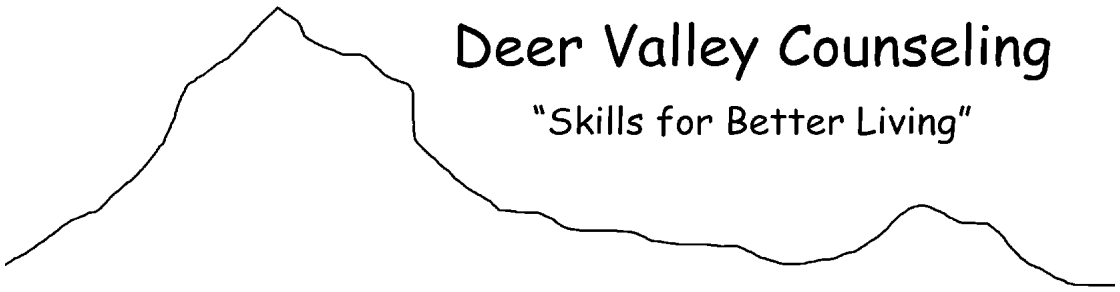

Client Information Sheet – Child or Adolescent

Child's Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ ZIP: _____

Parent/Guardian: _____

Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Mobile Phone: _____

☐ **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 _____

☐ Another client: _____

☐ Friend, relative, or acquaintance: _____

☐ Doctor or other professional: _____

☐ Other: _____

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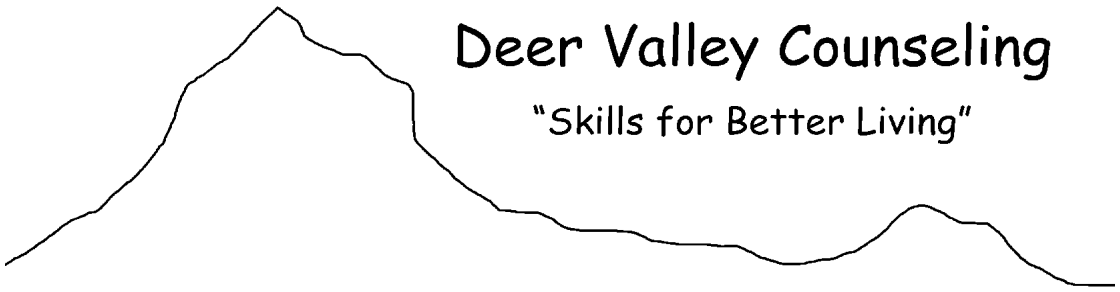

Acknowledgments, Permissions & Consents

Child's 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 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 for my child to participate in the treatment provided by Deer Valley Counseling.

I attest that I am the parent/legal decision-maker for the child named above.

_____

Parent/Guardian Name

_____

Parent/Guardian Signature **Date**

_____

Therapist Signature **Date**

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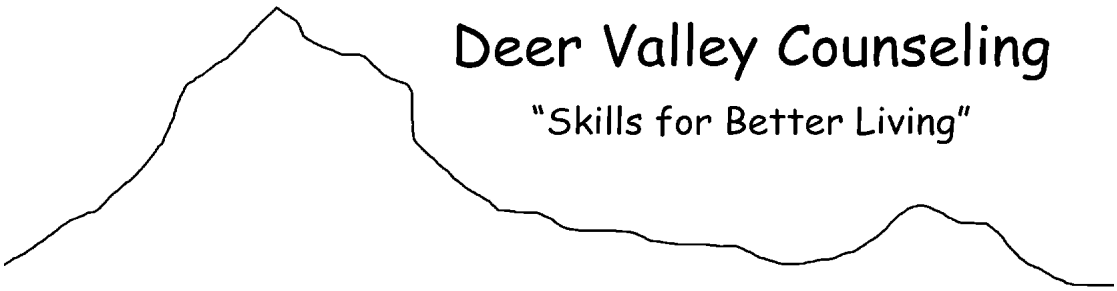

Primary Care Practitioner (PCP)

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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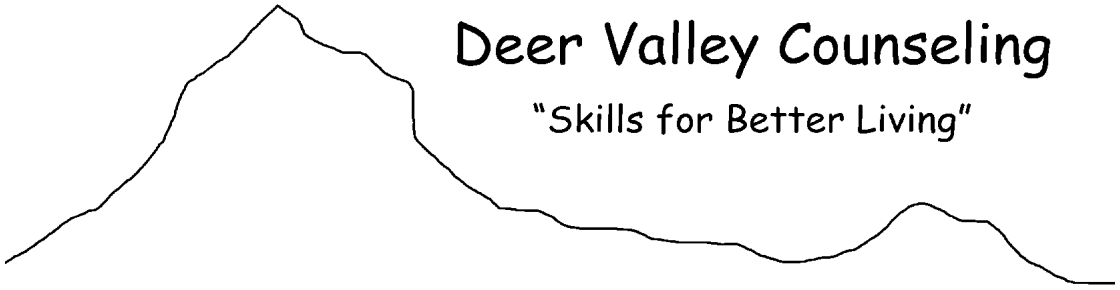

Deer Valley Counseling

"Skills for Better Living"

Name: _____

How often does the youth experience the following thoughts or behaviors?

