Valley Christian Counseling
Adolescent/Minor Client Intake Packet

Welcome to Valley Christian Counseling! To better serve you, please review the following and fill out all applicable information. We know this may feel like a lot, but know that your therapist will go over the important highlights and any questions you may have during your first session. All information you provide will be kept confidential. Leave blank any questions you would rather not answer at this time.

Client Intake Information

****The questions in this intake are addressed to the client. If you are a parent/guardian filling this out for your child, please just answer from your perspective accordingly.****

Please share what brings you to counseling at this time? Please include current issues and what you are hoping to accomplish through counseling.

_____
_____
_____
_____
_____

Are you looking for court-related services? If yes, please explain:

_____
_____

Contact and Basic Information

Client Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Email: _____ Phone: _____

Is it OK to contact and leave messages at the listed phone # regarding appointments? ☐YES ☐NO

Who do you live with? _____

Relationship to this person/people: _____

Parent Basic Information

Mother's Name: _____ Mother's Date of Birth: _____

Father's Address (if different from your address listed above): _____

_____

Mother's Phone: _____ Mother's Email: _____

Father's Name: _____ Father's Date of Birth: _____

Father's Address (if different from your address listed above): _____

_____

Father's Phone: _____ Father's Email: _____

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Education

What grade are you in? _____ Where do you go to school? _____
How is school going? Share what you like about school and what is difficult. _____
_____
_____
_____

Faith/Spirituality

Faith/Religious Orientation: _____
Are you part of a church or spiritual/religious community? If so, please share what/where: _____
What, if any, spiritual practices are important to you or do you regularly engage in? _____
_____
_____

Relationship Information

What is your relationship status? (E.g. "single", "dating", etc.) _____
Are you sexually active? ☐YES ☐NO
How satisfied are you in your current relationship/relationship status: _____
_____

Home Life Information

Please list anyone you live with:

Name	Age	Relationship to You

Describe what you like about your childhood/home life: _____
_____
_____

Describe what you do not like/is hard about your childhood/home life: _____
_____
_____

History and Health Information

Mental Health

Are you seeing any other mental health professional(s) at this time (psychiatrist, counselor, etc.)? ☐YES ☐NO
If yes, please describe: _____
Have you been to counseling before? If so, what was helpful (or not) about it? _____
_____

Have you ever been hospitalized for psychological problems? □YES □NO
Please list any family history of trauma, addiction, or mental health issues:

_____
_____
_____
_____

Have you ever experienced any of the following:

Experience/Symptom	**Currently Experiencing?**	**Experienced in the Past?**	**Please explain frequency/intensity**
Extreme depression			
Extreme anxiety			
Dramatic mood swings			
Hyperactivity			
Extreme low energy			
Extreme/Uncontrollable Anger			
Bed/day wetting			
Body image problems			
Panic attacks			
Phobia			
Hallucinations			
Unexplained lapse in time or memory			
Unhealthy relationship with food/ eating disorder			
Obsessive/repetitive or intrusive thoughts			
Repetitive/compulsive behaviors			
Relational/peer difficulties			
Learning disability			
Sexual issues (including excessive masturbation)			

Use the below space to share any more that you want to about any issues listed above:

Physical and Medical Health

Are you having any issues with sleep (e.g. sleeping too little, nightmares, etc.)? If so, please describe:

_____

How active are you?

□ Little to no exercise □ A few times a month □ A few times a week □ Nearly everyday

Do you have a primary care doctor? If so, who? _____

Please list any current or persistent major medical issues:

_____

_____

_____

Please list any medications or supplements that you are currently taking. For each, please include the reason for each and how long you have taken each.

_____

_____

_____

Substance Use and Addictive Behaviors

Please list any substances that you have used or currently use (including caffeine, tobacco, and alcohol). For each, share if it is past or current use, the amount and frequency of use, and the last time used:

_____

_____

_____

Please list any behaviors that are potentially addictive for you (e.g. pornography, gambling, gaming, etc.). Please list if behavior is current or past, and how frequently you engage in the behavior.

_____

_____

_____

Safety Screener

Have you ever attempted suicide or intentionally harmed yourself? □YES □NO

Do you currently have thoughts about suicide or harming yourself? □YES □NO

Do you currently have a desire to harm or kill someone else? □YES □NO

In the past, have you ever seriously considered suicide, harming yourself, OR harming someone else? □YES □NO

If yes for any of the above, please explain:

_____

_____

_____

Trauma Assessment
Have you ever experienced or witnessed any of the following? Please mark "V" if you were a victim and "W" if you were a witness.

