

INSTRUCTIONS FOR ENCLOSED FORMS

CHILD AND FAMILY

1. CONSENT FORMS

There are several consent forms enclosed.

- A. Informed Consent and Authorization for Services. This is a summary of information about Cobb Counselling & Consulting. It answers many common questions about confidentiality, fees, and frequency of visits.
- B. Consent to be Contacted. This form allows you to specify how you would like to be contacted in the future by Cobb Counselling & Consulting.
- C. Parental Consent for Treatment. Consent for providing treatment services to a minor is required by the parent(s) or guardian(s) of the minor.

Please read through the forms, mark the appropriate boxes where indicated, and sign the bottom of each form. Bring these forms with you to your initial session. Feel free to discuss any questions with your therapist before signing them.

Only one of each form is necessary per couple or family.

2. INTAKE QUESTIONNAIRES

The purpose of these questionnaires is to aid assessment and treatment planning by giving your clinician a broad overview of your background and current situation at a glance. All information you provide on these forms will be kept as part of your confidential file. The parents should each fill out the Adult form. One of the parents should fill out a Child form for each child that is the focus of treatment.

Please read each question carefully, write your answers in the spaces provided, and bring the completed forms with you to the first session. It will take about 5-10 minutes to finish.

These questionnaires are not required but it is strongly encouraged as they are very helpful to the assessment if completed ahead of time.

If you have any questions, please do not hesitate to telephone or email.

CONSENT TO BE CONTACTED

Some verbal and written communication from me to you is necessary from time to time so that I can provide services to you and operate the business side of my practice. Examples include: scheduling appointments, collecting payments, reminders about upcoming appointments, and follow-up to services being provided. Every effort is made, however, to be discrete in contacting you.

This form allows you to specify some of the purposes and methods of contact that you are comfortable receiving from me. Every reasonable effort will be made to limit contact to the methods you select. This consent is specifically for contact I initiate with you (i.e. follow-up, reminders, letters, invoices, etc.)

CHECK → Please check your preferred method(s) of receiving written communication initiated by Cobb Counselling & Consulting: *Mail* *Email* *Either*

Special Instructions (if any): _____

CHECK → Please check whether you would like to be on our email list to receive newsletters and notices of upcoming workshops or new services. *Yes* *No*

CHECK → Please check whether you are willing to complete a client satisfaction survey, up to 3-6 months post-treatment, giving feedback about the quality of services you received. *Yes* *No*

Your Contact Information

Mailing Address: _____
Street Address City Province Postal Code

Phone: Home _____ May a message be left at this number? Yes No
Work _____ Whose number? _____ May messages be left? Yes No
Cell _____ Whose number? _____ May messages be left? Yes No
Cell _____ Whose number? _____ May messages be left? Yes No
Fax _____ Is this a confidential fax? Yes No

Special Instructions: _____

PLEASE CIRCLE ONE OF THE ABOVE PHONE NUMBERS to indicate the number that you would prefer we use to make courtesy reminder calls about upcoming appointments (must be a number where it is okay to leave messages).

Email Address: _____
(Provide if you wish to receive correspondence from me by email, as indicated in your selections above).

YOUR SIGNATURE

I/we give our authorization to be contacted by Cobb Counselling & Consulting as outlined above.

Name Signature Date

Name Signature Date

INFORMED CONSENT

AND AUTHORIZATION FOR SERVICES

Welcome to Cobb Counseling & Consulting. This form provides information to help you make an informed decision about accepting services from me.

My Qualifications

- Ph.D. and M.S. in Marriage & Family Therapy from Brigham Young University
- B.A in Psychology from the University of Calgary
- Registered Psychologist with the College of Alberta Psychologists
- Clinical Member of the American Association for Marriage & Family Therapists
- Listed on the Registry of Marriage and Family Therapists in Canada

Frequency of Sessions

- Weekly or bi-weekly 50-minute sessions are most common.
- Frequency of sessions is based largely on your needs and situation.

How Long is Therapy?

- I usually work within a short-term model of therapy (i.e. 1-20+ sessions).
- The amount of sessions needed varies depending on the nature of each person's concerns, the complexity of the issues involved, the strength of our working relationship, and each person's commitment to work on the presenting issues. There is a direct relationship between effort applied between sessions and progress over time.

