

# Anne Salyers-Hudgens, MS, LPCC

## INITIAL CLIENT INFORMATION

### Client Information:

First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

Okay to call or leave message at: home:  Yes  No work:  Yes  No

SS# \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_ M \_\_\_\_ F

Would you like me to contact your Primary Physician?  Yes  No Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Are you currently seeing a psychiatrist?  Yes  No Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone No. \_\_\_\_\_

### Responsible Party Information:

First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

SS# \_\_\_\_\_ DOB \_\_\_\_\_ Relationship to Client \_\_\_\_\_

### Primary Insurance Information:

Ins. Co. \_\_\_\_\_ Plan Name \_\_\_\_\_

Policy # \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_

Deductible \$ \_\_\_\_\_ Copay Amount \$ \_\_\_\_\_

Insured's Employer \_\_\_\_\_ Relationship to client  Self  Spouse  Parent  Other

Insured's Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Home (\_\_\_\_) \_\_\_\_\_ SS# \_\_\_\_\_ DOB \_\_\_\_\_

### Information Below For Office Use Only:

Clinician: Anne Salyers-Hudgens, MS, LPCC Initial Appt \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Visits per year \_\_\_\_\_ Other \_\_\_\_\_

Dt of auth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ To \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Authorization # \_\_\_\_\_

CPT Code/Allowed: 90801 \_\_\_\_\_ 90806 \_\_\_\_\_ 90847 \_\_\_\_\_ Other \_\_\_\_\_

Claims address \_\_\_\_\_

**DX:** Axis I \_\_\_\_\_ Axis II \_\_\_\_\_ Axis III \_\_\_\_\_ Axis IV \_\_\_\_\_

Axis V: Pre \_\_\_\_\_ Post \_\_\_\_\_ Presenting Problem \_\_\_\_\_

# Anne Salyers-Hudgens, MS, LPCC

## OFFICE POLICIES

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After reading each section, please initial that you have read and understood the information. Feel free to ask questions if something is not clear and do not hesitate to raise any concerns regarding this information with your counselor.

### **CONFIDENTIALITY** \_\_\_\_\_ (initial)

When seeking psychological services, you have the right to expect that issues discussed during the course of individual psychotherapy will be kept confidential. Confidentiality means that your personal/private information will not be shared with others, since counselor/client communication is protected by law ("Privileged").

There are times however, when we believe that exchanging or receiving important information from others (e.g., doctors, teachers, etc.) allows us to better serve your psychological needs and provide a higher quality of care. Therefore, with your agreement, you may waive the privilege of confidentiality by providing your written permission on a Release of Information form. Once you sign a "release" form, you may withdraw your consent at any time. Please read the Notice of Privacy Practices guide provided to you.

### **EXCEPTIONS TO CONFIDENTIALITY** \_\_\_\_\_ (initial)

There are several possible exceptions to confidentiality:

1. *Danger to self and/or others:*

- a. If there is reason to believe that you are a serious danger to yourself or others, your counselor must take steps to reduce the risk, including reporting alleged or potential abuse/neglect.

2. *Insurance Reimbursement/Payment:*

- a. If insurance reimbursement is arranged, insurance companies reserve a right to have another professional review the case.
- b. Many insurers require periodic therapy summaries called Outpatient Treatment Reports (OTR) before they will authorize additional reimbursement.
- c. Information included on the insurance claim form is no longer considered confidential.
- d. Account information may be submitted to collections if an account becomes delinquent.

3. *Court Orders*

- a. There are cases where courts have subpoenaed records, testimony, or ordered the release of otherwise privileged records, such as in certain child custody cases where judges have ruled that the well being of the child outweighs the parent's privilege of confidentiality.
- b. If you are involved in a criminal case, your records can be subpoenaed.

### **EMERGENCIES/LIMITS OF SERVICE** \_\_\_\_\_ (initial)

If you have a clinical emergency, you may contact your counselor via the office's voicemail notification service. If your counselor is not available, you are advised to go to an emergency room or contact the local crisis hotline.

