3495 Piedmont Rd. NE, Bldg. 11, Ste. 708 • Atlanta, GA 30305 • Tel: 678-557-0822 •
Web: www.perspectivesatlanta.com

Welcome to Perspectives Counseling! I'm glad you've made the choice for personal growth. While it's a difficult first step to take, your courage to move forward will bring lasting effects. I hope you'll enjoy the journey!

If you haven't already done so, you may wish to take a moment to view our website at www.perspectivesatlanta.com for information about counseling, fees, and directions. Prior to your first visit, please complete the new client paperwork below and either submit it via email or bring a hard copy to your appointment. The parent will complete all paperwork except the final questionnaire to be completed by your child and to be shared at my first appointment with him or her. I will review important aspects of this paperwork (including HIPAA) in person, but also feel free to ask me for clarification if needed. Please note that the first appointments for minors under the age of 18 years old is with the parents, so please leave your child at home for this appointment.

Perspectives Counseling is located in The Fountains at Piedmont Center in the heart of Buckhead. Our address is: 3495 Piedmont Rd. NE, Building 11, Suite 708, Atlanta, GA 30305. Some GPS devices find the address to 3495 Piedmont *Avenue*, but this will take you to downtown Atlanta, so you may wish to double check your directions unless you'd prefer an excursion to the Fox Theatre! Once you turn in to The Fountains at Piedmont Center, take the first right and park in the parking deck ahead. We are located in Building 11, Suite 708 in the {Simplified} Counseling office. Enjoy the ambiance of our lobby, and I will greet you at your appointed time.

If you have any questions or concerns, please do not hesitate to contact me at 678-557-0822 Ext. 101 or Kristen@perspectivesatlanta.com. I look forward to meeting you soon!

Warm regards,

*Kristen*

Kristen Aycock, Ph.D.
Licensed Psychologist

# Child and Adolescent Information Form

*This form is to be completed by the parent/ legal guardian requesting services for a minor child. This information will help your therapist to understand your child and his/her needs better. This, as well as other communications with your therapist, will be kept confidential to the full extent of Georgia law.*

Child's name_______________________________________ Date of birth_____________ Age______

Name of person completing this form_______________________________________________
**I declare that I am the custodial parent or legal guardian of the child described in the document and that I have the legal authority to request and consent to his/her psychological treatment.**

_______________________________________________________ ______________________
Signature Date

Were you referred for consultation by another professional? Y or N

If yes, referral source____________________________________________________________
*If you would like for your therapist to contact your referring professional to coordinate treatment, you will need to fill out a "Release of Information" form to give permission.*

Parent name(s)________________________________________________________________________

Address______________________________________________________________________________

Home phone_________________ Cell Phone__________________ Other Phone________________

Parent email address_________________________________

**Current concerns**

Why are you bringing your child for treatment? *(What behaviors, feelings, thoughts, or problems are causing you to be concerned about your child?)*

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

What are your goals in coming here? *(What kinds of changes do you want to make, or how do you want things to be different for your child and/or your family?)*

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**Demographics**

Is the child living: ☐ With birth parent(s) ☐ With foster parent(s)
☐ With adoptive parent(s) ☐ With other relative(s) ☐ In a residential center

Are the child's parent(s): ☐ Married/ living together ☐ Divorced
☐ Single ☐ Separated ☐ Widowed

Child's siblings:

(Circle one)

Name______________________ Age____ Living in same home as child? Yes or No or Sometimes

Name______________________ Age____ Living in same home as child? Yes or No or Sometimes

Name______________________ Age____ Living in same home as child? Yes or No or Sometimes

Name______________________ Age____ Living in same home as child? Yes or No or Sometimes

Name______________________ Age____ Living in same home as child? Yes or No or Sometimes

Who else lives in the home?______________________________________________________________

**Problem areas**

Please place a check next to each problem or symptom that is currently a concern for your child:

