The Center for Counseling

Your Life Is Precious.℠

Cancellation Policy

The therapists and physicians have a waiting list to see patients, due to this fact we must insist that you give us at least a 24 hour notice if in fact you need to cancel or reschedule an appointment. This allows us to try and fill the spot with a client that may be on our waiting list.

You may also leave a message on our voice mail if you must cancel an appointment over the weekend or a holiday.

If we do not receive ample notification *prior* to your appointment, you will be charged $45.

I acknowledge my financial responsibility if I do not comply with The Center for Counseling's Cancellation Policy.

Signature client/guardian	Date
Clinician	Date

The Center for Counseling
Your Life Is Precious.℠

Client Name: _____

Your therapist name is: _____

CLIENT EMERGENCY PLAN

FOR A LIFE THREATENING EMERENCY: CALL 911

If you believe you are in danger or in imminent risk, suicidal or homicidal with intent*: Please do not waste time calling our office or the clinician on call! You may want to attempt to contact your physician, but proceed to the emergency room immediately.*

Business Hours:

The Center for Counseling is dedicated to delivering personal, client focused care. Our office is open 9 am-9 pm Monday through Thursday and 9 am – 4 pm Fridays to meet your needs. During business hours if you have the need to speak with your clinician prior to your next appointment, please call our office at 1-586-273.7095. If your clinician is not available, we will make every attempt to contact them in a timely manner to return your phone call within 24 hours. If this is an **EMERGENCY** as defined above, please follow the directions. Your clinician will do their best to provide intervention over the phone. However, your clinician may request after no more than 10 minutes on the phone, that you schedule an appointment within 72 hours.

It will be the policy of The Center for Counseling to formally charge a fee for phone calls. These charges are non-billable to your insurance and will need to be paid by your next session. The fees are: 10-30 minutes = $45, 30-60 minutes = $90, and after 60 minutes, the charge will be $1.00 per additional minute. _____

Before/After Business Hours:

If an urgent matter arises which you would like to discuss with your clinician, **dial 1-586-273-7095** to receive the pager number. You will receive instructions to page the on-call clinician and leave a number. You will receive a return call within 15 minutes. If your call is not returned, please re-page the number, or call the **24-HOUR CRISIS LINE at 1-586-307-9100.** The on-call clinician will make every effort to contact your clinician in a timely manner to return your call within 24 hours.

Client Address _____

_____

Client Phone _____

_____
Client/Guardian Signature Date

_____
Clinician Signature/Credentials Date

WELCOME

The Center for Counseling
Your Life Is Precious.℠

MINOR CLIENT INFORMATION **(must be over 18 to complete form)**

Client: _____ Date _____
Last First

Sex __M __F Birthdate _____Age ____

SS# _____ Address _____
Street City Zip

Preferred Language_____ Special Communication Needs_____

PHONE NUMBERS

Home _____ Cellular _____

May we send CFC information to your email? Y N e-mail address _____

Father's Name _____Birthdate _____SS#_____

Mother's Name _____Birthdate _____SS#_____

Whom may we contact in the case of an emergency? Name _____

Relationship _____ Phone _____ Alternate #_____

INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Client _____ Birthdate_____SS#_____

Insurance Co _____Contract # _____Group#_____

Is client covered by additional insurance _____Yes _____ No

Subscriber Name _____ Phone _____

Relationship to Client _____ Birthdate_____SS#_____

Insurance Co _____Contract # _____Group#_____

Whom may we thank for referring you to us? _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to The Center for Counseling all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I also understand it is my responsibility to pay any deductible amount, co-insurance, or any other balances not paid by y insurance company or pay the full client fee if I have no insurance coverage. Also, if The Center for Counseling is out-of-network, I am responsible for all charges. In the event that my insurance company does not pay within 120 days I am responsible for all charges and The Center for Counseling will provide receipts so that I may contact my insurance company. In the event that payment in full is not received within thirty(30) days, a service charge will be added to the outstanding balance, computed at the rate of one and a half (1.5%) percent per month. I hereby authorize The Center for Counseling to release al information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Client/Guardian Signature Relationship Date

