



Cynthia Garrett Counseling

Licensed Mental Health Counselor
Serving Individuals and Families in Need

Adolescent Intake Information

Legal Guardian/Parent Information

Name _____ DOB _____

Address _____ Apt. _____ City _____

State _____ Zip _____ Home Phone _____ Work Phone _____

Employer/School _____ Occupation/Studying _____

Name _____ DOB _____

Address _____ Apt. _____ City _____

State _____ Zip _____ Home Phone _____ Work Phone _____

Employer/School _____ Occupation/Studying _____

Are there any other agencies involved with the family (DCFS, Child Welfare, Courts, etc.)? _____

Family/Friend Relationships

With whom does the youth currently live?

	First Name	How frequently does the youth see this person?	How does the youth get along with this person? Please use a 1 to 5 scale, 1 indicating a highly problematic relationship
Parent/ Guardian			
Parent/ Guardian			
Step Parents			
Grandparents			
Uncles/ Aunts			
Brothers			
Sisters			

Other important relationships:

First Name	How Long?	How often does the youth see this person?

I hereby grant permission for _____, DOB, _____, for whom I am the parent/guardian, to receive psychological and/or mental health treatment by Cynthia Garrett, LMHC.

Parent/Guardian Signature

Date

Print Name

Relationship to Client

Witness

Date



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Client Intake Form

Please provide the following information for my records. If you are completing the form for another individual, please answer the questions regarding the individual. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as our sessions. Please print out this form and bring it to your first session or allow yourself thirty minutes prior to your appointment to complete the form in the office. Thank you.

Identification Information

Name _____ DOB _____

Address _____ Apt. _____ City _____

State _____ Zip _____ Home Phone _____ Work Phone _____

E-mail _____

Employer/School _____ Occupation/Studying _____

Emergency Contact Information _____

Medical Information

Primary Physician _____ Phone _____ Date of Last Exam _____

Major or Chronic Illness/Injuries _____

Operations _____

<i>Current Medication</i>	<i>Dosage</i>	<i>Frequency</i>	<i>Effectiveness</i>	<i>Prescribing Physician</i>

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How is your physical health at present? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Have there been recent changes in any of the following area?

Sleep Behaviors Amount of Exercise Sexual Desire Eating/Appetite

Weight Concentration

Substance Use

Tobacco

Do you smoke? Yes____ No____

Have you smoked in the past? Yes____ No____

If yes—Cigarettes/Day_____ Began at what age?_____

If you no longer smoke, when did you quit?_____

Alcohol

Do you consume alcohol? Yes____ No____

If so, how much?:

Less than 1x/month_____ 1-3x/month_____ 1x/week_____

Several times a week_____ Every Day_____

Check all that apply: Beer____ Wine____ Hard Liquor_____

Drugs

Do you use any street drugs or misuse prescription drugs? Yes____ No____

If yes, list as follows:

Name of Drug	Frequency of Use

Have you ever been in a drug or alcohol program? Y__N__ If yes, how many times?____

If so: When _____ Inpatient _____ Outpatient _____ How Long _____ Outcome _____

How long has the problem that initiated therapy existed? _____

What attempts have been made to resolve these difficulties? _____

Counseling Information

Please describe the main concerns that prompted you to seek counseling?

How have these concerns evolved over time? _____

Have you experienced any of the following?

Symptom	Yes	No	In the last 12 months
Extreme Depressed Mood			
Wild Mood Swings			
Rapid Speech			
Extreme Anxiety			
Panic Attacks			
Phobias			

Symptom	Yes	No	In the last 12 months
Sleep Disturbances			
Hallucinations			
Unexplained Losses of Time			
Unexplained Memory Lapses			
Alcohol/Substance Abuse			
Frequent Body Complaints			
Eating Disorder			
Body Image Problems			
Repetitive Thoughts (e.g. Obsessions)			
Repetitive Behaviors (e.g. Frequent Checking etc.)			
Homicidal Thoughts			
Suicide Attempt			

Stressor	Yes	No	In the last 12 months
Serious illness or injury			
Death of a friend or family member			
Major illness in the family			
Gain of a family member			
Divorce/Separation			
Job Change			
Other:			

What would you like to be different when therapy ends?

Are you currently receiving psychiatric services, professional counseling, or psychotherapy elsewhere? Yes___ No___

Have you had previous psychotherapy? No___ Yes (previous therapist's name)_____

Are you currently taking or have you previously been prescribed psychiatric medication (antidepressants or others)? Yes___ No___ If yes, please list in above medication area.

Have you ever been hospitalized for a psychiatric/emotional health reason? Y__N__

Is so, please describe when, where, for what reason, and the results_____

Spiritual Resources

How significant a role does spirituality play in your life?

None___ Somewhat Important___ Significant___ Very Significant___

Other

Is there anything else you think I should know about prior to beginning counseling?



