

ABC Solutions PAMELA SWANSON, Med., LPC
351 Farallon Dr., Lake Havasu City, AZ 86403
Phone: 928-453-5626 Fax-928-453-8111

Intake

Name _____ Phone _____
SS# _____ E-mail _____

Address _____ City _____ Zip _____

Sex _____ Birth Date _____ Age _____ Marital Status _____ Date of Marriage _____

Name of Spouse or Significant Other _____ Birthdate _____ Age _____

Children's names & Birth Date's _____

Employer _____ Work phone _____ # of years _____

Spouse's (or SO's) employer _____ # of years _____

Current physical health __excellent__ Good __Fair__ Poor. Please explain health concerns

Have you seen a counselor or therapist previously? _____ Where and when? _____

Have you been or are you involved in a 12-step program for alcohol or drug abuse? _____

Where and when? _____

How often in the last month did you drink alcohol? _____

What concerns brought you to counseling? _____

What do you want to see happening as a result of coming here? _____

Psychotropic Medications and dosage _____ Name of
prescribing physician _____ Referral source _____

Do you participate in a regular (3 times/wk) exercise/sports/recreation to keep fit? _____

Have you been dieting to lose weight? _____ Do you smoke cigarettes on a daily basis? _____

Health insurance company _____

Signature _____ Date _____

Client's Informed Consent

I have chosen to receive counseling services. The counselor will be working closely with me to establish a treatment plan and monitor progress. My choice has been voluntary and it is understood that I may terminate counseling at any time.

I understand that there is no assurance that I will feel better. Because counseling is a cooperative effort between the client and the counselor, I will work with the counselor in a cooperative manner to resolve the difficulties for which I sought treatment.

I understand that during the course of counseling, material may be discussed which will be upsetting in nature and that this may be necessary to help resolve the problems.

I understand that confidentiality of records or information collected about me will be held or released in accordance with state laws regarding confidentiality of such records and information.

I understand that state and local laws require that counselors report all cases of physical or sexual abuse or neglect of minors or the elderly and all cases in which there exists a danger to self or others. My records are subject to be released upon a court order from a judge.

I understand I have the following rights:

1. The right to be informed of the various steps and activities involved in receiving services.
2. The right to confidentiality under federal and state laws relating to the receipt of services.
3. The right to humane care and protection from harm, abuse, or neglect.
4. The right to make an informed decision whether to accept or refuse treatment.
5. The right to contact and consult with counsel and select practitioners of my choice and at my expense.

I understand that last minute cancellation and "no shows" increase the overhead cost of services being provided. Therefore, I agree to pay for appointments not canceled at least four hours in advance. No shows are not billable to insurance. It is my responsibility to know if the services rendered are covered by insurance, if there is a deductible, and/or co-pay and agree to pay remaining charges. I understand that accounts going to collections will have an additional 40% surcharge added.

I have read and understand the above.

Client Signature

Additional Client Signature

Witness Signature

I have had been offered a copy of the HIPAA privacy practices information and agree to let my Protected Healthcare Information be shared according to the law.

Client Signature

Please initial which of the following communications are permitted: letter _____, home phone _____, work phone _____, e-mail _____, cell phone _____

Adolescent Checklist of Characteristics

Please mark all the items below that apply to your child. Also feel free to add any others at the bottom. You may add a note or details in the space next to the concerns checked.

