Child and Adolescent Client Information

Child's Full Name_____Date of Birth_____Age_____Sex: _____Race: _____

School:_____Grade:_____School Counselor:_____

Parents/Guardians:_____Legal Documentation Provided : _____

Address_____

City_____State_____Zip_____Email: _____

Phone: Home_____WK_____Cell_____

List only numbers you give consent for me to contact you or leave a message.

Emergency Contact & Relationship:_____

Family History

Parents

Parents are / were married ____ years.

Are parents divorced? ____Yes ____No If yes, how old was the child at time of divorce:

_____

Are parents married? ____Yes ____No If no, who has legal custody:

_____

Is there any significant information about the parents' relationship or treatment towards the child which might be beneficial in counseling: ____Yes ____No

If yes, explain: _____

Parent with whom child lives: Both ____Mother ____Father ____Neither__**Court Documentation Provided**____

Mother's Name_____

___Natural parent ___Step-parent ___Adoptive parent ___Foster parent Other: _____

Is there anything unusual or stressful about the child's relationship with the mother? ____Yes ____No

If yes, explain:

_____

Occupation_____Employer_____Highest Level of Education:_____

Father's Name_____ _____

___Natural parent ___Step-parent ___Adoptive parent ___Foster parent Other: _____

Is there anything unusual or stressful about the child's relationship with the father? ____Yes ____No

If yes, explain:

_____

Occupation_____Employer_____Highest Level of Education: _____

Siblings and Others in Household

Names of Siblings	*Age*	*Gender*		*Lives*		*Quality of Relationship*		
		M	F	Home	Away	Poor	Average	Good
_____	____	__	__	____	____	____	____	____
_____	____	__	__	____	____	____	____	____
_____	____	__	__	____	____	____	____	____
_____	____	__	__	____	____	____	____	____

Significant Individuals in Child's Life (friends, family members, teachers, neighbors, etc.)

1)Name: _____ Relationship to Child:_____
2)Name: _____ Relationship to Child: _____
3)Name: _____ Relationship to Child:_____

Please Check all that apply.

- ☐ Headaches
- ☐ Sleep problems
- ☐ Memory problems
- ☐ Heart palpitations
- ☐ Depression
- ☐ Feeling tense or nervous
- ☐ Academic concerns
- ☐ Worries about money
- ☐ Having a lack of friends
- ☐ Feelings of panic , fear, phobias
- ☐ Feeling sad or depressed
- ☐ Feeling restless
- ☐ Low self-esteem
- ☐ Aggression
- ☐ Chest pain
- ☐ Sexual concerns
- ☐ Ideas of harming others
- ☐ Feeling tired
- ☐ Isolating self
- ☐ Feeling shy around others
- ☐ Stomach problems
- ☐ Trouble concentrating
- ☐ Grief or loss
- ☐ Feelings of hopelessness
- ☐ Disturbing thoughts
- ☐ Mood swings
- ☐ Suicidal thoughts
- ☐ Sexual identity concerns
- ☐ Memory problems
- ☐ Abusing others
- ☐ Problems at home
- ☐ Antisocial or illegal behavior
- ☐ Abused by others
- ☐ Disorganized thoughts
- ☐ Impulsive
- ☐ Blaming or criticizing self
- ☐ Anxiety
- ☐ Distractibility
- ☐ Drug use
- ☐ Not confident
- ☐ Concerned about eating habits
- ☐ Alcohol use
- ☐ Nightmares
- ☐ Feelings of worthlessness
- ☐ Hallucinations
- ☐ Recurring thoughts
- ☐ Trembling
- ☐ Anger
- ☐ Chronic pain
- ☐ Dizziness
- ☐ Feeling a need to be on the go
- ☐ Concerned about family members
- ☐ Sick often
- ☐ Relationship Problems
- ☐ Poor Judgment
- ☐ Irritability

Medical

List any medication your child is on and prescribing physician:

_____

_____

List any medical conditions the child has been diagnosed with and / or any surgeries:

_____

_____

Developmental / Social

List your child's three greatest strengths:

_____

_____

_____

List your child's three needed areas of improvement:

At Home:	At School:
1)_____	1)_____
2)_____	2)_____
3)_____	3)_____

Briefly describe the child's friendships/peer relationships:

_____

_____

Briefly describe the child's hobbies or interests:

_____

_____

What report card grades does the child usually receive?

_____

Have these changed lately? ____Yes ____No If yes, how:

_____

Referred By:_____

Reason for Referral:_____

_____

Legal Guardian or Client Signature_____Date:_____

Client Name _____ Date _____

Background Information (If you or any of your family members has a history of any of the following, please indicate and briefly describe.)

