Chrissy Zimmerman Counseling
cell: 503-502-8593 office: 503-777-0444 fax: 503-777-0445
4004 SE Woodstock Blvd. Portland, OR 97202

PARENT INFO

Name: _____ *DOB:*_____ *Today's Date:*_____
Physical Address: _____ *Phone:* _____
Email address: _____
Emergency Contact: _____
Are you utilizing your ***Insurance*** *or* ***Employee Assistance Program****?* _____

Insurance Info:

Carrier/{Provider: _____
Name if Insured: _____
Policy/Group# _____

Employment Info:

Employer: _____
Job Title: _____
+/-, hrs/yrs: _____

Parent involvement is crucial to successful therapy for your child and can look a number of different ways. It's important for your child to feel safe and comfortable within the context of their therapy. For that reason, I find it helpful to work individually with them as much as possible at first in order to develop rapport. Then, as trust grows, incorporate occasional Family Therapy sessions. It is also helpful for Parents to participate in ways of completing "homework" reading assignments, etc.

Let me know how you envision participating in/with your child's therapy.

****What would you and/or your child like as a result of coming to counseling?**

CHILD'S / CLIENT'S INFO

Child's Name: _____Child's Birthdate: _____Age: ___ Today's Date: ____
Child's Biological Mother: _____ Child's Biological Father: _____
Mom's address: _____ *Address:* _____
Contact Info: _____ *Contact Info:* _____
Other Primary Caregiver(s): _____
Child primarily resides with: _____
□ Biological Mo & Fa in same house □ 50/50 Biological Mother & Father
□ Biological Mother (and Step-parent Y/N) □ Biological Father□(and Step-parent Y/N)
□ Other: _____

Has your child ever been to counseling before? If so, when? Was it helpful? What was NOT helpful?

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CHILD'S / CLIENT'S INFO CONTINUED...

Name of School: _____ Grade: _____ Teacher(s): _____
Any Special Ed services? _____ Does *Child* like school? _____
See the school counselor (if so, provide name): _____
Child is really engaged in _____, and struggles most with _____
Has behavior at school been a problem (if so for how long and when is it "better")?

List BEST friends: _____ _____ _____ _____ _____ _____

Interest and performance in;
Math: _____Science: _____ Lang.Arts: _____Social Studies: _____
Making Friends : _____ Keeping Friends: _____
Coordination: _____ Concentration: _____

List extracurricular activities, interests, hobbies: _____ _____ _____
STRENGTHS, talents, abilities, dreams: _____
_____

Please indicate frequency of the following symptoms (identify the number of times per week):

__ Anxiety	__ Anger	__ Overeating	__Acts out sexually w/ others
__ Bedwetting	__ Defiance	__ Under eating	__ Masturbates excessively
__ Day wetting	__ Controlling	__ Sleeplessness	__ Unusual or excessive sexual knowledge
__ Day pooping	__ Lack of empathy	__ Nightmares	__ Plays out sexual themes
__ Obsesses	__ Lying	__ Hypervigilance	__ Plays out violent themes
__ Depression	__ Low impulse control	__ Startles easily	__Homicidal themes or actions
__ Low Energy	__ Stealing	__ Fears/ Phobias	__ Suicidal thoughts or actions/ plans
__ Shy	__ Drug/Alcohol use	__ Running away	__ Stomach aches/ headaches
__Tantrums	__ Impaired conscience	__ Peer problems	__ Spacing Out
__ Violent	__ Excessive crying	__ Low concentration	__ Feelings of inferiority
__ Grief	__ Putting self down	__ Memories	__ Academic problems
__ Allergies	__ Specific Fears: _____		__ Hallucinations (hearing/seeing things)

__ Other: _____

Significant people or family members NOT currently living with Child
Name_____Age_____Relationship_____
_____
_____
_____
_____
_____

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Medical and Health History

Overall health condition of *Child*: □ very good □ good □ average □ poor
Does *Child* have any specific, significant **Medical** problems/concerns? □ Yes □ No
If yes, please list them: _____
List any allergies: _____ Head Injuries: _____
Hospitalizations: (list reason for admission and duration of stay) _____

Any recent weight gain or loss? _____ If so, how much and when? _____
Date of last physical exam: _____Name of Hosp/Clinic:_____
Child's primary care physician is Dr. _____
Does *Child* take any prescription **Medications?** □ Yes □ No
If yes, please list them:

Medication	*Dose*	*Purpose*	*+/- Effect*

EARLY DEVELOPMENT
Was the pregnancy planned? _____ Parents'/Family's Reaction was... _____
During the pregnancy, was there drug or alcohol use? _____ What type: _____
What were the emotional / financial / relational / situational stressors in your family during the pregnancy and early childhood development of *Child*? _____
_____
Were there any unusual situations or complications surrounding pregnancy, birth, and delivery?
_____

Personality of *Child*

Briefly write about your child's character; their personality and temperament. Also, circle any of the words below that either you would use, or you've heard used, to describe your child.

