

# ***Next Step Counseling and Education Center***

## **Statement of Understanding and Consent for Treatment**

### **BENEFITS AND RISKS OF THERAPY:**

Research has shown that therapy can help a wide variety of problems for children, adolescents, and adults. However, because therapy is a cooperative effort between client and therapist, participation in therapy does not guarantee problem resolution or that the client necessarily will feel better. As with any treatment, whether psychological or medical, therapy should be entered into with appropriate consideration of the potential benefits and risks. If you have any questions about what to expect from therapy, please ask your therapist.

### **CONFIDENTIALITY:**

Records and information collected about clients will be held and released in accordance with state and federal laws governing confidentiality of client records and information. Disclosure of information regarding services provided to the client is generally released to another party only with the client's written permission. Exceptions to this rule include the following cases: 1) when there is imminent danger to the client or another person, 2) when child abuse or neglect is suspected, 3) when disclosure must be made to medical personal in a medical emergency, and 4) when the therapist is compelled by law to disclose client records or information.

### **CLIENTS WITH DISABILITIES:**

It is the policy of **Next Step Counseling** to accommodate clients with disabilities, pursuant to federal and state law. Any client with a disability who needs accommodations should inform the therapist prior to receiving services.

### **NONDISCRIMINATION POLICY:**

In accordance with Title VI of the Civil Rights Act of 1964 **Next Step Counseling** does not discriminate against participants or clients on the basis of race, color, or national origin. Services are offered to all eligible persons.

### **CONSENT FOR TREATMENT/RESPONSIBILITIES OF CLIENTS:**

I do hereby authorize and give my consent to **Next Step Counseling** to provide treatment in accordance with the customary standards of practice specified by the state and federal laws, regulatory agencies, and professional discipline governing **Next Step Counseling**. **Next Step Counseling** does not overbook appointments. Each appointment is a reservation of resources specifically for you. Applicable charges are made for appointments not canceled within 24 hours prior to the appointment.

**I have read, understand and agree to the conditions of treatment described in this document.**

---

**Client Signature / Parent or Guardian**

---

**Date**

# *Next Step Counseling and Education Center*

## **Client Information (for minor child)**

**Date:** \_\_\_\_\_

Name: \_\_\_\_\_ Parent/Guardian \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Okay to call: Yes \_\_\_ No \_\_\_

Cell Phone: \_\_\_\_\_ Okay to call: Yes \_\_\_ No \_\_\_

Work Phone: \_\_\_\_\_ Okay to call: Yes \_\_\_ No \_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Highest Grade Level: \_\_\_\_\_

Marital Status: Single \_\_\_ Married \_\_\_ (years married \_\_\_) Widowed \_\_\_ Separated \_\_\_

Cohabiting \_\_\_ Divorced \_\_\_ (number of years divorced \_\_\_)

Spouses' Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Okay to call Yes \_\_\_ No \_\_\_

Work Phone: \_\_\_\_\_ Okay to call Yes \_\_\_ No \_\_\_

<b>Other Household Members</b>	<b>Relationship</b>	<b>Age</b>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List additional household members on the back of this form.

How did you hear about this counseling service? \_\_\_\_\_

**Emergency Contact:** Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone number: Daytime \_\_\_\_\_ Evening \_\_\_\_\_

# *Next Step Counseling and Education Center*

## **Client Information (for minor child)**

Name: \_\_\_\_\_

### **PROBLEM INFORMATION:**

For whom are you requesting counseling? \_\_\_\_\_ If other than you what is your relationship to them? \_\_\_\_\_

Briefly describe the nature of the problem: \_\_\_\_\_

---

---

Have you (or the person who will be receiving counseling) ever received outpatient counseling? Yes \_\_\_ No \_\_\_

If yes, from whom? \_\_\_\_\_ When? \_\_\_\_\_

Have you (or the person who will be receiving counseling) ever received inpatient treatment? If yes from whom? \_\_\_\_\_ When? \_\_\_\_\_

Are you currently being treated by a mental health professional? Yes \_\_\_ No \_\_\_ If yes from whom? \_\_\_\_\_ When \_\_\_\_\_

Medication prescribed for mental health issues:

---

---

---

# Next Step Counseling and Education Center

## Medical Information

Name: \_\_\_\_\_ Date: \_\_\_\_\_

### MEDICAL INFORMATION:

Which of the following illnesses or complaints have you (the client) experienced?

- Diabetes  Head Injury  Ulcer  Irregular menses
- High Blood Pressure  Thyroid problems  Glaucoma  Difficulty Sleeping
- Epilepsy  Seizures  Dizzy Spells  Loss of Appetite
- Liver problems  Hepatitis  PMS  Herpes
- Kidney problems  Asthma  Back Pain  Sexually Transmitted
- Headaches/Migraines  Respiratory problems  Frequent constipation disease(s)
- Heart attack  Stroke  Loss of consciousness  Other \_\_\_\_\_

What prescription medications are you currently taking and why?

Medication Reason for taking it

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Please identify any allergies that you have:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

What over the counter medications do you regularly take? \_\_\_\_\_

Name and Phone number of your **Primary care Physician:** \_\_\_\_\_

When was the last time you saw your doctor? \_\_\_\_\_ Why? \_\_\_\_\_

The last time you had a physical? \_\_\_\_\_