Valley View Counseling

1652 NW Hughwood Court
Roseburg, OR 97471

Office use only
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New Client Information Sheet

(Please print clearly)

Client Name _____
Last Middle First

DOB: _____/_____/_____ Age:_____ Social Security #: _____/_____/_____

Gender: [ ] Male [ ] Female Marital Status: ___Married___ Single___ Divorced___ Separated___ Widowed

Client Address: _____City/State/Zip _____

Mailing Address: _____City/State/Zip _____

Phone: Home # _____Work # _____ Cell # _____

Email Address _____

May we leave a message at? **Home [ ] Yes [ ] No Work [ ] Yes [ ] No**
Cell [ ] Yes [ ] No Email [ ] Yes [ ] No

Client's Employer:_____

Client's School: _____ Grade: _____Teacher's Name: _____

Referred by: (Circle One) **Yellow Pages Family/Friend EAP Employer Professional _____**
doctor / attorney / counselor

PAYMENT SOURCE

[ ] EAP (name)_____ EAP Phone Number: _____
[ ] Self Pay
[ ] Other (please list)_____
[ ] Health Insurance (please provide information below)

INSURANCE INFORMATION

Policy Holder's Name (As it appears on the card): _____

Policy Holder Date of Birth: _____ Insurance Plan Name: _____

Policy Holder #:_____ Group Policy #:_____

Policy Holder's Relationship to the Client: __Parent __Spouse__Self __Other_____

Policy Holder's Employer: _____ Employer's Phone Number: _____

Address to Mail Claims: _____City/State/Zip _____

Ins. Co. Phone:_____ Ins. Effective Date: _____ Termination Date: _____

(Please Complete Other Side)

SECONDARY INSURANCE

Policy Holder's Name (As it appears on the card): _____

Policy Holder Date of Birth: _____ **Insurance Plan Name:** _____

Policy Holder #: _____ **Group Policy #:** _____

Policy Holder's Relationship to the Client: __Parent __Spouse__Self __Other _____

Policy Holder's Employer: _____ **Employer's Phone Number:** _____

Address to Mail Claims: _____ **City/State/Zip** _____

Ins. Co. Phone: _____ **Ins. Effective Date:** _____ **Termination Date:** _____

Emergency Contact Information

Name: _____

Relationship to Client: _____ **Phone:** _____

Please Complete if you are the Parent or Guardian of the Client

Your Name: _____

Relationship to Client: ___ Parent ___ Legal Guardian ___ Other _____

Address: _____ **City/State/Zip** _____

Home Phone:( ) _____ **Cell:( )** _____ **Work:( )** _____

DOB: ____/____/____ Social Security #: _____/_____/_____ Employer _____

Sex: Male___ Female___ Marital Status: Married___ Single___ Divorced___ Separated___ Widowed___

Other Biological Parent (please complete if client is a minor child and other parent is in another home)

Name: _____ **Date of Birth: _____/_____/_____**

Relationship to the child: [ ] Father [ ] Mother

Address: _____ **City/State/Zip** _____

Home # _____ **Work #** _____ **Cell #** _____

Signature: _____ **Date:** _____

VALLEY VIEW COUNSELING

CLIENT INFORMATION AND CONSENT TO SERVICES

I. VALLEY VIEW COUNSELING CONFIDENTIALITY STATEMENT: The material in these application forms, and all information you give us, will be held in strict confidence. All information you provide will be used only by those at Valley View Counseling who are involved in helping you. Information cannot be released without your written permission, as per Oregon Statutes 179.505 and 192.500.

However, there are some legal limits on confidentiality that you should be aware of:

1. When a fee is assessed for services provided to you information may be released to government agencies and/or insurance companies in order to obtain payment.

2. If there is definite, clear and convincing evidence that you are an immediate danger to yourself or others, the Agency may have to reveal this to the proper authorities.

3. If you are involved in a medical emergency, information needed to meet the emergency may be disclosed without your prior consent.

4. Incidents of child abuse, including physical injury, neglect or sexual molestation, must be reported by employees of Valley View Counseling.

5. A court of law may subpoena information and may order release of information in a legal proceeding.

6. At the discretion of the director of Valley View Counseling, disclosure is possible to persons conducting scientific research, programs evaluation, peer reviews and fiscal audits. These persons, in turn, must maintain confidentiality.

