New Growth Counseling Services
Introduction to Family Counseling

Welcome to counseling. We look forward to meeting with you and getting started. People and their situations are often very complex – your therapist will need to understand as much of the context as possible in order to help with a solution. The following paperwork (though extensive) is designed to give your therapist the context quickly. Please complete it and bring it to your initial appointment.

Thank you for completing these forms.

Sincerely,

New Growth Counseling Services

New Growth Counseling Services

Informed Consent for Families with Minors (ages 17 and younger)

Your signature at the bottom of this page means that you understand and consent to the following policies and procedures:

Counseling is a collaborative process between therapist and patient(s) who work together on mutually agreed upon goals. Participation is voluntary and is only effective when both patient(s) and therapist are actively striving for the patient's growth and change. Patients realize that participation in therapy can involve discussing issues that may be distressing – however, therapy is designed to help patients personally and in their relationships. When minors are involved, it may be necessary that parent(s)/guardian(s) participate in the counseling process with their child(ren) at the discretion of the therapist. Some problems may be best resolved with the participation of other family members or close relations.

Appointments are made in advance and start and end on time – a session lasts 50 minutes. If a patient is late, the session will still cost full price and end at the pre-arranged time. 24-hour advance notice is expected for cancellation or rescheduling. Any patient who fails to cancel, cancels at the "last minute," or doesn't attend a regularly scheduled session *will be held responsible for full payment of the missed session.* Lateness, or cancellations made by the therapist will be rescheduled.

Emergencies: in the event of an emergency dial 911 or (888) 724-7240. The therapist will discuss emergencies with you and may provide emergency contact information at their discretion. As a rule, most telephone calls will be returned during normal business hours on weekdays.

Payment is expected at the time of service and will be collected at the beginning of the session. Any check that is returned for insufficient funds will be assessed a $25 fee.

Confidentiality is vital to trust - all sessions are confidential. This means the therapist will not discuss any aspect of the session or case with anyone outside of therapy without prior written consent of patient(s). It is important that a patient (especially children) has a confidential relationship with their therapist.

- **Secrets** within relationships sometimes can be destructive or counter-productive to the goals of therapy. If a patient divulges such a secret to the therapist, the therapist will use his discretion about revealing it. Generally, the therapist will ask the patient to divulge the secret – if the therapist believes the secret is destructive or counter-productive to the counseling process, he may refuse to continue working with the patient until the patient reveals the secret. In cases of danger, the therapist may reveal the secret to maintain safety.

Limits of confidentiality: The following are exceptions to confidentiality and *MUST BE REPORTED* to the appropriate service and/or police. Please note – these reports are mandated by law and may be made without your consent or written permission.

1. If a client(s) become a danger to himself/herself, steps will be taken to keep the client safe.
2. If the client should become a danger to another identifiable person(s), the potential victim(s) will be warned and the police will be notified.
3. Any suspicion of child abuse (including physical, sexual, and/or emotional abuse as well as child neglect or endangerment) whether past or present, previously reported or not, will be reported.
4. Any abuse or neglect of an elder or dependent adult will be reported to Adult Protective Services.

I authorize New Growth Counseling Services staff / therapist to leave voice messages at my home or with a family member or friend regarding appointments, billing issues, or other pertinent information regarding my Behavioral Health Care.

YES / NO (choose one) ____________________
Signature

Only parent(s) or legal guardian(s) can give authorization for the treatment of minors. If both parents have legal custody, both parents' signatures are required for treatment. If someone other than the parent(s)holds guardianship, legal documentation must be presented prior to authorizing treatment If there are legal stipulations (a court order) that both parents must consent to ongoing treatment, I agree to contact the other parent and forward his/her consent for treatment to my child's therapist prior to treatment.

I hereby consent to the treatment of my child(ren):____
Print child(ren) name(s)

I agree to the above policies:____
Parent/Legal Guardian Signature(s) Date

I agree to participate in counseling:____
Child(ren) signature(s) Date

Joint legal custody issues:

A therapist at New Growth Counseling Services (NGCS hereafter) will be providing counseling to your child/children. In order to get started, the paperwork that follows needs to be completed by both parents who have joint legal custody of the children who are coming for counseling (your ex-spouse may visit the website and download the basic joint-legal custody forms – they should be returned to us as soon as possible).

