CREEKSIDE COUNSELING CENTER, INC

1170 Industrial St. Redding CA 96002

Telephone: 530-722-9957 Fax: 530-722-9294

CLIENT INFORMATION

Please fill this form out in its entirety. This information is not only helpful for the Therapist, it is also required to set up your client account and for insurance purposes.

Name: _____ Sex: _____

Address: _____

City: _____ Zip Code: _____

Phone: _____ Date of Birth: _____ Soc. Sec. # _____

Employer: _____ Yes / No Cell Phone: _____

Okay to call work ◯◯

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Other

RESPONSIBLE PARTY

(Complete this section only if minor is being seen.)

Parent/ Guardian Name: _____

Address if Different from Above: _____

City: _____ Zip Code: _____

Phone: _____ Date of Birth: _____ Soc. Sec. # _____

Employer: _____ Yes / No Work Phone: _____

Okay to call ◯◯

I, _____ Hereby give my consent for my child to receive psychotherapy from Creekside Counseling Center

Signature: _____ Relationship to minor: _____

INSURANCE INFORMATION

(Please attach a copy of Insurance Card.)

Insurance Company: _____ ID # _____

(if victim witness is there any other coverage)

Social Security # _____ Name: _____

Date of Birth: _____ Telephone: _____

I hereby authorize payment for medical benefits to the named provider for professional services.
I authorize the release of any medical information necessary to process these claims.
I also understand that I am responsible for any charges that are not covered by my insurance company.
Please read disclosure in welcome packet about insurance billing and fees.

Signature: _____ Date: _____

(Signature is valid one year from the date signed for insurance purposes)

WELCOME TO COUNSELING

INFORMATION FOR CLIENTS AND CONSENT FOR TREATMENT
Please read the following guidelines for services provided by CCCI. If you have any questions, feel free to discuss them with us. Please take the time to read each point before signing this form. We want to make sure that you understand our policies and procedures so that the therapy process will in no way be hindered.

THERAPY PROCESS
Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, anger, guilt, frustration, loneliness and helplessness. On the other hand, therapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems and significant reductions in feelings of distress. Therapy requires your very active involvement, honesty and openness in order to change your thoughts, feelings and/or behavior. You may be challenged on some of your assumptions or perceptions or propose different ways of looking at, thinking about or handling situations which can cause you to feel very upset, angry, depressed, challenged or disappointed. There are no guarantees on how therapy with affect you.

_____
Initial

SESSIONS
Our initial visit is the start of the evaluation process and can take up to 4 sessions, if needed. During this time, we both decide if I am the best person to provide the services you need in order to meet your treatment goals. Once therapy has begun, we will usually schedule one 60-minute session per week. Some sessions may be longer or may need to be more frequent.

_____
Initial

CONFIDENTIALITY
The law and standards of our profession require that we keep treatment records. You have a right to view these records at any time, except in limited legal, or when it is determined that viewing them may be emotionally upsetting. In this case your records will be provided to a legitimate mental health professional of your choice. All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be shown or discussed with any one without your written consent, except where disclosure is required by law. In the case of minors, we will ask for parents/guardians' permission as well to release information.

Disclosure is required by law when there is reasonable suspicion of abuse or neglect to a child, a dependent, or an elder and when a client presents a danger to self, property or threatening grave bodily harm to others.
Disclosure may be required pursuant to legal proceedings if your mental status is at question. The defendant may have a right to ask for your records and/or testimony from your therapist.

On occasion it may be necessary to consult with colleagues regarding our clients; however, no identifying information is mentioned. Your information remains anonymous and confidentiality is fully maintained. The consultant is also legally bound to keep the discussion confidential.

_____
Initial

CONTACTING YOUR THERAPIST

Your therapist is not often available by phone. We monitor our voicemail frequently when no one is available. Please leave a detailed message with a phone number and we will make every effort to return your call that day. In the case of a holiday or weekend your call may not be returned until the following business day.

_____
Initial

CANCELLATIONS AND RESCHEDULING

We require 24-hour advanced notice for cancellations, if you are unable to contact us due to an emergency please call as soon as possible to reschedule. Three consecutive no-shows will result in ineligibility to reschedule. No-shows will be billed to you at your established rate unless otherwise stated by your therapist.