_____
_____
_____

tense relaxed restless calm daydreamer self-starter active sluggish
stubborn eager to please easy to manage jokester disobedient
happy sad angry loving aloof friendly secure easily frightened
bold cautious whining generous jealous cruel aggressive affectionate
relates easily to adults relates poorly to adults negative
attached to certain toys or objects to the point of not being able to leave it/them at home

Have there been noticeable changes in *Child's* behavior or personality at any time?

How many transitions/ moves has the family made and what was the age of *Child* at each move?

Timeline:
0 ----------*-----
(Born) (present)

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What is C*hild's* greatest fear(s)? _____

What is C*hild's* greatest hope(s)? _____

Family History

Describe your family's (*Child's*) cultural background?

What is the relationship like between *Child* and Parent(s) ..or step-parent(s)?
Describe, for each parent, the quality of home life (*happy, tense, communication, relations with children, stability, security, religious commitment, abuse, substance use, etc.*)

Parent 1 _____

Parent 2 _____

_____

Did any *Caregiver* have similar characteristics or problems as *Child* is experiencing? Explain.

Does *Family/Child* have any religious affiliation? ____ If so, what role does this play in the family's life and the child's life?

What types of discipline are used within the family?

How does *Child* get along with others in the family.

Is there a history of mental illness or emotional problems within the family or extended family? Explain.

Maternal Side *Paternal Side*

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Please list anyone in the family, including *Child* and extended family, who use or used drugs or alcohol (including prescription or street drugs).

relationship to child ***type(s) of drugs*** ***purpose*** ***for how long***

_____
_____
_____

Are you concerned that your child is using alcohol and/or drugs? □ Yes □ No

Has your child ever threatened self-harm? □ Yes □ No□ If yes, when/how? _____

Has your child experienced any past (or current) **traumas (**any significant loss, physical injury, etc**)?** Yes /No
If yes, please specify: _____
_____
_____
_____

Legal History

Are there any custody disputes or current custody arrangements in place for *Child*? (please comment)

Are there any restraining orders in place?

Is *Child* currently on probation or parole? Y/N (comment)
Are any family members currently on probation or parole or currently incarcerated? Y/N (comment)

Please describe your reason(s) for making the difficult choice to see a counselor at this time. Please indicate a) the age the concern began and probable causes
b) what has made the problem/concern better or worse
c) describe feelings and moods you've observed
d) ..and in what way do these concerning behaviors interfere with Child's life (and family)

_____
_____
_____
_____
_____
_____
_____
_____

Please feel free to discuss any aspect of your responses with me. Thank you very much for taking the time to fill out this questionnaire!!

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PROFESSIONAL DISCLOSURE STATEMENT

My Philosophy and Approach: I believe that everyone has strengths and abilities that make us each special and resilient. A positive environment and nurturing relationships are ideal conditions to grow and heal. My goal is to tend to each of my client's needs with holistic and nurturing attention while providing a safe, confidential space for important transformations to develop. My approach is client-centered and strengths-based. I work with the individual, couple and/or family to incorporate obtainable and realistic goals and often use art therapy interventions as an avenue for expression and exploration.

My Credentials and Training: My undergraduate training was from Gonzaga University and I hold BAs in psychology and art. I have also earned a MA in Art Therapy & Counseling (ATR) from Marylhurst University. I am trained to utilize both Art and Talk Therapy. Major areas of study included human development, ethics, assessment and treatment, the counseling process, family therapy and the uses of art in the therapy process and addiction counseling. I have earned my Certification in Alcohol and Drug Counseling (CADC-I) and my License as a Professional Counselor (LPC). I constantly attend trainings and workshops to maintain current knowledge of issues, research, ethics and helpful approaches in my field. My continued studies have had a significant focus on attachment, trauma and relationships. I also participate in clinical supervision and consultation monthly. I commit to attending and learning more about interpersonal neurobiology, mindfulness practices and the enneagram. I believe that everyone has the strengths and abilities necessary to achieve resilience and that a positive environment and nurturing relationships are ideal conditions to grow and heal.

As a Licensee of the Oregon Board of Licensed Professional Counselors and Therapists,
I will abide by its **Code of Ethics**. In case any ethical concerns or questions arise, please feel free to ask me directly. You may also always contact the Oregon Board of Licensed Professional Counselors at 3218 Pringle Rd SE, #250 Salem, OR 97302-6312. Telephone: (503) 378-5499.