- ☐ Anxiety/ worry
- ☐ Fearfulness/ phobias
- ☐ Clingy or overly dependent
- ☐ Nervous habits (such as nail biting)
- ☐ Obsessive thoughts
- ☐ Compulsive behavior
- ☐ Emotional sensitivity
- ☐ Difficulty calming down when upset
- ☐ Anger/ temper
- ☐ Aggressive or destructive behavior
- ☐ Problems with accepting discipline
- ☐ Stealing
- ☐ Frequent lying
- ☐ Rigid thinking or stubborn behavior
- ☐ Difficulty with change or transitions
- ☐ Unusual or repetitive behaviors
- ☐ Impulsive behavior
- ☐ Loud, silly, or inappropriate behavior
- ☐ Acts immature for age
- ☐ Very disorganized or messy
- ☐ Takes too long to get through tasks
- ☐ Forgetful
- ☐ Short attention span
- ☐ Grief from the loss of an important person
- ☐ Feeling unhappy a lot of the time
- ☐ Depression
- ☐ Thoughts of suicide
- ☐ Self-harming behaviors
- ☐ Academic problems or educational concerns
- ☐ Work problems
- ☐ Conflict with siblings
- ☐ Conflict with parents
- ☐ Stress from parent conflict or separation
- ☐ Stress from other problems in the family
- ☐ Insecure/ timid/ lack of self-confidence
- ☐ Low self-esteem
- ☐ Loneliness
- ☐ Friendship problems
- ☐ Religious or spiritual concerns
- ☐ Stress from physical or health concerns
- ☐ Sexual concerns
- ☐ Use of alcohol or other drugs
- ☐ Legal problems
- ☐ Traumatic stress
- ☐ Unsafe or risky behavior
- ☐ Other ________________________________

**Recent changes or stressful circumstances** (Circle one)

1. Have there been any recent deaths in the family? Yes or No
2. Has a parent recently married or divorced? Yes or No
3. Have any new children been adopted or born or come to live with the family? Yes or No
4. Has a parent been separated from the family for a long period of time (such as from deployment, incarceration, or moving for work)? Yes or No
5. Has the child's residence recently changed? Yes or No
6. Has the child had a disruption in an important friendship or other relationship? Yes or No
7. Has the child witnessed stress in the family from a sibling's problems? Yes or No
8. Has the child been seriously ill or hospitalized? Yes or No
9. Has the child's parent or family member been seriously ill or hospitalized? Yes or No
10. Has a family member had recent legal problems? Yes or No
11. Has a family member had emotional, mental health, or substance use problems? Yes or No
12. Has the child had serious school problems? Yes or No
13. Has the child been under stress from having a lot of activities or responsibilities? Yes or No
14. Has the child had a very disappointing experience with an extracurricular activity, sports team, youth group, etc.? Yes or No
15. Has the child become involved with alcohol or drugs? Yes or No
16. Have there been a lot of arguments or conflicts at home? Yes or No
17. Has a parent recently lost a job or had a change in financial status? Yes or No
18. Has the family been in financial difficulty or had inadequate income, inadequate health care, inadequate or unsafe living situations, or frequent worry about these? Yes or No
19. Has the child recently become sexually active? Yes or No
20. Has the child witnessed verbal altercations, threatening behavior, physical violence, sexual behavior, or a scary situation (such as a car accident)? Yes or No
21. Has the child personally experienced verbal threats, threatening behavior, physical violence, sexual molestation, or a scary situation (such as a car accident)? Yes or No
22. Has the child or a family member been a victim of a crime? Yes or No
23. Has the child or a family member experienced a fire, flood, tornado, hurricane , or other natural disaster? Yes or No
24. Has the child or a family member experienced conditions such as a war, riot, assault, or other event involving or threatening physical harm? Yes or No

If you answered "Yes" to any of the questions about stressful circumstances, please explain briefly:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

In your experience, how does your child typically respond to problems or stress? (check all that apply)