When divorced parents share legal custody, they are usually entitled to be involved in the mental health care of their child. This does not mean that both parents will be involved in the counseling process – it just means that both parents consent and know that they are entitled to know about their child's mental health progress if they so choose.

Joint legal custody is defined by the courts – typically, it applies to the two biological parents of a child (or children) who have divorced, and gives each parent the ability to make decisions on behalf of their child/children. The court decides who has legal custody and notes this on the divorce documentation. Legal custody is not the same as visitation, physical custody, or where the child resides.

When a divorce has occurred, contact between former spouses can result in tension. To limit this NGCS takes the following position and set the following boundaries:

1. When a couple divorces, they essentially create two separate families – the child belongs to both families, but each spouse is typically excluded from the other – this is the basic premise of a divorce.
2. NGCS is typically open to hearing from both parents, though this is not required. Both parent's views on their child's mental health and behavior is important information. The exceptions are extreme cases where NGCS may deem such communication unhelpful to the therapeutic process (e.g., the other parent is incarcerated, or is incapacitated due to chronic drug addiction).
3. NGCS works directly with the family that initiates the counseling process, because they are the family who has sought help for their situation. NGCS works indirectly with the other parent, if they want to be involved.
4. If both parents are "friendly with each other" it is occasionally possible and sometimes helpful to have meetings that may involve both parents – this is rare, but in some cases, when all parties agree, it can be helpful. It is not required, however, and is dependant solely on the situation presented.
5. If both parents are "not friendly with each other" and NGCS deems that they are incapable of working together, or that the direct involvement of both parents in counseling is detrimental, the NGCS will limit their work to the family that contacted NGCS for help. However, NGCS may remain open to communication with the other parent.
6. There are extreme situations in which NGCS would not be open to communications from the other parent who may have legal custody (child abuse, incest, violence, other forms of abuse or danger). This is a matter of state law which gives mental health professionals discretion as to limit-setting within family therapy.

I have joint legal custody of ____

Child or children's name(s)

I understand what is written above ____

Parent with joint legal custody

New Growth Counseling Services

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I understand that New Growth Counseling Services (NGCS hereafter) uses administrative staff to perform basic clerical and bookkeeping duties that are ordinary and typical to run a therapy practice. NGCS clerical staff will ONLY have access to the following types of information about those attending therapy:

1. Demographic information (names, addresses, telephone numbers, dates of birth, etc.) taken from client intake questionnaire.
2. Billing information (names, dates, charges, payments, payment methods, diagnostic codes, etc.).
3. Emergency contacts – in the unlikely event that your therapist becomes so ill or incapacitated that he/she is unable to contact me/us, staff may contact me/us regarding logistical issues (for example, staff may call to cancel an appointment when my therapist is sick).

Clerical staff will not have access to information about the content of counseling and therapy sessions. Clerical staff will not have access to information about any communications (such as telephone, email, mail) that pertain to counseling and therapy matters.

I further understand that administrative staff will send me a monthly statement which acts as a receipt for payments received. It includes billing information (such as a diagnosis, billing codes, patient name, etc.) and is typically sent to me via email. Please check only one:

☐ I will accept monthly statements by email. Please send them to the following email address:

please print clearly: ____

☐ I do not want my monthly statement sent via email. Please give them to me directly at sessions.

