Oasis Counseling Services

Adolescent Services Form (14 – 17)

Welcome to the Oasis counseling center at Cairn University. We provide students and community members with professional and pastoral counseling to promote emotional, relational, psychological, and spiritual health. The following information will help you to understand how we work. If you still have questions after reading this, we'd be happy to answer them.

YOUR FIRST VISIT

During your first visit, we will collect information from you that will help us to select the right counselor for you. Please provide as much information as possible. All of our counselors are Christians who, at a minimum, have received master's level training in counseling or a related discipline. Whenever possible, we will try to accommodate your preference for a male or female counselor.

COUNSELING SESSIONS

Plan to meet weekly with your assigned counselor at a set day and time. Each session will be 45-50 minutes in duration. Services are provided by professional counselors and by advanced graduate interns in counseling. Senior staff supervises all graduate students providing services at the Oasis Counseling Center. Your counselor is either licensed or being supervised by someone who is licensed. As standard practice, all counselors will identify their licensure status and the names of any clinical supervisors at the Oasis Center. Clients may at any time ask to see a supervisor or the clinical director of the Center for a consultation. We want your counseling experience to be meaningful for you. If for any reason, you are dissatisfied with our services, please let your counselor know. If you are not able to resolve your concerns with your counselor, you may call Ashlyn Jones, Coordinator at 215-702-4304 ext. 4304

REFERRALS

At times, it may become necessary for us to refer you to another professional such as a general practitioner or a psychiatrist. Should this happen, please know that it is because we are committed to implementing best care practices and to the client's best interests.

CONFIDENTIALITY

We understand your need for privacy and will do everything in our power to protect it. Violations of Community Life Standards will not be reported to Student Life or others. Your information can only be released when permitted by you or mandated by law (see confidentiality policy).

CANCELLATION

If you are unable to keep an appointment, please notify us 24 hours in advance by calling 215-702-4224 or by emailing oasis@cairn.edu. If you don't show up for an appointment or you fail to give us sufficient notice, you will risk losing your day and time for future sessions.

EMERGENCY

Should you need to speak with someone in between sessions, call Dr. Jeffrey Black at 267-243-5008. If you are feeling like you might harm yourself or someone else or you otherwise need emergency attention, you can immediately call (911) or go to your nearest hospital emergency room for care. Additionally, Lenape Valley Crisis Intervention Services can be reached at 215-785-9765.

COST OF SERVICES

Registered students of Cairn University have the cost of counseling covered through the semester student services fee. Non-student counselees from the community are required to provide payment of $25.00 per session at the time services are rendered. Payments can be made with cash or a check made out to Cairn University. Credit/Debit cards are not accepted and we do not bill insurance companies.

CAMERAS

You will notice video/audio recording equipment in some of the counseling offices. These are used to assist in providing your counselor with professional clinical supervision. From time to time a member of the clinical supervision team including interns-in-training may observe your counseling session. This is done to ensure the highest level of care to you. If you have any concerns about this you may discuss this with your counselor.

OASIS COUNSELING CENTER

CLIENT INTAKE FORM (14 – 17)

DIRECTIONS: Please complete the following form and bring with you to your first appointment. It is recommended that the adolescent fill out the form on their own; however, they can ask for help from their parents if they so desire. ***ALL INFORMATION IS CONFIDENTIAL!***

CLIENT CONTACT INFORMATION:

Date: _____ Referred by:_____

Name: _____Date of Birth:_____ Age:_____

Mailing Address: _____

_____

City State Zip

Phone: (Cell) _____ (May we call or leave a message at this number?) Y☐ N☐

(Home) _____ (May we call or leave a message at this number?) Y☐ N☐

E-mail Address: _____ (May we e-mail you?) Y☐ N☐

(Note: Because e-mail is not confidential, we strongly discourage you from using e-mail to communicate sensitive information with your counselor.)

PARENT/GUARDIAN CONTACT INFORMATION (1):

Name: _____Date of Birth:_____ Age:_____

Relationship to Child:_____

Mailing Address: _____

_____

City State Zip

Phone: (Cell) _____ (May we call or leave a message at this number?) Y☐ N☐

(Home) _____ (May we call or leave a message at this number?) Y☐ N☐

E-mail Address: _____ (May we e-mail you?) Y☐ N☐

(Note: Because e-mail is not confidential, we strongly discourage you from using e-mail to communicate sensitive information with your counselor.)