- ☐ Sleeps a lot
- ☐ Has trouble sleeping
- ☐ Gets moody
- ☐ Talks about it with a friend
- ☐ Talks about it with an adult
- ☐ Gets irritable or argumentative
- ☐ Gets more sensitive
- ☐ Has physical symptoms or complaints
- ☐ Gets bossy or controlling
- ☐ Avoids thinking about it
- ☐ Watches a lot of TV
- ☐ Plays more video games/ computer activities
- ☐ Gets in trouble or breaks rules more
- ☐ Gets loud or acts silly
- ☐ Fights with siblings more
- ☐ Asks for help
- ☐ Ignores the problem
- ☐ Actively tries to solve the problem
- ☐ Seeks comfort from adults
- ☐ Uses alcohol or other drugs
- ☐ Vents anger or blows off steam
- ☐ Gives up easily
- ☐ Acts younger
- ☐ Withdraws
- ☐ Takes it out on other people
- ☐ Seeks out drama or excitement
- ☐ Cries a lot
- ☐ Gets "clingy"
- ☐ Over-uses "self-comfort" behaviors (such as eating more than usual)

## Health History

Has your child ever received any previous mental health treatment (therapy or psychiatric medication from a counselor, psychologist, psychiatrist, or pediatrician)? Yes or No

If yes, please list:

| Name | Location | Phone number | When |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

*Please fill out a "Release of Information" form for each provider listed, so your therapist may contact him/her to request information about current or previous treatment goals, methods, and outcomes.*

Please list your child's current medications:

| **Name of medication** | **Dosage** | **When did the child start taking it?** | **What is the medication for?** | **Who prescribes it?** |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

Does your child receive any supplements, herbal medicines, or alternative therapies? Yes or No

If yes, please describe:______________________________________________

____________________________________________________________

Has your child received any previous neurological evaluations, medical imaging, lab tests, neuropsychological assessments or psychological evaluations? Yes or No

If yes, please describe:______________________________________________

____________________________________________________________

Does your child have any history of serious illness, injury, concussions, car accidents, hospitalizations, or operations? Yes or No

Does your child have any current or chronic medical conditions or disorders? Yes or No

Does your child have any problems with vision? Yes or No

Does your child have any problems with hearing or speech? Yes or No

Does your child have any problems with motor skills or with being awkward or clumsy? Yes or No

Does your child have any allergies or sensitivities to drugs, food or other substances? Yes or No

If yes to any of the above, please describe the problem(s) and any treatment received:_______________

____________________________________________________________

____________________________________________________________

To your knowledge, has your child used… (check all that apply):

- ☐ Cigarettes
- ☐ Other forms of tobacco
- ☐ Caffeine
- ☐ Alcohol
- ☐ Non-prescribed painkillers
- ☐ Narcotics
- ☐ Steroids
- ☐ Marijuana
- ☐ Non-prescribed stimulants
- ☐ Methamphetamine
- ☐ Cocaine
- ☐ Heroin
- ☐ Hallucinogens
- ☐ Other recreational drugs

What best describes your child's sleep? (check all that apply):

- ☐ Has no sleep problems
- ☐ Sleeps too much
- ☐ Doesn't sleep enough
- ☐ Has problems falling asleep
- ☐ Wakes too early
- ☐ Wakes frequently at night
- ☐ Has irregular sleep patterns
- ☐ Has nightmares or night terrors
- ☐ Has nighttime bed-wetting
- ☐ Sleeps with parents or siblings

What best describes your child's activity level and exercise habits? (check all that apply)

- ☐ Has a low energy level
- ☐ Prefers quiet or seated activities
- ☐ Rarely gets exercise
- ☐ Has a moderate activity level
- ☐ Exercises/ plays outside a few times a week
- ☐ Exercises/ plays outside most days
- ☐ Has a high activity level
- ☐ Is constantly moving
- ☐ Needs a lot of vigorous exercise in order to relax or sleep well

What best describes your child's eating patterns? (check all that apply)

- ☐ Has a healthy appetite
- ☐ Appetite varies a lot
- ☐ Eats too little
- ☐ Eats too much
- ☐ Seems obsessed with food
- ☐ Eats a variety of foods
- ☐ Eats too much junk food
- ☐ Is a picky eater