Signature: ___________________________________ Date: _______________________

Signature: ___________________________________ Date: _______________________

Email / text communications with New Growth Counseling

Please read the following disclosures about communicating with **New Growth Counseling** (NGCS):

1. NGCS does not conduct therapy, give advice, or communicate about therapy via email, text, instant message, or any other "telemedicine" technologies. Therapy is face-to-face. NGCS will only use texts/emails for the purposes of arranging meetings. If you have an urgent need to connect with your therapist and want a response, you must call by phone. NGCS will make every attempt to respond to your call in a timely manner.
2. Employees of NGCS may opt-out of texting or emailing with you for various reasons. They may also participate in texting and emailing with you. This is handled individually between you and the person you are working with.
3. Email /texting and other forms internet-based communications are non-secure and non-confidential form of communication. Hackers and unauthorized users can also attempt to access emails through malicious software such as spyware or a virus that may be located on your computer unbeknownst to you. Other people may look at your computer/phone when you are not aware.
4. Many people still feel comfortable communicating via email / text because they have taken measures to secure their computer/phone. Despite this fact, there is no guarantee that such measures will work 100%.
5. Emails /texts sent and received are stored on computers / phones of NGCS clinicians and on your computer until deleted. NGCS may or may not delete such emails and texts.
6. In addition, whenever you send an email/ text, it is stored in cyberspace and the authorities can access these emails / texts under various circumstances – this is not a policy of NGCS, but is due to the nature in which email / texts are transmitted using the internet and other services or networks. For more information on this, please contact your Internet Service Provider, email service, or cell phone provider.

By signing below, I agree that I understand the disclosures listed above regarding communicating with NGCS using email or text. I also agree that if I send an email / text to NGCS and request a response via email, that I am willing to accept the above-stated risks:

If you do not want to correspond via email do not sign your name – instead, write "declined."

Print Name:____________________________Signature_______________________________Date:__________

Print Name:____________________________Signature_______________________________Date:__________

Permission for NGCS to initiate emails /texts to you

Sign below if you give your permission for NGCS to initiate sending emails/ texts to you. Example: NGCS may be the first one to send an email / text to you to cancel an appointment due to sickness. If you do not wish to have NGCS initiate emails to you, do not sign your name – instead, write "declined."

Print Name:____________________________Signature_______________________________Date:__________

Print your email clearly:____

Print Name:____________________________Signature_______________________________Date:__________

Print your email clearly:____

Caregiver's Authorization Affidavit

This form does NOT need to be completed if you are the biological parent of the child.
This form is for caregivers or guardians who are not biological parents of the child.

Use of this affidavit is authorized by Part 1.5 (commencing with Section 6550) of Division 11 of the California Family Code.

Instructions: Completion of items 1-4 and the signing of the affidavit is sufficient to authorize enrollment of a minor in school and authorize school-related medical care. Completion of items 5-8 is additionally required to authorize any other medical care (including mental health treatment). Please PRINT clearly.

The minor named below lives in my home and I am 18 years of age or older.

1. Name of Minor:____
2. Minor's date of birth:____
3. My name: ____
4. My home address: ____
5. [ ] I am a grandparent, aunt, uncle, or other qualified relative of the minor (see definitions below).
6. Check one or both (for example, if one parent was advised and the other cannot be located):
   [ ] I have advised the parent(s) or other person(s) having legal custody of the minor of my intent to authorize medical care and have received no objections.

   [ ] I am unable to contact the parent(s) or other person(s) having legal custody of the minor at this time to notify them of my intended authorization.

7. My date of birth: _________________
8. My California driver's license or identification card number: ____

Warning: Do not sign this form if any of the statements above are incorrect, or you will be committing a crime punishable by a fine, imprisonment, or both.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct:

Dated: _______________________ Signed: ____

DEFINITIONS/NOTICES

1. This declaration does not affect the rights of the minor's parents or legal guardian regarding the care, custody, and control of the minor, and does not mean that the caregiver has legal custody of the minor.
2. A person who relies on this affidavit has no obligation to make any further inquiry or investigation.
3. The affidavit is not valid for more than one year after the date on which it is executed.

TO CAREGIVERS:

1. "Qualified relative" for purposes of item 5, means a spouse, parent, stepparent, brother, sister, stepbrother, stepsister, half-brother, half-sister, uncle, aunt, niece, nephew, first cousin, or any person denoted by the prefix "grand" or "great" or the spouse of any of the persons specified in this definition, even after the marriage has been terminated by death or dissolution.
2. The law may require you, if you are not a relative or a currently licensed foster parent, to obtain a foster home license in order to care for a minor. If you have any questions, please contact your local department of social services.
3. If the minor stops living with you, you are required to notify any school, health care provider, or health care service plan to which you have given this affidavit.
4. If you do not have the information requested in item 8 (California driver's license or ID) provide another form of identification such as your social security number.

