Ormond Beach Counseling Center
200 East Granada Blvd. Suite #206
Ormond Beach, FL 32176
Phone: 386.615.9180
email:Office@salty.org

# YOUTH CONFIDENTIAL CLIENT INFORMATION FORM

**CHILD'S/TEENAGER'S INFORMATION** Date: _____

Full Name: _____ Sex: □ Male □ Female

Name you prefer: _____Age:_____ Date of Birth:_____

Current School Attending:_____Grade in School:_____

**REASONS FOR COUNSELING AND GOALS OF CHILD/TEENAGER**

What do you hope to gain or change by coming for counseling? _____

_____

**PARENT/GUARDIAN INFORMATION**

Referred by: □Internet □Friend □Radio □Magazine/Newspaper Ad□ Other:_____

Full Name: _____Sex: □ Male □ Female

Name you prefer: _____Age:_____ Date of Birth:_____

Employer:_____Length of Employment:_____

Occupation: _____Salary (monthly or Annual):_____

Highest Level of School Completed: □9 □10 □11 □12 □GED College: □1 □2 □3 □4 □Other:_____

Address: _____

City: _____State: _____Zip Code: _____ May we send mail here: □ Yes □ No

Home Phone: ( _____ ) _____-_____ May we leave a message here: □ Yes □ No

Cell Phone: ( _____ ) _____-_____ May we leave a message here: □ Yes □ No

Email Address: _____May we send a message here: □ Yes □ No

Current Marital Status: □ Single □ Engaged □ Married □ Separated □ Divorced □ Widowed

If married, how long? _____Number of previous marriages for you: _____

If separated or divorced, how long? _____If widowed, how long?_____

Please list family members and other household members (continue on back if necessary):

| Name: | In home or Out of home? | Age: | Gender: | Relationship: |
|---|---|---|---|---|
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**PARENT/GUARDIAN INFORMATION**

Full Name: _____Sex: □ Male □ Female

Name you prefer: _____Age:_____ Date of Birth:_____

Employer:_____Length of Employment:_____

Occupation: _____Salary (monthly or Annual):_____

Highest Level of School Completed: □9 □10 □11 □12 □GED College: □1 □2 □3 □4 □Other:_____

Address: _____

City: _____State: _____Zip Code: _____ May we send mail here: □ Yes □ No

Home Phone: ( _____ ) _____-_____ May we leave a message here: □ Yes □ No

Cell Phone: ( _____ ) _____-_____ May we leave a message here: □ Yes □ No

Email Address: _____May we send a message here: □ Yes □ No

Current Marital Status: □ Single □ Engaged □ Married □ Separated □ Divorced □ Widowed

If married, how long? _____Number of previous marriages for you: _____

If separated or divorced, how long? _____If widowed, how long?_____

**IF PARENTS ARE SEPARATED OR DIVORCED, THE PARENT INITIATING TREATMENT IS RESPONSIBLE FOR CONTACTING THE NON-INITIATING PARENT WITH FULL CONTACT INFORMATION OF THE COUNSELOR. COUNSELING CANNOT CONTINUE UNTIL BOTH PARENTS OR LEGAL GUARDIANS HAVE GIVEN CONSENT FOR COUNSELING.**

**By signing, you agree that you understand that both parents/ legal guardians must give consent for counseling services and will contact the non-initiating parent/ guardian immediately.**

**Signature _____ Date_____**

**LEVEL OF DISTRESS OF CHILD/TEENAGER**

Indicate how distressed you are by circling on the scale below *(1= Very Little Distress; 10=Extreme Distress)*:

1 2 3 4 5 6 7 8 9 10

Are they currently experiencing any suicidal thoughts? □ Yes □ No. Have they had them in the past? □ Yes □ No

Have you ever attempted suicide? □ Yes □ No. If yes, when & how?_____

Do you have any current thoughts of suicide? □ Yes □ No If yes, please explain:_____

