KATHLEEN JONES

therapy

CHILD PERSONAL DATA

Name:_____Date:_____

Home Phone:_____Work Phone:_____Cell:_____

Street Address:_____City:_____Zip:_____

Age:_____Birthdate:_____Ethnicity:_____Religion: _____

Mother's Name:_____Work Phone: _____

Father's Name:_____Work Phone: _____

If Divorced, Separated, or Unmarried, Who Has Legal Custody? _____

If Applicable, Describe Custody or Visitation Schedule: _____

Are There Pending Legal, Custody, Probation or Court Issues? Yes [ ] No [ ]

Referred to Counseling by:_____

Pediatrician Name:_____Phone:_____

School:_____Phone:_____

Teacher or Counselor:_____

Name of Emergency contact:_____Phone #:_____

Relationship to child:_____

Has Child Been in Other Counseling? Yes [ ] No [ ]

If Yes, Name and Dates_____

Psychiatric Hospitalization(s) (Where/When/Why):_____

_____

Current Medications/Dosages (Include Over the Counter):_____

_____

Type(s) of Help Desired:

[ ] Individual Counseling [ ] Group Counseling [ ] Family Counseling

[ ] Social Skills Group [ ] Substance Use/Abuse Treatment

[ ] Other_____

Major Reason seeking Help for Child at This Time:_____

_____

How Long Has the Situation with The Child Been Happening?_____

_____

How Often Does the Situation Occur?_____

_____

What Was It That Initiated You to Seek Help for The Child?_____

_____

_____

What Have You Tried to Resolve the Situation?_____

_____

Check Items Below That Apply to Behaviors That Fit Your Child:

[ ] bed wetting

[ ] daydreams/fantasizes

[ ] does not get along

[ ] does not want caretaker out of sight

[ ] excess interest in sex

[ ] expressing wish to die

[ ] fears and/or avoids things

[ ] harms animals

[ ] harms self

[ ] has rituals, habits, superstitions

[ ] inability to pay attention

[ ] inability to sleep alone

[ ] inability to stay asleep

[ ] ingests alcohol and/or drugs

[ ] involved in a gang

[ ] lies

[ ] nightmares/night terrors

[ ] over activity

[ ] over eats

[ ] physically aggressive

[ ] poor appetite

[ ] poor relating to adults

[ ] poor relating to children

[ ] sadness, crying

[ ] self-stimulation sexually

[ ] sleepwalking

[ ] smokes tobacco or drugs

[ ] steals

[ ] temper tantrums

[ ] tiredness/fatigue

[ ] twitches/unusual movements

[ ] wanting to/or runs away

[ ] other

School or Preschool Adjustment:

[ ] usual learning ability

[ ] grades above average

[ ] grades average

[ ] grades below average

[ ] resists going to school

[ ] refuses to go to school

[ ] learning disabilities:_____

[ ] speech therapy

[ ] difficulty reading

[ ] difficulty with math

[ ] difficulty with spelling

[ ] difficulty writing

[ ] discipline problems

[ ] repeated a grade_____

[ ] disrupts class

[ ] inattention in class

[ ] fighting

[ ] suspended

[ ] expelled

[ ] home schooled

[ ] psychological testing

[ ] school counseling

[ ] frequently tardy

[ ] truant

[ ] missed a lot of school

Adjustment in Family:

[ ] Follows Rules

[ ] Gets Along

[ ] Does Chores

[ ] Good Self-Care

[ ] Affectionate

[ ] Joins in with Family

Type of Discipline Used with Child:

List Sports, Activities, Hobbies, and Clubs Child Involved with:

Who Lives with Child Now?

Name	Age	Relationship

List Any Family Members, Living or Dead Who Has Had Any Emotional Problems, Mental Problems, Psychiatric Treatment, Depression, Alcohol, etc.…

Name	Relationship	Problem

List Current or Previous Serious Stressors in Your Family Life:

THE AMEN CLINIC QUESTIONNAIRE

0 = Never 1 = Rarely 2 = Occasionally 3 = Frequently 4 = Very Frequently

____1. Frequent feelings of nervousness or anxiety
____2. Panic attacks
____3. Avoidance of places due to fear of having an anxiety attack
____4. Symptoms of heightened muscle tension (sore muscles, headaches)
____5. Periods of heart pounding, nausea, or dizziness (not w/ exercise)
____6. Tendency to predict the worst
____7. Multiple, persistent fears or phobias (dying, doing something crazy)
____8. Conflict Avoidance
____9. Excessive fear of being judged or scrutinized by others
____10. Easily startled or tendency to freeze in intense situations
____11. Seemingly shy, timid, and easily embarrassed
____12. Bites fingernails or picks skin
____ Total number of questions with a score of 3 or 4 for questions 1- 12