### **APPOINTMENTS** \_\_\_\_\_ (initial)

Counseling appointments are typically scheduled for 50 minutes. You and your counselor will arrange the frequency of appointments that best suits your needs. Your insurance company may only allow for a specific number and frequency of appointments (e.g., every two weeks.) Should you wish to make a change in the frequency of appointments, please discuss it with your counselor.

**CANCELLATIONS AND MISSED APPOINTMENTS \_\_\_\_\_ (initial)**

Canceled appointments will be accepted up to **24 hours prior** to the time of the appointment without a fee incurred. Therefore, if you need to cancel or change your appointment for any reason, please call to do so at the earliest possible time.

Since appointment times are held exclusively for you, late cancellations or missed appointments are "lost time" which might have been utilized by someone else. Therefore, the first 2 cancellations with **less than 24 hours prior notice** to the appointment, or missed appointments, will result in a \$50 fee billed directly to you and is payable on or before the next scheduled appointment. **Any additional late cancellations or missed appointments will result in an \$85 fee billed to you.**

**APPOINTMENT REMINDERS \_\_\_\_\_ (initial)**

We can send you an appointment reminder by email. The appointment reminder will only include the date and time of your appointment and your service provider's name. We will not encrypt the message. Health care information sent by regular email could be lost, delayed, intercepted, delivered to the wrong address, or arrive incomplete or corrupted. If you understand these risks and would like to receive an appointment reminder by email, your initials confirm you accept responsibility for these risks, and will not hold us responsible for any event that occurs after we send the message. If you would like to receive appointment reminders, please write your email address clearly here: \_\_\_\_\_

**FEES \_\_\_\_\_ (initial)**

Payment is due at the time of service. If you have not previously verified your mental health copayment, a payment of \$100.00 will be required at time of service. You are responsible for the timely payment of all services rendered, even if health insurance may ultimately pay for a portion of your balance. Under special circumstances, your counselor may be willing to discuss other fee arrangements. A 10% charge will be applied to any unpaid portion on your account, accruing every thirty days. Failure to resolve an outstanding balance in a timely manner may result in suspension of services until such time debt is paid.

**Standard Fee Schedule**

Initial Intake Interview	\$135.00
Individual Psychotherapy (45-50 min.)	\$100.00
Family/Marital Psychotherapy (45-50 min.)	\$135.00
Reports/correspondence (e.g., letters, Soc. Sec. Disability, FMLA, etc.)	\$100.00 hour (billed in 15 min increments)
Court Prep/Travel/ Court related Correspondence, reports, etc.	\$200.00 hour (billed in 15 min increments)
Testimony/Deposition Fee	\$300.00 hour
Subpoenaed Records	\$1.00/page+\$75.00/hour admin time

**Notice of deposition/testimony must be provided no less than three weeks prior to the dated requested. A retainer/fee based on the estimated necessary Court time must be paid in full at least 2 weeks prior to the appearance.** Any remaining fees for additional time incurred must be paid within 30 days of the service. The retainer will be kept if the hearing or deposition is cancelled less than 48 hours in advance of the scheduled appearance by anyone other than the treating professional for any reason.

**A returned check fee of \$35.00 plus the original amount of the check will be charged for checks returned due to insufficient funds.**

**If your account should become delinquent the responsible party is aware that collections are sought, and he/she will be responsible to pay the agency's collection cost/fees of 40% as well as the outstanding balance.**

**INSURANCE COVERAGE \_\_\_\_\_ (initial)**

If you have health insurance, part of your expenses may be covered. Please call your insurance carrier by dialing the number on your insurance card to verify services covered. **We request a three day notice should your insurance change, in order to verify benefits and request proper authorization. Otherwise, the client/parent/guardian is responsible for any fees due to lapse in coverage.**

**Child Supervision Policy \_\_\_\_\_ (initial)**

We cannot accept responsibility for unattended children. Please make arrangements for proper supervision and be considerate of others in the waiting area.