Who in the child's family has a history of: (circle all that apply)

| | | | | | |
|---|---|---|---|---|---|
| Depression | mother | father | sibling | mother's relative | father's relative |
| Bipolar disorder | mother | father | sibling | mother's relative | father's relative |
| Anxiety disorder | mother | father | sibling | mother's relative | father's relative |
| Obsessive-compulsive | mother | father | sibling | mother's relative | father's relative |
| Phobias | mother | father | sibling | mother's relative | father's relative |
| Psychotic disorder | mother | father | sibling | mother's relative | father's relative |
| Autism or Asperger's | mother | father | sibling | mother's relative | father's relative |
| Attention disorder | mother | father | sibling | mother's relative | father's relative |
| Learning disorder | mother | father | sibling | mother's relative | father's relative |
| Intellectual disorder | mother | father | sibling | mother's relative | father's relative |
| Substance abuse | mother | father | sibling | mother's relative | father's relative |
| Gambling/ sexual addiction | mother | father | sibling | mother's relative | father's relative |
| Anger control problems | mother | father | sibling | mother's relative | father's relative |
| Eating disorder | mother | father | sibling | mother's relative | father's relative |
| Personality disorder | mother | father | sibling | mother's relative | father's relative |

**Developmental History**

Did your child have any problems during birth or any health problems as an infant? Yes or No

If yes, please describe______________________________________________________________

_____________________________________________________________________________

Was your child exposed to any alcohol, medications, cigarettes, or toxins before birth? Yes or No

If yes, please describe______________________________________________________________

_____________________________________________________________________________

Did your child babble and smile at other people by 4 months? Yes or No

Did your child sit without support by 9 months? Yes or No

Did your child crawl by 9 months? Yes or No

Did your child say at least one word by 12 months? Yes or No

Did your child walk independently by 18 months? Yes or No

Did your child say two-word sentences by 2 years? Yes or No

Did your child follow simple instructions by 2 years? Yes or No

Was your child toilet-trained by 3 years? Yes or No

Who were the child's primary caretaker(s) during the first five years?_____________________________

_____________________________________________________________________________

Has your child ever experienced circumstances of neglect or inadequate care? Yes or No

If yes, please describe______________________________________________________________

_____________________________________________________________________________

Which best describe your child's temperament during the first five years? (check all that apply)

- ☐ Usually cheerful or easy-going
- ☐ Frequently irritable/ fussy
- ☐ Usually played quietly
- ☐ Moderately active
- ☐ Very busy
- ☐ Adaptable
- ☐ Difficulty adjusting to changes
- ☐ Kept to a fairly regular schedule
- ☐ Irregular in daily schedule
- ☐ Cautious in new situations
- ☐ Eager or bold in new situations
- ☐ Generally calm or even-tempered
- ☐ Easily excitable or intense in reactions
- ☐ Very sensitive to noise, lights, stimulation
- ☐ Able to tolerate stimulation easily
- ☐ Concentrated well
- ☐ Easily distracted
- ☐ Persisted when frustrated
- ☐ Gave up easily

Which best describes your child's current ability to complete age-appropriate self-care tasks (such as dressing, bathing, brushing teeth, fixing hair, etc.)?

- ☐ Does not complete age-appropriate self-care
- ☐ Needs a lot of help with self-care
- ☐ Needs many reminders to complete self-care
- ☐ Fairly independent in self-care

Which best describes your child when interacting with other children? (check all that apply)

- ☐ Is interested in playing with other children
- ☐ Has little interest in playing with others
- ☐ Is sociable and outgoing
- ☐ Is shy
- ☐ Needs time to get used to new children
- ☐ Prefers to play alone
- ☐ Can play independently
- ☐ Has difficulty playing independently
- ☐ Gets along well with other children
- ☐ Has difficulty getting along with others
- ☐ Says "I don't have any friends"
- ☐ Has at least a few preferred friends
- ☐ Doesn't really have close friends
- ☐ Has trouble joining a group
- ☐ Doesn't seem to understand social rules
- ☐ Usually is a leader
- ☐ Usually is a follower
- ☐ Often is too bossy
- ☐ Has trouble standing up for herself/himself
- ☐ Gets feelings hurt easily with friends
- ☐ Gets along better with adults than children
- ☐ Other______________________________

What extra-curricular activities or organizations are your child involved in?

______________________________________________________________________

Does your child attend a church, synagogue, mosque, or other spiritual or religious center?