_____
Initial

PAYMENTS AND INSURANCE

I have read and signed the payment and insurance procedure.

_____
Initial

CONSENT FOR TREATMENT

I have read and received a copy of the above information and agree to abide by its terms during our professional relationship and hereby consent to my treatment.

_____

Client Name (Print) Date Signature

CONSENT TO TREAT A MINOR

I, _____, as the parent/guardian or social worker of minor_____ (DOB :_____) give permission to Creekside Counseling Center, INC to provide psychotherapy for the minor.

_____

Parent/ Guardian Name (Print) Date Signature

_____

Therapist Signature

Creekside Counseling Center

PAYMENTS AND INSURANCE

PAYMENT FOR SERVICES

Our standard cash fee is $180.00 for a 45 – 50-minute session and $200.00 for a 60-minute session. Payment is due prior to each session unless other arrangements have been made. There is a $25 fee for returned checks. Report writing, phone conversations, consultation with other professionals, longer sessions, as well as time spent performing any other services you may request will be charged at a higher rate. If you become involved in legal proceedings that require our participation, you will be expected to pay for our professional time. If you are having financial difficulties, please discuss this with us you may be eligible for a reduced fee (documentation is required).

INSURANCE BILLING

We will bill your insurance as a courtesy to you, but you are solely responsible for your account balance. As a courtesy we can contact your insurance on your behalf to get your mental health eligibility. This does not guarantee payment of benefits. Some insurance companies require a pre-authorization prior to being seen. Sessions without authorization will be the client's responsibility. If you have any questions about your benefits you should call the member services number provided on your card. Clients are encouraged to contact member services to obtain eligibility and coverage of services.

You may have a co-payment, or co-insurance due at the time of service. The amount will be determined by your benefits. In most cases the deductible must be met prior to the insurance paying out benefits. Mental health benefits may be more complex, and it is sometimes difficult to determine what coverage is available to you. We will do our best to quote you the correct co-payment or co-insurance. It is important to understand that you will receive a bill for the difference if you were undercharged; however, we will credit your account if you over paid and the credit will be applied to the next session owed.

Billing your insurance for payment of benefits requires that we provide them with a diagnosis. This information will be stored by the insurance company. They may require additional information about your claim, and it may be necessary to provide them with further documentation as to why you are being seen. In rare cases they can request copies of the entire record.

<u>You have the right to opt out of billing your insurance</u>. If you chose not to bill your insurance, you will be solely responsible for the payment. Please notify us if you do not want us to bill your insurance.

BILLING

If you have any questions about your statements or insurance payments, please contact our front office.

I have read and understand the above information.

_____

Client Name (Print) Date Signature

CREEKSIDE COUNSELING CENTER, INC
1170 Industrial St. Redding, CA 96002
530-722-9957

NO SHOW/ CANCELLATION POLICY

Creekside Counseling Center, Inc has adopted the following policy regarding No Shows and Cancellations.

Cancellations must be 24 hours advanced notice unless it's due to emergency or illness. Calling after your missed appointment time amounts to a No Show.

If you have a standing appointment time and you No Show you will need to confirm the next scheduled appointment, or your appointments will be cancelled until we hear from you. We can not guarantee that you will get your same appointment time back. Remember it is important to notify us of any changes.

If you No Show a second time, you will be charged for the missed session and a deposit will be required to continue counseling. The fee will be for your normal session. Once you have successfully attended three (3) consecutive sessions you will be refunded your deposit. If you fail to do so you will forfeit your deposit.

Medi-Cal and Medi-Care clients will be advised that a third No-Show or late cancelation will result in a discharge and referral to another therapist. If you are a Beacon client, we are required to notify them of the discharge and reason for discharge.

If you No Show a third time, you will not be rescheduled. You may leave a message for your therapist and ask them to reconsider you as a client.

I have read and understood the above statement.

_____ _____

Client signature Date

I, _____ hereby do consent to receive electronic communication from my therapist and or Creekside Counseling Center, Inc.

I understand that it may be in the form of either an email or a text message.

I understand that this is considered a "non-secure" form of communication.

This communication will not contain identifying information other than my name, phone number and email address.

I understand that should I disclose certain information about my treatment in email or text format that I do risk the chance of someone other than the intended recipient may receive it in error.