- Affectionate
- Argues, talks back smart-alecky, defiant
- Bullies/intimidates, teases, inflicts pain on others, is bossy to others, picks on, provokes
- Cheats
- Cruel to animals
- Concern for others
- Conflicts with parents over persistent rule breaking, money, chores, homework, grades, choices in music/clothes/hair/friends
- Complains
- Cries easily, feelings are easily hurt
- Dawdles, procrastinates wastes time
- Difficulties with parent's significant other/new marriage/new family
- Dependent, immature
- Developmental delays
- Disrupts family activities
- Disobedient, uncooperative, noncompliant, doesn't follow rules
- Distractible, inattentive, poor concentration, daydreams, slow to respond
- Dropping out of school
- Drugs or alcohol use
- Eating—poor manners, refuses, appetite increase or decrease, odd combinations, overeats
- Exercise problems
- Extracurricular activities interfere with academics
- Failure in school
- Fearful
- Friendly, outgoing, social
- Hypochondriac, always complains of feeling sick
- Immature, “clowns around”, has only younger playmates
- Imaginary playmates, fantasy
- Independent
- Interrupts, talks out, yells
- Lacks organization, unprepared
- Lacks respect for authority, insults, dares, provokes, manipulates
- Learning disability
- Legal difficulties—truancy, loitering, panhandling, drinking, vandalism, stealing, fighting, drug sales
- Likes to be alone, withdraws, isolates
- Lying
- Low frustration tolerance, irritability
- Mental retardation
- Moody

- Mute, refuses to speak
- Nail biting
- Nervous
- Nightmares
- Need for high degree of supervision at home over play/chores/schedule
- Obedient
- Obesity
- Overactive, restless, hyperactive overactive out o seat behaviors, restlessness, fidgety, noisiness
- Oppositional, resists refuses, does not comply, negativism
- Prejudiced, bigoted, insulting, name calling, intolerant
- Pouts
- Recent move, new school, loss of friends
- Relationships with brothers/sisters or friends/peers are poor—competition, fights, teasing/provoking, assaults
- Responsible
- Rocking or other repetitive movements
- Runs away
- Sad, unhappy
- Self-harming behaviors—biting or hitting self, head banging, scratching or cutting self
- Speech difficulties
- Sexual preoccupation, public masturbation, inappropriate sexual behaviors.
- Shy, timid
- Stubborn
- Suicide talk or attempt
- Swearing, blasphemies, bathroom language, foul language
- Temper tantrums, rages
- Thumb sucking, finger sucking, hair chewing
- Tics—involuntary rapid movements, noises, or word productions
- Teased, picked on, victimized, bullied
- Truant, school avoiding
- Under active, slow-moving or slow-responding, lethargic
- Uncoordinated, accident-prone
- Wetting or soiling the bed or clothes
- Work problems, employment, workaholism/overworking, can't keep a job
- _____
- _____
- _____

Which of the above characteristics is the one you most want your child to be helped with _____

Adult Checklist of Characteristics

Please mark all the items below that apply and feel free to add any others at the bottom. You may add a note or details in the space next to the concerns checked.

- I have no problem or concern to bring me here.
- Abuse—physical, sexual, emotional, neglect (of children or elderly), cruelty to animals
- Aggression, violence
- Alcohol use
- Anger hostility, arguing, irritability
- Anxiety, nervousness
- Attention, concentration, distractibility
- Career concerns, goals, and choices
- Childhood issues (my own)
- Children, child management, child care parenting
- Codependence
- Confusion
- Compulsions
- Custody of children
- Decision making, indecision, mixed feelings, putting off decisions
- Delusions (false ideas)
- Dependence
- Depression, low mood, sadness, crying
- Divorce separation
- Drug use—prescription medications, over the counter medications, street drugs
- Eating problems—over eating, under eating, appetite, vomiting (see also “weight and diet issues”)
- Emptiness
- Failure
- Fatigue, tiredness, low energy
- Fears, phobias
- Financial or money troubles, debt, impulsive spending, low income
- Friendships
- Gambling
- Grieving, mourning, deaths, losses, divorce
- Guilt
- Headaches, other kinds of pains
- Health, illness, medical concerns, physical problems
- Inferiority feelings
- Interpersonal conflicts
- Impulsiveness, loss of control., outbursts
- Irresponsibility
- Judgment problems, risk taking’ legal matters, charges, suits
- Loneliness
- Marital conflict, distance/coldness, infidelity/affairs, remarriage
- Memory problem
- Menstrual problems, PMS, menopause
- Mood swings
- Motivation, laziness
- Nervousness, tension