**Termination from Treatment Policy \_\_\_\_\_ (initial)**

As a client, you have the right to terminate treatment at any time, unless otherwise ordered by the Court. Providers also reserve the right to terminate clients from the practice for any reason we deem appropriate and/or necessary including, but not limited to verbal abuse to staff or other clients, physical assault or threat to assault staff, partners, personnel, clients, property, refusal to follow essential treatment recommendations that could result in harm to yourself or others, repeated no shows or late cancellations, and/or other individual reasons.

I have read the Office Policies outlined above and consent to abiding by these guidelines.

\_\_\_\_\_  
Client's Signature

\_\_\_\_\_  
Date

# Anne Salyers-Hudgens, MS, LPCC

## ADOLESCENT/GUARDIAN INFORMED CONSENT

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The purpose of meeting with a counselor or therapist is to get help with problems in your life that are bothering you or that are keeping you from being successful in important areas of your life. You may be here because you wanted to talk to a counselor or therapist about these problems. Or, you may be here because your parent, guardian, doctor or teacher had concerns about you. When we meet, we will discuss these problems. I will ask questions, listen to you and suggest a plan for improving these problems. It is important that you feel comfortable talking to me about the issues that are bothering you. Sometimes these issues will include things you don't want your parents or guardians to know about. For most people, knowing that what they say will be kept private helps them feel more comfortable and have more trust in their counselor or therapist. Privacy, also called confidentiality, is an important and necessary part of good counseling.

As a general rule, I will keep the information you share with me in our sessions confidential, unless I have your written consent to disclose certain information. There are, however, important exceptions to this rule that are important for you to understand before you share personal information with me in a therapy session. In some situations, I am required by law or by the guidelines of my profession to disclose information whether or not I have your permission. I have listed some of these situations below. Confidentiality cannot be maintained when:

- You tell me you **plan to cause serious harm or death to yourself**, and I believe you have the intent and ability to carry out this threat in the very near future. I must take steps to inform a parent or guardian of what you have told me and how serious I believe this threat to be. I must make sure that you are protected from harming yourself.
- You tell me you **plan to cause serious harm or death to someone else who can be identified**, and I believe you have the intent and ability to carry out this threat in the very near future. In this situation, I must inform your parent or guardian, and I must inform the person who you intend to harm.
- **You are doing things that could cause serious harm to you or someone else**, even if you do not intend to harm yourself or another person. In these situations, I will need to use my professional judgment to decide whether a parent or guardian should be informed.
- **You tell me you are being abused-physically, sexually or emotionally-or that you have been abused in the past**. In this situation, I am required by law to report the abuse to the Department of Social Services.
- **You are involved in a court case and a request is made for information about your counseling or therapy**. If this happens, I will not disclose information without your written agreement unless the court requires me to. I will do all I can within the law to protect your confidentiality, and if I am required to disclose information to the court, I will inform you that this is happening.

### **Communicating with your parent(s) or guardian(s):**

Except for situations such as those mentioned above, I will not tell your parent or guardian specific things you share with me in our private therapy sessions. This includes activities and behavior that your parent/guardian would not approve of — or would be upset by — but that do not put you at risk of serious and/or immediate harm. However, if your risk-taking behavior becomes more serious, then

I will need to use my professional judgment to decide whether you are in serious and immediate danger of being harmed. If I feel that you are in such danger, I will communicate this information to your parent or guardian.

**Example:** If you tell me that you have tried alcohol at a few parties, I would keep this information confidential. If you tell me that you are drinking and driving or that you are a passenger in a car with a driver who is drunk, I would not keep this information confidential from your parent/guardian. If you tell me, or if I believe based on things you've told me, that you are addicted to alcohol, I would not keep this information confidential.

