ADOLSECENT – SUPPLIMENTAL INFORMATION
(To be filled out by client – ages 12-17)
(Revised December 2023)

Client Name: ________________________________ Today's Date: ______________________________

Phone (cell): __________________________ E-Mail: ____

(Confidentiality of email communication cannot be guaranteed.)

Current Family Information

Please list those with whom you currently live and use the following words to describe your relationship (*abusive, bland, calm, conflicted, loving, satisfying, and unfulfilling*):

Name	Age	Relationship	Description

Educational Information

School: ____ Current Grade Level: ________

What is your current letter grade or grade point average? ____

Which subject(s) are the easiest for you? ____

What subjects(s) are the most difficult? ____

Are you currently behind in any of your class work? Y N

Are you currently under any school disciplinary actions? Detention Suspension Expulsion

Social Information

Who is(are) your best friend(s)? ____

What special interest, skills, or hobbies do you have? ____

What do you do for fun? ____

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Please list any extra curricular activities in which you are involved (for example: band, drama, sports, church youth group, etc.):

____

Relationship Information

Have you ever had a boy or girl friend? Y N

Do you currently have a boy or girl friend? Y N

How would you describe the relationship?

____

Are you sexually active? Y N

Medical Information

Are you currently taking medication? Y N Do you take it as prescribed? Y N

Please list medications: ____

Are you having trouble sleeping? Y N

Do you have trouble getting to sleep? Y N

Do you have trouble staying asleep? Y N

Do you have recurrent dreams or nightmares? Y N

Do you have trouble concentrating or getting organized? Y N

Have you noticed a recent change in your weight in the last 3-6 months? Y N

Gain or loss? How many pounds? _________

Have you noticed a recent change in appetite? Y N

Increase or Decrease?

Do you have any unexplained crying spells? Y N

Do you often feel any tightness in your chest or throat or heart palpitations? Y N

*(**Palpitation(s)** means an abnormality of heartbeat that ranges from often unnoticed skipped beats or accelerated heart rate to very noticeable changes accompanied by dizziness or difficulty breathing.)*

Do you often feel "nervous" or "anxious"? Y N

Do you often complain of headaches or stomach aches? Y N

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

Anorexia Anxiety Attention Deficit Disorder (ADD)

Attention Deficit Hyperactivity Disorder (ADHD) Bi-polar Disorder

Borderline Personality Bulimia Conduct Disorder Depression

Learning Disability Oppositional Defiant Disorder (ODD)

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Substance Use Information

Do you or have you used any of the following?

Alcohol Marijuana Tobacco (smoke or chew) Other: ____________________

How often? Daily Weekly Regularly Occasionally

Under what conditions? Alone With a friend At a party

Do you have a history of other addiction issues? (gambling, video games, sex,. pornography?) Yes No

If yes, please describe: ____

Abuse Information

Have you been exposed to any substance use/abuse? Yes No

If yes, please describe: ____

Have you experienced any emotional abuse? Yes No

If yes, please describe: ____

Have you experienced any physical abuse? Yes No

If yes, please describe: ____

Have you experienced any sexual abuse? Yes No

If yes, please describe: ____

Presenting Information

What is the problem for which you are coming to talk about today? ___________________________________

____

____

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

____

____

What about your life is currently most stressful and why?

____

____

_________________________________ _______________________

Client Signature Date

_________________________________ _______________________

Counselor Signature and Credentials Date

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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 request These 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.

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AUTHORIZATION TO TREAT

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 & 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 an Individual, Marriage and Family Counselor, with over 30 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 also holds a ministerial license through the state of AZ. Travis Dale 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*), or credit 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 (50 minutes): $180 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 a $100 fee or loss of 1 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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