CHILD AND ADOLESCENT PERSONAL HISTORY FORM

□ MENTAL HEALTH □ SUBSTANCE ABUSE

FORM COMPLETED BY (*Must be over 18 years of age*)_____Relation _____

A) What brought child to treatment: _____

_____

B) What are your expectations for treatment_____

_____

C) Prior treatment experiences (Dates and Location_____

_____

D) Name of Primary Care Physician:_____Phone_____

E) **Current Living Arrangements*:***

1. □ House □ Group Living □ Apartment □ Other (Specify)_____
2. □ Alone □ With Family □ Unrelated Significant Other

I. **CLIENT INFORMATION (past and present)**

1) **Treatment Experiences**

	Yes	No	Inpat./Outpt/ IOP	When	Where
Counseling/Psychiatric treatment					
Suicidal thoughts/attempts					
Drug/alcohol treatment					
Involvement with self-help groups (e.g. AA, Al-Anon, Overeaters Anonymous)					

2) **Presenting Problem** (Check all boxes that apply)

□ Medical/Organic condition
□ Depression
□ Mania
□ Chemical Abuse/Dependency
□ Delusions/Hallucinations
□ Family Issues
□ Relationship Issues
□ Other (please elaborate)

□ Anxiety
□ Aggressive Behavior
□ Suicidal Ideation's
□ Self-destructive Behavior
□ Anger
□ Life Decision
□ Uncertain

II. **INFORMATION ABOUT FAMILY / SIGNIFICANT OTHERS;** past and present

1. **Family Constellation**

	NAME	CURRENT AGE	CURRENTLY LIVING		CURRENTLY LIVING WITH YOU	
Client			YES	NO	YES	NO
Mother						
Father						
Significant Other						
Children						
Significant Others: (Brothers, Sisters, Grandparents Step-relatives, Half-relatives) *Specify Relationship*						

2) **FAMILY/EXTENDED FAMILY HISTORY**

	Yes	No	Inpt/Outpt/IOP	When	Where
Counseling/Psychiatric treatment					
Suicidal thoughts/attempts					
Drug/alcohol treatment					
Involvement with self-help groups					

3) **Family History**

1. What City/State was child born? _____
2. Where did child grow-up? _____
3. Who raised child? _____

4) **Parental Information**

- ☐ Parents legally married
- ☐ Parents ever separated
- ☐ Parents ever divorced
- ☐ Mother remarried (number of times)
- ☐ Father remarried (number of times)_____

Describe relationships with parents, step-parents

5) SIBLING INFORMATION

Number of living siblings/step siblings_____ Number of deceased siblings/step-siblings

What position are you in the order of siblings (oldest, 2nd, 3rd, youngest, etc.) _____

Describe relationships with siblings:

_____

_____

☐ Family will be involved in treatment

☐ Family uninvolved

Why/Why Not:_____

_____

_____

III. CHILD'S HISTORY:

Pregnancy: Planned: Yes ☐ No ☐ Length of pregnancy:_____

Mother's weight gain:_____

While pregnant, did you smoke: Yes ☐ No ☐ Amount:_____

Did you use alcohol and/or drugs: Yes ☐ No ☐ Type and amount:_____

While pregnant, did you have any medical or emotional difficulties: (e.g. Hypertension, surgery, medication, depression etc)

_____

_____

Birth:

Length of labor: _____ Induced: Yes ☐ No ☐ Caesarian: Yes ☐ No ☐

Describe any physical or emotional complications with delivery:

_____

Baby's birth weight: _____ Baby's birth length: _____

Describe any complications for mother or baby after birth:

_____

_____

Length of hospitalization: Mother: _____ Baby: _____

INFANCY/TODDLERHOOD (check all that apply)

☐ Breast Fed ☐ Milk Allergies ☐ Vomiting ☐ Diarrhea

☐ Bottle Fed ☐ Constipation ☐ Colic ☐ Rashes

Describe any particular eating or feeding problems: (e.g. overeating, under eating):

_____

_____

Describe your child as an infant: (e.g. happy, nervous, overactive, under active, playful, etc.)

