



6797 North High Street, Suite 350, Worthington, Ohio 43085
614.888.9200 tel / 614.888.3239 fax

Client Information (if minor check box)

Therapist Name:

Male Female

First Name

Middle Name

Last Name

Street Address

City

State

Zip

Date of Birth

Home Phone

Work Phone

Cell Phone

IF Parent/Guardian:

First Name

Last Name

Relation to Client

NAME, PHONE # AND RELATIONSHIP OF EMERGENCY CONTACT:

Appointment Status Notification

If you wish to receive an email alert regarding your appointments please fill-in the appropriate fields below.

Email address: _____

Signature of Authorization: _____ Date: _____

By providing my signature I consent and am aware that the email message I receive will contain the client's name listed above. I consent to receive emails notifications regarding the status of my appointment(s).

Feedback

We welcome your comments, complaints, and compliments in person, via phone, letter or via our online survey. If you wish to receive a link to our client satisfaction survey via your email address please check here:

DISCLOSURE OF POLICIES AGREEMENT

PARENTS OF MINOR CLIENTS: It is very important that children have a sense of privacy in their counseling in order for them to be open and honest. A child's right to confidentiality will be honored within the limits of state law. Although parents generally have an unlimited right to information involving their children, the counselor will attempt to disclose information to parents based on the counselor's judgement of what is in the child's best interest from a therapeutic standpoint.

THERAPY CONSIDERATIONS: You should understand that there are various types of therapy that may be involved in your treatment and that there are some risks that may be involved, which could range from feeling uncomfortable to a more intense reaction. The purpose of therapy is to help you handle problems/situations in a constructive way. You should understand that you have the right to discontinue therapy at any time as well as the right to change therapists until you find one with whom you feel comfortable. You should also understand that your therapist can provide you with information on alternative ways to handle your issues, which may include a referral to another therapist who specializes in a specific area, or to an agency that may handle your care in the event that you are unable to fulfill your financial obligations to Directions Counseling Group.

CRISIS SITUATIONS: Directions Counseling Group is not a crisis intervention facility. If a life-threatening or other crisis situation arises, please take the following steps: (1) Call 911 or your local police, (2) Call Netcare at (614) 276-2273. (3) Call your counselor to make them aware of the situation.

INTAKE PROCESS: It is our ultimate goal that you get the help you are searching for. Directions Counseling Group employs numerous counselors to address the various needs of our clients. During our intake process we make every effort to schedule you with a counselor who is best suited to address your unique situation. If you feel uncomfortable directing your concerns to your counselor, please inform our intake staff and we will attempt to find another counselor for you or if necessary an outside referral.

RECORDS RELEASE: Requests for release of records are authorized by our counseling staff and/or the Executive Director. Record retrieval can take up to 2 weeks depending on storage location and administrative processing. Administrative staff will contact the party when the record is ready for pick-up. Costs will be determined by what is allowable under Ohio Revised Code 3701.741.

LEGAL PROCEEDINGS: I understand that my therapist may be required to become involved in legal proceedings involving my therapy (or my child's therapy). In that case, I agree to pay for the therapist's time in preparing for such legal action, including, but not necessarily limited to: traveling to and attending a deposition, hearing, or trial, including any time spent waiting to testify, responding to a subpoena, in addition to any legal fees my therapist may incur as part of my involvement in such legal action.

COLLECTIONS: I understand that if I do not fulfill my financial responsibilities to make payments that I owe to Directions Counseling Group, that Directions Counseling Group may take appropriate collection action against me, up to and including taking legal action to collect amounts due from me. If that happens, I understand that the minimal amount of information necessary for such collection activity will be released and I consent to that release.

NO SHOW/CANCELLATION POLICY: The following fees are assessed for less than 24 hour cancellation and no-show to appointment: 1st no show or less than 24 hour cancellation: \$50.00; 2nd no show or less than 24 hour cancellation (at any time during treatment process): \$65.00; 3rd no show or less than 24 hour cancellation: Full fee. Please leave cancellation messages in general or scheduling voicemail box, NOT counselor's voicemail box.

FEES: All fees are due at time of service. The following list is not an exhaustive list of all services available. You may receive services from us that are not listed. Please consult with our staff to verify fees prior to receiving services from us. Initial Session \$165.00, 60 minutes; Follow-up Session \$135.00, 45-50 minutes; Marriage or Family Session \$145.00, 45-50 minutes; 80-90 minutes \$190.00; 30 minutes \$80.00. Returned check fee: \$40.00. Your fee may differ if a courtesy sliding-fee was previously arranged. All sliding fee arrangements are re-evaluated every six (6) months. Phone calls may be billed in 15 minute increments at the discretion of your therapist.