TO HEALTHCARE PROVIDERS:

1. No person who acts in good faith reliance upon a caregiver's authorization affidavit to provide medical or dental care, without actual knowledge of facts contrary to those stated on the affidavit is subject to criminal liability or to civil liability to any person, or is subject to professional disciplinary action, for such reliance if the applicable portions of the form are completed.
2. This affidavit does not confer dependency for health care coverage purposes.

Patient Information

Today's Date	Completed by	Relationship to patient

First Name (patient)	Last Name	M.	Date of Birth	Place of Birth

Full Address (street, city, state, zip)	home telephone	OK to leave message?
		Yes / No

Religion / Denomination	Race / Ethnicity	Gender	current grade level
		M / F	

Name of Patient's Current School and city of school	Grade Level	Current GPA	Length at school

Former School name and city	length attended	reason left:

Former School name and city	length attended	reason left:

All minors (17 and younger) have legal custodians or guardians – usually these are the biological parents. In the case of divorce, remarriage, adoption, or children living with other family members/adults, the legal custody or guardian is established by the courts. Please list all the parents and guardians of this patient (both living and deceased):

Full Name / Street address / City / State / Zip	male / female living / deceased
	Has **Full / Partial / No** legal custody?
Date of birth / age / primary telephone / other phone	Been divorced? ----------------------Y / N
	Been remarried? ---------------------Y / N
Occupation / current employer / length at job / hours worked / week	Biological parent of patient? -------Y / N
	Step-parent of patient? ------------- Y / N
	Adoptive parent of patient----------Y / N
	Other family member? ------------- Y / N

Full Name / Street address / City / State / Zip	male / female living / deceased
	Has **Full / Partial / No** legal custody?
Date of birth / age / primary telephone / other phone	Been divorced? ----------------------Y / N
	Been remarried? ---------------------Y / N
Occupation / current employer / length at job / hours worked / week	Biological parent of patient? -------Y / N
	Step-parent of patient? ------------- Y / N
	Adoptive parent of patient----------Y / N
	Other family member? ------------- Y / N

Full Name / Street address / City / State / Zip	male / female living / deceased
	Has **Full / Partial / No** legal custody?
Date of birth / age / primary telephone / other phone	Been divorced? ----------------------Y / N
	Been remarried? ---------------------Y / N
Occupation / current employer / length at job / hours worked / week	Biological parent of patient? -------Y / N
	Step-parent of patient? ------------- Y / N
	Adoptive parent of patient----------Y / N
	Other family member? ------------- Y / N

Full Name	Street address	City / State / Zip	
Date of birth / age	primary telephone	other phone	
Occupation	current employer	length at job	hours worked / week

male / female   living / deceased
Has **Full / Partial / No** legal custody?
Been divorced? ----------------------Y / N
Been remarried? ---------------------Y / N
Biological parent of patient? -------Y / N
Step-parent of patient? ------------- Y / N
Adoptive parent of patient----------Y / N
Other family member? ------------- Y / N

The following questions are being asked of you, the parent, and your current spouse/ partner.

	yourself	**your current spouse or partner**
race / ethnicity		
religion / denomination		
date of birth		
sexual orientation		
names & ages of children conceived with current spouse/ partner		
names & ages of children conceived with previous spouse(s)/ partner(s)		
highest level school completed		
current occupation		
current employer / school		
hours worked each week		
how long worked here?		
second jobs		
how long at this job?		
hours worked each week		
any problems at work / school?		
unemployed?		
why?		
how long unemployed?		
last physical exam date		
results of exam?		
current physical problems		

	yourself	Your current spouse / partner
any head injuries / seizures? when?		
any major illness past or present? what & when?		
any operations? what & when?		
any prior hospitalizations? for what & when?		
any family history of alcoholism?	**Y / N** who?	**Y / N** who?
any family history of depression?	**Y / N** who?	**Y / N** who?
any family history of mental illness?	**Y / N** who?	**Y / N** who?
list personal strengths		
list personal weaknesses		
list personal hobbies		