Fees

- **\$170 per 50-minute hour**
- I prefer payment at each session rather than a regular billing process.
- Additional time beyond the 50-minute hour is billed in 10-minute increments.
- Billable services include: face-to-face and telephone consultations (not including the initial intake or dealing with brief scheduling matters), report writing, and review of written records from other professionals.

About Privacy

- **All information you share with me is private and confidential.**
- **I will not release your information to anyone without your written permission.**
- If any information is to be released I will consult with you about what is released.
- Your information will be kept on file in a secure and private location.
- You may review the contents of your own counseling file upon request.
- The full privacy policy for Cobb Counselling & Consulting is available upon request. It can also be viewed at www.nathancobb.com/privacy-policy.html

Exceptions to Privacy

Your confidential information may be released without your consent under the following conditions:

- When the purpose is to protect individuals (including a client) who are at foreseeable and imminent risk of bodily harm or death as a result of a client's actions.
- Under law that requires reporting of child and elder abuse/neglect to authorities.
- Under subpoena from a court of law.
- There are exceptions that apply to personal information disclosed by minors. I will discuss these with you in session, as applicable.

Email Privacy

- Email is a quick and convenient method of communication. Many of my clients use it to correspond with me. Please be aware, however, that while every effort is made to safeguard your privacy, I cannot guarantee the confidentiality of email correspondence.
- If this is a concern for you, please do not send me email.
- I will only use email to communicate with you: a) in response to an email you send me, or b) as you authorize it or otherwise request it.

Consent to Release Information to Health Insurance Provider

Skip this section if you do not plan to submit claim to your health insurance provider

I understand that my insurance company _____
Name of company
 may contact Cobb Counselling & Consulting to obtain information necessary to verify my claim for reimbursement. I understand that the type of information requested would typically include: 1) date of service, 2) the nature of services provided, and 3) the individuals who received the service. It may also include diagnosis and treatment plan information.

I give my consent to Cobb Counselling & Consulting to release to my extended health insurance provider information that is necessary for processing of my insurance claim.

Initial Here →

_____ or Does not apply to me/us
Initials Initials

24-Hour Cancellation Policy

- If you cannot attend an appointment, please let me know 24 hours in advance.
- There is a charge for missed appointments and for late-cancelled appointments.
- The purpose of a cancellation policy is to allow me enough time to fill the appointment. I appreciate that unforeseen events sometimes happen, but please be as respectful of my time as you can. The decision to bill is at the discretion of the therapist.
- Please cancel by telephone since email delivery is not always instantaneous or reliable.
- If you arrive late, the session will have to be shorter.
- If you are more than 20 minutes late, I will assume you are not attending.

Initial Here →

I am aware of and agree to pay the late cancellation/missed appointment fee in the event that I cancel an appointment with less than 24 hours notice. I am aware that the charge is \$85.00 _____
Initials

Initial Here →

I understand that a notification to cancel initiated after hours (i.e. after 4:30PM or on weekends) for an appointment scheduled the following business day is considered a late cancellation regardless of the length of notice. _____
Initials

Emergencies

- If your life or safety is in danger please phone 911 or go to the nearest emergency room. For other emergencies a useful resource is the Calgary Distress Centre (24 hours) at **(403) 266-1605**. Non-urgent concerns should be reserved for a scheduled appointment.
- You can also call me at **(403) 255-8577**. Be aware, however, that I am not always available, particularly after hours, and may not be able to return your call immediately.

Complaints and Questions

- It is important to me that you feel you are benefiting from our meetings together. If at any time you are unhappy with the service you are receiving or if you are unsure about the goals or purposes of treatment, please express your concerns to me directly. I will do my best to resolve your concerns and answer your questions.
- If you would prefer, I will also assist you with a referral to another therapist.
- If I can improve the service you are receiving in any way, please let me know.

YOUR SIGNATURE

I have been informed of the procedures and conditions as outlined in this letter. I have had an opportunity to discuss these procedures and conditions with my therapist and I am satisfied that my questions have been answered to the extent possible. I accept the help offered with full knowledge and understanding of the relevant procedures and conditions.