_____

_____

Describe any changes/differences as a toddler:

_____

_____

Describe any past/current problems with wetting or soiling:

Describe any past/current sleeping problems:

Other than parents, describe significant caretakers:

Child's Age	Caretaker (babysitter, relative, etc)	Describe arrangements

DEVELOPMENTAL HISTORY:

Age at which child:

Sat alone: _____
Took first steps: _____
Spoke words: _____
Spoke sentences: _____
Weaned: _____
Fed self: _____

Toilet trained: _____
Dry during day: _____
Dry during night: _____
Dressed self: _____
Tied shoelaces: _____
Rode 2-wheel bike: _____

PAST/CURRENT DIFFICULTIES WITH ANY OF THE FOLLOWING:

- ☐ Attachment to doll, stuffed animal, blanket, etc
- ☐ nervous habits (eye blinking, nail biting, etc
- ☐ over activity
- ☐ imaginary friends
- ☐ sexual difficulties
- ☐ separation difficulties
- ☐ thumb sucking
- ☐ teeth grinding
- ☐ social contacts
- ☐ temper tantrums
- ☐ short attention span
- ☐ fears
- ☐ fascinations
- ☐ head banging
- ☐ masturbation
- ☐ other

If yes, describe when and nature of problem:

AGE FOR FOLLOWING DEVELOPMENTS: (to be completed where applicable)

Voice change: _____ Breast development: _____ Body hair: _____ Menstruation: _____

MEDICAL:

Immunization Record:

	DTP	POLIO		
2 months:	_____	_____		
4 months:	_____	_____	15 months _____	MMR(Measles, Mumps, Rubella)
6 months:	_____	_____	24 months _____	HBPV (hib)
1 ½-2 years:	_____	_____	Hepatitis Series	_____ _____ _____
4-5 years:	_____	_____		

IV. SOCIAL BEHAVIOR:

How well does your child get long with other children his/her own age:

Does child have friends: ☐ yes ☐ no Duration of best friendship: _____

Your opinion of child's choice of friends:

Family members your child is close to:

Family members your child has difficulties with:

THERAPY IMPLICATIONS: _____

3) **Interests/Hobbies**

Art_____ Book/Films_____

Music_____ Physical Fitness

Crafts_____ Outdoor Activity

Sports_____ Diet/Health_____

Current Memberships (church , clubs, organizations)_____

Do you participate in any cultural activities related to your ethnic background? ☐ Yes ☐ No

THERAPY IMPLICATIONS: _____

DESCRIBE THE FOLLOWING:

Recent change in child's feelings/attitudes toward family members:

Physical, emotional, sexual abuse, past or present:

Child's problem behavior (s):

Effect of problem behaviors on other family members:

Child's response to authority figures and reasonable limit setting:

Geographical moves (how many, when, where, and child's response)

EDUCATION:

Present School:_____School Phone#: _____

Grade:_____ Teacher:_____ School Counselor:_____

DESCRIBE THE FOLLOWING:

Placement in gifted/special education program:

Retention or acceleration in grade placement:

Past/current behavioral adjustment in school:

Past/current academic performance in school:

Your opinion of child's academic performance:

Child's attitude toward school:

Other pertinent information:

4) **Spirituality**

Do you believe in a god or a power greater than yourself? □ Yes □ No

What religion were you raised_____

What religion are you currently affiliated_____

At this point in your life, what is most important to you_____

THERAPY IMPLICATIONS:_____

V. **EMPLOYMENT/VOCATIONAL**

Has child had any after school jobs? □ yes □ no

If yes: Where _____ Dates _____

THERAPY IMPLICATIONS:

VI. **LEGAL DATA**

Are you presently on probation or parole: □ Yes □ No

If yes reason _____ From _____ To_____

Current Status:

Are you currently involved in any active legal cases (traffic, civil, criminal): □ Yes □ No

If yes, please describe and indicate the court hearing/trail date_____

THERAPY IMPLICATIONS: _____

_____

_____

VII Nutritional Assessment

Please circle the answer or indicated number and total the score from both columns at the bottom.