**Example:** If you tell me that you are having protected sex with a boyfriend or girlfriend, I would keep this information confidential. If you tell me that, on several occasions, you have engaged in unprotected sex with people you do not know or in unsafe situations, I will not keep this information confidential. You can always ask me questions about the types of information I would disclose. You can ask in the form of "hypothetical situations," in other words: "If someone told you that they were doing \_\_\_\_\_, would you tell their parents?"

Even if I have agreed to keep information confidential – to not tell your parent or guardian – I may believe that it is important for them to know what is going on in your life. In these situations, I will encourage you to tell your parent/guardian and will help you find the best way to tell them. Also, when meeting with your parents, I may sometimes describe problems in general terms, without using specifics, in order to help them know how to be more helpful to you.

### **Communicating with other adults:**

**School:** I will not share any information with your school unless I have your permission and permission from your parent or guardian. Sometimes I may request to speak to someone at your school to find out how things are going for you. Also, it may be helpful in some situations for me to give suggestions to your teacher or counselor at school. If I want to contact your school, or if someone at your school wants to contact me, I will discuss it with you and ask for your written permission. A very unlikely situation might come up in which I do not have your permission but both I and your parent or guardian believe that it is very important for me to be able to share certain information with someone at your school. In this situation, I will use my professional judgment to decide whether to share any information.

**Doctors:** Sometimes your doctor and I may need to work together; for example, if you need to take medication in addition to seeing a counselor. I will get your written permission and permission from your parent/guardian in advance to share information with your doctor. The only time I will share information with your doctor even if I don't have your permission is if you are doing something that puts you at risk for serious and immediate physical/medical harm.

Adolescent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Counselor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Anne Salyers-Hudgens, MS, LPCC

## NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003

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This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

### **OUR LEGAL DUTY**

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties and your rights concerning your health information. This Notice takes effect April 14, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices or for additional copies of this Notice, please contact us.

### **USES AND DISCLOSURES OF HEALTH INFORMATION**

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you with your consent.

**Payment:** We may use and disclose your health information to obtain payment for services provided to you per your consent.

**Healthcare Operations:** We may use and disclose your general health information (excluding personally identifying information) in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, and evaluating practitioner and provider performance. We may use or disclose your general health information (excluding personally identifying information) in order for us to review our services and to evaluate our staff's performance. We may also use or disclose your health information to obtain a medical consultation regarding your care or treatment.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while

it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you or someone in your home is a possible victim (or perpetrator) of abuse, neglect or domestic violence. We may disclose health information to appropriate authorities if we reasonably believe that you are a serious danger to yourself or others.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. If you authorize release of information, we may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare.

**Persons Involved in Care:** We may use or disclose health information to notify or assist in notification of a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare.

**Required by Law:** We may use or disclose your health information when we are required to do so by law, such as in legal response to valid judicial, administrative subpoenas or court orders.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized, federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of an inmate or patient under certain circumstances.

**Appointment Reminders:** We may provide you with appointment reminders (such as voicemail messages, postcards, or letters) unless you make a specific request to the contrary. (See alternative communication section).

## **PATIENT RIGHTS**

**Access:** You have the right to view or obtain a copy of your health information, with limited exceptions. You must make a request in writing to obtain access to your health information. You may request that we provide copies in a format other than photocopies. We will use the format requested unless it is not practical for us to do so. We will respond to your request for access within 30 days of receiving the request. We reserve the right to charge you a reasonable cost-based fee for expenses such as photocopying and staff time after the first request for copies. We will charge \$0.10 a page, \$35.00 per hour for staff time and postage if you want the copies mailed to you. If you prefer, we will prepare a summary or an explanation of your health information for a fee. If we deny your request to review or obtain a copy of your health information, you may submit a written request for a review of that decision. The person conducting the review will not be the person who denied



your request. In some circumstances, our denial of a request by you to inspect and/or receive copies of your information is not subject to review.