Art Therapy: Art Therapy is more than simply doing art; however, doing art is healing in and of itself. Art Therapy is a process. Exploring with and manipulating art materials allows us to gain insight into our own thoughts and feelings. Often how one interacts with the materials might reflect similar patterns present when interacting with life and within relationships. Exploring through art provides an opportunity to process, organize and reshape feelings and thoughts. It is from these expressions we can work together to find the underlying needs.

Payment for Services: The initial consultation is FREE! The fee for individual sessions is $120 and for couples or family therapy, the fee is $140. As I work towards getting on Insurance companies' provider lists, mine is currently a direct fee-for-service and I accept payments in credit/debit cards, cash or check. I do offer sliding scale fees depending on availability and on your financial situation and comfort.

Appointments: The usual session time is 50 minutes. In event of late arrival, the session will still end at the regular time and you will be charged for the full session fee. If you are going to be unable to keep an appointment, please contact me at least 24hours ahead of time. Without notice, and with the exception of a medical emergency, you will be charged for your session fee for the missed appointment. Cancellation less than 24 hours will result in a $50 late cancellation fee.

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CONFIDENTIALITY AND CONSENT FOR TREATMENT

Informed Consent for Treatment

You have certain rights and responsibilities when consulting a counselor for treatment or evaluation.

1. **Right to be informed regarding the terms under which treatment or evaluation will be provided**
Policies related to charges, billing third party payers, appointments, emergencies and coverage for when your therapist is unavailable, and other matters will be explained or provided to you. It is your responsibility as a client to stay informed.
2. **Right to choose the best treatment and provider.** There are a variety of professionals offering counseling and evaluations. There are also a number of different approaches to counseling. It is your right and responsibility to choose the treatment and provider that best match your needs. You also have a right to a detailed explanation of any treatment or procedure your provider may choose to use including the risks involved and the side effects if any. If you believe you are not receiving the treatment you require, then raise this concern with me and we will work to revise your treatment plan or to refer you to other professionals who may be able to meet your needs.
3. **Right to refuse or stop treatment.** Treatment may be stopped at any time and for any reason. In the case where a minor is the client, then the parent or legal guardian has the right to refuse or stop treatment for the minor. Your therapist also has the right to refuse or stop treatment, in which case you will be provided with alternative therapists. It is my hope that if you have concerns regarding your treatment you will discuss this with me.
4. **Right to confidentiality.** This means that what you tell me and what is contained in your clinical file will not be repeated or released to anyone else without your expressed permission. You have the right to see and have access to the contents of your file. You have the right to discuss your own therapy with anyone you choose, including another provider. The content within group therapy is confidential and may not be shared with anyone outside of the group.
5. **For minors 14 to 17 years old.** Oregon law requires your therapist to have your parents involved in treatment before the end of treatment unless there are clear clinical indications to the contrary, which must be documented in your clinical chart. If you have been sexually abused by your parent or if you are emancipated involvement can be waived. By signing this informed consent document you:

Authorize me to contact your parents and give them a summary of your treatment. _____ ***Initial***
Authorize me to use my clinical judgment on when to inform your parents of important issues related to your treatment.
_____ ***Initial***

<u>There are, however, some limits and exceptions to complete confidentiality:</u>

1. Child or Elder Abuse. I am required by law to report any known or suspected cases of child or elder abuse to the Children's Services Division or other appropriate state agencies.
2. Violence: If I learn that someone is about to kill or cause harm to someone else I will inform the intended victim.
3. Suicide: If I am aware a client intends to harm themselves, I'll breach confidentiality (if necessary) to insure safety.
4. Non-Custodial Parents are by law allowed to gain access to their children's records pertaining to treatment.
5. Consultation: Occasionally, it is in your best interest for me to consult with another provider regarding your treatment. This will be carried out with the utmost consideration for your privacy.
6. Insurance companies or their designated management company may require information about your diagnosis, treatment history, prognosis, treatment or other relevant information in order to authorize services and process claims. A release of information will be obtained for this.

*I have read and understand my rights and responsibilities as outlined in the "***Informed Consent for Treatment and Evaluation***" form. Furthermore, by signing this form, I consent to receiving Mental Health, Art Therapy and/or Chemical Dependency Services to be provided by Chrissy L. Zimmerman, LPC, ATR, CADCI.*

Client signature:_____ Date: _____

Parent/Guardian Signature: _____ Date: _____

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Limitation on Confidentiality when Providing Therapy to Families

This written policy is intended to inform you, the participants in therapy, that when I agree to treat a family, I consider that family to be the patient. For instance, if there is a request for the treatment records of the family, I will seek the authorization of all members of the treatment unit before I release confidential information to third parties. Also, if my records are subpoenaed, I will assert the psychotherapist-patient privilege on behalf of the patient (treatment unit).