 Name Signature Date

 Name Signature Date

PARENTAL CONSENT FOR TREATMENT

I/we, _____ and _____
(Name of custodial parent/ guardian) (Name of other custodial parent/ guardian, if necessary – see below)

consent to Nathan Cobb, Ph. D., Registered Psychologist, providing counseling services to:

(Name of minor/dependent adult) (Date of birth)

(Name of minor/dependent adult) (Date of birth)

(Name of minor/dependent adult) (Date of birth)

(Name of minor/dependent adult) (Date of birth)

Please select the appropriate custodial arrangement that applies to your situation:

Check one

- Biological parents residing together
- Consent for treatment form can be signed by one biological parent
- Biological parents not residing together – sole custody agreement
- Consent for treatment form must be signed by the parent with sole custody
- Biological parents not residing together – joint custody agreement
- Consent for treatment form must be signed by *both* biological parents

(Signature of Custodial Parent / guardian) (Date)

(Signature of Custodial Parent / guardian) (Date)

(Signature of Witness) (Date)

Intake Questionnaire – Adult

Today's Date: _____

Your Name: _____

Your Birthdate: _____ Age: _____

Marital Status: Single Never married Exclusive dating
(check all that apply) Cohabiting Married Remarried
 Separated Divorced Widowed

(If applicable): For how long have you *currently* been married, cohabiting, separated, divorced, or widowed? _____

How many children do you have? _____

How many of your children live with you? _____

Education: Some high school High school
(highest level) Technical / Trades 2-year associate degree
 Some undergraduate college or university
 Undergraduate degree Some graduate level
 Graduate degree: _____

Income: \$0-30,000 \$31-60K \$61-90K
(household annual) \$91-120K \$120-150K \$150K +

Current Occupation: _____

Years at Current Job: _____ Hrs per week: _____

Do you enjoy your work? A lot Moderately Very little

Career Goals: _____

SYMPTOM CHECKLIST

On a scale of 0-4 (0=none or not applicable, 1=a little, 2=moderate, 3=a lot, 4=extreme) rate how much you have experienced each symptom over **the past two weeks**. The first six symptoms (a-f) relate to your relationship with your spouse or partner. (If you are single, circle "0").

(Circle a number)

a. Not talking to each other	0	1	2	3	4
b. Having bad arguments	0	1	2	3	4
c. Lack of trust between us	0	1	2	3	4
d. Feeling lonely in the relationship	0	1	2	3	4
e. Lack of affection and caring between us	0	1	2	3	4
f. Feeling unhappy about our relationship	0	1	2	3	4
g. Feeling sad, down or depressed	0	1	2	3	4
h. Avoiding certain people or places	0	1	2	3	4
i. Loss of interest in activities I normally enjoy	0	1	2	3	4
j. Low energy/feeling tired	0	1	2	3	4
k. Sleep problems (insomnia, not staying asleep, or early waking)	0	1	2	3	4
l. Eating too much or too little	0	1	2	3	4
m. Not able to think clearly	0	1	2	3	4
n. Feeling no pleasure or joy in life	0	1	2	3	4
o. Anxiety attacks	0	1	2	3	4
p. Worrying about things	0	1	2	3	4
q. Angry outbursts	0	1	2	3	4
r. Low self-esteem or low self-confidence	0	1	2	3	4
s. Feeling guilty	0	1	2	3	4
t. Feeling too stressed	0	1	2	3	4
u. Thoughts of suicide	0	1	2	3	4
v. Drinking too much or abusing drugs (i.e. street drugs or prescribed medications)	0	1	2	3	4
w. Acting out other compulsive behaviors (i.e. gambling, sex, porn, shopping, etc.)	0	1	2	3	4
x. Not getting my work done	0	1	2	3	4
y. Feeling unhappy with my workplace	0	1	2	3	4

Symptoms Total: _____ / 100

Medical: Do you have any medical problems? Yes No

If yes, please list them: _____

Do you take any prescription **Medications**? Yes No

If yes, please list them:

Medication	Dose	Purpose	Since

Do you **Exercise**? Yes No If yes, what do you do?

