Disclosure Statement and Consent for Evaluation & Treatment

Patient's Name: _____ Date of Birth: _____

Social Security #: _____

1. **Consent to Evaluate/Treat**: I voluntarily consent that I will participate in a mental health (eg. psychological or psychiatric) evaluation and/or treatment by staff from Youth and Family Counseling. I understand that following the evaluation and/or treatment, complete and accurate information will be provided in the record concerning each of the following areas:

   a. The benefits of the proposed treatment
   b. Alternative treatment modes and services
   c. The manner in which treatment will be administered
   d. Expected side effects from the treatment and/or the risks of side effects from medications (when applicable).
   e. Probable consequences of not receiving treatment

The evaluation or treatment will be conducted by a psychotherapist, a licensed therapist or an individual supervised by the professionals listed. Treatment will be conducted within the boundaries of Texas Law for Psychological, Psychiatric, Social Work, Professional Counseling, or Marriage and Family Counseling.

2. **Benefits to Evaluation/Treatment:** Evaluation and treatment may be administered with psychological interviews, psychological assessment or testing, and psychotherapy; as well as expectations regarding the length and frequency of treatment. It may be beneficial to me, as well as the referring professional, to understand the nature and cause of any difficulties affecting my daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or academic performance, health status, quality of life, and awareness of strengths and limitations.

You have the right to competent, quality treatment that is consistent with professional standards established in practice and supported by research. Please be aware that the therapeutic process may involve personal awareness that may be emotionally painful, may cause heightened emotions, may cause anxiety, tension or stress and may cause some disruption or turmoil in your life as well as the lives of your significant others due to the subject matter being disclosed.

Counseling also has the potential to provide emotional support and stability for any family member involved in therapy. Further, it may relieve anxiety and create a safe environment for children or family members who are distressed. Finally, counseling has the potential for creating positive life changes in the form of long-term solutions to difficulties, and creating better communication. No guarantee can be offered as to the results of services.

3. **Charges**: Fees are based upon the a sliding scale, determined by city of residence and household yearly income, services or treatment, and if I am eligible for any specific programs available at the time. I will clearly be informed about my eligibility to each program. I will be responsible for any charges, including no show fees, related to the No-Show policy I agreed to. Fee review and scholarships are available upon request or funding availability.

4. **Confidentiality, Harm, and Inquiry:** Information from my evaluation and/or treatment is contained in a confidential medical record at Youth and Family Counseling, and I consent to disclosure for use by staff for the purpose of continuity of my care. Per Texas mental health law, information provided will be kept confidential with the following exceptions: 1) If I am deemed to present a danger to myself or others; 2) if concerns about possible abuse or neglect arise, or 3) if a court order is issued to obtain records.

5. **Right to Withdraw Consent:** I have the right to withdraw my consent for evaluation and/or treatment at any time by providing a written request to the treating clinician.

Disclosure Statement and Consent for Evaluation & Treatment

6. **Expiration of Consent**: This consent to treat will expire 90 days from closure with Youth and Family Counseling, unless otherwise specified.

All communication with your therapist / counselor becomes part of the clinical record. Files are closed once the counseling relationship ends. Records for adult clients are destroyed seven years after the file is closed. Records for minor clients are destroyed seven years after the client turns 18 years of age. Records are the property of Youth and Family Counseling. If at any time in the future you would like to request a copy of your records, you will need to submit a written letter of request in which your therapist / counselor has up to 15 days to produce copies (at a cost of $.50/page) for you. For more information on records request, please see the Texas Health and Safety Code, Title 7, Subtitle E, Chapter 611. All clinical records are stored and maintained according to HIPAA guidelines.

The counselors at Youth and Family Counseling are not specifically trained to testify in court. If you are seeking a mental health professional to advocate in court on your or your child's behalf, YFC would be happy to provide a referral to someone experienced in expert witness testimony.