During the course of my work with a family, I may see a smaller part of the treatment unit (e.g., an individual, parents, or two siblings) for one or more sessions. These sessions should be seen by you as a part of the work that I am doing with the family unless otherwise indicated. If you are involved in one or more of such sessions with me, please understand that generally these sessions are confidential in the sense that I will not release any confidential information to a third party unless I am required by law to do so or unless I have your written authorization. In fact, since those sessions can and should be considered a part of the treatment of the couple or family, I would also seek the authorization of the other individuals in the treatment unit before releasing confidential information to a third party.

However, I may need to share information learned in an individual session (or a session with only a portion of the treatment unit being present) with the entire treatment unit – that is, the family, if I am to effectively serve the unit being treated. I will use my best judgment as to whether, when, and to what extent I will make disclosures to the treatment unit, and will also, if appropriate, first give the individual or the smaller part of the treatment unit being seen the opportunity to make the disclosure. Thus, if you feel it necessary to talk about matters that you absolutely want to be shared with no one, you might want to consult with an individual therapist who can treat you individually.

This “no secrets” policy is intended to allow me to continue to treat the family by preventing, to the extent possible, a conflict of interest to arise where an individual’s interests may not be consistent with the interests of the unit being treated. For instance, information learned in the course of an individual session may be relevant or even essential to the proper treatment of the family. If I am not free to exercise my clinical judgment regarding the need to bring this information to the family or the couple during their therapy, I might be placed in a situation where I will have to terminate treatment of the family. This policy is intended to prevent the need for such a termination.

We, the members of the (couple/family or other unit) being seen, acknowledge by our individual signatures below, that each of us has read this policy, that we understand it, that we have had an opportunity to discuss its contents with Chrissy Zimmerman, LPC, ATR, CADCI and that we enter couple/family therapy in agreement with this policy.

Dated: _____ Signed: _____
Dated: _____ Signed: _____
Dated: _____ Signed: _____

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FEE AGREEMENT

My goal is to make counseling accessible for anyone who feels they would benefit.

° My standard fee for individuals paying by cash or check is $120 for a 50-minute session. If a different fee is needed, Client and Therapist will agree on that fee and identify below.

° Services are paid privately by cash, check or card at the time of the session.

° If you do not have the fee at the end of session, there will be only one follow up session made until payment is received.

° The fees associated with counseling are your responsibility.

° Refunds are not available.

° If unable to make an appointment, 24-hour notice is required. If 24-hour notice is not given, a $50 Session Fee charge will be assessed.

° If client does not show for an appointment, the Full Fee will be assessed.

° Services may be terminated at any time, for any reason by either client or therapist.

° I may refer you to another provider - it is your responsibility to arrange an appointment with that provider.

Fee for Services as agreed by clinician and client: _____ per 50-minute session

Client: _____ Date: _____

Guardian/Parent (if under 18): _____ Date:_____

Therapist: _____ Date: _____

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FOR THE RELEASE OF PROTECTED MENTAL HEALTH INFORMATION

By signing this form, confidential mental health information can be released to and/or discussed with the people or agencies listed below unless there are any noted exclusions or limitations. This form is signed voluntarily and you may make changes at any time. All disclosures made pursuant to this form are valid as long as they were made before the date of revocation.

I, _____, specifically authorize the release/exchange/receipt of the following
First Name *Last Name*

(Client must initial each item):

___ A&D treatment records (If initialed, specific consent below must be signed)
___ Identifying Information ___ Mental Health treatment records
___ Lab Reports ___ Psychiatric Evaluation(s)
___ Discharge Summary ___ Progress Notes
___ Consultation(s) ___ Other_____

This information will be shared between <u>Chrissy Zimmerman, LPC, ATR, CADCI</u> and:

Name: _____Address:_____
Phone #: _____Fax #: _____ City:_____State: ___ Zip: _____

The purpose(s) for this disclosure of information is

___ Diagnosis and Evaluation ___ Referral/Consultation
___ Treatment Planning ___ Coordinate Aftercare/Continuation of Care
___ Parent/Partner Consult ___ Other _____

Exclusions or Limitations to what information will be shared is listed here: _____
_____

By signing below, I acknowledge that I have read and understand this document and that I have voluntarily given my authorization to **Chrissy Zimmerman** to disclose my records. I also understand that I may revoke this Authorization at any time by providing a written notice.

Please refer to the Notice of *Health Information Privacy Practices* for more detailed information. This consent form will expire one year following the date signed unless revoked by you in writing or upon the happening of an event or condition as listed on the following date: _____

Signature of Client: _____	**Date:** _____
Signature of Authorized Representative (State relationship to patient/client) or Witness (if signature is mark.) _____	Date: _____

Witness: _____Date: __/__/__ Client Copy Received: ___Yes
___ Declined copy