PARENT/GUARDIAN CONTACT INFORMATION (2):

Name: _____Date of Birth:_____ Age:_____

Relationship to Child:_____

Mailing Address: _____

_____

City State Zip

Phone: (Cell) _____ (May we call or leave a message at this number?) Y☐ N☐

(Home) _____ (May we call or leave a message at this number?) Y☐ N☐

E-mail Address: _____ (May we e-mail you?) Y☐ N☐

(Note: Because e-mail is not confidential, we strongly discourage you from using e-mail to communicate sensitive information with your counselor.)

Employment: _____Hrs. per week:_____

ACADEMIC INFORMATION:

Name of School: _____

Grade/Year: _____

Grades (Please Circle): Mostly: A's B's C's D's F's

How would you rate your overall experience at school?

I Really Enjoy School School is okay I dislike school

1 2 3 4 5 6 7 8 9 10

Do you participate in any sports/activities at school or in your community? If yes, please list:

_____

_____

Please list the names of your closest friends:

1)_____2)_____3)_____

4)_____5)_____

Relationship Status: □ Single □ Dating

Do you attend church? Y N If yes, where ?

_____

Name of Pastor: _____

May we contact your pastor? Y or N

What brings you to counseling?

_____

_____

How severe do you believe this problem is?

□ Mildly Upsetting □ Very Upsetting □ Urgent, I'm in crisis

How would you rate the level of emotional pain you are currently experiencing?

Mild Moderate Extreme

1 2 3 4 5 6 7 8 9 10

Have you ever sought counseling before? □ Yes □ No

If so, please explain:

When? _____ Where? _____ Why? _____ _____

_____

When? _____ Where? _____ Why? _____

_____

Are you currently experiencing any suicidal thoughts? □ Yes □ No

If Yes, please explain:

_____

_____

Rate overall risk of suicide

Extremely low risk: 1 2 3 4 5 : Extremely high risk

(will <u>not</u> kill self) ☐☐☐☐☐ **(will kill self)**

Have you ever experienced suicidal thoughts/actions in the past? □ Yes □ No

If Yes, please explain:

_____

_____

How would you assess your current physical health?

□ Very Good □Good □Fair □Poor

Explain:

_____

_____

How often do you exercise?

_____

Describe your sleeping patterns:

_____

_____

How often do you eat?

_____

How much caffeine do you take in per day? (Coffee, Tea, Soda, Energy Drinks, etc.)

_____

Are you currently taking <u>any</u> prescription medication? □ Yes □ No

Name_____prescribed for_____Dosage (mg./day)_____

Name_____prescribed for_____Dosage (mg./day)_____

Name_____prescribed for_____Dosage (mg./day)_____

Have you ever had Surgery? □ Yes □ No

If Yes, When and what for?

_____

_____

Do you have a history of alcohol or drug use? □ Yes □ No

If Yes, please explain:

_____

_____

Have you ever had treatment for alcohol/drug use?

_____

_____

FAMILY HISTORY: (Check any that are/were present in your family.)

Who in your family has experienced:

☐ Depression _____

☐ Anxiety _____

☐ Substance Abuse _____

☐ Suicide Attempt _____

☐ Physical Abuse _____

☐ Sexual Abuse _____

☐ Eating Disorder _____

☐ Other Psychiatric/Emotional Disturbance (explain) _____

_____

☐ None

Please check any of the following concerns you are currently experiencing or have experienced:

Present	Past	
☐	☐	Anxiety
☐	☐	Depression
☐	☐	Bipolar disorder
☐	☐	Unwanted sexual experience
☐	☐	Sleep disturbance
☐	☐	Changes in appetite
☐	☐	Academic problem
☐	☐	Relationship concerns (e.g. break up, conflict)
☐	☐	Relationship violence (e.g. emotional, physical, sexual, verbal abuse)
☐	☐	Panic attacks
☐	☐	Shyness or Social Anxiety
☐	☐	Test Anxiety
☐	☐	Obsessive compulsive behavior
☐	☐	Phobia
☐	☐	Stress
☐	☐	Thoughts of suicide
☐	☐	Suicide attempt(s)
☐	☐	Self-Injury (e.g. cutting, burning, banging head, etc.)
☐	☐	Difficulty concentrating
☐	☐	ADHD
☐	☐	Low motivation or energy
☐	☐	Severe mood swings
☐	☐	Loneliness
☐	☐	Anorexia