Any suspected violations of counselor ethics may be reported in writing to the following governing agencies:
Texas State Board Examiners Complaint Process
Complaints Management and Investigative Section
P.O. Box 141369
Austin, Texas 78714-1369
or call 1-800-942-5540 to request the appropriate form or obtain more information.

Finally, we do not provide 24-hour crisis stabilization services. If you experience a crisis, please contact 911 or immediately go to your nearest emergency room. You may also contact the Denton County MHMR Crisis Hotline at: 1.800.762.0157.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment of myself and/or my child. I also attest that I am the legal guardian and have the right to consent for the treatment of this child, if applicable. I understand that I have the right to ask questions of my provider or my child's service provider about the above information at any time.

_____ _____
Signature of Client Date

_____ _____
Signature of Legal Guardian Date

_____ _____
Signature of Witness Date

YOUTH AND FAMILY COUNSELING
APPOINTMENT CANCELLATION POLICY

There is *no charge* for any appointments canceled 24 hours prior to the scheduled session time. Voice mail can be called 24 hours a day, seven days per week. Our voice mail system tags each call with a date and time identification. **Please be aware that once you cancel an appointment, that time may not be available the following week and you need to call the office for a new appointment time.**

HOWEVER, Youth and Family Counseling operates with a continual waiting list of families who need and desire our help. We schedule therapists to work on an hourly basis to attend to counseling needs. A client's failure to keep an appointment without 24 hour notice does not allow us with time to fill the appointment slot, nor does it relieve us of paying expenses such rent, utilities, and receptionist's time. Because Youth and Family Counseling is a non-profit agency we must defray a portion of these costs. **Therefore, the clients will be charged a $25.00 cancellation fee for appointments canceled with less than 24 hours notice**. Clients participating in the First Offender and At Risk Kids Program, Police Referral Program, or a City Employee Program will be charged **$25.00** for appointments canceled with less than 24 hours notice.

It is also the policy of Youth and Family Counseling to consider clients who do not attend scheduled appointments and do not contact the agency on the day of that appointment wishing to withdraw from the program, and they may be removed from the schedule.

We hope you understand that these policies were created by our Board of Directors in an effort to help minimize the loss of donated dollars and to maximize the use of the counseling center to those who need and want our assistance. Thank you for your understanding.

I, _____, have read and understand the above policies.

Signature
Client_____ Date_____

INFORMATION ON CONFIDENTIALITY

Under Texas Law, any information shared with a physician, clergyman, attorney, or psychological professional is "privileged and confidential". Your privacy is assured and carefully guarded by Youth and Family Counseling with the following exceptions of which you should be aware.

Personal information that you share with us may be entered into your records in written form. The only individuals with access to your files are your counselor, your counselor's supervisor, and those performing related clerical tasks. Our staff is aware of the strict confidential nature of the information in our records. City of Lewisville residents and referrals must be aware that city employees may review your case file in the course of periodic funding audits. No one else outside of our office is allowed access to our files.

If for some reason there is a need to share information in your records with someone not employed by Y.F.C. (your physician or another therapist), you will be notified and asked to sign a form authorizing transfer of the required information. You can revoke your permission at any time by giving us written notice.

There are important instances when confidential information may be released to others. If you have been referred to this agency by the court, you can assume that the court wishes to receive some type of report. You should discuss with us exactly what information may be included in a report to the court before you disclose any confidential material. In such instances, you have the right to tell us only what you want us to know.

If you are involved in litigation of any kind and inform the court of the services that you received from us (making your mental health an issue before the court), or if you are involved in any type of current or potential legal difficulties, you may be waiving your right to keep your records confidential. You may wish to consult your attorney regarding such matters before you disclose that you have received treatment.

If you threaten or harm yourself or someone else, we are mandated under the law to take whatever actions are necessary to protect you or other people from harm. This may include divulging confidential information to others and would only be done under unusual circumstances in which someone's life or safety appeared to be in danger.