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Adolescent Counseling Information

What to expect from therapy:

You can expect that I will do my best to understand your concerns. I will listen non-judgmentally and provide an opportunity for you to learn more about yourself and hopefully together we will find better solutions to the challenges in your life.

You can expect that what we discuss will be kept private.

There are a few exceptions, and here they are:

1. You tell me that you plan to hurt yourself or someone else.
2. You tell me that you are being abused physically, sexually, or emotionally, or that you have been abused in the past.
3. You are involved in a court case and a request is made for information about your counseling or your therapy.
4. You tell me that you are or have engaged in a sexual relationship with someone who is significantly older than you. In most cases I would be required by law to report this to Child Protective Services.

What to expect about my communications with your parent or guardian: Generally speaking... I will keep the specifics of what you share with me private.

There are few exceptions, and here they are:

1. If I do hear that you are involved in risk-taking behavior that becomes serious, then I will need to use my professional judgment to decide whether I must inform your parent/guardian, or we will discuss how to share this with your parent(s) together.

Even though I am committed to keeping your information confidential, I may believe that it is important for your parent/guardian to know what is going on in your life. In these situations we will work together to find the best way to discuss these things with your parent(s).

3. When meeting with your parents I will discuss challenges and progress that you have made in counseling. Generally speaking, I will talk about themes rather than specifics. The purpose of meeting with your parent(s) is to support our work together and to facilitate improved family relationships.

What I expect from you:

1. You agree to attend therapy sessions as scheduled and participate to the best of your ability.
2. You agree to participate in goal setting and take an active role in making positive life changes.
3. You agree to talk with me if you have thoughts or feelings about harming yourself or someone else

What I expect from your Parent/Guardian:

1. You agree to support your child's treatment by doing your best to arrange for regular attendance.
2. You agree to make yourself available for parenting consultations and/or family meetings as requested by your child or his/her counselor.
3. You agree to be supportive of the counseling process.

Counselor's Signature: _____ **Date:** _____

Minor's Signature: _____ **Date:** _____

Parent (s) Signature: _____ **Date:** _____



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Client Information and Service Agreement

Treatment Philosophy: Forming and experiencing a trusting, emotionally safe relationship brings about the most effective change in counseling. In the context of that relationship, clients increase self-awareness, challenge old beliefs, learn new skills, establish appropriate boundaries, as well as experience and let go of old pain.

My primary therapeutic technique is talking, however some clients find it helpful to supplement talking with more experiential activities such as art, journaling, role-playing and therapeutic games. These activities help us to experience levels of ourselves that are not always accessible through dialogue.

Please note that there may be times I ask you to do some specific activities outside our sessions, such as reading a book or tracking moods, behaviors or interactions.

My counseling style is shaped by several different theories including but not limited to: Developmental, object relations, systems, psychodynamic, and cognitive behavioral.

While I tend to be active in counseling—asking questions, offering observations, and looking for patterns in the client's life—I greatly rely on my client to set the direction for counseling. The client is the final expert on himself or herself, and I trust the unique healing process of each individual.

It is important that you feel comfortable with me and with my methods; at any time you may ask me to discuss my treatment approach. You have the right to request a change of counselor or to refuse treatment, and the length of time you spend in counseling is up to you.

Appointments: Standard appointments are 45-50 minutes long (the standard therapy hour), but extended sessions are available. Unless using insurance, telephone or Skype sessions can be scheduled if you are unable to come into the office.

Telephone Calls: My telephone is answered by voice mail that I check frequently. I return most calls within a few hours if you leave a message before 7pm. If you are difficult to reach, please inform me of some times when you will be available. On rare occasions, my voice mail may fail to record messages. Therefore, if I haven't returned your call within 24-hours, please call again. In an emergency, call 911 or go to your nearest emergency room.

Confidentiality: Counseling often involves sharing sensitive, personal, and private information. All sessions are confidential to people outside of the therapy, with some exceptions. I cannot and will not tell anyone what you have told me without your prior written permission. You may direct me to share information with whomever you choose and you can change your mind and revoke that permission at any time. The following are *legal* exceptions to your right to confidentiality.

1. If I have a credible reason to believe that you will harm another person, I must attempt to inform that person and warn them of your intentions. I must also call the police and ask them to protect your intended victim.
2. If I have a good reason to believe you are abusing or neglecting a child or vulnerable adult, or if you give me information about someone else who is doing this.
3. If I believe that you are in imminent danger of harming yourself, I may legally break confidentiality and call your family, the police and/or a local crisis team.
4. In some legal proceedings, upon a court order, testimony and/or records may be rendered.

In addition, information may be shared for supervision or consultation reasons or to collect payments from your insurance company. Like anything on the internet, communication by email is able to be intercepted by 3rd parties, and is therefore not considered a confidential means of communication.

