Threshold Counseling and Coaching, LLC
suzanne berry , LPC

This questionnaire will help me get to know a little more about your situation and how I may be of help to you. If you feel uncomfortable with any question you may leave it blank and we can discuss it when we meet.

Adolescent please fill out pages 1-3, parent/guardian please fill out pages 4-7.

ADOLESCENT INTAKE FORM (ages 12-17)

CLIENT INFORMATION

Name:_____

Date of Birth: _____ Age: _____ ❒ Male ❒ Female

Physical Address: _____

Mailing Address: _____

Phone (Cell): _____ Messages okay?_____

Phone (Home): _____ Messages okay?_____

School: _____ Grade: _____

Race/Ethnic Origin: _____

Religious Preference: _____

PERSONAL STRENGTHS

What activities do you enjoy and feel you are successful when you try?

_____

_____

Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your life? (Please describe)

_____

_____

CURRENT REASON FOR SEEKING COUNSELING

Briefly describe the problem for which you are seeking counseling?

_____

_____

What would you like to see happen as a result of counseling?

_____

_____

COUNSELING/MEDICAL HISTORY

Have you previously seen a counselor? ❒Yes ❒No

If yes, what did you find **most helpful** in therapy? _____

_____

If yes, what did you find **least helpful** in therapy? _____

_____

CHEMICAL USE AND HISTORY

Do you currently use alcohol? _____Yes _____No

If yes, how often do you drink? _____Daily _____Weekly _____Occasionally _____Rarely If yes, how much do you drink? _____(#) per time.

Do you currently use Tobacco? _____Yes _____No

If yes, how much do you smoke/chew? _____

Do you currently use any other drugs? _____Yes _____No

If yes, what drugs do you use? _____

If yes, how often do you use? _____Daily _____Weekly _____Occasionally _____Rarely

Have you received any previous treatment for chemical use? Y/N _____

If so, where did you go?_____

____Inpatient ____Outpatient

ADOLESCENTS (*please answer the following with* Y/N)

Have you ever used more than 1 chemical at the same time to get high? _____

Do you avoid family activities so you can use? _____

Do you have a group of friends who also use? _____

Do you use to improve your emotions such as when you feel sad or depressed?? _____

LEGAL ISSUES

Please list any legal issues that are affecting you or your family at present, or have had a significant effect upon you in the past. _____

FAMILY HISTORY

Are your parents married or divorced? _____

Do you think their relationship is good? (Y/N/Unsure)_____

If your parents are divorced, whom do you primarily live with? _____ How often do you see each parent? Mom_____% Dad _____%.

Did you experience any abuse as a child in your home (physical, verbal, emotional, or sexual) or outside your home? Please describe as much as you feel comfortable.

FAMILY CONCERNS (*Please check any family concerns that your family is currently experiencing*)

	Fighting		Disagreeing about relatives
	Feeling distant		Disagreeing about friends
	Loss of fun		Alcohol or Drug use
	Lack of honesty		Trauma
	Medical Concerns		Infidelity (couple)
	Education problems		Divorce/separation
	Financial problems		Issues regarding remarriage
	Death of a family member		Birth of a child
	Inadequate health insurance		Job change or job dissatisfaction
	Inadequate housing/feeling unsafe		Other

Other concerns not listed above _____

PEER RELATIONS

How do you consider yourself socially: ___outgoing ____shy ____depends on the situation.

Are you happy with the amount of friends you have? (Y/N)_____

Have you ever been bullied? (Y/N) _____

Are your parents happy with your friends? (Y/N)_____ Are involved in any organized social activities (e.g. sports, scouts, music)?

_____

SCHOOL HISTORY

Do you like school? (Y/N)_____

Do you attend regularly? (Y/N)_____

What are your current grades? _____

Do you feel you are doing the best you can at school? (Y/N) _____

Is there anything else you would like me to know: _____

_____

_____

Please note that the information is important for your child's care. Please fill out forms as completely as possible and have them ready before your first counseling session.

ADOLESCENT INTAKE FORM (PARENT SECTION)

Adolescent's Name: _____Date of Birth: _____

Mother's/Guardian's Name: _____ Phone Contact:_____

Mother's/Guardian's Physical Address: _____

Mother's/Guardian's Mailing Address: _____

Father's/Guardian's Name: _____ Phone Contact:_____

Father's/Guardian's Physical Address: _____

Father's/Guardian's Mailing Address: _____

CURRENT HOUSEHOLD AND FAMILY INFORMATION

Name	Relationship (parent, sibling, etc)	Age	Sex	Type (bio, step, etc)	Living with you? Y/N

(If additional space is need please list on the back of page)

Current Reason For Seeking Counseling For Your Adolescent

Briefly describe the problem for which your adolescent is seeking to have counseling for?

_____

_____

What would you like to see happen as a result of counseling?

_____

_____

What is most concerning right now?