**PREVIOUS COUNSELING OF CHILD/TEENAGER**

Please list any previous counseling, psychiatric treatment, or residential/in-patient care you have received:

| Location | Therapist | Dates | Reason |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**CURRENT STATUS OF CHILD/TEENAGER**

**Please check any of the following physiological symptoms that apply to you presently or in the recent past**:

| | | | | | |
|---|---|---|---|---|---|
| Headaches | □ Past □ Present | Visual Trouble | □ Past □ Present | Weakness | □ Past □ Present |
| Insomnia | □ Past □ Present | Change in Appetite | □ Past □ Present | Hearing Voices | □ Past □ Present |
| Dizziness | □ Past □ Present | Sleep Trouble | □ Past □ Present | Tension | □ Past □ Present |
| Intestinal Trouble | □ Past □ Present | Tiredness | □ Past □ Present | Seeing Things | □ Past □ Present |
| Stomach Trouble | □ Past □ Present | Trouble Relaxing | □ Past □ Present | Rapid Heart Rate | □ Past □ Present |
| Hearing Noises | □ Past □ Present | Pain | □ Past □ Present | Other | □ Past □ Present |

How has your weight changed in the last 2-3 months? (If so, how?) _____

**Please check any of the following problems that apply to you and/or your family.**

| | | | | | |
|---|---|---|---|---|---|
| Abortion | □ You □ Family | Eating Problems | □ You □ Family | Trouble with Job | □ You □ Family |
| Ambition | □ You □ Family | Being a Parent | □ You □ Family | Disaster | □ You □ Family |
| Anxiety | □ You □ Family | Depression | □ You □ Family | Terminal Illness | □ You □ Family |
| Bad Dreams | □ You □ Family | Unwanted Thoughts | □ You □ Family | Impulsive Behavior | □ You □ Family |
| Career Choices | □ You □ Family | Children | □ You □ Family | Recent Loss | □ You □ Family |
| Communication | □ You □ Family | Verbal Abuse | □ You □ Family | Anger | □ You □ Family |
| Concentration | □ You □ Family | Memory | □ You □ Family | Self-Control | □ You □ Family |
| Grief | □ You □ Family | Alcoholism | □ You □ Family | Fears | □ You □ Family |
| Hopelessness | □ You □ Family | Loneliness | □ You □ Family | Friends | □ You □ Family |
| Making Decisions | □ You □ Family | Finances | □ You □ Family | Other | □ You □ Family |
| Marriage | □ You □ Family | Emotional Abuse | □ You □ Family | Temper | □ You □ Family |
| Nervousness | □ You □ Family | Unhappiness | □ You □ Family | Apathy | □ You □ Family |
| Physical Abuse | □ You □ Family | Sexual Abuse | □ You □ Family | Aggressiveness | □ You □ Family |
| Pregnancy | □ You □ Family | Trauma | □ You □ Family | Alcohol Use | □ You □ Family |
| Racing Thoughts | □ You □ Family | Loss of Control | □ You □ Family | Compulsive | □ You □ Family |
| Recent Death | □ You □ Family | Inferiority Feelings | □ You □ Family | Shyness | □ You □ Family |
| Sexual Problems | □ You □ Family | Legal Matters | □ You □ Family | Drug Use | □ You □ Family |
| Stress | □ You □ Family | Panic | □ You □ Family | Guilt | □ You □ Family |

**FAMILY HISTORY**

Has anyone in the Child/Teenager's immediate family ever had any of the following:

Mental illness requiring hospitalization Yes or No Who? _____ Depression Yes or No Who? _____

Counseling for any reason Yes or No Who? _____ Anxiety Yes or No Who? _____

Addiction to Alcohol/Drugs Yes or No Who? _____ Suicidal Thoughts Yes or No Who? _____

**LEGAL HISTORY**

Is any family member facing any pending civil or criminal litigation? □ Yes □ No

Has any family member been subject to a restraining order in the last 10 years? □ Yes □ No

Has any family member filed for a restraining order in the last 10 years? □ Yes □ No