Mental health problems/diagnosis ____ Yes ____No

_____

_____

Psychiatric hospitalizations ____ Yes ____ No

_____

_____

Substance abuse problems ____ Yes ____No

_____

_____

History of physical, emotional, and/or sexual abuse ____ Yes ____ No

_____

_____

Criminal background/Legal problems ____ Yes ___ No

_____

_____

Family history of suicide/suicide attempts ___ Yes ___ No

_____

_____

Client history of suicide attempts ___ Yes ___No

_____

_____

Briefly describe your educational background and list your current place of employment.

_____

_____

In the past two years, have you experienced any deaths, losses, serious illness, or any other significant changes in your family that have affected you?

_____

_____

Do you have any medical problems and/or ongoing illnesses? ___ Yes ___No (If yes, please explain.)

_____

_____

Please list any other information that you would like your counselor to know about you.

_____

_____

Screening Form

1. I've been thinking about suicide. _____YES NO
2. I have attempted suicide. _____YES NO
3. I'm thinking about harming someone. _____YES NO
4. People describe me as violent. _____YES NO
5. I have flashbacks from a terrible experience. _____YES NO
6. I've lost interest since the time something terrible happened. _____YES NO
7. I am being abused (physically, emotionally, and/or sexually) _____YES NO
8. My safety is being threatened by another person. _____YES NO
9. My use of alcohol negatively affects my life. _____ YES NO
10. I use drugs. _____YES NO
11. I see or hear things others can't. _____YES NO
12. People are out to get me. _____ YES NO
13. People say that my worrying interferes with my life. _____ YES NO
14. Changes in my routine cause too much stress. _____ YES NO
15. My thoughts and speech are so fast others can't follow. _____YES NO
16. People say I have too much energy. _____YES NO
17. I have purposefully cut on myself. _____YES NO
18. I often feel abandoned. _____YES NO
19. I find myself crying for no reason. _____ YES NO
20. Things are hopeless. _____YES NO
21. I engage in binge-eating and/or purging. _____YES NO
22. People have expressed concern about my weight. _____YES NO

For Counseling Staff Only

__SH	__AB	__AN	__DE
__AG	__SA	__MA	__ED
__TR	__PE	__BO	

DECLARATION OF PRACTICES AND PROCEDURES

The Clinic for Counseling and Personal Development
200 East Devalcourt St., Lafayette, LA 70506
(337) 482-1018

Qualifications: Staff members of The Clinic for Counseling and Personal Development include licensed counselors through the Louisiana Licensed Professional Counselor Board of Examiners, 8631 Summa Avenue, Suite A, Baton Rouge, Louisiana 70809, Telephone (225) 765-2515, and counseling intern and practicum students currently enrolled in the Counselor Education Graduate program at the University of Louisiana at Lafayette. Intern and practicum students are provided direct supervision by board approved supervisors.

Clinical Staff:

Marc Bourgeois, Ph.D., LPC #4930
Irv Esters, Ph.D., LPC-S #2147
Katie Hermann, Ph.D., PLPC
Latifey LaFleur, Ph.D., LPC-S # 3030
David Spruill, Ph.D., LPC-S, LMFT

Clinic Interns

The Clinic for Counseling and Personal Development (CCPD) is the clinical training facility for the students of the Counselor Education graduate program at the University of Louisiana at Lafayette. Graduate level counselor interns and practicum students working under faculty supervision provide short-term, goal-directed counseling and related services to the students, faculty, and employees of UL Lafayette and their immediate families. The services offered include:

● Individual and group counseling ● Family and couples counseling ● Child and adolescent counseling
● Career assessment services ●Consultation and outreach services ● Clinical supervision training

Clients Served: The counselors work with adults and children 4 years and older. When minors are involved, parent(s) or guardian(s) may be asked to participate in the counseling process with their child(ren) as needed and at the counselor's discretion. Some presenting issues may also require the participation of other family members or close relations.

Counseling Relationship: The relationship between the counselor and the client will be one of respect, professionalism, openness, and safety. Counseling is a collaborative process between counselor and client(s) who work together on mutually agreed upon goals. The time-frame for treatment and counseling goals will be established together between client(s) and counselor during the first four sessions of counseling. Counseling is to happen within the 50 minute session, and contact outside of session is reserved for scheduling purposes only.