**Disclosure Accounting:** You have the right to receive a record of disclosures made by us of your health information when you submit a written request. This record will not include: disclosures made for treatment, payment or health care operations; disclosures made directly to you; disclosures authorized by you pursuant to a signed authorization; or disclosures made for law enforcement purposes. You may request one such record at no charge every twelve (12) months. The record request must state the time period desired and may not exceed six (6) years prior to the date of the request and may not include any dates prior to April 14, 2003. The first disclosure record request in a 12-month period is free; additional requests will be provided for a fee. We will inform you of the fees before you incur any costs.

**Restriction:** You have the right to request that we place additional restrictions on our use and disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except when required by law or in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request. We will make reasonable efforts to accommodate your request.

**Amendment:** You have the right to request that we correct your records if you believe information in your record is incorrect or that important information is missing, by submitting a written request that provides your reason for requesting the amendment. We have the right to deny your request to amend a record if the information was not created by us; if it is not part of the health information maintained by us; if it is not part of the information which you would be permitted to inspect and copy; or if in our opinion that record is accurate.

### **Questions and Complaints:**

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information, you may contact (in writing) our Privacy Officer (listed below). You may also send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights. We will provide you the address. Under no circumstances will you be penalized or retaliated against for filing a complaint.

**Privacy Officer:** Anne Salyers-Hudgens, MS, LPCC  
34 Erlanger Road  
Erlanger, KY 41018  
Facsimile #: 859-341-5783

# Anne Salyers-Hudgens, MS, LPCC

## ACKNOWLEDGEMENT OF NOTICE OF PRIVACY

Effective 04/14/2003

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**I acknowledge that I have received a copy of the Notice of Privacy Practices.  
The effective date of the notice is April 14, 2003.**

Client's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Client or Authorized Guardian: \_\_\_\_\_

Relationship of Authorized Guardian to Client: \_\_\_\_\_

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### For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (specify) \_\_\_\_\_

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Signature of Professional Attempting to Obtain Signature

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Date

# Anne Salyers-Hudgens, MS, LPCC

CLIENT SURVEY- TEEN (13-17 YEARS OLD)

Client's Name: \_\_\_\_\_ Date: \_\_\_\_\_

## IDENTIFY STRENGTHS

*Let's start by identifying your child's strengths. These are the building blocks from which change can take place. Please indicate if your child has the ability to:*

- |  |   |
|--|---|
| <input type="checkbox"/> describe feelings, ask somebody for feedback          | <input type="checkbox"/> forgive, cooperate, get along                    |
| <input type="checkbox"/> says good things about self, looks forward to things  | <input type="checkbox"/> remember info, handle belongings                 |
| <input type="checkbox"/> follow example of role models, learn from experiences | <input type="checkbox"/> congratulate others, offer help, express concern |
| <input type="checkbox"/> keep trying, takes steps to achieve goals             | <input type="checkbox"/> wait turn, adjust to change in plans             |

Others: \_\_\_\_\_

## FAMILY INFORMATION

*Please identify all those people who currently live with your child.*

Name	Age	Relation to Child
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

*Other family members or persons important in your child's life that was not mentioned above, include all siblings:*

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has your child ever lived with anyone else or been in foster care?  Yes  No

If yes, please elaborate: \_\_\_\_\_

Marital History of Parents:  Married  Separated  Divorced  Never Married

If divorced or separated, what age was the child? \_\_\_\_\_ months/ \_\_\_\_\_ years old

Please describe visiting/custody arrangements: \_\_\_\_\_

Please list any person(s) who died that played an important role your child's life: \_\_\_\_\_

Counselor Notes: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## PRESENTING CONCERN