____13. Persistent sad or empty mood
____14. Loss of interest or pleasure from activities that are normally fun
____15. Restlessness, irritability, or excessive crying
____16. Feelings of guilt, worthlessness, helplessness, hopelessness
____17. Sleeping too much or too little, or early morning waking
____18. Appetite changes/ weight loss or weight gain through overeating
____19. Decreased energy, fatigue, feeling "slowed down"
____20. Thoughts of death or suicide, or suicide attempts
____21. Difficulty concentrating, remembering, making decisions
____22. Physical symptoms; headaches, chronic pain, digestive problems
____23. Persistent negativity or low self esteem
____24. Persistent feeling of dissatisfaction or boredom
____ Total number of questions with a score of 3 or 4 for questions 13-24

____25. Excessive or senseless worrying
____26. Upset when things are out of place or don't go according to plan
____27. Tendency to be oppositional or argumentative
____28. Tendency to have repetitive negative or anxious thoughts
____29. Tendency toward compulsive behaviors
____30. Intense dislike of change
____31. Tendency to hold grudges
____32. Difficulty seeing options in situations
____33. Tendency to hold on to own opinion and not listen to others
____34. Needing to have things done a certain way or you become upset
____35. Others complain you worry too much
____36. Tendency to say no without first thinking about the question
____ Total number of questions with a score of 3 or 4 for questions 25-36

____37. Periods of abnormally happy, depressed or anxious mood
____38. Periods of decreased need for sleep, energetic on much less sleep
____39. Periods of grandiose thoughts and ideas (feeling very powerful)
____40. Periods of increased talking or pressured speech
____41. Periods of too many thoughts racing through your mind
____42. Periods of increased energy level
____43. Periods of poor judgment that leads to risk-taking behaviors
____44. Periods of inappropriate social behavior
____45. Periods of irritability or aggression
____46. Periods of delusional or psychotic thinking
____ Total number of questions with a score of 3 or 4 for questions 37–46

____47. Short fuse or periods of extreme irritability
____48. Periods of rage without being provoked
____49. Often misinterprets comments as negative when they are not
____50. Periods of spaciness or confusion
____51. Periods of panic or fear for no specific reason
____52. Visual or auditory changes (seeing shadows or hearing sounds)
____53. Frequent periods of déjà vu (feeling you've been somewhere you have never been)
____54. Sensitivity or mild paranoia
____55. Headaches or abdominal pain of uncertain origin
____56. History of head injury or family history of violence/ explosiveness
____57. Dark thoughts, may be homicidal or suicidal
____58. Periods of forgetfulness or memory problems
____ Total number of questions with a score of 3 or 4 for questions 47-58

____59. Trouble staying focused
____60. Spaciness or feeling like you're in a fog
____61. Overwhelmed by tasks of daily living
____62. Feels tired, sluggish, or slow moving
____63. Procrastination, failure to finish things
____64. Chronic boredom
____65. Loses things
____66. Easily distracted
____67. Forgetful
____68. Poor planning skills
____69. Difficulty expressing feelings
____70. Difficulty expressing empathy for others
____ Total number of questions with a score of 3 or 4 for questions 59-70

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CREDIT CARD AGREEMENT

Please note: New clients are required to keep a valid credit card number on file. Please complete the following information and provide your credit card at your initial session.

CC Type: MC Visa Amex Other _____

Name as shown on card _____

CC Number _____

3-digit security code on back of the card _____

Billing zip code associated with the card _____

Expiration Date _____

This card may be charged for:

_____ Regular session fees (at your request, as a convenience to you)

_____ Fees for cancellation without 24 hours' notice (according to Policy)

_____Delinquent session fees (fees more than 30 days overdue)

Agreement:

"I (print name) have read and understand the terms of providing my credit card to Kathleen Jones, LMFT. I understand that my credit card may be charged for the reasons indicated above. Any questions I have about this practice have been answered."

_____ (Signature) _____(Date)

INFORMED CONSENT AGREEMENT

Therapy involves both benefits and risks. Risks include the possibility of experiencing uncomfortable levels of feelings like sadness, guilt, anxiety, anger, loneliness and helplessness. Therapy often requires recalling experiences, some of which may be unpleasant. Therapy may involve making changes that can feel uncomfortable to you and those close to you. Should you notice any negative effects, please tell me immediately. I will make every effort to remedy the situation or provide you with names of other therapists should you prefer a referral. Psychotherapy has been shown to have benefits for those who undertake it. It often leads to reduction of feelings of distress, and to better relationships and resolution of specific problems. The objective is to find more peace, joy, and healthier relationships.

