TRAVIS DALE COUNSELING
CLIENT INFORMATION – PARENT (Child Client)
(Revised July 2019)

Today's Date: ___________________

Referring Agency/Person: ____

Client Name: ______________________________ Form Completed By: __________________________

Address: ____

City: ______________________________ State: _______________ Zip Code: _________________

Home Phone: _______________________ Alternate Phone (cell): ______________________________

E-Mail: ______________________________ (Confidentiality of email communication cannot be guaranteed.)

Date of Birth: _________________________

Gender: Male ______ Female ______ Ethnicity: ____

Birth History

Where was the client born? ____

Did the client's mother have any illness, injuries or operations during pregnancy? Yes No

If yes, please describe:____

Was the client adopted? Yes No

If yes, please describe adoption process: ____

Family Information

Mother's Name ____

Mother's Address ____

City_____________________________________ State____________ Zip Code ______________________

Birthdate: _________________________ Occupation: ____

Employed by: _________________________________

Telephone Number: _______________________________ (Home) _________________________ (Work)

_______________________________ (Cell) _________________________ (Other)

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Father's Name ____

Father's Address (if different) ____

City____________________________________ State__________ Zip Code ____________________

Birthdate: ____________________ Occupation: ____

Employed by: ______________________________

Telephone Number: ____________________________ (Home) ______________________ (Work)

____________________________ (Cell) ______________________ (Other)

What is the status of the client's parents' relationship? ________________________________

Names of Siblings: Age of Siblings:

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

If parents are remarried or living with someone else, please give names and birthdates of step-family members:

Name of step-family members: Relation

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

To which relatives does the client feel closest and why? __________________________________

Developmental History

Please describe any developmental delays or regressions (sleep difficulties, bed wetting, thumb-sucking, toilet training, etc: ____

____

Does the client have any particular fears? Please describe: ______________________________

____

Has the client suffered any recent traumas or loses? (death of loved one/friend/pet, recent move, etc.):

____

What special interests or hobbies does the client have? __________________________________

____

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Educational Information

School: ____________________________________ Grade: ________ Teacher: __________________________

Did the client have any difficulty starting or continuing in school and if so, please describe? ________________

____

How does the client do academically? ____

How does the client do socially? ____

To which friends does the client feel closest and why? ____

Describe any school problems: ____

What kinds of discipline have been used with the child? ____

____

What special interest, skills, or hobbies does the child have? ____

____

Medical Information

Doctor: ______________________________________ Telephone Number:______________________________

Date of last physical:____

May we contact the client's physician? Yes ____ No ______

Immunizations—are they current? Yes ____ No_____

Is client taking any medication or supplements? Yes______ No_______If yes, list below:

Medication/Supplement	Dosage/Frequency	Begin Date	End Date	Prescribing Physician

What past and present health issues, including pain, has the client experienced?

Past health issues: ____

Current health issues/symptoms: ____

History of hospitalizations(s): ____

Please describe the client's current habits regarding nutrition and exercise: _________________________________

____

Has the client ever had weight/growth problems? Yes ____ No____

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Mental Health Information

Has the client sought help in counseling or psychotherapy before? Yes No

If so, with whom? ____

Has the client ever been diagnosed with any of the following conditions? (please circle all that apply)

Autism Anorexia Anxiety Asperger's

Attention Deficit Disorder (ADD) Attention Deficit Hyperactivity Disorder (ADHD)

Bi-polar Disorder Borderline Personality Bulimia Conduct Disorder

Depression Learning Disability Oppositional Defiant Disorder (ODD)

Abuse Information

Is the client exposed to any substance use/abuse? Yes No

If yes, please describe: ____

Has the client experienced any emotional abuse? Yes No

If yes, please describe: ____

Has the client experienced any physical abuse? Yes No

If yes, please describe: ____

Has the client experienced any sexual abuse? Yes No

If yes, please describe: ____

Presenting Concerns

What is the problem for which you are seeking counseling for the client? ______________________

____

____

____

____

____

What changes would you like to occur as a result of counseling? ____________________________

____

____

____

____

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INFORMED CONSENT

The following information is for your benefit so you can enter a cooperative counseling partnership in an informed manner. Counseling is a helping relationship for which you are voluntarily entering for assistance with specific and stated problems. It is expected that you will benefit from your counselor relationship, but there are no guarantees that you will. Keep in mind that it is common to feel worse before feeling better. It is also expected that the counseling relationship should end through mutual agreement once desired goals have been reached; however, you have the right to terminate counseling at any time. Understand that you have the right to refuse any recommended services, and to be advised of the consequences of that refusal.