☐ ☐ Bulimia
☐ ☐ Disordered eating
☐ ☐ Anger management
☐ ☐ Family concerns
☐ ☐ Traumatic event
☐ ☐ Physical abuse
☐ ☐ Sexual abuse
☐ ☐ Pornography use
☐ ☐ Gambling
☐ ☐ Recent death or loss
☐ ☐ Legal/Judicial Affairs problem
☐ ☐ Alcohol abuse
☐ ☐ Marijuana use
☐ ☐ Other drugs (e.g. methamphetamine, cocaine, etc.)
☐ ☐ Sexual dysfunction
☐ ☐ Health concern
☐ ☐ Work-related concern
☐ ☐ Identity problem
☐ ☐ Religious or spiritual problem
☐ ☐ Cultural concerns
☐ ☐ Excessive video or online game use
☐ ☐ Other: _____

What do you see as your top 5 **strengths**?
1. _____ 2. _____ 3. _____
4. _____ 5. _____

What do you do for fun (i.e. hobbies, interests, etc.)?

_____
_____

Have you experienced any of the following types of abuse or exploitation?

□ Physical □ Emotional
□ Sexual □ Rape/date rape

Please select the option that best explains your <u>parents</u> Marital Status:

□ Single, Never married □ Married (how long? _____)
□ Divorced (how long? _____) □ Separated (how long? _____)
□ Widowed (how long?_____)

Do you prefer to speak with a: □ Male Counselor □ Female Counselor □ Either

What is your availability?

	Mon	Tue	Wed	Thur	Fri	Sat
Morning						
Afternoon						
Evening						

Please indicate the service(s) you are interested in exploring during the triage appointment:

☐ Self-help materials
☐ Brief problem-solving (1-2 sessions)
☐ Individual counseling, short (1-4 sessions)
☐ Individual counseling (4-12 sessions)
☐ Long-term individual counseling
☐ Group counseling
☐ Referral to other appropriate services
☐ Psychiatric assessment and services
☐ Dietitian assessment and services

What is your Goal for counseling?

_____

_____

_____

At the present time, how well do you feel you are getting along emotionally and physically?

□ Very poorly: I can barely manage to deal with things.

□ Fairly poorly: life is pretty tough for me at times.

□ So-so: I manage to keep going with some effort.

□ Pretty well: I have my ups and downs, but I generally manage to do okay.

□ Very well: much the way I would like to be.

Please feel free to provide any additional information:

THANK YOU!! If you received this form via email **please print this form and bring to your initial appointment.** You and your intake counselor will determine the most appropriate therapeutic service for your particular concern. Options include: **Individual Counseling, Group Counseling, Couple's Counseling, and Referral to the Community.**

CONFIDENTIALITY POLICY FOR ADOLESCENT (AGES 14-17)

- In the state of Pennsylvania, in the field of mental health, any child over the age of 14 is no longer considered a minor and obtains the right to obtain mental health services without their parents' consent. A parent/guardian of a child under 18 can consent for their child to be in outpatient treatment even if the child does not wish to participate. Clients ages 14-17, have the sole right to the access of their mental health records and must sign a release of information to grant their parents/guardians this same right.

At Oasis Counseling Center we believe it is important to include parents in the therapeutic process. Given the fact that parents of clients (ages 14-17) do not have the right to access their child's mental health records or information regarding therapy sessions, it is strongly recommended that clients ages 14-17 sign a release of information at the beginning of counseling.

At Oasis Counseling Center we believe it is equally important that all of our clients feel comfortable talking to their counselors. It is imperative for the success of the counseling relationship that a client be able to rely upon the confidential nature of the counseling relationship. For this reason, counselors may choose to maintain a level of confidentiality by describing problems to parents in more general terms. *Parents should not expect to know the details of the counseling process unless an immediate safety concern arises*. Anything the counselor chooses to discuss with the parent/guardian will first be discussed and agreed upon with the adolescent client.

All counseling communications, records, and contacts between the adolescent and their counselor will be held in confidence, and will be discussed only with the Director of Counseling Services and supervising team for case management purposes. Exceptions to this confidentiality policy may occur only under the following conditions:

1. Adolescent signs a written release for counselor to release information to another person or agency.
2. Adolescent expresses serious intent to harm himself/herself or someone else.
3. Reasonable indication arises during counseling of abuse of client, any child under the age of 18, elderly person or dependent adult. It is required by law to report this information to law enforcement or the ChildLine Abuse Registry (1-800-932-0313)
4. A court order is received mandating disclosure of information