______________________________________________________________________

What are your child's interests, hobbies, or preferred activities?

______________________________________________________________________

What are your child's daily/weekly responsibilities or chores?

______________________________________________________________________

______________________________________________________________________

What are the rules and behavioral expectations in the family for your child?

______________________________________________________________________

______________________________________________________________________

What type of behavioral guidance and discipline strategies do you use in your family?

______________________________________________________________________

______________________________________________________________________

Which best describe your family? (check all that apply)

- ☐ Fairly structured with consistent routines
- ☐ Fairly laid-back and flexible
- ☐ Generally cooperative with each other
- ☐ Often argumentative
- ☐ Usually peaceful atmosphere
- ☐ Often stressful atmosphere
- ☐ Parents usually agree in parenting approach
- ☐ Parents often differ in parenting approach
- ☐ Family often spends time together
- ☐ Family does not often spend time together

Please describe the child's relationship with each parent:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Please describe the child's relationship with his/ her sibling(s) (if applicable):

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**Academic History**

Please list the child's current school, grade, and teachers *(if your child is in middle school or high school, list one or two teachers who know your child well)*:

________________________________ ______ ____________________________________

School Grade Teacher(s)

Does your child like school? ☐ All or most of the time ☐ Sometimes ☐ Almost never

Are your child's grades currently:

- ☐ Excellent/ As and Bs
- ☐ Good/ Bs and Cs
- ☐ Satisfactory/ Cs and Ds
- ☐ Unsatisfactory/ Ds and Fs

In the past year, how much school has your child missed because of illness, injury or other reasons?

- ☐ Less than 2 weeks
- ☐ 2 weeks to 4 weeks
- ☐ 5 weeks to 8 weeks
- ☐ More than 8 weeks

Has your child ever received (check all that apply):

- ☐ "Babies Can't Wait" services
- ☐ Head Start services
- ☐ Early Intervention services
- ☐ Speech therapy at school
- ☐ Occupational therapy at school
- ☐ "Collaborative" classroom placement
- ☐ Resource room/ small group instruction
- ☐ Exceptional children's services or IEP
- ☐ Student assistance services (C.A.R.E.)

Has your child ever repeated a grade? Yes or No If so, which grade(s)?___________

In primary grades (Kindergarten – 2nd), did your child have… (check all that apply):
☐ No academic, social, or school adjustment concerns
☐ Academic or learning problems
☐ Problems completing homework
☐ Problems with adjusting to school, classroom routines or teacher(s)
☐ Social difficulties
Please describe any difficulties______________________________________________________________

______________________________________________________________________________

In elementary grades (3rd – 5th), did your child have… (check all that apply):
☐ No academic, social, or school adjustment concerns
☐ Academic or learning problems
☐ Problems completing homework
☐ Problems with adjusting to school, classroom routines or teacher(s)
☐ Social difficulties
Please describe any difficulties______________________________________________________________

______________________________________________________________________________

In middle school, did your child have…. (check all that apply):
☐ No academic, social, or school adjustment concerns
☐ Academic or learning problems
☐ Problems completing homework
☐ Problems with adjusting to school, classroom routines or teacher(s)
☐ Social difficulties
Please describe any difficulties______________________________________________________________

______________________________________________________________________________

In high school, did your child have… (check all that apply):
☐ No academic, social, or school adjustment concerns
☐ Academic or learning problems
☐ Problems completing homework
☐ Problems with adjusting to school, classroom routines or teacher(s)
☐ Social difficulties
Please describe any difficulties______________________________________________________________

______________________________________________________________________________

Please note any additional information you would like your therapist to know____________________

______________________________________________________________________________

______________________________________________________________________________

**Thank you for taking the time to provide this important information to your child's therapist!**

# INFORMATION, AUTHORIZATION, & CONSENT TO TREATMENT/HIPAA

Welcome to Perspectives Counseling. We are very pleased that you selected our facility for your therapy, and we are sincerely looking forward to assisting you. This document is designed to inform you about what you can expect from your therapist or group leader, policies regarding confidentiality and emergencies, and several other details regarding your treatment here at Perspectives Counseling. Although providing this document is part of an ethical obligation to our profession, more importantly, it is part of our commitment to you to keep you fully informed of every part of your therapeutic experience. Please know that your relationship with your therapist or group leader is a collaborative one, and we welcome any questions, comments, or suggestions regarding your course of therapy at any time.

