Valley View Counseling

1652 NW Hughwood Court
Roseburg, OR 97471

Information Sheet

PLEASE PRINT

Minor

Name: _____
(First) (Middle Initial) (Last)

Birth Date: ____/____/____ Age: _____ Gender: M/F

School: _____ Grade: _____ Teacher: _____

Parent/Guardian

Name: _____ Date of Birth: _____

Relationship to minor: _____

Address: _____ City/State/Zip _____

Mailing Address: _____ City/State/Zip _____

Home # _____ Work # _____ Cell # _____

For confidentiality may we leave a message at? **Home** [ ] Yes [ ] No **Work** [ ] Yes [ ] No **Cell/Mobile** [ ] Yes [ ] No

Marital Status: [ ] Single [ ] Married [ ] Separated [ ] Divorced [ ] Widowed [ ] Partner

Ethnicity/Race: [ ] Caucasian [ ] Hispanic [ ] African American [ ] Asian/Pacific Islander [ ] Native American/Alaskan [ ] Other

Complete this section if not paying session in full with cash at the time they are provided.

Drivers License #: _____ Expires: _____ Social Security #: _____/_____/_____

Occupation: _____ Employer: _____

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

Others living in the home:

Name	Birth Date	Age	Relationship to Minor

In Case of Emergency Contact:

Name_____ Relationship _____ Phone #_____

(Complete the other side)

Other Biological Parent (if not in the home with the Minor)

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

Relationship to minor: [ ] Father [ ] Mother Social Security #: _____/_____/_____

If known provide the following information:

Address: _____ City/State/Zip _____

Home # _____ Work # _____ Cell # _____

Employer: _____ Occupation _____

(For Parents of Child Clients) Parent(s) bringing in minor children for therapy agree that counseling is for the benefit of the child. In the case of divorced parents, the parent who brings the child in for therapy assumes full financial responsibility for the treatment. However, both parents are legally entitled to information concerning the child's therapy.

Parents agree not to call the counselor or any other person used in therapy as a witness in court, administrative proceeding or any other proceedings. Therapy may not be used as custody evaluation. Therefore, the counselor has the absolute right and obligation to refuse to testify or disclose information at any such proceeding. This prevents the misuse of the counseling situation for hidden legal objectives.

If you have any questions, which are not answered by the above information, or if anything above is not clear to you, please feel free to discuss it with me before signing below.

I understand the above information and have agreed to these terms for counseling.

Parent/Guardian 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
FAMILY INTAKE QUESTIONNAIRE

Child's Name:_____ **Date of Birth:**_____ **Today's 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. use the back side of the form if you need additional space for your answers.

Please list any other children in your family:

Child's Name	Sex	Date of Birth	Living with you?	If not, where?

Please list all other adults currently living in your household:

Name	Date of Birth	Relationship

1. Has anyone in your family ever been to a counselor before? Yes [ ] No [ ]

2. Has anyone in your family taken medication to help with an emotional or psychological problem? Yes [ ] No [ ]

3. Has anyone in your family had a bad (or allergic) reaction to any kind of medication? Yes [ ] No [ ]

4. Has anyone in your family been hospitalized for psychiatric reasons? Yes [ ] No [ ]

5. Who is your child's medical doctor? _____

6. Has anyone in your family had significant medical (health) problems or disabling condition(s)? Yes [ ] No [ ]

7. Is anyone in the family experiencing a different sleep pattern (sleeping too much or too little)? Yes [ ] No [ ]

8. Is anyone in the family currently experiencing a significant change in appetite from what is normal? Yes [ ] No [ ]

9. Has anyone in your family ever eaten a great deal of food and then made themselves throw up (bulimia), or refused to eat to the point that person's health was affected(anorexia). Yes [ ] No [ ]

10. Does your family have any significant religious or cultural influences (i.e., Hispanic. German. Italian)? Yes [ ] No [ ]

11. Does anyone in your family have a history of legal difficulties? Yes [ ] No [ ]
If yes, please describe and specify whom.

12. Have you, or anyone in your family ever threatened, or attempted, to end their life? Yes [ ] No [ ]
If yes, which family member, when, what did they threaten to do, how did they attempt to end their life, and why?

13. Have you or anyone else in your family ever physically assaulted someone, or been physically assaulted? Yes [ ] No [ ]
(including any physical fights in the family home) If yes, which family member, when and who was involved?

14. Has anyone ever been in trouble with the law (i.e. been on probation or parole, been in jail, etc.)? Yes [ ] No [ ]
If yes, what type of trouble, which family member, and when did this occur?

15. Has anyone in the family ever been emotionally, physically, or sexually abused? Yes [ ] No [ ]
If yes, which family member was abused, who was the abuser, when the abuse occurred, and how did the abuse affect that family member?

16. Has anyone in your family ever behaved in a manner that was clearly self-damaging (i.e., punching walls, cutting or burning him/herself, etc.)? Yes [ ] No [ ]
If yes, which family member, in what way(s)?

17. Does anyone in your family have any significant anxieties (worries and fears) or phobias (overpowering fears)?
If yes, please describe. Yes [ ] No [ ]

18. Please provide information about any current and/or past substance use by anyone in your family.

Name of family member	Drug of choice	Amount and frequency of past use	Amount and frequency 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		

19. Has anyone in our family ever received treatment because of an alcohol or drug problem? Yes [ ] No [ ]
If yes, when, where, and for what type of problem?

20. Please describe any involvement your family may have had in AA or any other 12 step program.

21. Has alcohol or drug use caused problems in your family 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			

Please explain those items marked "SOME" or "A LOT".

22. Were there any complications during pregnancy or during the birth for any of your children. Yes [ ] No [ ]
If yes, please explain.

23. How old was your child when she or he began to:
    a. Crawl _____
    b. Walk _____
    c. Talk _____
    d. Potty Trained _____

24. Have your children ever been teased or made fun of to a significant degree by other children? Yes [ ] No[ ]
If yes, which child, about what and by whom?

25. How do your children like school?

26. Describe any problems your children may have in school.

27. Were there any periods of your children's upbringing when she or he lived with someone other than you *(i.e.*. relatives, friends, foster parents)? Yes [ ] No [ ]
If yes, please explain.

28. If the children's biological father or mother is not in the home where is she/he?

    a. How often does your children see him or her, and what is their relationship like?

31. What methods of discipline did your parents utilize when you were growing up?

32. What method of discipline does each parent in your home use and how well does it work?

33. What types of behavior does your child engage in that requires you to discipline him/her?

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

35. What other kinds of work has each parent done in the past? (include military, job corps, etc.)

36. What is the longest each parent has ever worked in one job?

37. Please give a brief description of all parental significant relationships (including marriages) and how long each of them lasted.

38. Are there periods of either parents past which she/he cannot (or choose not to) remember? Yes [ ] No [ ]
If yes, please identify them to the best of your ability.

39. Are either parent noticing any changes in their ability to concentrate or to remember day to day details? Yes [ ] No [ ]
If yes, please explain.

40. Do you have any concerns about therapy which you would like us to know? Yes [ ] No [ ]
If yes, please list.

41. Please add any information not asked for by this questionnaire that may help your therapist in understanding and/or helping you and your family.

42. List the benefits you hope to derive from therapy.