In counseling adolescents, I prefer to keep confidentiality as much as possible in order for the therapeutic process to work. While you, as a parent or guardian, may have a legal right to information, know that if you insist on knowing what is being said, your son or daughter may well lose confidence in the process, and in me, and the benefits of the counseling may be lost.

You acknowledge that you have received a copy of your privacy rights and have had the opportunity to discuss them with me.

Other Rights: You have the right to ask questions about anything that happens in counseling. I'm always willing to discuss how and why I've decided to do what I am doing, and to look at alternatives that might work better. You can feel free to ask me to try something that you think will be helpful. You can ask me about my training for working with your concerns, and can request that I refer you to someone else if you decide I am not the right therapist for you. You are free to leave therapy at any time. If I am away, or unavailable, for an extended period of time, I will provide you with the name of a colleague to contact, if necessary.

Record-Keeping: I keep very brief records, noting only that you have been here, what interventions happened in session, and the topics we discussed. If you prefer that I keep no records, you must give me a written request to this effect for your file and I will only note that you attended counseling in the record.

Payment Policy: You agree to make payment at the time of service. You are responsible for paying for your session weekly, unless we have made other arrangements, in advance. My fee for a session is \$100.00/individual, \$120.00/family or couple (except for the initial session, which is \$150.00), and \$40.00/group, unless we have made other arrangements. Phone calls made on your, or your adolescent's behalf, to collateral contacts (teachers, guidance counselors, physicians, probation officers, etc.), will be billed at \$80.00 per hour if more than 15 minutes is required. All insurance information is taken as a courtesy. You agree your insurance company will pay me directly for services rendered. If the information proves to be invalid or inaccurate, you agree that you are responsible for any outstanding balance you may have accrued (balances carried for 30 days or more will be charged directly to your credit card on file). You authorize the release of any records, which may be necessary to process your or your child's insurance claims.

Insurance Reimbursement: I accept limited insurance plans (Blue Cross/Blue Shield, Tufts, United Behavioral Health, Harvard Pilgrim). I am considered a "private pay" counseling service. There are many benefits to private pay counseling:

- Managed care does not always cover high quality services
- Personalized treatment and service
- Complete privacy (confidentiality)

Insurance companies require diagnosis, which is not always protected information and can affect things like denial of health insurance, and unnecessary exposure. You would pay my fee similar to how you might pay an attorney, accountant, personal trainer, mechanic or hairdresser. I can provide you with a receipt for services, which you may be able to submit to your insurance company for Out of Network reimbursement. You might also check with your employer about Health Savings accounts (HAS) or Flexible Spending Accounts (FSA). The responsibility is on the client to inquire about the possibilities of these benefits.

Cancellation Policy: You agree to cancel appointments only in the event of extreme necessity. You understand you will be charged \$100.00 unless you provide 24 hours advance notice of a cancelation. You give your permission for me to charge this late cancel/no show fee to your credit card on record.

Permission to Treat: You acknowledge that it is your choice to participate in psychotherapy (or have your adolescent participate). You will take responsibility for your psychotherapy and will come prepared and ready for each session. You will discuss termination prior to ending treatment.

Signature _____

Date ____/____/____



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Welcome to my practice!



The Basics: I am a Licensed Mental Health Counselor in the State of Massachusetts. I have a Bachelor's degree in Theater Arts and a Master's degree in Psychology—Mental Health Counseling. I am a current member of the Massachusetts Mental Health Counselors Association and the South Shore Independent Therapist Association.

My Work:

My primary areas of specialty are with pre-teens and adolescents. I have several years of experience working with youth and their families in regard to issues such as substance abuse, foster care and relative placement, academic challenges, anger issues depression, difficulties with peer relationships, ethnic and racial issues, anxiety, sexual orientation, identity development, legal problems, and family conflict.

The majority of my work has been in the non-profit sector with children and families. However, I have been successful working with ages ranging through the lifespan, families and couples in a variety of settings. Some of the settings I have worked in, and am currently working in are: mental health consulting for the South Shore Head Start program, community counseling for youth at risk, crisis intervention, parent education, and in-home counseling focused on keeping families together. Additionally, I am working with some community agencies and schools to provide counseling services to youth. As an experienced counselor, I understand that personal problems can affect relationships, and I therefore work with families, couples, siblings, or individuals.

My Style: My style of therapy is open and direct. I believe establishing a solid, trusting relationship is critical to working effectively with anyone, but particularly with adolescents and children. The primary therapeutic technique I use is through talking (cognitive behavioral therapy). However, I also use experiential activities such as art, journaling, role-playing and therapeutic games. My counseling approach has been shaped by several counseling theories including developmental, systemic, psychodynamic, and cognitive behavioral. Although I certainly carry my own therapeutic style, I strongly believe in adapting to the needs of the individual or family in order to create a supportive and comfortable environment and see the best results.