If we know or suspect that you are abusing or neglecting your children, we are mandated BY TEXAS LAW to report this to the appropriate state agency. The law is designed to protect children from harm, and the obligations to report suspected abuse or neglect are clear in this regard. We make every reasonable effort to safeguard the personal information that you share with us; however, there are certain instances under which we may be obligated by law to release information to others. If you have any questions about confidentiality, please feel free to discuss them with any member of our staff.

By signing below, I document that I have read and understood the limits of confidentiality.

_____ Date_____

Signature of Client (If Minor)

_____ Date_____

Signature of Adult Client, Parent or Guardian

Youth & Family Counseling

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. When we provide treatment we may request that your primary care physician or other specialists share your medical information with us. Also, we may provide your primary care physician and other specialists with information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any. Other Mental Health professionals who may provide your treatment may be consulted by staff members.

Payment. Your information may be used to seek payment from your referring provider or credit card companies that you may use to pay for services. For example, the provider may ask for date of birth, or other identifying information.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of our practice. For example, your referring provider may request and receive information on dates of service, the services provided, and medical condition being treated.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law enforcement investigation, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment Reminders. Your health information will be used by our staff to complete appointment reminders via the telephone, electronic mail and/or the US mail.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

The right to request restrictions on the use and disclosure of your protected health information

The right to receive confidential communications concerning your medical condition and treatment

The right to inspect and copy your protected health information

The right to amend or submit corrections to your protected health information

The right to receive an accounting of how and to whom your protected health information has been disclosed

The right to receive a printed copy of this notice

Practice Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to inspect Protected Health Information

You may generally inspect the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect protected health information be submitted in writing. You may submit your written request to your records by contacting the receptionist or the Privacy officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request. You will be charged a fee as limited by The Texas State Board of Medical Examiners for the copy of your records.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can contact the Executive Director at 972-724-2005 to let us know. If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern. You will not be penalized or otherwise retaliated against for filing a complaint.

You may also send a letter outlining your concerns to the U.S. Department of Health and Human Services.

Youth & Family Counseling

Acknowledgement of Receipt of Notice of Privacy Practices

Our practice reserves the right to modify the privacy practices outlined in the notice.

I have reviewed this offices' Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of your Notice of Privacy Practices.

_____

Patient's Name(PRINT) Date of Birth

_____

Patient's Signature

_____

Date

_____

Signature of Patient Guardian / Representative (If Applicable)

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

_____
Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

_____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (_____)_____ **ALT. PHONE** (_____)_____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____)_____ Fax (_____)_____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____)_____ Fax (_____)_____

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☐ **All health information**
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other_____

Your initials are required to release the following information:

_____Mental Health Records (excluding psychotherapy notes)
_____Drug, Alcohol, or Substance Abuse Records
_____Genetic Information (including Genetic Test Results)
_____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X_____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X_____ _____
Signature of Minor Individual **DATE**

IMPORTANT INFORMATION ABOUT THE AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

The Attorney General of Texas has adopted a standard Authorization to Disclose Protected Health Information in accordance with Texas Health & Safety Code § 181.154(d). This form is intended for use in complying with the requirements of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act (Texas Health & Safety Code, Chapter 181). **Covered Entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.**

Covered entities, as that term is defined by HIPAA and Texas Health & Safety Code § 181.001, must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. (Tex. Health & Safety Code §§ 181.154(b),(c), § 241.153; 45 C.F.R. §§ 164.502(a)(1); 164.506, and 164.508).

The authorization provided by use of the form means that the organization, entity or person authorized can disclose, communicate, or send the named individual's protected health information to the organization, entity or person identified on the form, including through the use of any electronic means.

Definitions - In the form, the terms "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR 164.501). "Legally authorized representative" as used in the form includes any person authorized to act on behalf of another individual. (Tex. Occ. Code § 151.002(6); Tex. Health & Safety Code §§ 166.164, 241.151; and Tex. Probate Code § 3(aa)).

