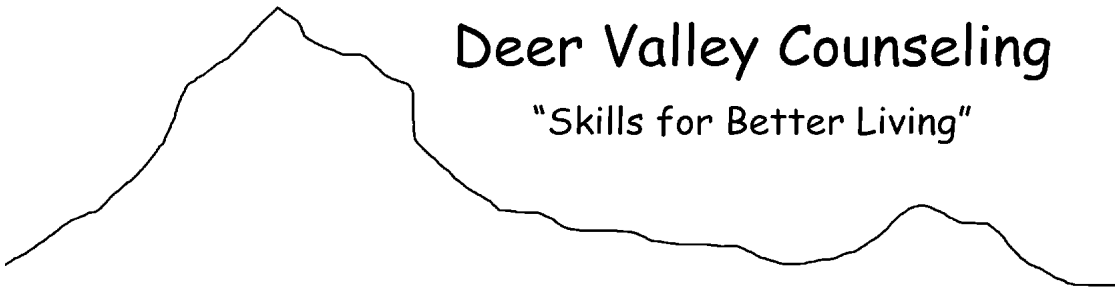


# Client Information Sheet – Child or Adolescent – UHC

Child's Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ ZIP: _____

Parent/Guardian: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Mobile Phone: _____

Preferred Method for Courtesy Appointment Reminders to Parent:

☐ **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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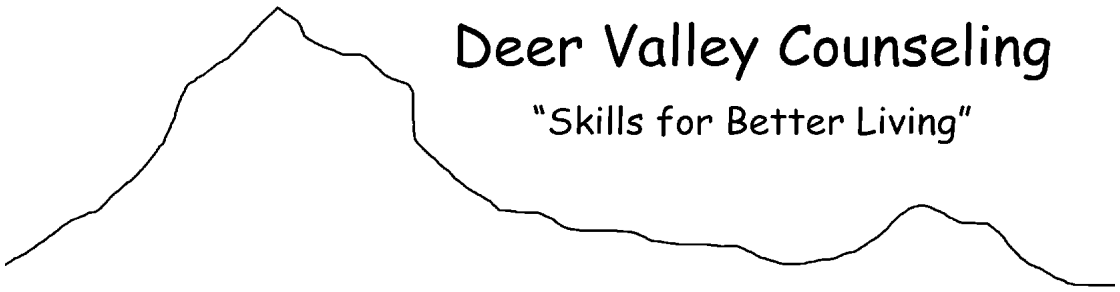


# Acknowledgments, Permissions & Consents

**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 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 my child arrives 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 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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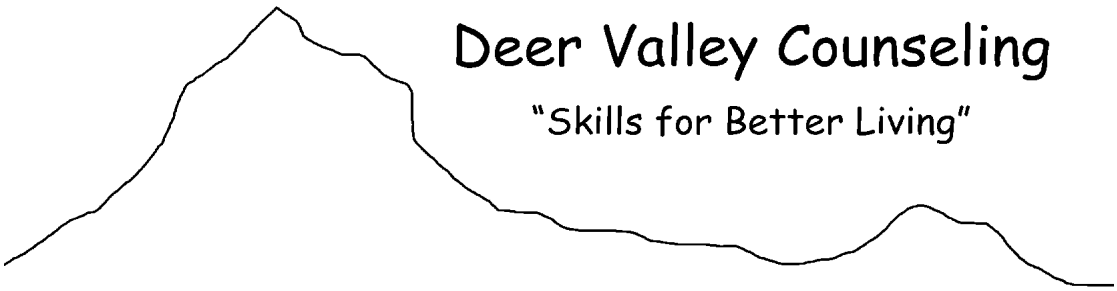


# Primary Care Practitioner (PCP)

## 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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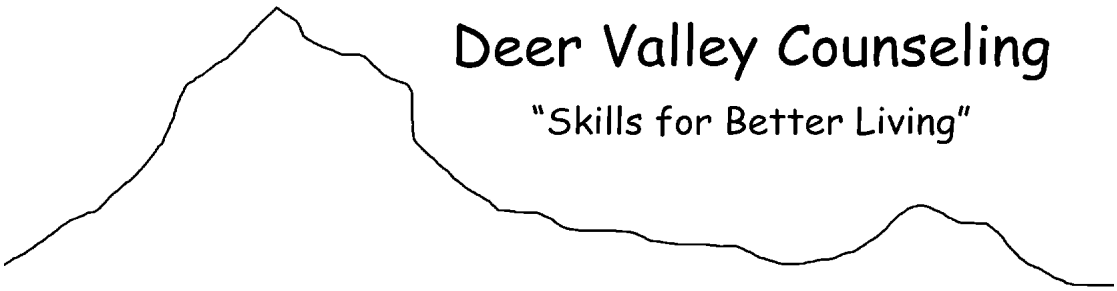


