

Terry Rogers Counseling - INTAKE INFORMATION

Terry Rogers - LPC, CACIII, NCACII

Client Name: _____ Gender: _____ Entry Date: _____
Address: _____ Home Phone: _____
_____ Social Security #: _____
D.O.B.: _____ Ethnicity: _____ County of Residence: _____
Other Contact Numbers (Cell, Work, e-mail, etc.): _____

Responsible Parties (if applicable)

Check here if Client is responsible party

SPOUSE: _____
Address: _____
Phone: _____
Alt Phone: _____

GUARDIAN: _____
Address: _____
Phone: _____
Alt Phone: _____

INDICATE THE PHONE NUMBER WHERE IT IS SAFE TO LEAVE MESSAGE:

EMAIL: _____
OCCUPATION: _____
SSN#: _____ **DOB:** _____

EMAIL: _____
OCCUPATION: _____
SSN# _____ **DOB:** _____

FATHER: _____
Address: _____

Home Phone: _____
Work Phone: _____ Cell _____
OCCUPATION: _____
SSN#: _____ **DOB:** _____
EMAIL: _____

MOTHER: _____
Address: _____

Home Phone: _____
Work Phone: _____ Cell _____
OCCUPATION: _____
SSN# _____ **DOB:** _____
EMAIL: _____

Emergency contact: (please list at least one name and phone number)

Religious Preference: _____
Church/Pastor Name & Contact Information: _____

CASE WORKER: _____
County: _____
Address: _____
Phone: _____
GAL: _____
Address: _____
Phone: _____

PROBATION OFFICER: _____
Address: _____
Phone: _____
ATTORNEY: _____
Address: _____
Phone: _____

Emergency contact: (please list DHS hotline/crisis phone number)

Previous Counseling:
Name of Facility _____ Date/Duration _____ Contact: _____

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PAYMENT IS EXPECTED AT THE TIME OF SERVICE

CLIENT NAME:	ALL FEES FOR SERVICE ARE THE RESPONSIBILITY OF THE INDIVIDUAL NOTED IN THIS FORM AS "RESPONSIBLE PARTY". A SLIDING SCALE FEE SCHEDULE IS AVAILABLE BASED ON INCOME AND UNIQUE CIRCUMSTANCES.
BILL TO	
ADDRESS	
PHONE:	

PRIVATE PAY SESSION RATES

SESSION	STANDARD CHARGE	CLIENT CHARGE / Co-PAY AS AGREED TO WITH THERAPIST
INTAKE PROCESSING FEE	N/C	OUT-OF-POCKET _____ INITIAL
INTAKE SESSION 1.0 HRS.	\$75.00	_____ INITIAL
1.0 HR. INDIVIDUAL.	\$75.00	_____ INITIAL
1.0 FAMILY		_____ INITIAL
1.0 HR COUPLES		_____ INITIAL
1.0 HR. GROUP LIST SPECIFIC GROUP:	\$35.00	_____ INITIAL
1.0 HR PHONE SESSION	\$85.00	_____ INITIAL
PSYCHOLOGICAL EVALUATION	\$400.00-\$800.00 DEPENDING ON INVOLVEMENT	_____ INITIAL
EMERGENCY PAGER	\$120.00	\$30.00 EACH 15 MINUTES _____ INITIAL
LATE CANCELLATION/NO SHOW	\$75.00	_____ INITIAL
RETURNED CHECK FEE*	\$30.00	_____ INITIAL
LEGAL/PROFESSIONAL RETAINER EXPERT WITNESS PROFESSIONAL REPORTING/DOCUMENTATION	\$500.00-\$1500.00 DEPENDING ON INVOLVEMENT	PAYMENT AT TIME OF AGREEMENT _____ INITIAL

CASH PAYMENTS

I accept cash or checks. Payment is required before the next session is scheduled.

*Cash required for all future payments following a returned check: **(initial/date here)** _____.

EMERGENCIES

I recognize that sometimes emergencies arise, and am able to accommodate occasional emergency situations.

Attest:

I attest by my signature below that I understand that I am responsible for payment for all services provided as agreed to in this contract including any charges not covered or paid for by my insurance company.

SIGNATURE OF RESPONSIBLE PARTY

DATE

SIGNATURE OF THERAPIST, TERRY ROGERS

DATE

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POLICIES AND ACKNOWLEDGEMENTS

(All lines/questions must be filled out. If it does not apply indicate by writing: N/A)

FEE RELATED POLICIES

Initial on the line provided for each statement. If client is a minor both Client and Guardian initial and sign.