Physical abuse ____
Sexual abuse ____
Emotional/mental abuse ____
Neglect/abandonment ____
Community violence ____
Natural disaster ____
Other (please explain below) ____
_____

On a scale of 1-10 (1 being very little or not at all and 10 being multiple times a day), how often do you have thoughts about any of these traumatic experience/s? (1-10): ___

Is there anything else (not covered above) that you want your therapist to know before starting counseling?
_____
_____
_____
_____
_____
_____

Depression and Anxiety Screeners

On the next two pages, please fill out the two short screeners per the instructions for each. These are NOT diagnosing you – they are just helpful indicators on these two aspects of emotional and mental health.

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(*For office coding: Total Score T*____ = ____ + ____ + ____)

Valley Christian Counseling
Informed Consent

Overview of Counseling Process
You have taken a brave and positive step in deciding to seek therapy, and it is my honor and privilege to walk with you in this process. In counseling, I will seek to create a safe and trusting relationship with you so that you can grow and pursuit of lasting change. We will work together to determine your goals for therapy, and we will explore your life, family, history, and situation/issues in pursuit of those goals. The outcome of therapy largely depends on your willingness to engage in this process. At times, it may feel uncomfortable, but I will never require you to talk about or do anything that you do not want to – we will honor your story and move at your pace. I will regularly check in with you about how therapy is going for you, and we will make adjustments and decisions together accordingly.
Just a little about me is that I am currently an Associate Licensed Counselor (ALC) in the state of Alabama, under the supervision of Nancy DeHaas, LPC-S. I am also a Christian, and this guides my approach and perspective on personal and spiritual formation. However, we will only talk about faith and spirituality to the extent that you want to.

Minors and Parents
If the client is under 14, a parent/guardian must sign these forms to give consent for treatment. However, in the State of Alabama, a minor who is 14 years old or older may seek therapeutic services without the consent or knowledge of their parents/guardians. In such cases, the minor has the right to privacy and the parents are not privy to confidential information unless a release has been obtained. I generally suggest that teenage clients sign said release, as it is often helpful in the treatment for guardians to be involved in the process.
Generally in all other situations, (e.g. minors under 14, guardians are consenting to treatment for the minor, etc.), parents/guardians have legal rights to records and confidential information. However even when parents have the legal right, before giving sensitive information to parents/guardians, I will generally seek to discuss the matter with the client first so as to protect the therapeutic alliance.

Sessions
Therapy appointments typically last for 50 minutes. Longer sessions may also be available upon advanced request. We will determine together how often to meet based on your individual needs.

Cancellation Policy
A scheduled appointment means that time is reserved only for you. If an appointment is missed or cancelled without 48 hours' notice, I reserve the right to charge you a missed/cancelled appointment fee equal to the agreed-upon session rate.

Appointment Confirmation Reminders
Our office typically send you appointment confirmation reminders before each of your sessions. However, appointments are ultimately your responsibility, so please set self-reminders as needed, as it cannot be guaranteed that appointment reminders will reach you.

Emergencies
If you are in a crisis or emergency and are unable to reach our office during normal business hours, please call 911 (or 988 for mental health, substance use, and suicide crises), go to your nearest emergency room, or contact Crisis Services of North Alabama at 256-716-1000, and then alert me at your earliest convenience.

Consultation with Other Professionals
Consultations are sometimes requested by other professionals involved in your care. If you or another professional that cares for you requests a consultation, I reserve the right to bill at the hourly rate for consultation services, including any prep and travel time.

Communication and Boundaries
If you need to contact me, please call Valley Christian Counseling Center and leave a message with the receptionist or at the appropriate extension. I will periodically check messages, and return your call as soon as possible.
If we ever see each other outside the therapy office, I will not acknowledge you first. This is purely out of respect for your privacy. However, you are welcome to acknowledge me, and if you do, I will be more than happy to speak with you in public, though we will not engage in any therapeutic or lengthy discussions. I also will not respond to any attempts to connect via social media or any other method of contact outside of those formally mentioned above and agreed upon. This is all to maintain a healthy and clear therapeutic relationship.

Records
Records will be kept based your therapy sessions, and may include information regarding your reason for seeking therapy, a description of the impact your problems may be having on your life, your treatment progress and goals, your medical and social history, your billing records, and any reports received from other clinicians. **You have the right to review your records at any time**. However, it is recommended that the records be reviewed in the presence of your therapist before viewing them individually. A fee may be applied to the request of your records. Your records will be electronically stored and are compliant to all HIPPA requirements.

Release of Information
Valley Christian Counseling is not a HIPAA covered entity; however, unless you grant written permission, we will neither inform anyone that you are receiving services, nor will we disclose personal information provided (see Limits to Confidentiality below for exceptions to this). If you would like for information from your clinical record to be sent to a third party (e.g., physician, attorney, etc.) you must **both** first sign a Release of Authorization.