# Mental Health Practitioner (MHP)

## 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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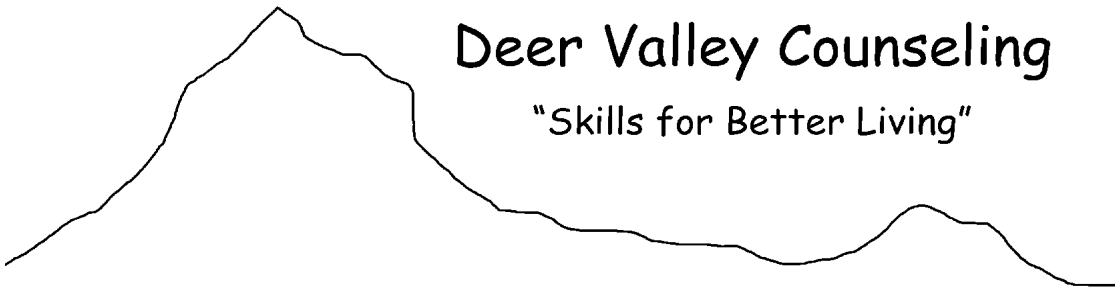


# Client History – Child or Adolescent

Name: _____

Employer/School: _____ Grade: _____

Occupation/Studying: _____

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

Number of Sisters: ___ Number of Brothers: ___ Birth Order: ☐ Eldest ☐ Middle ☐ Youngest ☐ Only

With Whom Does Youth Live: _____

| | Frequency and Quality of Relationships |
|---|---|
| Parents/Stepparents/Guardians | |
| Siblings | |
| Other Relatives | |
| Friends | |

Family History of:
☐ Depression ☐ Suicide Attempts ☐ Anxiety
☐ Chronic Illness ☐ Mental Illness ☐ Eating Disorders ☐ Alcoholism
☐ Violence ☐ Sexual Abuse ☐ Emotional Abuse ☐ Drug Addiction

Please explain any items checked above: _____

_____

_____

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

| Who or Where | Problem Addressed | How Many Sessions | Result |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

_____



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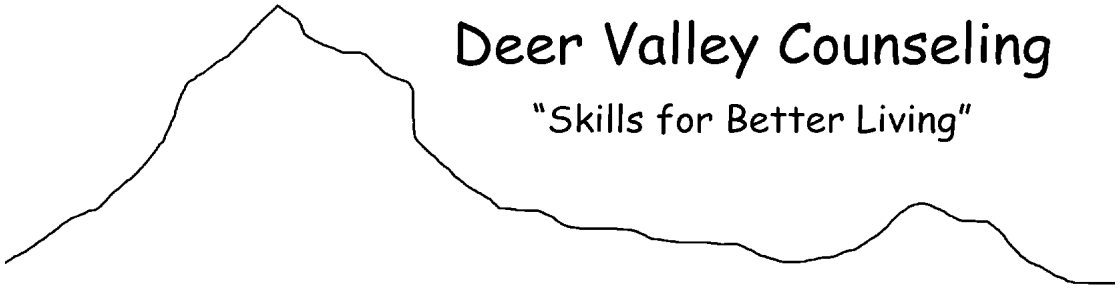

# Deer Valley Counseling

"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 | | | | | |
| Lack of interest in old activities | | | | | |
| 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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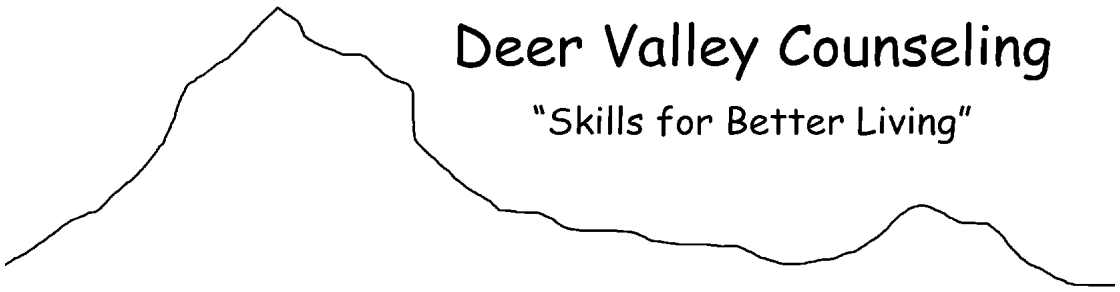

# Deer Valley Counseling

"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: _____

| | | | | |
|---|---|---|---|---|
| Mother: | □ Alive | □ Deceased Age at Death: _____ | Cause of Death: | _____ |
| Father: | □ Alive | □ Deceased Age at Death: _____ | Cause of Death: | _____ |
| Grandparent: | □ Alive | □ Deceased Age at Death: _____ | Cause of Death: | _____ |
| Grandparent: | □ Alive | □ Deceased Age at Death: _____ | Cause of Death: | _____ |
| Grandparent: | □ Alive | □ Deceased Age at Death: _____ | Cause of Death: | _____ |
| Grandparent: | □ 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 - Youth