QUESTION	YES	NO
Do you have an illness/condition that made you change the type/amount of food you eat?	Yes=2	No
Do you eat at least two or more meals per day?	Yes	No=3
Do you eat fruits or vegetables, or milk products every day?	yes	No=2
Do you have 3 or more drinks of beer, liquor, or wine almost every day?	Yes=2	no
Do you have teeth or mouth problems that make it hard for you to eat?	Yes=2	no
Do you always have enough money to buy the food you need?	yes	No=4
Do you eat alone most of the time?	Yes=1	no
Do you take 3 or more prescription or over-the-counter drugs?	Yes=1	No
Have you lost or gained 10 lbs. in the last six months?	Yes=1	No
Are you always physically able to shop, cook, and/or feed yourself?	Yes	No=2

TOTAL SCORE _____

0-2= Low Risk 3-5= Moderate Risk 6-21= High Risk* *Referral

THERAPY IMPLICATIONS:

VII. MEDICAL INFORMATION (past and present)

1. **Recent Treatment History**

	Date	Reason	Results
Last physical check-up			
Last Doctor's visit			
Last Dental visit			

2. **Review of Past/Present Conditions**

Please check any of the following medical problems you have, or have had in the past:

- ☐ Adrenal problems
- ☐ Diabetes
- ☐ Thyroid problems
- ☐ Seizures/Epilepsy
- ☐ Meningitis or Encephalitis
- ☐ Head Injury/Loss of Consciousness
- ☐ Kidney/Bladder problems
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Sexually transmitted disease
- ☐ Anemia
- ☐ Liver problems
- ☐ Lung problems
- ☐ Heart problems
- ☐ Allergies
- ☐ Brain Tumor
- ☐ Cancer
- ☐ Glaucoma
- ☐ Asthma

If yes to any of the above, please describe and give dates:

_____

_____

3. Is child in any physical pain? □ yes □ no

If yes: where/what kind? _____

If yes please rate pain _____ 0=none 5= mild(tolerable) 10=severe (referral)

4) **Current Medical Symptoms/Problems:**

Please check all that pertain to you now:

EYES
- □ Double Vision
- □ Eye pain
- □ Problems with vision

EARS
- □ Hearing Aid
- □ Buzzing/Ringing in ears
- □ Infection in ears
- □ Problems with balancing
- □ Problems with hearing

NOSE
- □ Nose bleeds
- □ Stuffy nose

MOUTH
- □ Loss of taste
- □ Problems with teeth
- □ Dentures

irregularities

RESPIRATORY
- □ Shortness of breath
- □ Chronic cough
- □ Sputum/mucus production
- □ Positive TB test
- □ Coughing up blood

SKIN/JOINT/MUSCLE
- □ Changes in skin
- □ Changes in nails
- □ Changes in hair
- □ Skin rash
- □ Skin itchy/dry
- □ Cramps in legs/arms
- □ Stiff/swollen joints
- □ Difficulty walking

GASTROINTESTINAL
- □ Difficulty swallowing
- □ Heartburn
- □ Nausea
- □ Vomiting
- □ Diarrhea
- □ Constipation
- □ Blood in stool
- □ Black tarry stool
- □ Abdominal pain

GENITO/URINARY
- □ Pain/burning with urination
- □ Frequent urination at night
- □ Bloody/brown urine
- □ Difficulty starting urine flow
- □ Constant need to urinate

.**NERVOUS SYSTEM**
- □ Headaches
- □ Numbness
- □ Fainting spells
- □ Convulsions/seizures
- □ Memory problems
- □ Coordination problems
- □ Tremor/shakes
- □ Loss of movement
- □ Loss of sensation

GENERAL HEALTH
- □ Overweight
- □ Underweight
- □ Chills
- □ Fever
- □ Tire easily
- □ Night/day sweats

CARDIOVASCULAR
- □ High blood pressure
- □ Low blood pressure
- □ Heart skips a beat
- □ Palpitations
- □ Fast heart rate
- □ Chest pains
- □ Swollen ankles