Limits to Confidentiality
The contents of our sessions are strictly confidential, except for the following limits:

1. As an Associate Licensed Counselor, I regularly consult with my supervisor about cases to promote the best care as possible for my clients. Additionally, I may request permission to record our session or for my supervisor to observe it. In such cases, I will ask your permission beforehand, and you have the right to deny recording/observation.
2. Occasional consultations with other mental health professionals about a case are helpful or even necessary in order to provide quality care. We make every effort to ensure your confidentiality during this process.
3. I have a legal duty to report to the appropriate authorities and your parents/guardians if:
    a. If you are a danger to yourself or others.
    b. If I have reasonable suspicion that abuse or neglect of a child or vulnerable adult is occurring.
4. I may be required or permitted to disclose information without your consent if requested to do so from a court order **or** if I become the defendant in a case filed against me.

_____ Date _____
Print Client or Legal Guardian Name

_____ Date _____
Client or Legal Guardian Signature

_____ Date _____
Therapist Signature

Custody and Consent to Treatment

If the client is under the age of 14, **and/or the parent/guardian is consenting to the minor's treatment in the rest of this packet then the following is required if applicable. **If the client is over 14 and parents/guardians are not signing this packet then the below is not required.***

In the case of divorced parents, a copy of the most recent custody agreement is required to receive treatment. Please bring this to the first session. This document is required to provide proof of parental right to consent to the minor's treatment. If both parents have rights, then your therapist will need to obtain the other parent's permission and inform them of her involvement.

By signing below, I am stating that I understand that I am required to prove my parental rights to consent to the minor's treatment. I understand that my child's other parent may be contacted regarding consent for treatment.

_____ Date _____

Client or Legal Guardian Signature

Valley Christian Counseling
Financial Agreement

The following information explains Valley Christian Counseling's current financial policies. Please review and sign this form to indicate that you have read and agree with the information presented.

Reimbursement/Insurance Coverage
Your therapist does not accept insurance. However, you may submit to your insurance for reimbursement as your therapist would be considered an Out-of-Network Provider. Your therapist does not determine how your insurance will reimburse counseling services - that is between you and your insurance company. Your therapist's fees are subject to change and you will have advance notice of those changes as they arise.

Methods of Payment
We ask that you pay in full upon the time of services, unless previously agreed upon by you and your therapist. We accept most forms of payment, including cash, check, or credit card.

Unpaid Balance
If you accrue an unpaid balance, we ask that you make arrangements to pay the balance within 30 days. In the event that we cannot reach you to collect payment, Valley Christian Counseling may pursue reimbursement by submitting a claim to small claims court, or by hiring a collections agency. Payment plans may be offered when requested with approval from the director of VCC. Confidential information may be shared in claims court or to collections agencies as needed.

Late Cancellation/No Show Fees
If cancellations have not been made within 48 hours of the appointment or the client did not show up for the session, the client is subject to a no-show fee equal to the normal session fee of $110. Exceptions are made in cases of emergencies. Grace is often offered, especially in unforeseen circumstances. Your therapist asks for communication, and in response, fees may be waved at your therapist's discretion.

Court Related Fees
Clients who require court related services can expect a rate of $200 per hour. Court related work can include, but is not limited to, consultations, phone calls, travel time, depositions, and time spent at court. There is a minimum retainer fee of $1000 to appear/testify in court. Payment must be received 48 hours prior to the court appearance. Subpoenas must be received within 48-hour notice or the client may be subject to an additional charge of $200. If a court date is rescheduled with less than 72 business hours, your therapist reserves the right to charge an additional fee of $300. It is important to note that any given testimony may not result in your favor. In the event that you lose your case, you will still be responsible for court related fees.

Statement of Understanding
I certify that I understand the above statement and I agree to its terms. By signing below, I am stating that I have read and agree with the financial fees set by my practitioner. I understand that Valley Christian Counseling and/or my practitioner reserve the right to adjust or lower that fee on as needed basis.

_____ Date _____
Print Client Name

_____ Date _____
Client Signature

_____ Date _____
Therapist Signature

Valley Christian Counseling
Client Rights

As a client at Valley Christian Counseling, **you can expect**:

• Humane care and treatment, with respect and consideration
• Privacy and confidentiality when seeking or receiving services, except in the case of life-threatening situations or conditions
• Confidentiality of your health records
• Accurate information concerning diagnostic impressions, treatment, and risks
• Active participation in decisions regarding your own treatment
• Accessible information regarding the scope and availability of services
• Information about any legal reporting requirements regarding any aspect of screening or treatment
• A copy of your records upon request and written authorization
• Ability to file a complaint with the director of VCC regarding any concerns related to the privacy, confidentiality or security of your medical record
• Competent treatment in a respectful environment that acknowledges your dignity and worth
• To gain knowledge regarding strategies and therapy techniques used to aid in your treatment
• Participation in establishing and reestablishing goals throughout therapy
• Option to participate in or refrain from services (except when mandated)
• Ability to request referrals for alternative service

_____ Date _____
Print Client Name

_____ Date _____
Client Signature

_____ Date _____
Therapist Signature

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