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

Child's Name

Child's 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

Relationship to child: ○ Mother ○ Father ○ Stepparent ○ Other Relative ○ Child/Self ○ Other

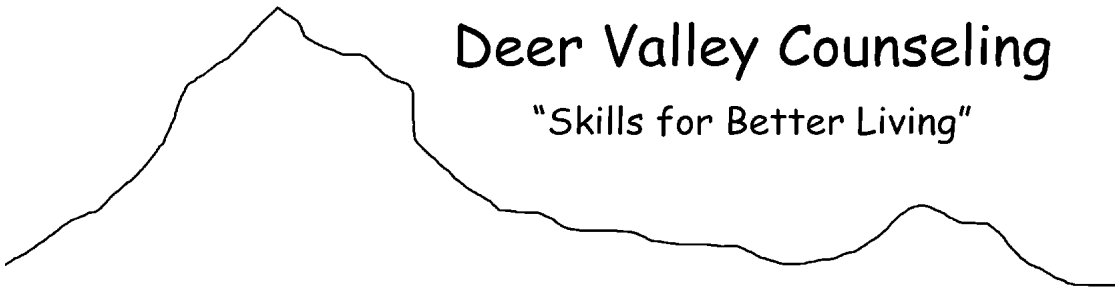
***For questions 1-21, please think about your experience in the past week.***

| **Fill in the circle that best describes your child:** | *Never* | *Sometimes* | *Often* |
|---|---|---|---|
| 1. Destroyed property | ○ | ○ | ○ |
| 2. Was unhappy or sad | ○ | ○ | ○ |
| 3. Behavior caused school problems | ○ | ○ | ○ |
| 4. Had temper outbursts | ○ | ○ | ○ |
| 5. Worrying prevented him/her from doing things | ○ | ○ | ○ |
| 6. Felt worthless or inferior | ○ | ○ | ○ |
| 7. Had trouble sleeping | ○ | ○ | ○ |
| 8. Changed moods quickly | ○ | ○ | ○ |
| 9. Used alcohol | ○ | ○ | ○ |
| 10. Was restless, trouble staying seated | ○ | ○ | ○ |
| 11. Engaged in repetitious behavior | ○ | ○ | ○ |
| 12. Used drugs | ○ | ○ | ○ |
| 13. Worried about most everthing | ○ | ○ | ○ |
| 14. Needed constant attention | ○ | ○ | ○ |

| **How much have your child's problems caused:** | *Not at All* | *A Little* | *Somewhat* | *A Lot* | |
|---|---|---|---|---|---|
| 15. Interruption of personal time? | ○ | ○ | ○ | ○ | |
| 16. Disruption of family routines? | ○ | ○ | ○ | ○ | |
| 17. Any family member to suffer mental or physical problems? | ○ | ○ | ○ | ○ | |
| 18. Less attention paid to any family member? | ○ | ○ | ○ | ○ | |
| 19. Disruption or upset of relationships within the family? | ○ | ○ | ○ | ○ | |
| 20. Disruption or upset of your family's social activities? | ○ | ○ | ○ | ○ | |
| 21. How many days in the last week was your child's usual routine interrupted by their problems? | | | | ☐ | Days |

**Answer the following questions only if this is your first time completing this questionnaire for this child.**

22. In general, would you say your child's health is: ○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor
23. In the past 6 months, how many times did your child visit a medical doctor? ○ None ○ 1 ○ 2-3 ○ 4-5 ○ 6+
24. In the past month, how many days were you unable to work because of your child's problems? *(answer only if employed)* ☐☐ Days
25. 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 child's problems? *(answer only if employed)* ☐☐ Days



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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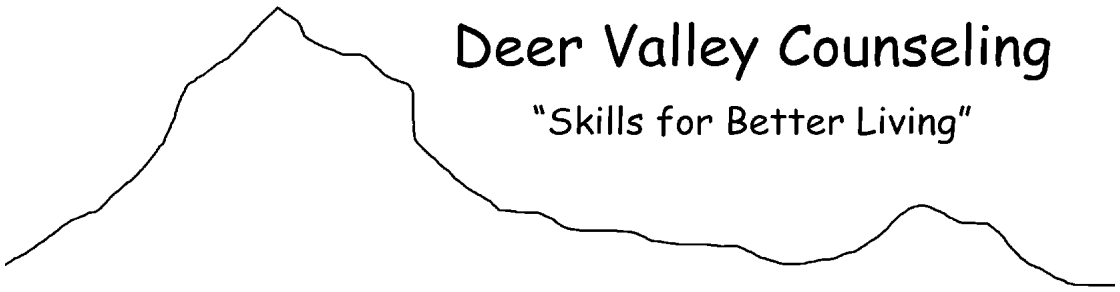


# Treatment Plan, Original or Revised
# Therapist Fills Out This Page

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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