_____

Signature Date

Email:_____

Cell#_____

Cell Phone Carrier:_____
For email to text option

Creekside Counseling Center, Inc.
1170 Industrial St.
Redding, CA 96002
PO BOX 491750
Redding, CA 96049
(530)722-9957 Fax (530)722-9294

If you are treated by a trainee:
NOTICE TO CLIENTS The Clinical Director(s) and Executive Director of the Creekside Counseling Center, Inc. receives and responds to complaints regarding the practice of psychotherapy by any unlicensed or unregistered Practitioner providing services at Creekside Counseling Center, Inc. To file a complaint, contact us by phone: (530)722-9957, email: creeksidecounselingcenter@gmail.com, website contact form: https://creeksidecounseling.org/contact/, or mail: PO Box 491750, Redding, CA 96049.

X_____
Client or parent/guardian of client

Date_____

If you are treated by a licensed or registered clinician:

NOTICE TO CLIENTS The Board of Behavioral Sciences receives and responds to complaints regarding services provided by individuals licensed and registered by the board. If you have a complaint and are unsure if your practitioner is licensed or registered, please contact the Board of Behavioral Sciences at 916-574-7830 for assistance or utilize the board's Online license verification feature by visiting www.bbs.ca.gov.

X_____
Client or parent/guardian of client

Date_____

Personal Demographics: Please list everyone who resides in the home with you

(Example: mother, father, grandparents, siblings, aunts/ uncles, roommates, partners, etc...)

Household 1			**Household 2** (If between two households)		
Name	**Age**	**Relation**	**Name**	**Age**	**Relation**

My Occupation: _____

Employer: _____

Hours per week: _____

Spiritual Preference _____

Partners Occupation: _____

Employer: _____

Hours per week: _____

Spiritual Preference _____

If Student, List School _____ **Grade level** _____

Emergency Contact:

Name: _____ **Phone:** _____

Address: _____

Are you currently on any medications? (*Circle one)* **YES** **NO**

Medication	Dosage	Prescribing Physician	Date Started

Personal Demographics Continued

Where do you receive your health care? _____

Who is your physician? _____

Did anyone refer you to Creekside: (*circle one)* **YES NO SELF**

If so, list their info here. Name: _____ Phone: _____

Address: _____

List any other info regarding your personal demographics and or living arrangements that may be good for us to know.

Creekside Counseling Center

What is the main reason for which you are seeking therapy?

Have you had therapy in the past? If yes, for what reason?

Have you ever been hospitalized in a psychiatric facility? If yes, for what reason?

Has anyone in your immediate family had a psychiatric illness? Please list relation and illness

Have you had thoughts about hurting your self or others? If so, please explain.

Have any of these issues effected your work or school performance? If so, please explain.

Please include additional comments here, please include critical or unique events that have occurred in your family or other individuals that are connected to you and any other concerns not listed:

Creekside Counseling Center

In the past three months, have you experienced any of the following symptoms?

Please rate on a 1 to 5 scale, 1 = minimal impact and 5 = severe impact

- ☐ **Anger**
- ☐ **Aggression**
- ☐ **Anxiety**
- ☐ **Apathy (lack of interest or concern)**
- ☐ **Avoidance or Isolation**
- ☐ **Behavioral Problems**
- ☐ **Compulsive Behavior**
- ☐ **Crying**
- ☐ **Denial**
- ☐ **Depression**

Medication: _____

_____

- ☐ **Difficulty Concentrating**
- ☐ **Eating Disorder Symptoms**
- ☐ **Emotional Numbing**
- ☐ **Fear** _____

_____

- ☐ **Financial Problems**
- ☐ **Flashbacks** _____

_____

- ☐ **Guilt**
- ☐ **Substance Abuse**

- ☐ **Harm or threats to others**
- ☐ **Hyperactivity**

Medication _____

- ☐ **Hyper Arousal**
- ☐ **Insomnia / Sleep Problems**
- ☐ **Irritability**
- ☐ **Memory Problems**
- ☐ **Nightmares**
- ☐ **Obsessive Behavior**
- ☐ **Panicky Feelings**
- ☐ **Phobias** _____

_____

- ☐ **Self Blame** _____

- ☐ **Self-Destructive Relationships**
- ☐ **Self Harming Behavior**
- ☐ **Sexual Acting Out**
- ☐ **Sexual Dysfunction**
- ☐ **Somatic Complaints** _____

_____

- ☐ **Substance Abuse Withdrawal**
- ☐ **Tremors or Tics**

- ☐ **Work or school related issues**

Please list any substances that you use and include frequency or NA if not applicable.