1. _____ I understand that all individual, family, and group sessions are scheduled for a 50 minute hour.
2. _____ I am aware that 24-hour notice is required for cancellation of appointments.
 - a. _____ appointments not cancelled with a 24-hour notice will be billed in full.
 - b. _____ additionally, I agree to provide at least 24-hour notice of intent to terminate therapy to avoid being subject to the no show/cancellation fee.
3. _____ I understand that payment is expected at the time of service.
4. _____ I understand that my treatment may be interrupted/terminated for lack of commitment to the therapeutic process for the following:
 - a. _____ after 3 unpaid NO SHOWS.
 - b. _____ due to 3 consecutive cancellations
 - c. _____ unresolved debt of 3 sessions or more.
5. _____ Phone calls in excess of 10 minutes will be billed to the client's account in 15 minute increments at a rate of \$30.00.
6. _____ Clients are not to be in possession of alcohol, drugs, paraphernalia or weapons at any time while meeting with the therapist. Individuals who come to their session under the influence of alcohol or drugs will be:
 - a. _____ asked to leave the premises
 - b. _____ cancelled for session time and held responsible for re-scheduling.
 - c. _____ billed for cancelled time at full session rate.

Client/Guardian Print

Signature

Date

Terry Rogers, LPC, CACIII, NCACII

Therapist Signature Print

Signature

Date

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FACILITY RELATED POLICIES

Initial on the line provided for each statement. If client is a minor both Client and Guardian initial and sign.

1. _____ I understand that Terry Rogers is a Christian counselor, that biblical principles may be used and referred to appropriately in the context of the therapy session. I understand that I have the freedom and right to ask for prayer with my counselor. I have the right to refuse prayer/spiritual guidance.
2. _____ I understand that I am responsible for my children's behavior. I agree not to leave children unattended during therapy sessions for any reason. I understand that supervision for children is not provided before, after, or during my therapy session. I agree to pick up my children immediately after their session.
3. _____ I understand that sessions are a smoke-free environment and that smoking is prohibited during this time.
4. _____ I am aware that during sessions I will not be allowed to harm myself, others, or any property. If I become a threat of harm to any of these, the authorities will be notified immediately and I will be held responsible for any damages incurred.
5. _____ I agree to give Terry Rogers permission to correspond with me by letter, telephone, or by other means necessary to check on my progress after discharge.
6. _____ I understand that my records are protected by HIPPA regulation.
7. _____ I understand that I must fill out a specific Authorization for Release of Information form indicating to whom and for what reason(s) records are being requested per HIPPA standard.
8. _____ I understand that recommendations for nutrition, supplements, exercise, and other healthcare suggestions, are not intended to replace medical advice and treatment from my primary care physician.
9. _____ By means of my/our signature, I/we hereby release Terry Rogers from all suit, libel, damages or legal litigation of any kind that could be brought against him for any reason by us on our behalf.
10. _____ I/we do also hereby state that this agreement and contract is to be in effect for the life of my/ourselves and that even after death this contract shall stay in effect.

I attest that I have read, reviewed, understood and agreed to abide by all the above-initialed policies, disclosures, and acknowledgments:

Client Name (**Please PRINT**)

Guardian Name (**Please PRINT**)

Signature of Client

Date

Signature of Guardian

Date

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INTAKE QUESTIONNAIRE

(From the Client perspective. All lines must be filled out. If it does not apply, indicate by writing: N/A.)

1. Whose idea was it for you to come today?
2. Where do you attend church? Who is your pastor? (Please list your church/pastor contact information)
3. What concern has led you to seek counseling? What would you like help with?
4. List any current or past drug use:
5. Is domestic violence a part of your concern? Yes No If yes please describe:
6. Describe any sexual problems or concerns:
7. Describe any mental or emotional health concerns:
8. Describe any behaviors that seem out of control:
9. Describe any marital concerns:
10. Describe any parenting issues:
11. Describe any spiritual concerns:
12. Describe any other issues or concerns that you want me to be aware of:
13. List anyone you would like for me to be in contact with regarding your therapy:
(Please list names, titles and how to contact below)

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SOCIAL HISTORY

(All lines/questions must be filled out for ALL HISTORIES. If it does not apply indicate by writing: N/A)

IMMEDIATE FAMILY:

Marital status: Single Married Divorced Re-married Other

Name of spouse or partner: _____

Names of Children: _____ ages: _____

Who lives in your household, and what is your relation to them? _____

FAMILY OF ORIGIN:

Mother: _____ Father: _____

Stepmother: _____ Stepfather: _____

Other: _____ Other: _____

Siblings: (oldest to youngest, include yourself) Ages

Other significant people living in the home you were raised in: _____

Briefly describe yourself: _____

Briefly describe your family: _____

Is there any family history of emotional, physical, or sexual abuse? _____

If yes, please describe: _____

Who were you closest to growing up? _____

Was school a positive or negative experience for you? _____

What level of education have you completed? _____

What is your occupation? _____ Are you satisfied in your current occupation? _____

What is your sexual orientation? _____

Describe your spiritual beliefs or religious preferences: _____

What types of music do you listen to? _____

What activities are you involved in? _____

Do you have a Guardian ad Litem (G.A.L.) or attorney that you would like us to be in contact with? Yes No

If Yes please list name, address, and phone number: _____

Have you ever been in trouble with the law? Yes No

If yes please describe: _____

Are you currently facing charges, on probation, on parole? Yes No

Please describe: _____

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MEDICAL HISTORY

Physician's Name: _____ Phone: _____

Address: _____

I give my permission for my therapist to contact my PCP (or medical doctor) Yes No _____ (Initial)

List current medical conditions: _____

List any physical complaints or health concerns? _____

Describe your current health: _____

Describe any recent changes in:

Weight: _____

Appetite: _____

Sleep: _____

Sex drive: _____

Have you ever seen a Doctor or Therapist for mental or emotional concerns? Yes No

If yes, Please list dates and Individuals you have seen: _____

Are you currently pregnant? Yes No

If yes please list the doctor you are seeing for pre-natal care (include address and phone #): _____

Please list any drugs or medications you are taking at this time:

Prescription:

Drug name	dosage	frequency	length of time used
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_____	_____	_____	_____
-------	-------	-------	-------

_____	_____	_____	_____
-------	-------	-------	-------

_____	_____	_____	_____
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_____	_____	_____	_____
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Over the counter:

Drug name	dosage	frequency	length of time used
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_____	_____	_____	_____
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_____	_____	_____	_____
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_____	_____	_____	_____
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GENERAL HEALTH CONCERNS

Client Name: _____ Date: _____

Age: _____ Gender: _____

GENERAL HEALTH HISTORY:

Do you use a seatbelt? Always Usually Sometimes Never

Do you use a helmet when cycling: Always Usually Sometimes Never

Do you exercise regularly: Always Usually Sometimes Never

When was your last physical exam? _____

Are you pregnant at this time? Yes No **Immunizations Current?**

Yes No

If yes, how many weeks/months are you? _____

Do you have allergies? Yes No **TB Test?** Yes No Date _____

If yes, please list: _____

SUBSTANCE ABUSE HISTORY:

What type of drugs are you currently using? _____

Have you used illicit drugs in the past 60 days? _____

Date of last use: _____

What form of ingestion do you use?: Oral Intravenous Inhalation Smoking

Do you presently share needles?: _____

Do you understand how to use bleach and water? _____ Can you explain how to clean your works?: _____

Are you a tobacco user? Yes No

How long have you used tobacco? _____

How many times have you tried to quit? _____

SEXUAL HISTORY:

When was your last sexual contact? _____

How many different sexual partners have you had in the past 12 months? _____

How many different sexual partners have you had in the past 5 years? _____

Have you ever had sex with a male? Yes No

If yes, did you use a condom? Yes No

Do you give or receive Vaginal sex Oral sex Anal sex (check all that apply)

Have you ever been a prostitute? Yes No

Have you ever been with a prostitute? Yes No When? _____

Have you ever had a sexually transmitted disease? Yes No

If yes, what diseases have you had? _____

Have any of your sexual partners: Used IV drugs Prostituted Tested positive for HIV (Check all that apply)

Have you been tested for HIV? Yes No When? _____

If you were to test positive for HIV, what effect do you feel it would have on you? _____

If you were to test negative what, if anything would you do differently? _____

Would you be willing to submit a blood specimen? Yes No

If no, please explain why you would not wish to have one done: _____

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SUBSTANCE ABUSE HISTORY

1. How old were you when you first used alcohol or illicit substances? _____
2. At what age did you start using alcohol/drugs on a regular basis? _____
3. List the substances you have experimented with or used: _____