	Never	Rarely	Sometimes	Frequently	Please Explain
Depression					
Restless or easily annoyed					
Uncontrolled crying					
Suicidal thoughts or attempts					
Fatigue or difficulty sleeping					
Difficulty concentrating					
Harms self					
Anxiety					
Panic attacks or nightmares					
Specific fears					
Startles easily					
Low self-esteem or shyness					
Peer problems					
Learning difficulties					
Bed-wetting/day-wetting					
Inappropriate sexual behavior					
Verbally/physically aggressive					
Tantrums or defiance					
Running away					
Conduct problems/lying/stealing					
Alcohol or drug use					
Persistent thoughts/behaviors					
Excessive energy or activity					
Hears voices					
Excessive weight gain or loss					
Questions about gender					
Questions about orientation					

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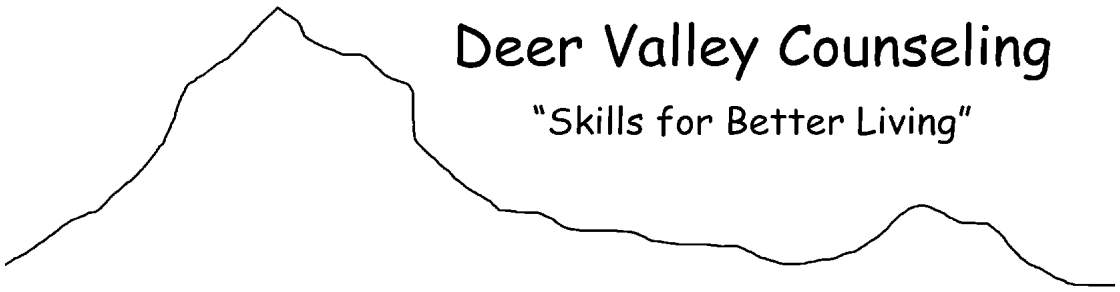

Deer Valley Counseling

"Skills for Better Living"

Name: _____

Has the youth experienced any of the following?

□ Neglect: _____

□ Physical, sexual or emotional abuse: _____

□ Trauma or assault: _____

□ Witness trauma, assault or domestic violence: _____

□ Death of a someone important: _____

□ Physical illness (self or family): _____

□ Mental illness (self or family): _____

□ Legal issues (self or family): _____

□ Alcohol or drug abuse (self or family): _____

□ Other family problems: _____

□ School problems: _____

□ Bullying: _____

□ Head trauma or injury: _____

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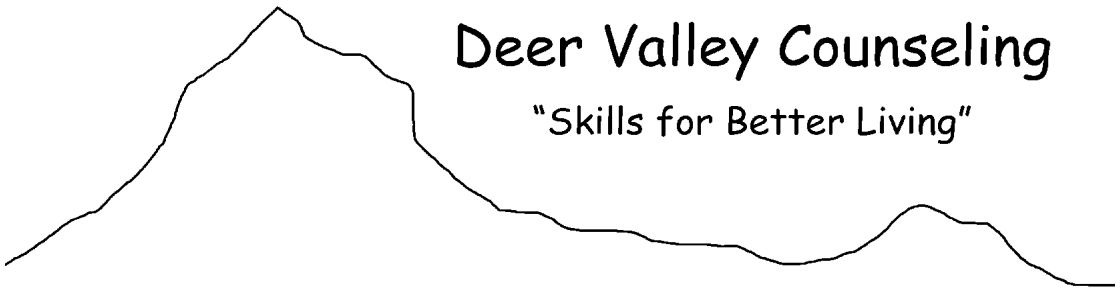

Deer Valley Counseling

"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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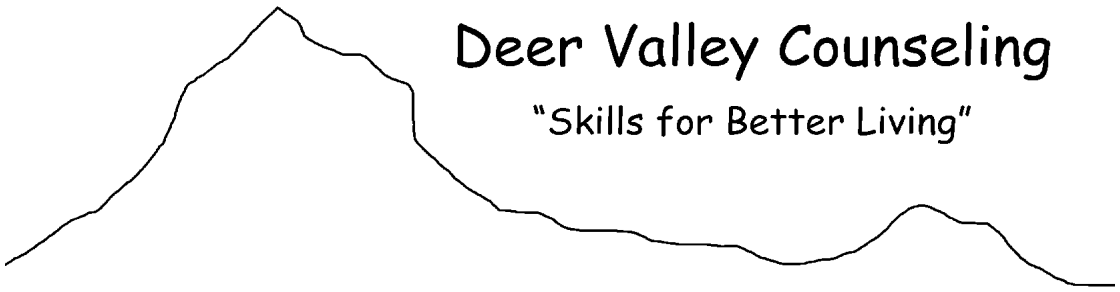

Treatment Plan, Original or Revised
Therapist Fills Out This Page

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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