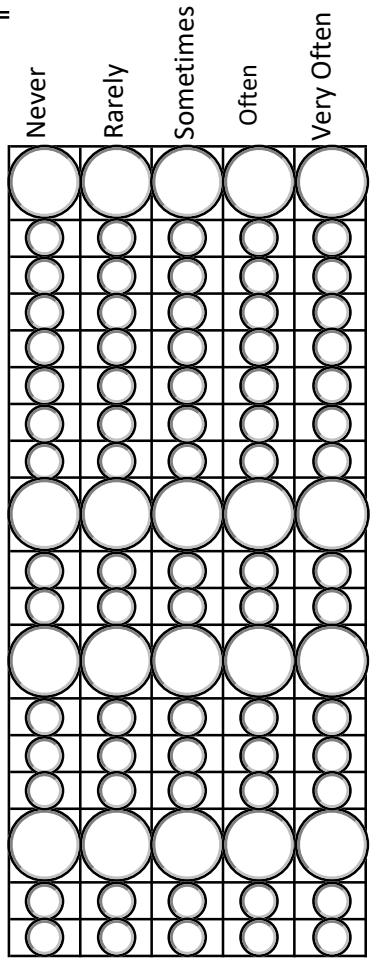
☐	Alcohol	☐	Cocaine
☐	Marijuana	☐	Psychedelics
☐	Caffeine	☐	Methamphetamine
☐	Tobacco	☐	Other
☐	Prescription Medication	☐	

Check the one response from A and B which best applies

	(A) My current concerns and symptoms are:		**(B) My current symptoms developed:**
☐	The continuation of a long standing condition	☐	Suddenly (less than four weeks)
☐	A recent worsening of an on-going condition	☐	Gradually (one to several months)
☐	The reoccurrence of a previous condition	☐	Very gradually (one to several years)
☐	Significantly different from any previous condition	☐	
☐	My first occurrence of any condition	☐	

Adult ADHD Self-Report Scale

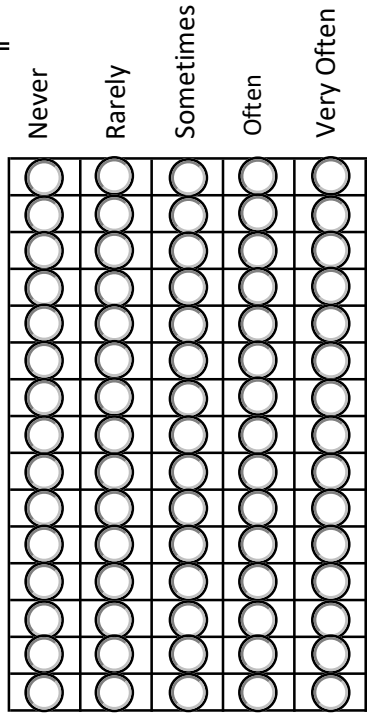
Over the past 6 months how often have you felt or conducted your self?



1. Having trouble wrapping up final details on a project once the challenging parts are completed?
2. Having difficulty organizing things for a task?
3. Having problems remembering appointments or obligations?
4. Do you avoid or delay getting started on a task that requires a lot of thought?
5. Do you squirm or fidget with your hands or feet?
6. Do you feel like you are being driven by a motor and are overly active?
7. When working on a boring or difficult problem, do you make careless mistakes?
8. Difficulty focusing on boring or repetitive work?
9. Difficulty concentrating on what people say to you, even when they are speaking directly to you?
10. Do you misplace or have difficulty finding things at home or at work?
11. Are you distracted by activity or noise around you?
12. Leaving your seat during meetings or other situations when you're supposed to remain seated?
13. Do you feel restless or fidgety?
14. Having difficulty unwinding and relaxing when you have time to yourself?
15. Do you talk to much in social situations?
16. Do you finish someone else's sentences during conversations before they are done speaking?
17. Having difficulty waiting your turn in situations when taking turns is required?
18. Do you interrupt others when they are busy?