FEMALES ONLY
- □ Menstrual
- □ Menopause
- □ Problem pregnancy
- □ Miscarriage #_____
- □ Abortion # _____
- □ Premenstrual problems
- □ Infertility
- □ Currently pregnant

If you checked any of the above, please describe:_____

_____

5) **Medication and Drug Use**

Include prescription, non-prescription, and illegal drugs

Name of Drug	Prescribed	Prescribing Physician	Date 1st used	Date last used	Amount last used	Used in past 48 hr
	yes no					
	yes no					
	yes no					
	yes no					

Any history of drug overdose: □ Yes □ No If yes, please describe:_____

Any history of drug allergies: ☐ Yes ☐ No If yes, please describe:______________________________

THERAPY IMPLICATIONS:____

8. **Trauma**

Any history of trauma, abuse, neglect or exploitation? ☐ No ☐ Yes

If yes: When and type ____

____

THERAPY IMPLICATIONS: ____

Do you believe child would benefit from any of the following?

☐ Anger Management Education Series ☐ Substance Abuse Education Series ☐ Grief Group

- -

STAFF USE ONLY

Client currently being treated by Primary Care Physician for symptoms checked on page 8
☐ **yes** ☐ **no** ☐ **n/a**

Referred for physical ☐ **yes** ☐ **no**

____ ________________________________

_CLINICIAN SIGNATURE/CREDENTIALS **DATE**

Please fill out alcohol/substance use only if your child is 12 years old or older.

X <u>Alcohol/Substance Use</u>

Substance preferred _____

Date of last drink_____/ Date of last drug use _____

Type and amount of drink at last episode □ Beer _____oz □ Wine _____ oz □ Liquor ____ oz

Age drinking/ drug use began_____

Type of alcohol preferred: □ Beer □ Wine □ Liquor

How often do you drink/use drugs? □ Daily □ Weekly □ Monthly □ Other

Have you ever had any legal problems related to your use of alcohol/drugs? □ Yes □ No

Have you ever had any relationship problems related to your use of alcohol/drugs? □ Yes □ No

*****Has drinking or drug use ever become a problem? □ Yes □ No**

*****If YES, please complete next page. (Substance Abuse Addendum)**

If NO go to page 10

THERAPY IMPLICATIONS:_____

SUBSTANCE USE ADDENDUM

I. USAGE HISTORY

Drug type	Method of use	Age first used	Age of regular, daily use	Date last used	Last 48 hours	Last 30 days	Last year
A. DEPRESSANTS							
Alcohol (beer, wine, liquor)							
Anti-Anxiety Agents (Valium, Librium, Tranxene, Xanax, Ativan, Serax, etc.)							
Barbiturates (Phenobarbital, Tuinal, Seconal, etc.)							
Others (Methaqualone, Paraldehyde, Equanil, Miltown, muscle relaxants, etc.)							
B. NARCOTICS (Heroin, Opium, Morphine, Codeine (Tylenol #3/#4, Cough Syrup), Methadone, Dilaudid, Percodan, Darvon, Talwin, etc.)							
C. STIMULANTS							
Amphetamines (Benzedrine, Dexedrine, Ritalin, etc.)							
Cocaine/Crack							
Caffeine							
Nicotine							
D. CANNABIS (Marijuana, Hashish)							
E. INHALANTS (glue, poppers, gasoline, etc.)							
F. HALLUCINOGENS							

THERAPY IMPLICATIONS:

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This notice is effective as of July 7, 2003. (This date
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The Center for Counseling
Your Life Is Precious.℠
32743 23 Mile Road, Suite 130
New Baltimore, MI 48047

www.thecenterforcounseling.net

Notice of Privacy Policies and Practices

PRIVACY NOTICE

THE FOLLOWING NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND MADE KNOWN, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THE INFORMATION CAREFULLY.

- Your private healthcare information may be released to other healthcare professionals within The Center for Counseling for Counseling purposes, for payment purposes, and for the use of providing you with quality mental health and substance use care.