While there thus appear to be quite a few limits on confidentiality, in actual practice the incidents where we would have to disclose information without your full knowledge and permission are rare. Valley View Counseling is committed to protecting and preserving your right to privacy.

II. POTENTIAL BENEFITS AND RISKS: In the process of counseling, unpleasant or painful events may be recalled and you may temporarily feel increased anxiety and/or emotional distress. You are encouraged to talk this over with your counselor. As a result of counseling, you may also find you are better able to cope, feel a reduction in your stress and develop a greater understanding of yourself and your situation.

III. WAITING ROOM POLICY: **All** children who are not a part of the counseling process must have private arrangements made for their care. **No children should be left unattended in the waiting room. If private care is unavailable** at the time of the parent/guardian,'s appointment, **the staff will be happy to reschedule to a more convenient time.**

IV. GRIEVANCE PROCEDURE: If at any time you are uncertain about or displeased with the services you are receiving at Valley View Counseling, you should discuss these concerns with your therapist. If you are unable to discuss your problems with your therapist or if after talking with them you feel your concerns have not been resolved, you should ask to speak with his/her supervisor. If you feel your legal rights have been violated present your complaints **immediately** to a supervisor.

Complete Other Side

V. CONSENT TO SERVICES:

SELF

I, _____, have read and understand the above information.
Please print

I hereby consent to participate in the services as provided by Valley View Counseling.

_____
Signature of Client

MINOR/CHILD

Name of Minor: _____ Age: _____ years, birth date: _____

I, _____, am the legal custodian of the above-named minor.
Please print

Please check one.
☐ I have full legal authority to consent to treatment of the minor without obtaining consent or approval of another person.
☐ I have joint custody of the minor pursuant to a decree that requires both my consent and the consent of another person.

I herby authorize Valley View Counseling to provide counseling to the minor in connection with substance abuse, mental health and/or other personal problems.

_____
Parent or Legal Guardian

HANDICAP

I, _____, have read the above information to _____
(Print Caregiver Name) *(Print Client Name)*

on there behalf. They hereby consent to participate in the services as provided by Valley View Counseling.

_____
Signature of Caregiver

_____ _____
Witness to above Signature Date

Read Other Side

Effective: August 1, 2003

VALLEY VIEW COUNSELING
NOTICE: PATIENT PRIVACY

We are committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your counseling information and to provide you with Notice describing:

HOW COUNSELING INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.

* We are required by law to have your written consent before we use or disclose to others your counseling information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

* We may be required or permitted by certain laws to use and disclose your counseling information for other purposes without your consent or authorization.

* As our patient, you have important rights relating to inspecting and copying your counseling information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your counseling information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

* We have available a detailed NOTICE OF PRIVACY PRACTICES which fully explains your rights and our obligations under the law. We may revise our NOTICE from time to time. The Effective Date at the top left hand side of this page indicates the date of the most current NOTICE in effect.

* You have the right to receive a copy of our most current NOTICE in effect. If you have not yet received a copy of our current NOTICE, please ask at the front desk and we will provide you with a copy.

* If you have any questions, concerns or complaints about the NOTICE or your counseling information, please contact Anne Marie P. at our office at 541-673-3985.

I _____have read and understand the above,
Print Client Name

_____ _____ _____
Signature Relationship to Client Date

VALLEY VIEW COUNSELING
CLIENT QUESTIONNAIRE

Name:_____ **Date of Birth:** _____ **Date:** _____

Effective mental health treatment is founded on accurate information both about a client's present and past experiences. The questions that follow are designed to help your therapist obtain a thorough understanding of your situation so that treatment can proceed in both a timely and an effective manner. Please answer each question as completely as possible before the intake appointment.

