, would you say your health is: ○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor

18. Please indicate if you have a serious or chronic medical condition:
○ Asthma ○ Diabetes ○ Heart Disease ○ Back Pain or Other Chronic Pain ○ Other

19. In the past 6 months, how many times did you visit a medical doctor? ○ None ○ 1 ○ 2-3 ○ 4-5 ○ 6+

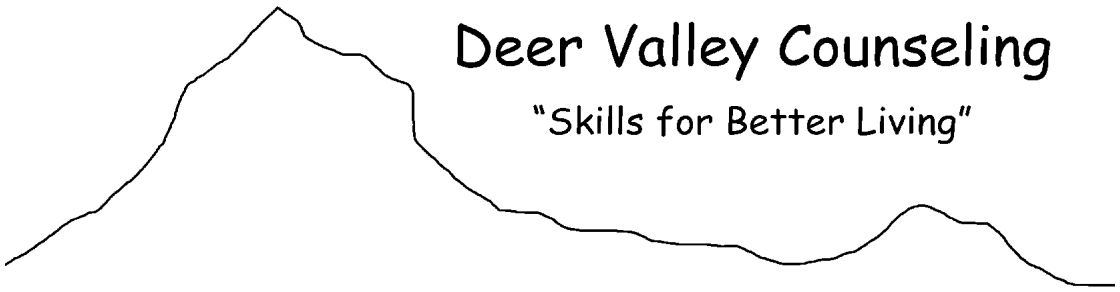
20. In the past month, how many days were you unable to work because of your physical or mental health? *(answer only if employed)* ☐☐ Days

21. In the past month, how many days were you able to work but had to cut back on how much you got done because of your physical or mental health? *(answer only if* ☐☐ Days

22. In the past month have you ever felt you ought to cut down on your drinking or drug use? ○ Yes ○ No

23. In the past month have you ever felt annoyed by people criticizing your drinking or drug use? ○ Yes ○ No

24. In the past month have you felt bad or guilty about your drinking or drug use? ○ Yes ○ No



Deer Valley Counseling

"Skills for Better Living"

Treatment Plan, Original or Revised
Client Fills Out This Page

Name: _____

Client Statement of Problems: _____

_____

_____

_____

_____

_____

_____

_____

_____

Goal 1: _____

_____

Goal 2: _____

_____

Goal 3: _____

_____

Attach additional sheets if necessary.

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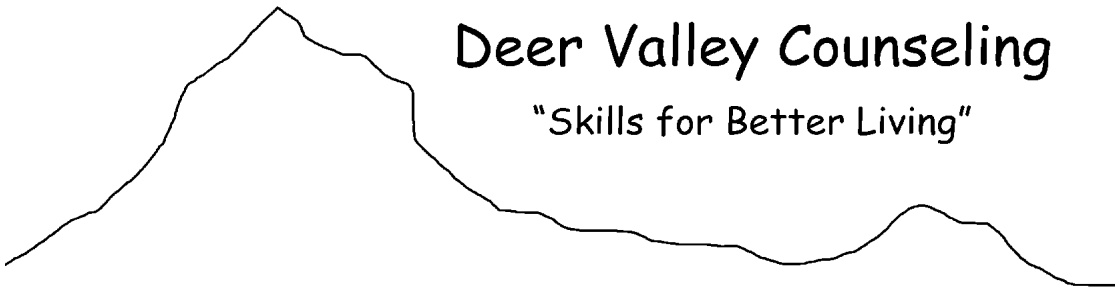

Treatment Plan, Original or Revised
Therapist Fills Out This Page

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

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