Child / Adolescent ADHD Self-Report Scale

Over the past 6 months how often have you felt or conducted your self?



1. Fails to pay close attention to details or makes careless mistakes?
2. Has difficulty sustaining attention during play or school activities?
3. Does not seem to listen when spoken to directly?
4. Does not follow through on instructions; fails to finish schoolwork/ chores?
5. Has difficulty organizing tasks and activities?
6. Loses things necessary for tasks and activities (toys, pencils, etc.)?
7. Is easily distracted by irrelevant stimuli?
8. Is forgetful in daily activities?
9. Is figidity or squirms in seat?
10. Has difficulty remaining seated?
11. Runs or climbs excessively; is restless?
12. Talks excessively?
13. Blurts out answers before questions have been completed?
14. Has difficulty waiting turn?
15. Interrupts or intrudes on others?

Creekside Counseling Center

Over the past two weeks have you been bothered by the following problems?

A. Patient Health Questionnaire

	Not at all	Several days	Over half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
Add columns				
TOTAL:				

B. Generalized Anxiety Disorder

	Not at all	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Being easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add columns				
TOTAL:				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

A.

Not difficult at all	
Somewhat difficult	
Very difficult	
Extremely difficult	

B.

Not difficult at all	
Somewhat difficult	
Very difficult	
Extremely difficult	

DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

Child's Name: _____ **Age:** ____ **Sex:** ☐ **Male** ☐ **Female** **Date:**_____

Relationship with the child: _____

Instructions *(to the parent or guardian of child):* The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during the **past TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS,** how much (or how often) has your child…	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1.	Complained of stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Said he/she was worried about his/her health or about getting sick?	0	1	2	3	4	
II.	3.	Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4	
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than he/she used to?	0	1	2	3	4	
	6.	Seemed sad or depressed for several hours?	0	1	2	3	4	
V. &	7.	Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
VI.	8.	Seemed angry or lost his/her temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or did more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual for him/her, but still had lots of energy?	0	1	2	3	4	
VIII.	11.	Said he/she felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	0	1	2	3	4	
IX.	14.	Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?	0	1	2	3	4	
	15.	Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	0	1	2	3	4	
	17.	Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS,** has your child …						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes	☐ No	☐ Don't Know			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes	☐ No	☐ Don't Know			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes	☐ No	☐ Don't Know			
	23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes	☐ No	☐ Don't Know			
XII.	24.	In the past **TWO (2) WEEKS,** has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	☐ Yes	☐ No	☐ Don't Know			
	25.	Has he/she EVER tried to kill himself/herself?	☐ Yes	☐ No	☐ Don't Know			

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 11–17

Name: _____ **Age:** ____ **Sex:** ☐ **Male** ☐ **Female** **Date:**_____

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS,** how much (or how often) have you…	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1.	Been bothered by stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Worried about your health or about getting sick?	0	1	2	3	4	
II.	3.	Been bothered by not being able to fall asleep or stay asleep, or by waking up too early?	0	1	2	3	4	
III.	4.	Been bothered by not being able to pay attention when you were in class or doing homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than you used to?	0	1	2	3	4	
	6.	Felt sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Felt more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Felt angry or lost your temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or done more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual but still had a lot of energy?	0	1	2	3	4	
VIII.	11.	Felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Not been able to do things you wanted to or should have done, because they made you feel nervous?	0	1	2	3	4	
IX.	14.	Heard voices—when there was no one there—speaking about you or telling you what to do or saying bad things to you?	0	1	2	3	4	
	15.	Had visions when you were completely awake—that is, seen something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Had thoughts that kept coming into your mind that you would do something bad or that something bad would happen to you or to someone else?	0	1	2	3	4	
	17.	Felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Worried a lot about things you touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Felt you had to do things in a certain way, like counting or saying special things, to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS,** have you…						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes		☐ No			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes		☐ No			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like Ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes		☐ No			
	23.	Used any medicine without a doctor's prescription to get high or change the way you feel (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes		☐ No			
XII.	24.	In the last 2 weeks, have you thought about killing yourself or committing suicide?	☐ Yes		☐ No			
	25.	Have you EVER tried to kill yourself?	☐ Yes		☐ No			