What to Expect from Counseling: The goal of counseling is for the client to make changes necessary so that his/her presenting issue no longer exists or is no longer a problem. The counselor facilitates changes that the client has chosen; however, responsibility for change

ultimately rests with the client. Goals/objectives for the counseling sessions will be established together with the client(s) and counselor(s). With the counseling experience being goal-directed, we will set and work towards short-term (1-3 weeks), mid-term (3-6 weeks), and long-term (6-9 weeks) objectives. *As we work together, if you have suggestions or concerns about your counseling, I expect you to share these with me so that we can make the necessary adjustments.* The overall objective for counseling is always the successful resolution of the issues that are deemed the most important through the collaborative process. "Homework" is a vital part of the therapeutic process. The completion of homework is necessary if the client is to get the most from the therapeutic experience.

Co-Therapy: The Clinic for Counseling and Personal Development now offers co-therapy to our clients. With the option of co-therapy, clients will be awarded the unique opportunity of having two counselors per client/couple/family. Both counselors will sit in each session with you and offer a variety of insights for a more collaborative experience.

Client Responsibilities: Clients must make their own decisions regarding such issues as deciding to marry, separate, divorce, reconcile and how to set up custody and visitation. That is, we will help you think through the possibilities and consequences of decisions, but our Code of Ethics does not allow us to advise you to make a specific decision.

If you are currently receiving services from another mental health professional, we expect you to inform us of this and grant us permission to share information with this professional so that we may coordinate our services to you. If it develops that another provider would better serve you, we will assist you with the referral process.

Appointments are usually scheduled one time a week for approximately 30-50 minutes, with the first session devoted to gathering necessary information. The entire counseling process may take on average 4 to 12 sessions. However, each client is different and the frequency of sessions as well as the average number of sessions may differ from client to client based on the need and the nature of the problem.

Cancellation Policy: Please give your counselor a 24 hour notice prior to cancellation. Due to scheduling restrictions, it is not guaranteed that your counselor can see you outside of your weekly scheduled time.

Scheduling Policies: Appointments are typically set to recur at the same time and date on a weekly basis, but will be discussed at the close of each session. If you arrive late, your session may be shortened in order to accommodate others whose appointments follow yours. No appointments shall run into the next hour if another client is waiting.

Attendance: The Clinic for Counseling and Personal Development is currently utilizing a waiting list. Because of this, the time of our counselors is valuable. If clients accumulate a total of 3 non-emergency cancellations or no shows over the course of counseling, we will, unfortunately, no longer be able to provide services. We will provide clients with resources and outside referral sites to help transition if needed. At any point, if you feel you no longer want services, notify your counselor.

Hospitalizations: The Clinic for Counseling and Personal Development employs a "90 day wait" policy for any clients who have been hospitalized for inpatient mental health treatment within the 90 days previous to their intake session, as well as for current clients who are hospitalized during the course of receiving services at the CCPD. If you have been hospitalized within the previous 90 days, your intake counselor will provide you with resources and outside referral sites that will be better suited to your needs. If you are hospitalized while receiving services at our agency, please notify your CCPD counselor as soon as possible. Your counselor will make arrangements to see you following your discharge from inpatient treatment and will conduct a referral session to help you find a counselor who can offer the appropriate level of care for your needs.

Minors: When services are being provided for a minor, a legal guardian or an agreed upon adult caregiver must remain in the building. Also, in order to provide the best services, we suggest that you make appropriate arrangements for childcare before individual appointments. Children will not be allowed in the counseling rooms or left unattended in the halls during adult sessions.

Code of Ethics/Conduct: The counselors of The Clinic for Counseling and Personal Development are dedicated to advancing the welfare of families and individuals. They are guided in this pursuit by a code of ethics published by the AAMFT, and/or ACA. Each counselor is required by law to adhere to the code of their profession: American Association for Marriage and Family Counselors Code of Ethics for Licensed Marriage and Family Counselors, and the American Counseling Association Code of Ethics for Licensed Professional Counselors, and Louisiana Law. Copies of these codes are available upon request for any client who might wish to study them further, or may be found online at www.counseling.org.