## Background Information, Theoretical Views, & Client Participation

Information regarding your therapist's educational background and experience may be found on our website under his or her name. Please feel free to view that information at www.perspectivesatlanta.com.

It is our belief that as people become more aware accepting of themselves, they are more capable of finding a sense of peace and contentment in their lives. However, self-awareness and self-acceptance are goals that may take a long time to achieve. Some clients need only a few sessions to achieve these goals, whereas others may require months or even years of therapy. As a client, you are in complete control, and you may end your relationship with your therapist/group leader at any point.

In order for therapy to be most successful, it is important for you to take an active role. This means working on the things you and your therapist talk about both during and between sessions. This also means avoiding any mind-altering substances like alcohol or non-prescription drugs for at least eight hours prior to your therapy sessions. Generally, the more of yourself you are willing to invest, the greater the return.

Furthermore, it is our policy to only see clients who we believe have the capacity to resolve their own problems with our assistance. It is our intention to empower you in your growth process to the degree that you are capable of facing life’s challenges in the future without your therapist. We also don’t believe in creating dependency or prolonging therapy if the therapeutic intervention does not seem to be helping. If this is the case, your therapist will direct you to other resources that will be of assistance to you. Your personal development is our number one priority. We encourage you to let us know if you feel that transferring to another facility or another therapist is necessary at any time. Our goal is to facilitate healing and growth, and we are very committed to helping you in whatever way seems to produce maximum benefit.

## Confidentiality & Records

Your communications with your therapist will become part of a clinical record of treatment, and it is referred to as Protected Health Information (PHI). Your PHI will be kept in a file stored in a locked cabinet in our locked business office. Additionally, your therapist will always keep everything you say to him or her completely confidential, with the following exceptions: (1) you direct your therapist to tell someone else and you sign a “Release of Information” form; (2) your therapist determines that you

are a danger to yourself or to others; (3) you report information about the abuse of a child, an elderly person, or a disabled individual who may require protection; or (4) your therapist is ordered by a judge to disclose information. In the latter case, your therapist's license does provide him or her with the ability to uphold what is legally termed "privileged communication." Privileged communication is your right as a client to have a confidential relationship with a counselor. This state has a very good track record in respecting this legal right. If for some unusual reason a judge were to order the disclosure of your private information, this order can be appealed. We cannot guarantee that the appeal will be sustained, but we will do everything in our power to keep what you say confidential.

Please note that in couple's counseling, your therapist does not agree to keep secrets. Information revealed in any context may be discussed with either partner.

## Structure and Cost of Sessions

Your therapist agrees to provide psychotherapy for the fee of $175 per 45 minute session or $200 per 45 minute session after hours, unless otherwise negotiated by you and your therapist. Doing psychotherapy by telephone is not ideal, and needing to talk to your therapist between sessions may indicate that you need extra support. If this is the case, you and your therapist will need to explore adding sessions or developing other resources you have available to help you. Telephone calls and emails that exceed 10 minutes in duration will be billed at $30 per 10 minute increments. The fee for each session will be due at the conclusion of the session. Cash, personal checks, Visa, MasterCard, or Discover are acceptable for payment, and we will provide you with a receipt of payment at your request. The receipt of payment may also be used as a statement for insurance if applicable to you. Please note that there is a $30 fee for any returned checks.

Insurance companies have many rules and requirements specific to certain plans. Unless otherwise negotiated, it is your responsibility to find out your insurance company's policies and to file for insurance reimbursement. We will be glad to provide you with a statement for your insurance company and to assist you with any questions you may have in this area.

## Cancellation Policy

An appointment represents time reserved personally for you. In the event that you are unable to keep an appointment, you must notify your therapist at least 24 hours in advance. If such advance notice is not received, you will be charged the full fee for your session ($175 or $200 after hours). This fee will be waived in cases of emergencies.