Do you drink **alcohol**? Yes No

If yes, estimate how many times you typically drink in a month (i.e. how many drinking occasions): _____

Estimate how many standard drinks you typically drink per occasion (estimate your range if it varies): _____

Do you **smoke** tobacco? Yes No

If yes, please estimate quantity per day: _____

Do you drink **coffee/ tea**? Yes No

If yes, please estimate quantity per day: _____

Do you use any **illicit drugs**? Yes No

If yes, please specify: _____

If you drink alcohol or use illicit drugs, please answer the following questions:

C. Have you ever thought you should **Cut** Yes No **down** on your drinking/ drug use?

A. Have people **Annoyed** you by Yes No criticizing your drinking/ drug use?

G. Have you ever felt bad or **Guilty** about Yes No your drinking/ drug use?

E. Have you ever had a drink / used drugs Yes No in the morning (**Eye opener**) to steady your nerves or to get rid of a hangover?

Are you concerned about the alcohol and/or drug use of anyone close to you? Yes No If yes, who?

Are you experiencing **abuse** in any of your **current** relationships?

Yes No If yes: Physical Emotional Sexual
By whom? _____

Have you ever experienced **abuse** in your **past** relationships?

Yes No If yes: Physical Emotional Sexual
By whom? _____

REASONS FOR SEEKING FOR COUNSELING

Check only those that apply. If you check more than one, please select your top three and rank them from highest to lowest in terms of the priority you place on resolving them (1=highest priority, 2=second highest, 3=third highest).

- | | |
|---|-------|
| (√) (Check all that apply) | Rank |
| <input type="checkbox"/> Depressed Mood | _____ |
| <input type="checkbox"/> Anxiety | _____ |
| <input type="checkbox"/> Anger Management | _____ |
| <input type="checkbox"/> Self-Esteem or Confidence | _____ |
| <input type="checkbox"/> Social Difficulties | _____ |
| <input type="checkbox"/> Stress Management | _____ |
| <input type="checkbox"/> Bereavement/ Loss | _____ |
| <input type="checkbox"/> Domestic Violence or Abuse (Current) | _____ |
| <input type="checkbox"/> Premarital Counselling | _____ |
| <input type="checkbox"/> Communication Problems/Relationship Conflict | _____ |
| <input type="checkbox"/> Sexual Intimacy Concerns | _____ |
| <input type="checkbox"/> Emotional or Sexual Infidelity/affairs | _____ |
| <input type="checkbox"/> Other Marital/Relationship Concerns | _____ |
| <input type="checkbox"/> Separation / Divorce / Relationship Break-Up | _____ |
| <input type="checkbox"/> Custody Concerns | _____ |
| <input type="checkbox"/> Parenting | _____ |
| <input type="checkbox"/> Parent-Adult Child Relations | _____ |
| <input type="checkbox"/> Blended Family Issues | _____ |
| <input type="checkbox"/> Family Conflict | _____ |
| <input type="checkbox"/> Work problems | _____ |
| <input type="checkbox"/> Education/ Career Concerns | _____ |
| <input type="checkbox"/> Financial Concerns | _____ |
| <input type="checkbox"/> Legal Concerns | _____ |
| <input type="checkbox"/> Medical Issues | _____ |
| <input type="checkbox"/> Substance Abuse (Alcohol/Drugs) | _____ |
| <input type="checkbox"/> Gambling Difficulties | _____ |
| <input type="checkbox"/> Other Addictions (i.e. Sex, Shopping) | _____ |
| <input type="checkbox"/> Eating Disorder | _____ |
| <input type="checkbox"/> Weight Management / Body Image | _____ |
| <input type="checkbox"/> Spiritual Problems | _____ |
| <input type="checkbox"/> Child – Behavioral Problems | _____ |
| <input type="checkbox"/> Child – Mood / Anxiety Problems | _____ |
| <input type="checkbox"/> Child – Academic Problems | _____ |
| <input type="checkbox"/> Child – Social/ Relational Problems | _____ |
| <input type="checkbox"/> Other _____ | _____ |

PREVIOUS TREATMENT

Have you participated in therapy or counseling in the past?
 Yes No If yes, please specify:

Date	Duration	Therapist / Location	Was it Helpful?

Who do you turn to for social support (e.g. for encouragement, advice, friendship, etc.)?