4. List the drugs you have used or use most frequently: _____

5. Has the use of these substances ever created problem situations for you? Yes No
Describe: _____
6. Have you ever forgotten where you have been or where you were after an extended period of using any of these substances (blackouts)? Yes No Describe: _____

7. Have you ever had convulsions, hallucinations or other abnormal experiences while using? Yes No
Describe: _____
8. How often do you use substances? _____
9. When did you last use? What and how much did you use? _____

10. How long have you been able to use on a continuous basis? _____

11. When did this kind of continuous use last occur? _____

12. How much and what did you use during this time? _____

13. Describe your substance use pattern and frequency of use: _____

14. Describe the mood you are generally in when you use: _____

15. Describe the benefits you gain from use of substances: _____

16. Describe your substance use preferences (alone, groups, parties etc.): _____

17. Do you occasionally use heavily for periods of time? Yes No
18. What is the longest period of time you have gone without using? _____
19. How did you manage to avoid substance use during this time? _____

20. Have you been arrested or cited due to substance use? Yes No
21. Have you ever lost a job or time from work due to substance use? Yes No
22. Have you ever attended A.A./N.A. or other 12 step meetings? (When and how long?) _____

23. Describe any other programs you have been in for substance use problems: _____

24. What do you need in order to modify, control, change or stop your substance use patterns? _____

25. How does your family or system of influence react to your substance use? _____

26. Describe the patterns of substance use in your family system: _____

27. Do you think you are an addict/alcoholic? Yes No

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Individual Disclosure Statement of Terry Rogers, CACIII, NCACII, LPC #1641

Degrees:

Master of Arts - Counseling - Colorado Christian University, 1992
Bachelor of Arts - Youth Ministry/Bible - Colorado Christian University, 1986

Certifications:

Level III Certified Addictions Counselor (CACIII)
Division of Behavioral Health
(Colorado Department of Health/Alcohol and Drug Abuse Division)
Level II National Certified Addictions Counselor (NCACII)
- National Certification of Addiction Counselors

Licensure:

LPC #1641 - April 1997

Affiliations:

Colorado Division of Behavioral Health
(formerly - Alcohol and Drug Abuse Division, Colorado Department of Health)
Colorado Association of Family and Children's Agencies – Board Member
American Association of Christian Counselors

Ordinations:

Ordained Minister - Grace Gospel Fellowship by Grace Bible Church of Lakewood

General Disclosures:

1.) The Colorado Department of Regulatory Agencies has the responsibility of regulating the practice of licensed psychologists, licensed social workers, licensed professional counselors, certified addictions counselors, and all non-licensed individuals who practice psychotherapy. The agency within the department that has specific responsibility for this issue is the:

State Grievance Board
1560 Broadway - Suite 1350
Denver, CO 80202
(303)-894-7766

2.) You, as my client, are entitled to receive information from me about my methods of therapy, the techniques I use, the duration of therapy (if I can determine it), and my fee structure. Please ask me if you would like to receive this information.

3.) You may receive a second opinion from another therapist or terminate therapy at any time.

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4.) In a professional relationship (such as ours), sexual intimacy between a Therapist and a Client is never appropriate! If such occurs, it should be immediately reported to the State Grievance Board.

5.) Information provided by and to a client during therapy sessions with a licensed psychotherapist is legally confidential, and the therapist cannot disclose the information without the client's consent. As an ordained minister I cannot be forced to disclose information.

6.) There are exceptions to the general rules of confidentiality. These are listed in the Colorado statutes (see section 12-43-218, CRS - 1988, in particular). You should be aware that, except in the case of information given to a licensed psychologist or ordained minister, legal confidentiality does not apply in a criminal or delinquency proceeding. There are other exceptions that I will identify to you if and/or as the situations arise during therapy. I may release information if, in my opinion, you are a danger to yourself (suicidal), or others (homicidal) or if there has been the revelation of previously unreported incidences of child abuse.

7.) My clinical supervisor is: Harl Hargett, PhD., L.P.C., CACIII, NCACII
He may be reached at: 6700 W. 44th Ave, Wheat Ridge, CO 80033
(303) 420-8080 x1121

Attesting that I understand the above and agree to therapy under the above list of disclosures I have signed below:

Client Signature: _____ Date _____

Signature of Spouse
if Family/Marital Counseling: _____ Date _____

Signature of Parent or Guardian
if Client is a Minor: _____ Date _____