## In Case of an Emergency

Perspectives Counseling is considered to be an outpatient facility, and we are set up to accommodate individuals who are reasonably safe and resourceful. We do not carry pagers nor are we available at all times. If at any time this does not feel like sufficient support, please inform your therapist, and he or she can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. Generally, your therapist will return phone calls within 24 to 48 hours. If you have a mental health emergency, we encourage you not to wait for a call back, but to do one or more of the following:

- National Suicide Prevention Lifeline: 1-800-273-8255
- Call Behavioral Health Link/GCAL: 1-800-715-4225

- Call Ridgeview Institute at 770.434.4567
- Call Peachford Hospital at 770.454.5589
- Call 911.
- Go to your nearest emergency room.

## Professional Relationship

Psychotherapy is a professional service we will provide to you. Because of the nature of therapy, your relationship with your therapist has to be different from most relationships. It may differ in how long it lasts, the objectives, or the topics discussed. It must also be limited to only the relationship of therapist and client. If you and your therapist were to interact in any other ways, you would then have a "dual relationship," which could prove to be harmful to you in the long run and is, therefore, unethical in the mental health profession. Dual relationships can set up conflicts between the therapist's interests and the client's interests, and then the client's (your) interests might not be put first. In order to offer all of our clients the best care, your therapist's judgment needs to be unselfish and purely focused on your needs. This is why your relationship with your therapist must remain professional in nature.

Additionally, there are important differences between therapy and friendship. Friends may see your position only from their personal viewpoints and experiences. Friends may want to find quick and easy solutions to your problems so that they can feel helpful. These short-term solutions may not be in your long-term best interest. Friends do not usually follow up on their advice to see whether it was useful. They may *need* to have you do what they advise. A therapist offers you choices and helps you choose what is best for you. A therapist helps you learn how to solve problems better and make better decisions. A therapist's responses to your situation are based on tested theories and methods of change.

You should also know that therapists are required to keep the identity of their clients confidential. As much as your therapist would like to, for your confidentiality he or she will not address you in public unless you speak to him or her first. Your therapist also must decline any invitation to attend gatherings with your family or friends. Lastly, when your therapy is completed, your therapist will not be able to be a friend to you like your other friends. In sum, it is the duty of your therapist to maintain a professional role at all times. Please note that these guidelines are not meant to be discourteous in any way, they are strictly for your long-term protection.

## Statement Regarding Ethics, Client Welfare, & Safety

Perspectives Counseling assures you that our services will be rendered in a professional manner consistent with the ethical standards of the American Psychological Association, the American Counseling Association, and the American Association for Marriage and Family Therapy. If at any time you feel that your therapist is not performing in an ethical or professional manner, we ask that you please let him or her know immediately. If the two of you are unable to resolve your concern, please contact Dr. Kristen Aycock at 678-557-0822. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. Dr. Aycock can provide you with the appropriate address upon request.

Due to the very nature of psychotherapy, as much as we would like to guarantee specific results regarding your therapeutic goals, we are unable to do so. However, your therapist, with your participation, will work to achieve the best possible results for you. Please also be aware that changes

made in therapy may affect other people in your life. For example, an increase in your assertiveness may not always be welcomed by others. It is our intention to help you manage changes in your interpersonal relationships as they arise, but it is important for you to be aware of this possibility nonetheless.

Additionally, at times people find that they feel somewhat worse when they first start therapy before they begin to feel better. This may occur as you begin discussing certain sensitive areas of your life. However, a topic usually isn't sensitive unless it needs attention. Therefore, discovering the discomfort is actually a success. Once you and your therapist are able to target your specific treatment needs and the particular modalities that work the best for you, help is generally on the way.

## Technology Statement

In our ever-changing technological society, there are several ways we could potentially communicate and/or follow each other electronically. It is of utmost importance to us that we maintain your confidentiality, respect your boundaries, and ascertain that your relationship with your therapist remains therapeutic and professional. Therefore, we've developed the following policies:

Cell phones: It is important for you to know that cell phones may not be completely secure and confidential. However, we realize that most people have and utilize a cell phone. Your therapist may also use a cell phone to contact you. If this is a problem, please feel free to discuss this with your therapist.