CONFIDENTIALITY

Legal Confidentiality

By law, the counselor considers all information and issues presented in the course of counseling as privileged and confidential. Confidential information may be released only with the written consent of the person being treated or that person's legal guardian. State law also requires the release of confidential information under the following conditions:

1. The client threatens suicide.
2. The client threatens harm to another person(s), including murder, assault, or other physical harm.
3. The client is a minor (under age 18) and reports suspected child abuse, including but not limited to, physical beatings, and sexual abuse.
4. The client reports abuse of the elderly.
5. The client reports sexual exploitation by a counselor.

In addition, in certain circumstances, a judge may require court-ordered counseling records, a deposition or testimony from a counselor. The contemplation, commission of a crime or harmful act is not considered confidential communication.

Consultation and Professional Training

In accordance with ethical standards, the counselor is required to participate in direct supervision. The counselor requires your consent to obtain professional supervision or collegial consultation outside our ministry when he/she feels it will facilitate the work with you/your family. Your name and any uniquely identifying information about you/your family will be deleted or changed to protect your identity. **Your signature on this form indicates your consent. Please let your counselor know if you are withholding consent.**

Professional Records

The laws and standards of counseling require the keeping of case records. Records are locked and kept on site. You are entitled to receive a copy of your records or a summary of your care if you make a written requestThese request forms for the summary of your care are available to you. Please note that these are professionally-held records and can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records it is recommended that you review them with your counselor so that the contents can be discussed. You have the right to amend your record, if you find something disagreeable or concerning. Your record will NOT be disclosed to others unless you ask the counselor to do so in writing, or unless the law compels the counselor to do so. Communications between the counselor and client will otherwise be deemed privileged and confidential as stated under the laws of this state. You will be charged an appropriate fee for any professional time spent in responding to your request for information. Meetings will be scheduled at mutually convenient times.

AUTHORIZATION TO TREAT

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Authorization for Treatment
My signature below indicates that I have read and understand this policy statement and its limits and have had my questions answered to my satisfaction. I accept, understand and agree to abide by the contents and terms of this agreement and further, I am voluntarily consenting to my counseling for specific and stated problems.

_________________________________ _______________________
Parent/Guardian Signature Date

_________________________________ _______________________
Counselor Signature and Credentials Date

FEES and AGREEMENT

In order to be fully informed about the counseling you will be receiving, please read through this following agreement, sign and date it at the bottom. This form must be signed and the client information form must be completed before the first session.

QUALIFICATIONS and AFFILIATION

Travis Dale is a Board Certified Pastoral Counselor and Individual, Marriage and Family Counselor, with over 25 years of experience, who received a Master of Arts in Counseling/Marriage and Family Therapy from Ottawa University and a Bachelor of Science in Christian Ministries from Arizona Christian University. He is on staff with Life Changers Counseling and New Life Counseling where he receives ethical oversight. He also holds a ministerial license through the state of AZ. Travis Dale is not a behavioral health professional and cannot prescribe medicine or diagnose mental illness. Clients will be referred to outside sources when treatment required is beyond the scope of care available here.

COUNSELING FEES

Payment is due at the beginning of each session and accounts must be kept current in order to continue counseling. Cash, checks (***payable to Travis Dale***), credit card or HSA/FSA card are accepted forms of payment. Please note that we do not accept insurance, and you are responsible to pay for services rendered.

Fee Schedule:

General Sessions (45 minutes): $150 or agreed amount on sliding scale __________ (per session)

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CLIENT EXPECTATIONS

Please plan to arrive 5 minutes prior to your appointment so the session can begin on time. You may be asked to complete homework assignments, or read books in conjunction with your counseling. Your commitment to the counseling process will greatly determine the outcome of your experience.

CONFIDENTIALITY

Your counselor will adhere to commonly accepted codes of privacy and confidentiality in counseling ethics. All counseling notes and client files are locked and only accessible to the counselor. There are situations, however, in which the law requires that certain information can be revealed without your consent. Under the discretion of the counselor, if there is any indication that you may be a danger to yourself or others, or are involved in the abusing of a minor, your information may be disclosed to appropriate mental health services or law enforcement. Also, an issue may occasionally arise that would benefit from the counsel or involvement of a mental health professional.

RIGHTS AS A CLIENT

You are entitled to information about any procedures, methods of counseling, techniques and possible duration of recommended care. You have the right to end counseling at any time without any moral, legal or financial obligations other than those already accrued. You have the right to expect confidentiality within the limits described.

CANCELLATION POLICY

I request that you notify me at least 24 hours before your scheduled appointment time if you need to cancel or reschedule a session. There is ***$75 fee*** or loss of prepaid session credit if you fail to give notice before 24 hours.

By signing below, you are acknowledging that you understand and accept the guidelines stated above.

Signed ____ Date _____________

Counselor ____ Date _____________

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