--------For any questions answered "Yes" please describe in detail, use the back side of form if necessary.--------

1. Have you ever been to a counselor before? Yes [ ] No [ ]

2. Have you ever taken medication to help with an emotional or psychological problem before? Yes [ ] No [ ]

3. Have you ever been hospitalized for a emotional or psychological problem? Yes [ ] No [ ]

4. Do you have any significant anxieties (worries and fears) or phobias (overpowering fears)? Yes [ ] No [ ]

5. Are there periods of your past, or specific ages, which you cannot remember? Yes [ ] No [ ]

6. Are you noticing any changes in your ability to concentrate or to remember day to day details? Yes [ ] No [ ]

7. Have you ever had a head injury or head trauma? Yes [ ] No [ ]

8. Have you ever attempted to end your life? Yes [ ] No [ ]

9. Who is your current medical doctor? _____

10. Please list any medication which you are currently taking, the dosage, and the reason you are taking it.

_____

_____

11. Have you ever had a bad (or allergic) reaction to any kind of medication? Yes [ ] No [ ]

12. Have you ever had any significant medical (health) problems or disabling condition(s)? Yes [ ] No [ ]

13. When was your last physical exam? _____ Who performed it? _____

14. Are you having any difficulty going to sleep, staying asleep, or sleeping to much? Yes [ ] No [ ]

15. Is your current appetite different than it is normally? Yes [ ] No [ ]
If yes, how? _____

16. Have you ever behaved in a manner that was clearly self-damaging (cutting or burning yourself, etc.)? Yes [ ] No [ ]

17. What are the names and ages of your family members' (family of origin)? _____

_____

_____

17a. Describe your relationship with your family members' while you were growing up:

_____

17b. And currently:

_____

18. Were you raised with any significant religious or cultural influences in your family? Yes [ ] No [ ]

19. Does anyone in your family have a history of either drug/alcohol problems, legal difficulties, or psychiatric problems? Yes [ ] No [ ]

21. Were there any periods of your upbringing when you lived with someone other than your parents (i.e. relatives, friends, foster parents)? Yes [ ] No [ ]

22. Were you ever teased or made fun of to a significant degree growing up? Yes [ ] No [ ]

23. Please list any stressful or hurtful experiences you had as a child (younger than 18)? _____
_____

24. Were you or anyone in your family ever emotionally, physically, or sexually abused growing up? Yes [ ] No [ ]

25. Please list any stressful or hurtful experiences you've had as an adult? _____
_____

26. Please give a brief description of all of your significant relationships (including number of marriages), how long each lasted, and why each ended. _____
_____
_____

27. Has there been any domestic violence (i.e. hitting, slapping, pushing, intimidation, throwing things etc.) or verbal violence (threats, name calling etc.) in any of your relationships? Yes [ ] No [ ]

28. When you reflect back over all of the friends and family members you have known in your life, who do you feel closest to and why?_____
_____

29. What is the main source of income in the household and who earns it? _____

30. What do you currently consider your "career field"?_____
30a. What other kinds of work have you done? (include military, job corps, etc.)_____
_____
30b. What is the longest you have ever worked in one job?_____

31. How did (do) you like school?_____
31a. What were your average grades? _____
31b. Describe any problems you may have had in school. _____
_____
31c. What was the highest grade that you completed? _____
31d. What were your favorite subjects (or major)? _____
31e. Least favorite? _____

32. Have you ever physically assaulted someone? Yes [ ] No [ ]

33. Have you ever been in trouble with the law(i.e. probation, parole, or jail)? Yes [ ] No [ ]

34. Please provide information about both your current and past substance use in the following section:
Rank in order of most to least used (1,2,3, etc.)

	Period of Heaviest Use	Date Last Used	Current Use
Alcohol (beer, wine, liquor)			
Amphetamine (crank, speed, cross-tops)			
Marijuana (pot, hash)			
Cocaine (crack)			
Hallucinogens (lsd, peyote, mushrooms)			
PCP (angel dust)			
Opiods (heroin, morphine, methadone, codeine)			
Barbiturates/Tranquilizers (valium, reds, quaaludes)			
Steroids			
Inhalants (sniffing)			
Others not listed above			

35. To what extent has your alcohol and/or drug use ever caused problems with: (check one space for each item)

	NONE	SOME	A LOT
Jobs			
Emotional & Mental Health			
Physical Health			
Relationship with family			
Relationship with friends			
Relationship with spouse			
Finances			
Law enforcement			
Sexual functioning			

36. Have you ever received treatment because of an alcohol or drug problem? Yes [ ] No [ ]

37. Does anyone in your family have/had an alcohol or drug problem? Yes [ ] No [ ]

38. Please add any information that may help your therapist in understanding and/or helping you._____
_____
_____
_____

39. Do you have any concerns about therapy which you would like us to know?_____
_____
_____