Please check any of the following for which you are seeking help for your child:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Nightmares               | <input type="checkbox"/> Aggression toward adults          | <input type="checkbox"/> Significant weight gain/loss  |
| <input type="checkbox"/> Sleeping Difficulty      | <input type="checkbox"/> Aggression toward peers           | <input type="checkbox"/> Does not get along with peers |
| <input type="checkbox"/> Fearfulness/Nervousness  | <input type="checkbox"/> Temper outbursts                  | <input type="checkbox"/> Problems concentrating        |
| <input type="checkbox"/> Social withdraw          | <input type="checkbox"/> Irritability                      | <input type="checkbox"/> Hyperactivity                 |
| <input type="checkbox"/> Depression/Sadness       | <input type="checkbox"/> Not obeying rules                 | <input type="checkbox"/> Destructive behavior          |
| <input type="checkbox"/> See/Hear things not real | <input type="checkbox"/> Running away from you             | <input type="checkbox"/> Clingy behaviors              |
| <input type="checkbox"/> Drug/Alcohol Use         | <input type="checkbox"/> Constant crying                   | <input type="checkbox"/> Fire setting                  |
| <input type="checkbox"/> Parental Stress          | <input type="checkbox"/> Threatens to hurt self or others  | <input type="checkbox"/> Homicidal thoughts or threats |
| <input type="checkbox"/> Sexual Promiscuity       | <input type="checkbox"/> Legal concerns/illegal activities | <input type="checkbox"/> Frequent Illness              |

Other: \_\_\_\_\_

Has your child ever experienced:  Physical Abuse  Sexual Abuse  Emotional Abuse  
If yes, by whom: \_\_\_\_\_ though what age? \_\_\_\_\_

Has your child ever witnessed domestic violence?  Yes  No  
If yes, between whom? \_\_\_\_\_ though what age? \_\_\_\_\_

How long have these behaviors been a concern? \_\_\_\_\_

Have you ever sought help for these concerns before?  No  Yes

If yes, from: \_\_\_\_\_

What has been done to address these concerns? \_\_\_\_\_

What are your goals for treatment? \_\_\_\_\_

## SOCIAL INTERACTIONS

Does your child regularly interact with other people?  Yes  No

If yes, are they:  Same age  Older  Younger

Your child:  makes friends easily  has few friends  has friends, but fights frequently

How well does your child get along with his/her siblings?

Better than average  Average  Worse than average  Not applicable- no siblings

How does your child react to strangers:  No fear  Hesitant  Panics around new people

Child's favorite pastimes are: \_\_\_\_\_

Child participates in organized religion:  Yes  No If yes, please identify: \_\_\_\_\_

Counselor Notes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## SCHOOL HISTORY

What is your child's favorite subject in school? \_\_\_\_\_

Does your child have problems at their current school?  Yes  No

Please explain: \_\_\_\_\_

Has your child had problems in the past?  Yes  No If yes, what? \_\_\_\_\_

Has your child ever been suspended?  Yes  No If yes, why? \_\_\_\_\_

Has your child ever been expelled?  Yes  No If yes, why? \_\_\_\_\_

Name of current school attending: \_\_\_\_\_ Dates Attended: \_\_\_\_\_

What kind of grades does your child get most often?

A

B

C

D

F

Does your child have an IEP or accommodations to assist in their education?  Yes  No

If yes, please describe : \_\_\_\_\_

## LEGAL HISTORY

Is attending this counseling session court mandated?  Yes  No

Is there current involvement in the family by Social Services?  Yes  No

If yes, name of worker: \_\_\_\_\_

Reason for involvement: \_\_\_\_\_

Has there ever been involvement with the family and Social Services?  Yes  No

If yes, list reason and outcome: \_\_\_\_\_

Other legal involvement outside of Social Services? \_\_\_\_\_

## OTHER INFORMATION

Other information you would like your counselor to know: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Completed by (signature): \_\_\_\_\_

Date: \_\_\_\_\_

Counselor Notes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature of Clinician \_\_\_\_\_

Date: \_\_\_\_\_

# Anne Salyers-Hudgens, MS, LPCC

TEEN SURVEY

(TO BE COMPLETED BY **CLIENTS** 13-17 YEARS OLD)

Your Name: \_\_\_\_\_ Date: \_\_\_\_\_

## YOUR STRENGTHS

What do you think are the best things about you?