_____

_____

COUNSELING HISTORY

Have your son or daughter previously seen a counselor? ❒Yes ❒No

If Yes, where: _____

Approximate Dates of Counseling: _____

For what reason did your son or daughter go to counseling?

_____

_____

Does your son or daughter have a previous mental health diagnosis? _____

What did you find **most helpful** in therapy?

_____

_____

What did you find **least helpful** in therapy?

_____

_____

Has your son or daughter used psychiatric services? Yes____ No____ If yes, who did they see?

_____

If yes, was it helpful? N/A____ Yes____ No_____

Has your son or daughter taken medication for a mental health concern? Yes_____ No _____

Does your son or daughter have other medical concerns or previous hospitalizations? Y/N _____

If so, please describe: _____

CHILD'S DEVELOPMENT

Were there any complications with the pregnancy or delivery of your child?

Yes ___ No ___ If yes, describe:

_____

_____

Did your child have health problems at birth? Yes _____ No _____ If yes, describe:

_____

_____

Did your child experience any developmental delays (e.g. toilet training, walking, talking)? Yes ___ No ___ Not sure_____ If yes, describe:

_____

_____

Did your child have any unusual behaviors or problems prior to age 3?

Yes ___ No ___ Not sure_____ If yes, describe:

_____

_____

Has your child experienced emotional, physical, or sexual abuse?

Yes ____ No ____ Not sure _____ If yes, describe:

_____

_____

CHEMICAL USE

Do you have any concerns with your son or daughter using alcohol or drugs? (Y/N) _____ If yes, please explain your concern:

_____

_____

INTERNET/ELECTRONIC COMMUNICATIONS USAGE

Do you have any concerns with your son or daughter using the internet or electronic communication such as Facebook, Snapchat, Twitter, texting etc? (Y/N) _____ If yes, please explain your concern:

_____

_____

LEGAL ISSUES

Please list any legal issues that are affecting you or your family, son or daughter, at present, or have had a significant effect upon you or your son or daughter in the past.

_____

_____

FAMILY HISTORY

(Please answer the following as best as you can, we understand that you may not be able to answer some of the questions pertaining to the other parent.)

Father's Name: _____Birth Date:_____ Age: _____

Ethnic Origin: _____

Total years of education completed: _____ Occupation: _____

Place of Employment: _____

Military experience? Y/N _____ Combat experience? Y/N _____

Assessment of current relationship if applicable: Poor_____ Fair_____ Good_____

Mother's Name: _____Birth Date:_____ Age: _____

Ethnic Origin: _____

Total years of education completed: _____ Occupation: _____

Place of Employment: _____

Military experience? Y/N _____ Combat experience? Y/N _____

Assessment of current relationship if applicable: Poor_____ Fair_____ Good_____

PARENT'S MARITAL STATUS

❒Single ❒Married (legally) ❒Divorced ❒Cohabitating ❒Divorce in process ❒Separated ❒Widowed ❒Other _____

Length of marriage/relationship:_____ If divorced, how old was your child at time of divorce? _____

If divorced, How much time does your child spend with each parent?

Mother_____%, Father _____%

FAMILY CONCERNS

Please check any family concerns that your family is currently experiencing.

	Fighting		Disagreeing about relatives
	Feeling distant		Disagreeing about friends
	Loss of fun		Alcohol or Drug use
	Lack of honesty		Trauma
	Medical Concerns		Infidelity (couple)
	Education problems		Divorce/separation
	Financial problems		Issues regarding remarriage
	Death of a family member		Birth of a child
	Inadequate health insurance		Job change or job dissatisfaction
	Inadequate housing/feeling unsafe		Other

Have you or anyone in your family experienced any abuse (physical, verbal, emotional, or sexual) inside or outside of your home? Please describe as much as you feel comfortable.

_____

_____

Have you or anyone in your family been treated for issues relating to depression, anxiety, suicide or other mental health disorders? If so, please describe:

_____

_____

YOUR ADOLESCENT'S STRENGTHS

What activities do you feel your son or daughter is successful when they try?

_____

_____

What personal qualities would you say your son or daughter has?

_____

_____

Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your son or daughter's life? (Please describe)

_____

_____

Is there anything else you would like me to know: _____

_____

_____

AGREEMENT FOR SERVICE / INFORMED CONSENT

This document contains important information about my professional services and business policies, including limits of confidentiality. Please read it carefully. When you sign this document, it will represent an agreement between us.

Therapist Background and Qualifications. I have a Bachelor's in Education and a Master's in Counseling. .I am a Licensed Professional Counselor in the state of Colorado. My practice focuses primarily on teens and young adults up to 24 years of age.

Risks and Benefits of Therapy. Participating in therapy can result in a number of benefits to you, including a deeper understanding of yourself and your personal goals, improved relationships with others, and resolution of the specific concerns that are your motivation for beginning therapy. However, therapy can have risks as well as benefits. While the primary goal of therapy may be to improve your well-being, it can also result in considerable discomfort. You may experience uncomfortable feelings such as sadness, guilt, anger, shame, frustration, loneliness, and helplessness. Should you have any concerns regarding your progress in therapy, it is important to let me know.