Text Messaging and Email: Both text messaging and emailing are not secure means of communication and may compromise your confidentiality. However, we realize that many people prefer to text and/or email because it is a quick way to convey information. If you choose to utilize texting or email, please discuss this with your therapist. **However, please know that it is our policy to utilize these means of communication strictly for brief topics such as appointment confirmations.** Please do not bring up any therapeutic content via text or email to prevent compromising your confidentiality. **You also need to know that we are required to keep a copy of all emails and texts as part of your clinical record.**

Facebook, LinkedIn, Instagram, Pinterest Etc: It is our policy not to accept requests from any current or former client on social networking sites such as Facebook, LinkedIn, Instagram, Pinterest, etc. because it may compromise your confidentiality.

Google, etc.: It is our policy not to search for our clients on Google or any other search engine. We respect your privacy and make it a policy to allow you to share information about yourself to your therapist as you feel appropriate. If there is content on the Internet that you would like to share with your therapist for therapeutic reasons, please print this material out and bring it to your session.

Twitter & Blogs: We may post psychology news on Twitter or write an entry on a blog. If you have an interest in following either of these, please let your therapist know so that he/she may discuss any potential implications to your therapeutic relationship. Once again, maintaining your confidentiality is a priority. We would recommend using an RSS feed or locked Twitter list, which would eliminate you having a public link to our content.

In summary, technology is constantly changing, and there are implications to all of the above that we may not realize at this time. Please feel free to ask questions, and know that we are open to any feelings or thoughts you have about these and other modalities of communication.

Our Agreement to Enter into a Therapeutic Relationship

We are sincerely looking forward to facilitating you on your journey toward healing and growth. If you have any questions about any part of this document, please ask your therapist.

Please print this page, date, and sign your name below indicating that you have read and understand the contents of this form, you agree to the policies of your relationship with your therapist/group leader, and you are authorizing your therapist/group leader to begin treatment with you.

________________________________________ ________________
**Client Name (Please Print)** **Date**

________________________________________
**Client Signature**

**If Applicable:**

________________________________________ ________________
**Parent’s or Legal Guardian’s Name (Please Print)** **Date**

________________________________________
**Parent’s or Legal Guardian’s Signature**

The signature of the Therapist below indicates that she or he has discussed this form with you and has answered any questions you have regarding this information.

________________________________________ ________________
**Therapist’s Signature** **Date**

**To be completed by the adolescent to share with therapist at his/her first appointment:**

What is your favorite band or artist?

______________________________________________

What is your favorite TV show?

______________________________________________

How would you describe your school?

______________________________________________

What do you like the most about your mom, dad and/or parents?______________________________________________

______________________________________________

______________________________________________

What frustrates you the most about your mom, dad and/or parents?______________________________________________

______________________________________________

______________________________________________

What qualities do you appreciate the most about your best friend?______________________________________________

______________________________________________

______________________________________________

What sports do you play or hobbies do you have?______________________________________________

______________________________________________

______________________________________________

What is your favorite way to spend a Saturday?______________________________________________

______________________________________________

______________________________________________

**Sentence Completion**

*Finish the following sentences with something that makes sense for you. There are no wrong answers.*

1. I would like
2. If I were older
3. Girls
4. My friends think
5. What makes me mad is
6. My father
7. I miss
8. I am scared
9. I often think of myself as
10. My only trouble
11. I dream of
12. Being younger would
13. I hate

14. If I don't get what I want at home
15. What worries me is
16. When I grow up
17. Nothing bothers me more than
18. Other people think I'm
19. I feel unhappy sometimes because
20. Boys
21. There are times when I
22. Being my age is
23. I don't think I can
24. It's tough when
25. At home
26. Teachers are
27. If only I were not so
28. If I am left behind
29. Sometimes I think about
30. If I were smarter
31. Sometimes I feel like
32. It is more important to
33. I wonder if I should
34. My mother
35. If my parents had only
36. I would be happier if
37. I'm glad I'm
38. I wish I were
39. If I could choose my family
40. It would be funny if
41. The world would be a better place if