Please list **everyone** who lives in the household at least two days / week - please list from oldest to youngest

Full name	Date of Birth	Age	School / occupation

Emergency contact – other than spouse	Phone	City	Relationship to patient

Why are you coming to counseling at this time?____

____

____

____

Are you being pressured to come to counseling? By whom and why?________________________________

____

Have you been referred? **Yes / No** by whom?____

May your therapist have your permission to thank the person who referred you? **Yes / No** ____________________

signature authorization

What problems are you wanting to address in counseling?:____

____

____

____

How long have these problems existed? ____

____

____

What makes these problems worse? ____

____

____

What makes these problems improve? ____

____

____

Overall, how motivated are you to change these problems? **Circle one:**

Very motivated----------------------------not motivated
10 – 9 – 8 – 7 – 6 – 5 – 4 – 3 – 2 – 1

What do you expect from therapy?____

____

____

Is anyone currently getting counseling? **Yes / No** Who?_________________ why?_________________________

for how long?_________________ With whom?________________________ telephone ____________________

Any hospitalizations for mental health reasons? **Yes / No** who?____

When?_______________________ Why? _________________________________ Where?___________________

Has anyone received help for any drug / alcohol use? **Yes / No**

who? _________________ what for? ___________________________________ when?________________________

who? _________________ what for? ___________________________________ when?________________________

Is anyone currently under the care of a physician for physical problems? **Yes / No** **w**ho?___________________

For what? _______________________________With whom? ___________________telephone:_______________

Name of patient's primary physician_________________________________ Telephone_____________________

Has anyone ever been arrested and/or committed a crime? **Yes / No** who?_______________________________

When ___________________________ For what?____

Outcome of situation____

If need be, would other relatives be willing to come into therapy sessions? **Yes / No**

If not why?____

____

____

____

____

Problems and Other Symptoms

Please check any of the following which may apply to **anyone who the child/children live with (include ex-spouse's household if applicable).** Please check issues even if they do not relate to the primary reasons you are coming to counseling.

☑	problem	who has problem?		☑	problem	who has problem?
	alcohol use				inability to relax	
	angry outbursts				legal matters	
	anorexia or bulimia (past / present)				loneliness	
	anxiety				loss of interest in things	
	bad dreams				loss of sexual interest or desire	
	boredom				marriage problems	
	can't get motivated to do things they usually enjoy				memory problems	
	career choices				nervousness	
	crying easily				overeating	
	depression				parent - child conflict	
	difficulty concentrating				poor appetite	
	difficulty falling asleep or staying asleep				poor or decreased ambition	
	difficulty getting up in the morning				pornography use	
	difficulty making decisions				preoccupation with death	
	difficulty parenting				school problems	
	divorce				self-confidence	
	drug use				self-mutilation	
	easily annoyed or irritated				sexual problems	
	energy problems				shyness	
	extreme fear of places or events				stuttering	
	faintness or dizziness				suicidal attempts	
	fatigue				suicidal thoughts	
	feeling fearful				thoughts hard to get rid of	
	feeling inferior to others				trouble remembering things	
	feeling tense or nervous				uncontrollable outbursts of temper	
	financial problems				unhappiness	
	friendship problems				violent behavior	
	gambling				violent thoughts	
	guilt				work problems	
	impulsiveness				worrying about things	

Medication Survey

Current **Non-Psychiatric** Medications

person taking medicine	medicine	dose	purpose	how long on this medicine?

Current **Psychiatric** medications

person taking medicine	medicine	dose	purpose	how long on this medicine?

Previous Psychiatric Medications

Please list each drug chronologically, starting with the first medication ever given for an emotional problem

person taking medicine	medicine	dose	purpose	how long on this medicine?