- Your private healthcare information may be released to your insurance company for any purposes for the use of The Center for Counseling for Counseling purposes, for receiving payment for providing you with needed healthcare services.

- Your

Our promise to you on the privacy of your health information

The Center for Counseling
Your Life Is Precious.℠

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- You may be contacted by the agency to remind you of any appointments, treatment options or other health services that may be of interest to you.
- You have the right to limit the use of your private healthcare information. However, the agency may chose to refuse limitation if it is in conflict of providing you with quality healthcare or in the event of an emergency situation.
- You have the right to receive private communication about your health status.
- You have the right to review and photocopy any/all portions of your healthcare information.
- You have the right to make changes to your healthcare information.
- You have the right to know who has accessed your private healthcare information and for what purpose.
- You have the right to possess a copy of this Privacy Notice upon request. This copy can be in the form of an electronic transmission or on paper.
- The agency is required by law to protect the

r ivacy of its p atients. It will keep p r ivate any and all p atient healthcar e infor m ation and will p r ovide p atients with a list of duties or p r actices that p r otect p r ivate healthcar e infor m ation.

- The ag ency will ab ide b y the ter m s of this notice. The ag ency r ese r ves the r i g hts to m ake chang es to this notice and continue to m aintain the p r ivacy of all healthcar e infor m ation.

P atients will r eceive a m ailed cop y of any chang es to this notice within 60 days of m akin g the chang es.

- You have the r i g ht to com p lain to the ag ency if you b elieve your r i g hts to p r ivacy have been violated. If you feel your p r ivacy r i g hts have been violated, p lease m ail your com p laint to the ag ency :

The C r for

ente

C ounselin g ATTN : O ffice M ana g e r 32743 23 M ile Road N ew Baltim o r e, M I 48047

All com p laints will b e investig ated. N o p e r sonal issue will b e r aised for filing a com p laint with the ag ency.

CLIENT'S BILL OF RIGHTS

*Each client has a right to impartial access to treatment, regardless of race, religion, sex, sexual preference, marital status, veteran status, ethnicity, age or handicap. The personal dignity of each client is recognized and respected in all care or treatment provided.

*Each client has the right to be free from neglect, exploitation; and verbal, mental, physical and sexual abuse.

*Each client has the right to expect that all treatment records or information will be kept confidential in compliance with agency policy except as authorized and as required by law. No information/records will be released without written permission of client or other appropriate designee, except to the physician, insurance company or hospital/facility client transferred to. The client will have access to all their health care records.

*Each client has the right to exercise personal privacy by with holding consent or family's or significant other's participation and to be informed of the possible consequences of that action.

*Each client has the right to be informed of the nature and purpose of any services rendered and the name and title of personnel providing that service.

*There are circumstances that would allow for exceptions to obtaining informed consent such as: situations involving threat of harm to self or others, child or elder abuse. Under these circumstances information about the individual served must be disclosed or reported.

*Each client has the right to participate in the development of their plan of treatment, evaluate the plan of treatment and voice grievances without fear of negative impact on the service provided and be aware of the process of voicing those grievances.

*It is the right of each client to receive individualized treatment which includes:

*Adequate and humane services regardless of the source of financial support.
*Services provided in the least restrictive environment possible.
*An individualized treatment plan which is reviewed periodically and as needed.
*To be treated by competent, qualified and experienced professional clinical staff who are supervised as appropriate.

*If at anytime during the course of treatment it is felt by client, the family, or surrogate decision maker that a care-related conflict exists between themselves and the agency:

They have the right to request the opinion of or have their plan reviewed by a staff consultant or an independent consultant at his/her expense.

*The client has the right to request a referral for services which the organization does not provide, to be involved in the discharge planning process, and be aware of any aftercare needs.

*The client will be informed of his/her rights in a language they can understand.

*Each client has the right to be notified of any/all costs of services rendered, the source of the organization's reimbursement, and any limitations placed on duration of services.

*Each client has the right to make decisions regarding the with holding or resuscitative measures with these decisions respected per agency policy.