I have read and agree to the terms of the policies on this page. I have had the opportunity to ask questions about them; and agree to abide by and be bound by them.

PRINT CLIENT NAME

SIGNATURE (Client / Parent / Guardian / Responsible Party)

DATE

Client Medical History and Current Concerns

Client Name: _____

Height: Weight: Recent Weight Gain/Loss:

Number of Children: Allergies:

Date of Last Physical: Physician and phone:

Current Medical Problems:
ALL Current Medications (include dosage, prescribing doctor, and phone number):
Past Medical Problems (include prior mental health treatment and psychotropic medications):

Number of Pregnancies: Use of Alcohol x/week: Use of Caffeine x/week:

Use of Tobacco x/week: Exercise x/week:

What changes or benefits do you hope to obtain from counseling?

- 1.
- 2.
- 3.
- 4.
- 5.

Child Mood Checklist

Child's Name _____ Name of Person Completing Form _____

Date _____ Please circle the number that best describes how often your child has been experiencing these symptoms within the last six months.

	Never or Rarely	Sometimes	Often	Very Often
Persistent sad or irritable mood	1	2	3	4
Lost of interest in activities once enjoyed	1	2	3	4
Significant change in appetite or body weight	1	2	3	4
Difficulty sleeping or oversleeping	1	2	3	4
Psychomotor agitation or retardation	1	2	3	4
Loss of energy	1	2	3	4
Feelings of worthlessness or inappropriate guilt	1	2	3	4
Difficulty concentrating	1	2	3	4
Recurrent thoughts of death or suicide	1	2	3	4
Frequent vague, non-specific physical complaints such as headaches, muscle aches, stomachaches or tiredness	1	2	3	4
Frequent absences from school or poor performance in school	1	2	3	4
Talk of or efforts to run away from home	1	2	3	4
Outbursts (shouting, complaining, unexplained irritability, crying)	1	2	3	4
Being bored	1	2	3	4
Lack of interest in playing with friends	1	2	3	4
Alcohol or substance abuse	1	2	3	4
Social isolation, poor communication	1	2	3	4
Fear of death	1	2	3	4
Extreme sensitivity to rejection or failure	1	2	3	4
Increased irritability, anger, or hostility	1	2	3	4
Reckless behavior	1	2	3	4
Difficulty with relationships	1	2	3	4
Severe changes in mood- either extremely irritable or overly silly and elated	1	2	3	4
Overly-inflated self-esteem; grandiosity	1	2	3	4
Increased energy	1	2	3	4
Decreased need for sleep – able to go with very little or no sleep for days without tiring	1	2	3	4
Increased talking – talks too much, too fast; changes topics too quickly; cannot be interrupted	1	2	3	4
Distractibility – attention moves constantly from one thing to the next	1	2	3	4
Hypersexuality – increased sexual thoughts, feelings, or behaviors; use of explicit sexual language	1	2	3	4
Increased goal-directed activity or physical agitation	1	2	3	4
Disregard of risk – excessive involvement in risky behaviors or activities	1	2	3	4
Excessive anxiety and worry, occurring more days than not about a number of events or activities	1	2	3	4

Finds it difficult to control the worry	1	2	3	4
Restlessness or feeling keyed up or on edge	1	2	3	4
Being easily fatigued	1	2	3	4
Difficulty concentrating or mind going blank	1	2	3	4
Irritability	1	2	3	4
Muscle tension	1	2	3	4
Sleep disturbance (difficulty falling or staying asleep, restlessness, or unsatisfying sleep)	1	2	3	4
Loses temper	1	2	3	4
Argues with adults	1	2	3	4
Actively defies or refuses to comply with adults' requests or rules	1	2	3	4
Deliberately annoys people	1	2	3	4
Blames others for his or her mistakes or misbehavior	1	2	3	4
Touchy or easily annoyed by others	1	2	3	4
Angry and resentful	1	2	3	4
Spiteful and vindictive	1	2	3	4
Impairment in the use of nonverbal behaviors such as eye contact, facial expressions, body postures/gestures	1	2	3	4
Failure to develop peer relationships appropriate to age	1	2	3	4
Lack of spontaneous seeking to share enjoyment, interests, or achievements with other people	1	2	3	4
Lack of social or emotional reciprocity	1	2	3	4
Preoccupation with an interest that is abnormally intense or focused	1	2	3	4
Inflexible adherence to routines or rituals	1	2	3	4
Repetitive motor mannerisms, e.g. hand or finger flapping or twisting	1	2	3	4
Persistent preoccupation with parts of objects	1	2	3	4