Health Information to be Released - If "All Health Information" is selected for release, health information includes, but is not limited to, all records and other information regarding health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain health information. As indicated on the form, specific authorization is required for the release of information about certain sensitive conditions, including:

- Mental health records (excluding "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501).
- Drug, alcohol, or substance abuse records.
- Records or tests relating to HIV/AIDS.
- Genetic (inherited) diseases or tests (except as may be prohibited by 45 C.F.R. § 164.502).

Note on Release of Health Records - This form is not required for the permissible disclosure of an individual's protected health information to the individual or the individual's legally authorized representative. (45 C.F.R. §§ 164.502(a)(1)(i), 164.524; Tex. Health & Safety Code § 181.102). If requesting a copy of the individual's health records with this form, state and federal law allows such access, unless such access is determined by the physician or mental health provider to be harmful to the individual's physical, mental or emotional health. (Tex. Health & Safety Code §§ 181.102, 611.0045(b); Tex. Occ. Code § 159.006(a); 45 C.F.R. § 164.502(a)(1)). If a healthcare provider is specified in the "Who Can Receive and Use The Health Information" section of this form, then permission to receive protected health information also includes physicians, other health care providers (such as nurses and medical staff) who are involved in the individual's medical care at that entity's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purposes permitted by law for that specified covered entity or person. If a covered entity other than a healthcare provider is specified, then permission to receive protected health information also includes that organization's staff or agents and subcontractors who carry out activities and purposes permitted by this form for that organization. Individuals may be entitled to restrict certain disclosures of protected health information related to services paid for in full by the individual (45 C.F.R. § 164.522(a)(1)(vi)).

Authorizations for Sale or Marketing Purposes - If this authorization is being made for sale or marketing purposes and the covered entity will receive direct or indirect remuneration from a third party in connection with the use or disclosure of the individual's information for marketing, the authorization must clearly indicate to the individual that such remuneration is involved. (Tex. Health & Safety Code §181.152, .153; 45 C.F.R. § 164.508(a)(3), (4)).

Limitations of this form - This authorization form shall not be used for the disclosure of any health information as it relates to: (1) health benefits plan enrollment and/or related enrollment determinations (45 C.F.R. § 164.508(b)(4)(ii), .508(c)(2)(ii); (2) psychotherapy notes (45 C.F.R. § 164.508(b)(3)(ii); or for research purposes (45 C.F.R. § 164.508(b)(3)(i)). **Use of this form does not exempt any entity from compliance with applicable federal or state laws or regulations regarding access, use or disclosure of health information or other sensitive personal information (e.g., 42 CFR Part 2, restricting use of information pertaining to drug/alcohol abuse and treatment), and does not entitle an entity or its employees, agents or assigns to any limitation of liability for acts or omissions in connection with the access, use, or disclosure of health information obtained through use of the form.**

Charges - Some covered entities may charge a retrieval/processing fee and for copies of medical records. (Tex. Health & Safety Code § 241.154).

Right to Receive Copy - The individual and/or the individual's legally authorized representative has a right to receive a copy of this authorization.

YOUTH & FAMILY COUNSELING

Counseling Intake Form

All Information Is Confidential - Please Fill Out Form for Primary Client

Name:	Date:
Date of Birth:	Gender: M / F
Age:	Relationship Status:
Street Address:	City & Zip:
Home/Mobile Phone:	May we leave a message for you at this number? Y / N
Work Phone:	May we leave a message for you at this number? Y / N
Employment Status:	
Employer:	Position Title:
Highest Level of Education Completed:	
Spouse/Partner's Name & Age:	
Length of Time in Relationship:	
Other People in Household & Ages:	

Are you currently involved in a divorce or other legal proceedings? Explain.	
Emergency Contact Name:	
Emergency Contact Phone: Emergency Contact Relationship:	
How were you referred?	If online, which website?

Current Concerns: (Please answer questions for primary person seeking counseling.)

What concern brings you in? When did this concern begin (give dates)?

Are you having any difficulties/stressors at work or school? If so, please briefly describe those difficulties.

What do you hope to accomplish in counseling?

What kind of obstacles could get in the way?