FOR ADOLESCENT:
I understand that since I am 14 years of age or older, I alone have the right to access my mental health records. I also understand that it is important for my parents to be informed of the general process of my counseling goals and treatment. It is recommended that I sign a consent to release information so that my counselor may update my parent/guardian about my progress. I understand that my counselor would communicate with me first regarding any information that would be shared with my parents, protecting my right to confidentiality unless a serious safety concern arises. Initial _____

FOR PARENT(s)/GURADIAN(S):
I understand that I do not have the legal right to request written records/session updates unless my child chooses to sign a release of information. Should my child sign a release, I agree to respect the need for my child to have confidentiality and will refrain from asking detailed information about counseling sessions. I understand that I will be informed of any serious concerns regarding the safety of my child and that I may be asked to participate in therapy sessions as needed. *Initial(s)* _____ _____

Please sign here to indicate you have read and understand this agreement and policy:

_____ _____ _____ _____
Client Signature Date Counselor Signature Date

_____ _____
Parent Signature Date

_____ _____
Parent Signature Date

INFORMED CONSENT/COUNSELING SERVICES AGREEMENT

CONFIDENTIALITY POLICY

All counseling communications, records, and contacts between you and your counselor will be held in confidence, and will be discussed only with the Director of Counseling Services and supervising team for case management purposes. Counseling sessions may be periodically viewed or recorded by Oasis team members and supervisors for counselor-training purposes. Violations to CU's Community Life Standards **will not** be reported to Student Life or others. Exceptions to this confidentiality policy may occur only under the following conditions:

1. You sign a written release for your counselor to release information to another person or agency.
2. You express serious intent to harm yourself or someone else.
3. Reasonable indication arises during counseling of abuse of a minor child, elderly person or dependent adult.
4. A court order is received mandating disclosure of information.

Other than these possibilities your treatment, history and personal information will not be disclosed without your full knowledge and a signed release of information.

I have read and understand this paragraph_____(initial)

AUDIO/VISUAL CONSENT

I, _____, understand that my counselor is involved in internship training and/or a staff counselor at Oasis Counseling Center. I understand that Oasis is a training facility where my sessions have the possibility of being recorded for quality assurance and training purposes. As a training facility it will be expected that sessions be recorded. I understand that quality counseling is achieved through quality supervision.

I understand that all information shared will be held in strict confidence and restricted to supervision. **If used in any other setting a separate consent agreement will be signed.** I understand that all audiotapes and videotapes will be destroyed in a timely fashion.

I have read and understand this paragraph_____(initial)

SUPERVISION AGREEMENT

Oasis Counseling Center is a training facility that employs interns and part time staff counselors. My counselor (both interns and staff counselors) have made me aware that they are meeting for supervision with a licensed supervisor to ensure best care practices. I have been advised that my counseling may be reviewed in these sessions; however, both counselor and supervisors are held to the same practice and adherence of professional and ethical guidelines and will always keep my information confidential.

I have read and understand this paragraph_____(initial)

COUNSELING SESSIONS

A counseling session is generally 45-50 minutes and typically scheduled on a weekly basis. If you are unable to keep your appointment, please email or call to cancel or reschedule at least 24 hours prior to the appointment. If you routinely miss appointments or do not give notice you will risk losing your time slot with your counselor.

The duration of counseling varies. Some individuals require a shorter time to meet their goals while others require counseling over an extended period of time. Counseling requires effort on your part and the commitment to change inside and outside of sessions. This includes efforts to change thoughts, feelings, and behaviors. There will be homework such as writing, journaling, and other assignments. Sometimes change will be achieved quickly but, for the most part, it will be slow and deliberate. Remember that change often requires practice and repetition.

Please note: It is impossible to *guarantee* specific results from the goals we set together. You have the right at any time to discuss with the counselor goals of counseling and methods of achieving these goals. We will periodically evaluate progress and, if necessary, rewrite the treatment plan (goals and methods). We will work to **achieve the best possible results for you**. Ending therapy is often mutually planned, however; you may stop at any time.

Counseling is a powerful intervention and, as such, it has both benefits and risks. You may acquire benefits such as change, a new outlook and a healthier life; you may take risks that produce uncomfortable levels of feelings like sadness, guilt, anxiety, anger, or difficulties with people, before you feel better. Circumstances may worsen and you may experience losses, for example, therapy will not necessarily keep a marriage intact.

I enter this relationship with you with anticipation. You and I will have a professional relationship, that is, we will work together in sessions and we will not have social connections. Although you will learn about me in session, our primary focus is on your concerns.

I have read and understand this section_____(initial)

_____ Date_____
(Client, Parent/Guardian)

_____ Date_____
(Counselor)