***Recipients have rights protected by state and federal law and promulgated rules. For Information contact:**
Office Manager
32743 23 Mile Road, Suite 130
New Baltimore, MI 48047

The above Bill of Rights have been reviewed with me and any questions I may have had were explained to my understanding. A copy of the Client's Bill of Rights was given to me.

_____

Client/Guardian Signature Date

Informed Consent Statement

1. I voluntarily consent to participate in the initial intake and assessment process.

1. I have been given the opportunity for discussion of any concerns that I have regarding treatment.

2. I have been informed of the planned course of treatment.

3. I understand:
    - **that I may withdraw my consent at any time**.
    - **That if there are any changes in my insurance coverage, I will be notified within 15 days.**
    - **That I must notify The Center for Counseling if my insurance carrier or coverage changes**.
    - **that at this time and unless otherwise notified, my financial responsibility will be $ per session.**
    - **that I am responsible for payment of any services not covered by third party payors and I will pa any and all charges, co-pays and deductibles owing The Center for Counseling in accordance with their regular rate.**
    - **that if I must cancel an appointment, I am required to contact the office 24 hours prior to the appointment. Voice mail is available 24 hours a day, 7 days a week. If I fail to contact the office, I will be charged a <u>$45.00</u> fee.**
    - **that this fee is not billable to insurance, and is due at the beginning of the next session.**
    - **that I will be charged <u>$25.00</u> for any non-sufficient funds checks**.
    - **that in case of inclement weather, I am to call the office prior to my appointment to confirm that the CFC is open. If we have closed, there will be a message on our recording indicating the closure.**

4. I have read and received a copy of the fire evacuation/fire drill procedure, tornado warning drill procedure and building map.

5. It will be the policy of The Center for Counseling to formally charge a fee for phone calls either before or after business hours. These charges are non-billable to your insurance and will need to be paid by your next session. The fees are: up to 30 minutes = $25.00, 30-60 Minutes = $45.00, after 60 minutes, the charge will be .75 cents per additional minute.

Client Signature **Date**

Clinician Signature/Credentials **Date**

WHODAS 2.0

WORLD HEALTH ORGANIZATION
DISABILITY ASSESSMENT SCHEDULE 2.0

36-item version, self-administered

This questionnaire asks about difficulties due to health conditions. Health conditions include diseases or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs.

Think back over the past 30 days and answer these questions, thinking about how much difficulty you had doing the following activities. For each question, please circle only one response.

In the past 30 days, how much difficulty did you have in:						
Understanding and communicating						
D1.1	Concentrating on doing something for ten minutes?	None	Mild	Moderate	Severe	Extreme or cannot do
D1.2	Remembering to do important things?	None	Mild	Moderate	Severe	Extreme or cannot do
D1.3	Analysing and finding solutions to problems in day-to-day life?	None	Mild	Moderate	Severe	Extreme or cannot do
D1.4	Learning a new task, for example, learning how to get to a new place?	None	Mild	Moderate	Severe	Extreme or cannot do
D1.5	Generally understanding what people say?	None	Mild	Moderate	Severe	Extreme or cannot do
D1.6	Starting and maintaining a conversation?	None	Mild	Moderate	Severe	Extreme or cannot do
Getting around						
D2.1	Standing for long periods such as 30 minutes?	None	Mild	Moderate	Severe	Extreme or cannot do
D2.2	Standing up from sitting down?	None	Mild	Moderate	Severe	Extreme or cannot do
D2.3	Moving around inside your home?	None	Mild	Moderate	Severe	Extreme or cannot do
D2.4	Getting out of your home?	None	Mild	Moderate	Severe	Extreme or cannot do
D2.5	Walking a long distance such as a kilometre [or equivalent]?	None	Mild	Moderate	Severe	Extreme or cannot do

Please continue to next page ...