Privileged Communications: All information shared in counseling will be kept strictly confidential *except* information in the following circumstances, in accordance with state law:
1) When there is clear and immediate danger to a person or a person's life, in which case, client confidences will be disclosed in an effort to prevent any such clear and immediate danger. *This may include the notification of next of kin, another person who may prevent the clear and immediate danger, and/or the appropriate law enforcement agency.*
2) As mandated reporters, we must report a reasonable suspicion or knowledge of child abuse or neglect, elder abuse or neglect, and/or abuse or neglect of disabled or dependent adult.
3) If a waiver is previously obtained in writing and signed by all adults involved in the counseling sessions, then such information may only be revealed in accordance with the terms of the waiver.
4) Certain types of litigation, where the counselor is a defendant in a civil, criminal or disciplinary action, may lead to the court-ordered release of information, even without a client's consent, in which case client confidences will only be disclosed in the course of that action.
5) For the purpose of adequate supervision and team consultation, sessions may be discussed within the supervision team, videotaped, or observed.
6) When more than one member of the family is seen, we consider the family system as the client. Within that system, information may be shared by me with other members of the system if it is deemed necessary to bring about the change you have requested; therefore, do not tell me anything you wish to keep a secret from other members. If safety issues are involved, I will make recommendations regarding the course of counseling. If clients do not wish to proceed with the recommendations, I will refer them to other mental health providers in the area. It is our policy to assert privileged communication on behalf of the client and the right to consult with the client if

at all possible, except during an emergency, before mandated disclosure. We will endeavor to apprise clients of all mandated disclosures as conceivable.

After Hours and Emergencies: Clients with emergency medical or mental health situations needing an immediate response are directed to call 911 or go directly to the local emergency room for intensive crisis assessment. **Counselors are not available for crisis care or after-hours emergencies.**

Fees: The Clinic for Counseling and Personal Development charges a one-time, non-refundable intake fee of $25. This fee is due in the form of a check or money order made out to UL Lafayette. This fee will be collected by a designated employee of the Counselor Education department before the intake session begins, and a written receipt will be recorded and given to the potential client. No fees will be assessed for services subsequent to the intake session. A Non-Sufficient Funds fee of $30 will be assessed for all personal checks that are returned from the bank. A Counselor Education department employee will notify clients should this occur.

Physical Health: Physical health may be an important factor in the emotional well-being of an individual. If you have not had a physical examination in the last year, it is recommended that you do so. Also, you were asked in the application packet to provide a list of the medicines you and/or your family members are currently taking.

Potential Benefits and Risks of Counseling: The client should be aware that counseling poses potential risks.

1) In the course of working together, additional problems may surface of which you were not initially aware. If this occurs, feel free to share these new concerns with me.
2) Studies suggest that counseling involving only one spouse can lead to the dissolution of the marriage instead of improving it.
3) Changes in relationship patterns that may result from counseling/family counseling may produce unpredicted and/or possibly adverse responses from other people in the client's social system. It is possible that as one family member changes, additional strain may be placed on the family.

I have read and discussed the above information with my counselor, and I agree to follow the policies of The Clinic for Counseling and Personal Development. This agreement will remain in effect until termination of services occurs.

_____ _____
Client signature Date

_____ _____
Client signature Date

_____, _____
Counselor signature License/Intern Status Date

Legal Guardian Authorization for Treatment of Minors

As a legal guardian, I understand that I have the right to information concerning my minor child in counseling, except where otherwise stated by law. I also understand that The CCPD counselors believe in providing a minor child with a private environment in which to disclose himself/herself to facilitate counseling. I, therefore, give permission to _____ (Counselor/Counselor Intern) to use his/her discretion, in accordance with professional ethics and state and federal laws and rules, in deciding what information revealed by my child is to be shared with me.

I, _____ (Legal Guardian), give permission for the Counselor/Counselor Intern to conduct counseling with my

_____, _____.

Relationship Name of Minor

I, _____ (Legal Guardian), have provided the appropriate paperwork to confirm legal guardianship of my

_____, _____.

Relationship Name of Minor

Signature_____

Date_____

Acknowledgement of Working with Counselor Intern

The Clinic for Counseling and Personal Development is a training site for graduate students. To provide the best possible clinical services, sessions are subject to videotaping and/or live supervision by the clinical supervisory staff and team, which may on occasion include an invited consultant in the counseling field.

- I consent to receive counseling services by _____ (Graduate student) in the field experience class in the Counselor Education program at the Clinic of Counseling and Personal Development at the University of Louisiana at Lafayette.
- I understand that I am working with a Counselor Intern under the Supervision of a Licensed Professional Counselor.
- I understand that videotaping *may* be used during the sessions for purpose of supervision and training. Interview tapes will be erased by the supervisor at the end of the semester. I understand that if I decline to be videotaped, I may not be eligible to receive services at the CCPD.

Please check:

_____ I *agree* to participate in videotaped sessions.

_____ _____
Client signature Date

_____ _____
Client signature Date

_____ , _____
Counselor intern signature License/Intern Status Date

_____ , _____
Supervisor signature License Date