CONFIDENTIALITY:

As part of the counseling process, I am bound by ethical responsibilities to keep confidential the information shared during the sessions and will not release any information without your written permission. There are important **exceptions to the confidentiality** of the counseling relationship. I am required by law to reveal certain information under the following circumstances:

a) **Disclosure of serious intent to do harm to self or others**
b) **Disclosure of child abuse or my suspicion of child abuse, elder abuse, or dependent adult abuse**
c) **If a court of law orders the release of specific information**

APPOINTMENTS:

The length of a usual appointment is 50 minutes, except for the initial session, which may take 80-90 minutes. Appointments are usually scheduled weekly and on a regular basis until you have accomplished the majority of your goals and other arrangements are made.

CANCELLATIONS AND MISSED APPOINTMENTS:

Cancellation of appointments must be made at least **24 hours in advance**. A credit card number will be taken at the onset of your counseling. Late cancellations will be charged at the regular hourly fee to your credit card. If you have a true emergency your credit card will not be charged.

PAYMENT:

Payment is expected at each session unless other arrangements have been made in advance. I am a licensed therapists with specialized training in individual, couples, family, and trauma therapy. You are responsible for payment for all services rendered either by debit card, credit card, check or cash. All checks and credit cards will be paid to Kathleen Jones, LMFT.

CHECKS/OVERDUE ACCOUNTS:

There is a fifteen-dollar ($15.00) service charge for all checks returned by the bank.

TELEPHONE, TEXT AND EMAIL POLICY:

Generally, I ask that clients reserve discussing problems that arise between sessions for the next scheduled appointment time. I encourage you to use resources you have and to reach out to your support system. Unless there is an emergency, my schedules does not permit me to talk on the phone, respond to lengthy texts or answer lengthy emails in between sessions. If you feel the need to text or email information beyond the routine scheduling of appointments, I will wait to discuss the content in our next scheduled session. If telephone calls are necessary for a client emergency, please schedule a time for a telephone consultation, which will be charged at our regular rates (In 15-minute segments). **Please do not text anything other than appointment times as confidentiality is not secure with texting.**

INSURANCE:

I am what is referred to as an "Out of Network Provider." I do not bill your insurance company and payment is due at each session. However, I will provide a "Super-bill" if you are eligible for re- imbursement from your insurance company. Services may be covered in full or in part by your health insurance company or employee benefit plan.

PHYSICAL EXAMINATION:

I strongly recommend that each client obtain a thorough physical exam prior to commencing therapy. This is especially important if you are suffering symptoms of anxiety or depression, headaches, and/or weight gain/loss. Symptoms may be biologically caused or may be there for a protective reason.

TRAINING AND SUPERVISION:

My training is extensive and I constantly seek more advanced training to be the best therapist for my clients.. Your case may be discussed in a group or individual training format with a licensed supervisor present for feedback, education, and discussion. This is always done in a manner where the client and any identifying information is kept confidential.

EMERGENCIES:

Counseling services are available only during scheduled office hours. In a crisis, you may utilize the Sacramento County Mental Health Crisis Service (phone: 916-875-1000)

If you have any questions about my policies or about psychotherapy, please ask before signing below. Your signature indicates that you have read my policies and agree to enter therapy under these conditions. Further, it indicates your understanding that I may terminate therapy if you do not comply with the policies or if I feel you are not benefiting from treatment.

Client/Parent Signature_____ Date:_____

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Parent Agreement - Consent to treat a minor

Thank you for entrusting me with the psychological care of your child. My role is to help your child develop the coping skills needed to handle the challenges in his/her life, both now and in the future.

California law requires that I do my best to work with both parents of children that I see, when possible. As a result, I attempt to contact both parents and, if necessary, I document reasons for working only with one parent and the steps I have been taking to involve the other parent. If only one parent or a legal guardian signs the form, we I need a copy of the custody order.

The law gives both parents reasonable expectations for information from me regarding their child's progress or lack of it. Also, the law requires that I share specific types of information, i.e. circumstances when a child is behaving in ways that endanger him/herself, others or property. The law grants me the right to withhold information that I believe will result in damage to my professional relationship with the child or will place the child in physical or emotional danger if disclosed. For these reasons, I ask parents to allow me to share only what I am required to by law to share and whatever information the child wishes discussed with parents.

I also want parents to understand that there are two requests I cannot grant, as doing so would endanger their child's safety and the progress of their therapy. 1) I do not confer with attorneys for either side in a divorce or custody dispute (nor do I hold lengthy conferences with one parent that I would not hold with the other parent) and, 2) I do not write letters or make statements regarding what custody or visitation arrangements I believe to be in the best interests of the child. I can and will confer with a child's own attorney, if one has been retained or appointed, or a child's legal guardian, if one has been appointed. I charge a retainer of $1000 if I am subpoenaed to go to court for any reason.

I have read and understood this agreement:

Name of Minor: _____

Parent Name: _____

Parent Signature: _____ Date: _____

Parent Signature: _____ Date: _____