Summary of Prior Counseling / Psychotherapy

Please begin with the FIRST therapist you ever had and move forward to the most recent therapist if you need more room, use back side.

	name of therapist and degree (MD, PhD, MFT, etc.)	start & end dates -- how often did you meet? (weekly?)	reasons for seeking treatment -- reasons for stopping treatment	what type of therapy? was it helpful? did you have any negative reactions?
1				
2				
3				
4				
5				
6				
7				

Substance use Checklist – Name_______________

(any adults who live with patient must complete this form)

	I consume alcohol….
	never
	1time/ month
	2-4 times / month
	2-4 times / week
	daily

	When I drink, I usually drink….
	none
	1-2 drinks or beers
	2-3 drinks or beers
	3-4 drinks or beers
	5+ drinks or beers

	I get drunk….
	never
	1x/ month
	1-4x/month
	2-4x / week
	daily

	I've been drinking like this for the...
	last month
	2-6 months
	6-12 months
	more than a year
	more than 3 years

	My drinking has resulted in one or more of the following...
	passing out
	sleep disturbances
	can't stop once I start
	blackouts
	relationship problems
	binges
	work/school problems
	seizures
	Assaults &/or arrests
	physical withdrawal
	legal problems
	medical complications

	The following apply to me (check all that apply)
	I rarely or never drink – not even socially
	I'm an occasional/ social drinker
	I'm not sure if I have a problem
	I probably have a problem
	I have a problem, and I want to stop
	I have a problem, but I don't want to stop

	I've tried to control my drinking with....
	Nothing!
	I stopped on my own
	I've attended AA / other 12-step program a **few times**
	I've attended AA / other 12-step program a **regularly**
	I attended day or outpatient treatment
	I attended inpatient / residential treatment
	I attended a community-based program (e.g., church program, etc.)
	I was forced to attend treatment of some kind

I currently use / I once used / I only ever tried….

	only tried	used regularly	age started	age stopped
none				
pot				
sedative				
stimulant				
cocaine				
meth				
inhalants				
Heroin/ opium				
prescription drugs				
LSD, mushrooms				
other				

	The following apply to me (check all that apply)
	I don't gamble
	I gamble occasionally
	I like to gamble
	Gambling has caused me problems
	I have gambled until all my money was gone
	I have gambled more than I planned to
	I like to gamble to escape worry or trouble
	I have borrowed money in order to gamble
	At times I've felt remorse after gambling
	I've lost time from work or school due to gambling

Substance use Checklist – Name_______________

(any adults who live with patient must complete this form)

	I consume alcohol….
	never
	1time/ month
	2-4 times / month
	2-4 times / week
	daily

	When I drink, I usually drink….
	none
	1-2 drinks or beers
	2-3 drinks or beers
	3-4 drinks or beers
	5+ drinks or beers

	I get drunk….
	never
	1x/ month
	1-4x/month
	2-4x / week
	daily

	I've been drinking like this for the...
	last month
	2-6 months
	6-12 months
	more than a year
	more than 3 years

	My drinking has resulted in one or more of the following...
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	seizures
	Assaults &/or arrests
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	legal problems
	medical complications

	The following apply to me (check all that apply)
	I rarely or never drink – not even socially
	I'm an occasional/ social drinker
	I'm not sure if I have a problem
	I probably have a problem
	I have a problem, and I want to stop
	I have a problem, but I don't want to stop

	I've tried to control my drinking with....
	Nothing!
	I stopped on my own
	I've attended AA / other 12-step program a **few times**
	I've attended AA / other 12-step program a **regularly**
	I attended day or outpatient treatment
	I attended inpatient / residential treatment
	I attended a community-based program (e.g., church program, etc.)
	I was forced to attend treatment of some kind

I currently use / I once used / I only ever tried….	only tried	used regularly	age started	age stopped
none				
pot				
sedative				
stimulant				
cocaine				
meth				
inhalants				
Heroin/ opium				
prescription drugs				
LSD, mushrooms				
other				

	The following apply to me (check all that apply)
	I don't gamble
	I gamble occasionally
	I like to gamble
	Gambling has caused me problems
	I have gambled until all my money was gone
	I have gambled more than I planned to
	I like to gamble to escape worry or trouble
	I have borrowed money in order to gamble
	At times I've felt remorse after gambling
	I've lost time from work or school due to gambling