Are there any organizations or agencies that you are currently receiving assistance or support from? Yes No If yes, please specify: _____

EXTENDED FAMILY HISTORY OF PSYCHOSOCIAL / HEALTH DIFFICULTIES

Please check any of the conditions below that are or have been present in your extended family. Please write any additional explanatory comments that may be helpful for your therapist to understand.

- | | |
|---|------------|
| | Who? When? |
| <input type="checkbox"/> Depression | _____ |
| <input type="checkbox"/> Bipolar Disorder | _____ |
| <input type="checkbox"/> Schizophrenia | _____ |
| <input type="checkbox"/> Other psychiatric disorders (i.e. psychosis, hallucinations) | _____ |
| <input type="checkbox"/> Suicide | _____ |
| <input type="checkbox"/> Physical / Sexual Abuse | _____ |
| <input type="checkbox"/> Substance Abuse (Alcohol/Drugs) | _____ |
| <input type="checkbox"/> Autism/Asperger’s Syndrome | _____ |
| <input type="checkbox"/> Eating Disorder | _____ |
| <input type="checkbox"/> Chronic Illness (please specify illness) | _____ |
| <input type="checkbox"/> Accidental or Untimely Death | _____ |
| <input type="checkbox"/> ADHD or Learning Disorders | _____ |
| <input type="checkbox"/> Other | _____ |

OTHER INFORMATION

Please include here any additional background information you feel would be helpful for your therapist to know:

REFERRAL SOURCE

Please let us know how you learned about Cobb Counselling & Consulting. (Check all that apply):

- Internet search / website
- Word of mouth (family/friend)
- Another professional (physician, lawyer, etc.)
- Workshop or seminar
- I am a returning client
- My employer or health insurance provider
- Other _____

Thank-you very much for taking the time to fill out this questionnaire.

Intake Questionnaire – Child

Today's Date: _____
 Child's Name: _____
 Child's Birthdate: _____ Age: _____
 Child's Biological Mother: _____
 Child's Biological Father: _____

Child Primarily Resides With: Biological Mother and Father in same house
 Biological Mother Biological Father
 50/50 Biological Mother & Father

Name of School: _____
 Grade Level: _____
 Average Grades: Math: _____
 Science: _____
 L.A.: _____
 Social Studies: _____

Does your child have a job? Yes No
 Current Job: _____
 Years at Current Job: _____ Hrs per week: _____

SYMPTOM CHECKLIST

On a scale of 0-4 (0=none, 1=rarely, 2=sometimes, 3=frequently, 4=many times) rate how much you have observed each symptom in your child over **the past year** (circle the number).

a. Withdrawal from family	0	1	2	3	4
b. Irritability or mood changes	0	1	2	3	4
c. Stealing	0	1	2	3	4
d. Lying	0	1	2	3	4
e. Loss of interest in extracurricular activities	0	1	2	3	4
f. Being secretive	0	1	2	3	4
g. Defying parents/house rules	0	1	2	3	4
h. Angry outbursts	0	1	2	3	4
i. Negative attitude to school	0	1	2	3	4
j. Drop in grades	0	1	2	3	4
k. Frequent change in friends	0	1	2	3	4
l. Worrying excessively	0	1	2	3	4
m Difficulties sleeping	0	1	2	3	4
n. Loss of drive/motivation	0	1	2	3	4
o. Difficulties making friends	0	1	2	3	4
p. Low self-image	0	1	2	3	4
Symptoms Total:					 / 64

How much do these symptoms interfere with the following?

Personal well-being	0	1	2	3	4
School performance	0	1	2	3	4
Family relationships	0	1	2	3	4

Does your child:
 Have any **Medical** problems? Yes No
 If yes, please list them: _____

Take any prescription **Medications**? Yes No
 If yes, please list them:

<i>Medication</i>	<i>Dose</i>	<i>Purpose</i>	<i>Since</i>

Do any **Extracurricular** Activities? Yes No
 If yes, please specify: _____

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

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

Has your child experienced any past **trauma**? Yes No
 If yes, please specify: _____

PREVIOUS TREATMENT

Has your child participated in therapy or counseling in the past? Yes No If yes, please specify:

Date	Duration	Therapist / Location	Was it Helpful?

OTHER INFORMATION

Please include here any additional background information you feel would be helpful for your therapist to know:

Thank-you very much for taking the time to fill out this questionnaire.