- Obsessions, compulsions (thought or actions that repeat themselves)
- Oversensitivity to rejection
- Panic or anxiety attacks
- Perfectionism
- Pessimism
- Procrastination, work inhibitions
- Relationship problems
- School problems
- Self-centeredness
- Self-esteem
- Self-neglect, poor self-care
- Sexual issues, dysfunctions, conflicts, desire differences
- Shyness, oversensitivity to criticism
- Sleep problems—too much, too little, insomnia, nightmares
- Smoking and tobacco use
- Stress, relaxation, stress management, stress disorders, tension
- Suspiciousness, suicidal thoughts
- Temper problems, self-control, low frustration tolerance
- Thought disorganization and confusion
- Threats, violence
- Weight and diet issues
- Withdrawal, isolation
- Work problems, employment, workaholism/overworking, can't keep a job
- _____
- _____
- _____

Please look back over the concerns and choose the one you most want help with:

○ **Consent for Treatment of Minors**

I/We are the legal parents of _____ and give
my/our permission to Pamela Swanson to provide counseling services
to my/our child (children).

Signature Date

Signature Date

This document is only necessary if you want me to get information from a previous counselor psychiatrist, or your Primary Care Physician,

ABC Solutions

Pamela J. Swanson
351 Farallon Dr
Lake Havasu City, AZ 86403

Phone 928-453-5626

Fax 928-453-8111

E-mail: swanson@citlink.net

Confidential Information Release Authorization

I, _____, authorize the two-way release any and all information

Obtained by PAMELA SWANSON and ABC Solutions, and contact named here:

_____ at (phone#) _____

For the purpose of coordination of care.

This release remains in effect until _____ (1 year) or when treatment has ended.

I understand that I can revoke the release at any time.

Client Signature: _____ Date: _____

Provider Signature: _____ Date: _____

The following documents are used once we begin the counseling to assess the usefulness of the counseling and to document change throughout the process..

Outcome Rating Scale (ORS)

Name _____ Age (Yrs): _____ Sex: M / F
Session # _____ Date: _____
Who is filling out this form? Please check one: Self _____ Other _____
If other, what is your relationship to this person? _____

Looking back over the last week, including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels. *If you are filling out this form for another person, please fill out according to how you think he or she is doing.*

Individually

(Personal well-being)

I-----I

Interpersonally

(Family, close relationships)

I-----I

Socially

(Work, school, friendships)

I-----I

Overall

(General sense of well-being)

I-----I

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Session Rating Scale (SRS V.3.0)

Name _____	Age (Yrs): _____
ID# _____	Sex: M / F
Session # _____	Date: _____

Please rate today's session by placing a mark on the line nearest to the description that best fits your experience.

Relationship

I did not feel heard,
understood, and
respected.

I-----I

I felt heard,
understood, and
respected.

Goals and Topics

We did *not* work on or
talk about what I
wanted to work on and
talk about.

I-----I

We worked on and
talked about what I
wanted to work on and
talk about.

Approach or Method

The therapist's
approach is not a good
fit for me.

I-----I

The therapist's
approach is a good fit
for me.

Overall

There was something
missing in the session
today.

I-----I

Overall, today's
session was right for
me.

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The following form is used at the end of counseling to evaluate my effectiveness and help me to improve.

EVALUATION

Please fill out the following evaluation and send anonymously. Thank you for your cooperation.

	Very Satisfied	Satisfied	Dissatisfied	Very Dissatisfied	Not applicable
1) I was scheduled for an appointment in a timely manner.					
2) I was informed of my rights and given a chance to ask questions.					
3) I found the counseling office inviting and pleasant.					
4) The issues for which I sought counseling were addressed.					
5) Assignments were adequately explained.					
6) The counseling met my needs at the time.					
7) Counseling goals were discussed and assessed from time to time.					
8) I would recommend this counselor to others.					
9) I was treated with respect.					
10) Counseling was affordable.					