Records and Record Keeping. The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, or I can prepare a summary for you instead.

Confidentiality. The information disclosed by you in therapy is generally confidential and will not be released to others without your written consent. However, there are a few exceptions. Exceptions to confidentiality, include:

- If there is reason to believe a child, elderly person, or dependent adult is or has been abused.
- If you threaten to commit serious bodily harm to yourself or another person.
- If I am presented with a subpoena or court order that has been signed by a judge.

In any of the above circumstances, I will only reveal the minimum information that is necessary, and I will do my best to inform you of the information being disclosed and to whom it will be provided before I do so.

Minors and Confidentiality. If you are a minor, under the age of 18, your parents may be legally entitled to some information about your therapy. I will discuss with you and your parents what information is appropriate for them to receive and which issues are more appropriately kept confidential.

Fee and Fee Arrangements. A standard session is 55 minutes and the standard fee is $95.00. Sessions longer than 50-minutes are charged for the additional time. If I need to adjust my fees in the future, you will be notified of any fee adjustment in advance.

Sliding scale fees are available on a limited basis. **All fees are due at the time of service.** Please ask if you wish to discuss a written agreement that specifies an alternative payment procedure. If for some reason you find that you are unable to continue paying for your therapy, please let me know. I would be happy to help you to consider any options that may be available to you at that time.

Insurance. If your insurance plan provides reimbursement for out-of-network providers, I can provide you with a statement, which you can submit to your insurance company to receive some insurance reimbursement, depending upon your benefits. You should be aware that insurance companies require that some clinical information is shared in order to reimburse for services. All insurance companies require a clinical diagnosis. Some may require additional information such as treatment plans or treatment summaries. In these instances I will disclose the minimum amount of information required for the requested purpose. You should also be aware that you are responsible for verifying and understanding the limits of your insurance coverage, and that you are responsible for any and all fees not reimbursed by your insurance company. Please let me know if you have any questions or concerns.

Cancellation Policy. Standard policy for most therapists, myself included, is a 24-hour cancellation policy. If you do not show up for your scheduled therapy appointment, and have not notified me at least 24- hours in advance, payment will be required for the full cost of the session. A total of two missed appointments without prior notification may lead to ending the therapy relationship.

Therapist Availability and Emergencies. I will make every effort to return calls within 24 hours (or by the next business day), but cannot guarantee your call will be returned immediately. I am unable to provide 24-hour crisis service. In the event that you are feeling unsafe or require immediate medical or psychiatric assistance, please call 911,or go to the nearest local emergency room. The Colorado Crisis Hotline at (844) 493-8255; or check yourself into the nearest hospital emergency room. You may also call the 24-hour crisis line for your county: Adams County (303) 853-3500; Arapahoe and Douglas Counties (303 779-9676; Jefferson County (303) 425-0300; and Denver County (303) 343-9890. Since enCOURAGE Counseling does not provide after hours service without an appointment, you are solely responsible for any fees incurred in seeking after hour treatment from any counseling agency, center, or emergency room.

Social Media and Telecommunication. Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

Electronic Communication. I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. Threats to

confidentiality include, but are not limited to: 1) the transmission may be intercepted; 2) the transmission may be sent to the wrong recipient; and 3) the e-mail or text message may be accessed by an unauthorized person. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, I will do so. While I may try to return messages in a timely manner, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

Termination of Therapy. Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment, after appropriate discussion with you, if I determine that the psychotherapy is not being effectively used or if you are in default on payment. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. You also have the right to terminate therapy at your discretion. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified therapists. You may also choose someone on your own or from another referral source.

Should you fail to schedule an appointment for four consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued.

CONSENT TO TREATMENT

I, _____, have read *Agreement for Services/Informed Consent*. In signing below, I consent to treatment and agree to abide by its terms during the course of therapy.

Patient Name (please print)

Signature of Patient (or authorized representative) Date

Parental Consent to Treat a Minor

I, _____ (Name of Parent or guardian of child), give my permission for my child, _____ (Full Name of Minor), _____ (Birth Date of Minor), to be treated by Suzanne Berry, LPC in therapy. I also understand that in order for therapy to be successful with any individual, their confidentiality needs to be respected, even in the case of a minor child, with exceptions of if the minor is a danger to him/herself or to others.

I understand that this permission to treat with respect for my child's confidentiality is given with my full consent. This consent will be valid throughout the duration of therapy, or until the following date: _____ (Date consent expires).

_____

Parent or guardian's signature Relationship to minor Today's date

_____

Name and Address of Parent or guardian (Street, City, State and Zip)

_____

Other parent or guardian's signature Relationship to minor Today's date

_____

Name and Address of other parent or guardian (Street, City, State and Zip)

_____

Address of minor (Street, City, State and Zip)