- I'm a good friend     I'm helpful     I'm funny     I'm a hard worker     I'm smart  
 I can express myself     My special talent: \_\_\_\_\_

Other: \_\_\_\_\_

What are you most proud of? \_\_\_\_\_

\_\_\_\_\_

## PRESENTING CONCERN

Please tell me why you think you are coming to counseling: \_\_\_\_\_

\_\_\_\_\_

Is this a concern for *you*?  Yes     No, If yes, for how long? \_\_\_\_\_

How are you feeling right now?     Nervous     Sad     Angry     Happy     Confused  
 Chaotic     Alone     Excited     Don't really know

What do you think would make things better for you right now? \_\_\_\_\_

\_\_\_\_\_

Have you ever gotten help before?  Yes     No, If yes, from whom? \_\_\_\_\_

How have you coped/made it through hard times in the past?

- Talk     Be alone     Hit something     Yell     Listen to music     Watch TV     Friends

Other: \_\_\_\_\_

Have you ever had thoughts about:  Not wanting to live     Wanting to stop the pain  
 Hurting yourself     Hurting someone else     Other thoughts that worry you     None

Have you ever tried to hurt yourself?  Yes     No

If yes, how? \_\_\_\_\_

When? \_\_\_\_\_

## FAMILY INFORMATION

In your family, do you get along with:

Mother:  Usually  Sometimes  Hardly ever **Other** (Who: \_\_\_\_\_)  Usually  Sometimes  Hardly ever  
Father:  Usually  Sometimes  Hardly ever **Other** (Who: \_\_\_\_\_)  Usually  Sometimes  Hardly ever  
Brothers:  Usually  Sometimes  Hardly ever **Other** (Who: \_\_\_\_\_)  Usually  Sometimes  Hardly ever  
Sisters:  Usually  Sometimes  Hardly ever **Other** (Who: \_\_\_\_\_)  Usually  Sometimes  Hardly ever

Do the adults in your house get along?  Yes  No If yes, how often? \_\_\_\_\_

Do you have a spiritual belief you care to share?  Yes  No If yes, what? \_\_\_\_\_

What would you like me to know about your family? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## SCHOOL INFORMATION

Do you like school?  Yes  No  Sometimes

What do you like about school? \_\_\_\_\_

What do you wish you could change about school? \_\_\_\_\_

What is your favorite subject? \_\_\_\_\_ Least favorite? \_\_\_\_\_

Compared to *last term*, your grades are:  Better  Same  Worse  Too soon to tell

Are you a member of a club, team, or organization?  Yes  No

If yes, what? \_\_\_\_\_

Where do you go/what do you do after school? \_\_\_\_\_

Is there anything else you would like your counselor to know? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Client's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Counselor Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Clinician: \_\_\_\_\_ Date: \_\_\_\_\_

# Anne Salyers-Hudgens, MS, LPCC

## CONSENT TO TREAT A MINOR

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We, (Parents Names) \_\_\_\_\_ and \_\_\_\_\_ are legal custodial parents with decision-making responsibility for (Minor's Name) \_\_\_\_\_, a minor. (If sole legal custodian, please attach a copy of Permanent Court Order Provision.)

We authorize Anne Salyers, MS, LPCC in her capacity as Licensed Professional Clinical Counselor to begin the mental health assessment and treatment of said minor on (Date) \_\_\_\_\_. Authorization will be in effect until such time as this psychotherapeutic relationship is terminated.

As legal custodial parents, we understand that we have the right to information concerning our minor child in therapy, except where otherwise stated by law. We also understand that this therapist believes in providing a minor child with a private environment in which to disclose himself/herself to facilitate therapy. We therefore give permission to this therapist to use her discretion, in accordance with professional ethics and state and federal laws and rules, in deciding what information revealed by my child is to be shared with us. This is my written consent to the mental health assessment and treatment of minor child under the terms stated above.

Both parents must consent for treatment unless the treatment is court ordered (please provide order) or one parent is sole legal custodian (please attach provision).

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness/Provider

\_\_\_\_\_  
Date