Have you been in therapy before or received any prior professional assistance for your concerns? If so, please give dates of treatments and results:

Behaviors – circle any of the following behaviors that apply to person seeking counseling:

Overeat	Suicidal attempts	Can't keep a job	Take drugs
Insomnia	Vomiting	Smoke	Take too many risks
Withdrawal	Lack of motivation	Drink too much	Nervous tics
Work too hard	Procrastination	Sleep disturbance	Crying
Phobic avoidance	Outbursts of temper	Loss of control	Aggressive behavior
Compulsions	Odd behaviors	Eating problems	Impulsive reactions
Concentration difficulties			

Are there any specific behaviors, actions, habits that you would like to change?

Feelings – circle any of the following feelings that apply to person seeking counseling:

Angry	Guilty	Unhappy	Annoyed	Happy	Bored	Sad
Conflicted	Restless	Depressed	Regretful	Lonely	Anxious	Hopeless
Contented	Fearful	Hopeful	Excited	Panicky	Helpless	Optimistic
Energetic	Relaxed	Tense	Envious	Jealous	Others:	

Physical – circle any of the following symptoms that apply to person seeking counseling:

Headaches	Stomach trouble	Skin problems	Dizziness	Tics
Numbness	Palpitations	Fatigue	Flushes	Muscle spasms
Twitches	Chest pains	Tension	Back pain	Rapid heart beat
Sexual disturbances	Tremors	Unable to relax	Fainting spells	Blackouts
Visual disturbances	Hear things	Excessive sweating	Tingling	Don't like being touched

Biological Factors:

Do you have any current concerns about your physical health? Please specify:

Please list medicines you are currently taking, or have taken during the past 6 months (include any medicines that were prescribed or taken over the counter):

Please list any past hospitalizations, including date, reason, and hospital.

Do you get regular exercise? If so, what type and how often?

Check any of the following that apply to you:

	Never	Rarely	Frequency	Very Often		Never	Rarely	Frequently	Very Often
Anxiety					Coffee				
Sadness					Alcohol				
Headaches					Nicotine				
Anger/Rage					Painkillers				
Crying					Marijuana				
Panic Attacks					Illegal Drugs				
Loss of interest in activities					Sleep Aids				
Backaches					Eat “junk foods”				
Trouble getting out of bed					Compulsive Exercise				
Poor appetite					Binge / Purge				
Sleep Issues					Self Injury/ Cutting				

Explain :

_____

_____

_____

Developmental History (Child/adolescent only)

Normal Pregnancy- delivery : Yes / No
Premature Birth : Yes / No
Milestones at normal sequence : Yes / No
Potty Training Issues : Yes / No
Developmentally delayed : Yes / No
(describe) _____

_____

_____

Degree/certificates_____

Educational Assessment (All Youth)

Presently a student: Yes / No
Last Grade completed? _____
Attention Deficit Problems: Yes / No
Failing in School: Yes / No
Learning Disability: Yes / No
Special Education Placement: Yes / No
Changes in school performance: ._____
_____
School attendance problems (describe) _____
_____

Concerns with Learning / Academics : _____
_____

Strengths : _____

Challenges : _____

Cognitive / Behavioral / Social :

Does your child have nightmares? How Often?

Does your child have any specific fears?

Does your child ever report intrusive or repetitive thoughts?

Has your child ever purposely harmed himself/herself, or reported thoughts of harming himself/ herself?

Would you describe your child as a follower or a leader?

Does your child have any close friends? How many?

Spiritual / Supportive Factors :

Does your family have any religious or spiritual beliefs? If yes, please describe.

Has your child experienced any major losses? If yes, please explain.

Has your child experienced any major transitions? If yes, please explain.

What additional supports can you identify in your family's environment?