Has any family member experienced any litigation relating to divorce or child custody in the last 10 years? □ Yes □ No

Does any family member anticipate the possibility of litigation relating to divorce or child custody in the next

5 years? □ Yes □ No

**MEDICAL INFORMATION OF CHILD/TEENAGER**

Primary Physician: _____City:_____ Zip:_____

Phone number: ( _____ ) _____-_____ Fax number: ( _____ ) _____-_____

Are you currently receiving medical treatment? □ Yes □ No. If yes, please specify:_____

List all current medications you are taking, including those you seldom use or take only as needed.

| Medication | Dosage | Purpose for Medication |
|---|---|---|
| | | |
| | | |
| | | |

Are you taking these medication(s) according to your doctor's recommendations. □ Yes □ No. If no, briefly explain:

_____

List significant conditions, illnesses, surgeries, hospitalizations, traumas, or treatments you've had.

_____

_____

**VOLUNTARY MEDICAL RELEASE OF INFORMATION**

I authorize Ormond Beach Counseling Center to release and or obtain medication records and relevant medical information from_____ (*doctor's name and office name*) for the purpose of providing continuity of quality mental health services.

*I understand that I do not have to sign this authorization and my refusal to sign will not affect my ability to obtain treatment.*

*I understand that I may revoke this authorization at any time by written request to Port Orange/Ormond Beach Counseling Center.*

Print Name: _____ Date: _____

Client Signature: _____ Date:_____

Parent/ Guardian Signature: _____ Date: _____

**TRAUMA/ABUSE HISTORY OF CHILD/TEENAGER**

Have you ever experienced a severe trauma? □ Yes □ No □ Maybe

Have you ever been abused? □ Yes □ No □ Maybe

**RELIGIOUS/SPIRITUAL INFORMATION OF CHILD/TEENAGER**

Is Faith, Religion or Spirituality important to you? □ Yes □ No □ Maybe. If yes or maybe, please explain:_____

_____

Would you like to include prayer as part of your counseling experience? □ Yes □ No

**WHAT ELSE DO WE NEED TO KNOW ABOUT YOUR SITUATION:**

**SUGGESTED SLIDING SCALE FEE**

**We do not accept insurance and solely work with clients on a sliding scale fee. Upon completion of your intake paperwork and prior to your first counseling session, your therapist will review your payment options based on your reported income.**

If you fail to show for a scheduled appointment or do not call to cancel 24 hours before a scheduled appointment (386.615.9180), we will require that you pay the full amount of the session.

Initial: _____

**TERMS OF SERVICE:** *I understand that it is customary to pay for professional services when rendered. I accept full responsibility for payment of any balance incurred for services. I further understand that without 24-hour notice of cancellation, I will be charged the full fee for professional service.*

**PAYMENT:** *All accounts are requested to have a credit card on file to reserve appointments. This information will be kept confidential and will only be used to process payments at your request or to bill for late cancellations and missed appointments.*

Credit Card Number: _____ Exp Date: _____

Type of Card: □ AMEX □ VISA □ MC Code on the back of card: _____ Name on card: _____

Billing Address: (Same as above □ Yes)_____

Parent's Signature: _____ Date:_____

Therapist Signature: _____ Date:_____

**CLIENT RIGHTS AND RESPONSIBILITIES**

Ormond Beach Counseling Center is committed to providing service to you, the client, without regard to race, sex, color, religion, handicapping condition, national origin, or ability to pay in a manner appropriate to your need.

*AS A CLIENT YOU HAVE THE RIGHT TO:*

INDIVIDUAL DIGNITY, to be treated in a respectful and confidential manner.

QUALITY SERVICES, suited to your needs, administered skillfully, safely, humanely, with full respect for your dignity and personal integrity, and in accordance with all statutory and regulatory requirements.

WITHDRAW YOUR CONSENT for any specific activity.