In the past 30 days, how much difficulty did you have in:						
Self-care						
D3.1	Washing your whole body?	None	Mild	Moderate	Severe	Extreme or cannot do
D3.2	Getting dressed?	None	Mild	Moderate	Severe	Extreme or cannot do
D3.3	Eating?	None	Mild	Moderate	Severe	Extreme or cannot do
D3.4	Staying by yourself for a few days?	None	Mild	Moderate	Severe	Extreme or cannot do
Getting along with people						
D4.1	Dealing with people you do not know?	None	Mild	Moderate	Severe	Extreme or cannot do
D4.2	Maintaining a friendship?	None	Mild	Moderate	Severe	Extreme or cannot do
D4.3	Getting along with people who are close to you?	None	Mild	Moderate	Severe	Extreme or cannot do
D4.4	Making new friends?	None	Mild	Moderate	Severe	Extreme or cannot do
D4.5	Sexual activities?	None	Mild	Moderate	Severe	Extreme or cannot do
Life activities						
D5.1	Taking care of your household responsibilities?	None	Mild	Moderate	Severe	Extreme or cannot do
D5.2	Doing most important household tasks well?	None	Mild	Moderate	Severe	Extreme or cannot do
D5.3	Getting all the household work done that you needed to do?	None	Mild	Moderate	Severe	Extreme or cannot do
D5.4	Getting your household work done as quickly as needed?	None	Mild	Moderate	Severe	Extreme or cannot do

Please continue to next page ...

If you work (paid, non-paid, self-employed) or go to school, complete questions D5.5–D5.8, below. Otherwise, skip to D6.1.

Because of your health condition, in the past 30 days, how much difficulty did you have in:						
D5.5	Your day-to-day work/school?	None	Mild	Moderate	Severe	Extreme or cannot do
D5.6	Doing your most important work/school tasks well?	None	Mild	Moderate	Severe	Extreme or cannot do
D5.7	Getting all the work done that you need to do?	None	Mild	Moderate	Severe	Extreme or cannot do
D5.8	Getting your work done as quickly as needed?	None	Mild	Moderate	Severe	Extreme or cannot do

Participation in society						
In the past 30 days:						
D6.1	How much of a problem did you have in joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.2	How much of a problem did you have because of barriers or hindrances in the world around you?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.3	How much of a problem did you have living with dignity because of the attitudes and actions of others?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.4	How much time did you spend on your health condition, or its consequences?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.5	How much have you been emotionally affected by your health condition?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.6	How much has your health been a drain on the financial resources of you or your family?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.7	How much of a problem did your family have because of your health problems?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.8	How much of a problem did you have in doing things by yourself for relaxation or pleasure?	None	Mild	Moderate	Severe	Extreme or cannot do

Please continue to next page ...

H1	Overall, in the past 30 days, how many days were these difficulties present?	***Record number of days*** ____
H2	In the past 30 days, for how many days were you totally unable to carry out your usual activities or work because of any health condition?	***Record number of days*** ____
H3	In the past 30 days, not counting the days that you were totally unable, for how many days did you cut back or reduce your usual activities or work because of any health condition?	***Record number of days*** ____

This completes the questionnaire. Thank you.

DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

Child's Name: _____ **Age:** ____ **Sex:** ☐ **Male** ☐ **Female** **Date:**_____

Relationship with the child: _____

Instructions *(to the parent or guardian of child):* The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during the **past TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS,** how much (or how often) has your child...	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1.	Complained of stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Said he/she was worried about his/her health or about getting sick?	0	1	2	3	4	
II.	3.	Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4	
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than he/she used to?	0	1	2	3	4	
	6.	Seemed sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Seemed angry or lost his/her temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or did more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual for him/her, but still had lots of energy?	0	1	2	3	4	
VIII.	11.	Said he/she felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	0	1	2	3	4	
IX.	14.	Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?	0	1	2	3	4	
	15.	Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	0	1	2	3	4	
	17.	Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS,** has your child ...						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes	☐ No	☐ Don't Know			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes	☐ No	☐ Don't Know			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes	☐ No	☐ Don't Know			
	23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes	☐ No	☐ Don't Know			
XII.	24.	In the past **TWO (2) WEEKS,** has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	☐ Yes	☐ No	☐ Don't Know			
	25.	Has he/she EVER tried to kill himself/herself?	☐ Yes	☐ No	☐ Don't Know			