FIRST OFFENDER AND AT RISK KIDS PROGRAM

The First Offender and At Risk Kids Program consists of six weekly 50 minute sessions of counseling, provided at no charge to participants. Families can be referred to this program by police, schools, or court. Participation in the program is voluntary; however, there may be repercussions for choosing not to participate, if related to court and pending charges. Your therapist will explain in your first session what these repercussions may be. If your family has been referred due to a police or court charge, be advised that if you choose not to complete all six sessions, your file will be returned, as unsuccessful completion of the program. This only applies if related to court charges.

The First Offender and At Risk Kids Program involves family counseling. All family members, aged 7 and older, must be willing to participate, unless otherwise indicated by the therapist in charge of your case. We also ask that families who choose to participate be willing to attend all six sessions. Counseling is a process that takes time, and a minimum of six sessions is needed for changes to be made.

I consent to participate in all 6 weeks of the First Offender and At Risk Kids Program.

_____ _____

Signature of Client (Minor) **Date**

_____ _____

Signature of Parent or Guardian **Date**

Home Phone_____

Cell Phone_____

Home Address_____

City_____ State_____ Zip Code_____

Referral Source: _____ Reason: _____

Client Information

Today's Date_____ Name of Client_____

Sex_____ Date of Birth_____ Age_____ Ethnicity_____

Education Level_____ Name of School_____

Since the First Offender Program is a Family Counseling Program, it is required that all family members attend all counseling sessions unless specified by your individual therapist. Please list all family members that will attend:

Name	Relationship	Sex	Age
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have any of your children repeated a grade or had any difficulty with school? Please explain.

_____

_____.

Have any family members ever been in counseling or sought treatment for mental health? If yes, please give dates and doctor's/counselor's name and details.

_____

_____.

Are there any family members currently under medical care and/or taking any prescription medications? If yes, please give the name of the condition, doctor's name and name of the medication.

_____

_____.

Has anyone in your family or immediate family ever threatened or committed suicide? Please give brief details.

_____

_____

What concerns do you have about your child/children (emotionally, behaviorally, socially, etc.)?

_____

_____

_____

_____

REQUIREMENTS OF THE FIRST OFFENDER & AT RISK KIDS PROGRAM

Youth and Family Counseling has a long history of service to the community in providing excellent family counseling at no cost to our participating families. In order to use the funding from the municipalities responsibly and to make the best use of counseling resources, we ask those using our services to be aware of the following policies. We hope your experience with Youth and Family Counseling is a very positive one.

Please initial each item to indicate that the requirement is understood; you may speak verbally your therapist during the first counseling session about any questions or concerns:

_____ 1. The First Offender & At Risk Kids Program requires the participation of everyone living in the household of the referred minor. Not all family members will be required to attend every session but all family members must be willing to participate when asked to attend counseling.

_____ 2. Counseling sessions are held every week at the same time until the six sessions required are completed. Missing more than one appointment will result in the case being returned to the referring police department or court for court action. The reasons for the missed appointments do not affect this policy.

_____ 3. The six counseling sessions are offered to families at no cost with one exception:
If the family has a scheduled appointment and cancels that appointment with less than 24 hours advance notice or does not appear for that appointment, there is a $25.00 charge.

_____ 4. The counseling center is very protective of the confidentiality and privacy of our client families. Please be aware that state law (not YFC) requires that we report child abuse and/or neglect to Child Protective Services and we comply with that law.

_____ 5. The counseling center does everything possible to protect the safety of the client families. State law requires that if clients threaten to harm themselves or others, it must be reported to the authorities and we comply with that law.

_____ 6. Once a week counseling may not be appropriate for clients who are currently suicidal, violent or who have active chemical addictions because we do not have the facilities to assure the person's safety. If you or family members need more intensive therapy, your counselor will provide you with a list of resources.

_____ 7. Youth and Family Counseling is independent from the courts and police departments and cannot speak to decisions that may be made regarding your case by the referring agency. Once a family completes the required number of sessions, a termination report is sent to the police department or court documenting completion of the program and any additional requirements are handled by the police or court. Please contact them for any legal questions.

By signing below, the client confirms that the policies above were discussed and agreed to:

_____ _____

Parent or Guardian Date