CONFIDENTIALITY OF CLIENT RECORDS, Ormond Beach Counseling Center has the obligation to obtain your written consent prior to any exchange of confidential information. There are a few exceptions to confidentiality listed below:

If you present a danger to yourself or others, we are legally, ethically and morally required to protect the safety of threatened persons. If abuse or neglect of a child, elder or disabled person is known or suspected, we are required by law to report it to the Florida Abuse Hotline. If Ormond Beach Counseling Center receives a court order for client records, deposition or court testimony, we are required to comply. We are also required to report attendance compliance by court ordered clients. In the event that group or family services are provided, it is acknowledged that Ormond Beach Counseling Center or its counselors/therapists cannot be held responsible for a breach of confidentiality on the part of a family member.

**AS A CLIENT YOUR RESPONSIBILITIES INCLUDE:**

*Appointments:* Regular attendance is very important to ensure progress with the concerns and issues that have been presented. If there is an emergency and you need to cancel or reschedule an appointment, please call as soon as you know. *Participation:* Your honest and accurate reporting of dilemmas and concerns is vital to your progress. To the best of your ability you must be open and honest in your sessions. *Safety:* It is important that you and your children exercise appropriate caution, control and safe behavior on the premises. *Termination*: Services may be discontinued for repeatedly missed appointments, if you come to appointments intoxicated and/or under the influence of substances, or if you show evidence of inappropriate behavior. *Transfer*

*Plan:* Files/Records are the responsibility of your therapist as long as they work at Ormond Beach Counseling Center. If your therapist leaves Ormond Beach Counseling Center, your files will stay with Ormond Beach Counseling Center. *Weapons*: No weapons, including handguns are allowed on any counseling center property.

**THERAPY INFORMED CONSENT**

SERVICES: We provide many different types of therapy and counseling. Counseling services can vary in length depending on the collaborative effort between therapist and client. The goals for counseling are developed with the therapist and are based on the client's needs and concerns, and are reviewed on a regular basis to monitor progress. Our counseling services are voluntary. If the client has court documentation for counseling a copy of this documentation must be provided by the next counseling session. *When bringing children for counseling services, the adult providing transportation is required to stay on the premises during the session.* STAFF: Counselors providing services are Licensed or Registered Clinical Social Workers, Marriage and Family Therapists, Mental Health Counselors, or they are Master Degree Student Interns in these fields supervised by Licensed Therapists.
FEES: Counseling session fees are based on the client's agreed upon rate, set at the first counseling session. All fees are due at the beginning of each session. AUDIO/VIDEO TAPES: *Videotapes are used to assist with supervision, consultation and training of counselors working with their clients*. These tapes are not considered part of client files and will be used only to assist the progress of the client's case. The tapes are the destroyed on a regular basis. TERMINATION: The client is expected to inform the therapist if the client plans to discontinue counseling for any reason. If a client fails to show up or cancel two appointments, their file will be closed. Counselors may have to discontinue therapy if the client is currently involved in domestic violence, substance abuse, or has shown violent or threatening behavior. The client may be given a referral to other more appropriate services for issues of substance abuse, violence, or severe mental health issues. BENEFITS/RISKS: The majority of individuals and families that obtain counseling, benefit from the process. Self- exploration, gaining insight, exploring options, for dealing with problem behavior, learning new skills, or venting difficult feelings and experiences are generally quite useful. But, some risks do exist. As counseling is begun some individuals experience unwanted feelings. Examining ones life can produce unhappiness, anger, guilt or frustration. These unwanted feelings are a natural part of the psychotherapeutic process and often provide the basis for change. Also, sometimes a decision that is positive for one family member will be viewed quite negatively by another. QUESTIONS: Do not hesitate to discuss counseling goals, procedures, concerns, or your impression of services provided. If there is something you do not understand, please ask for a clarification.

**I have read and understand the nature and limits of therapeutic services provided by Ormond Beach Counseling Center.**

Client: _____ Date:_____

Parent/Guardian: _____ Date:_____

Counselor/Therapist: _____Date:_____