



Poetry of Life
Counseling Services
Valerie Bye-Wolfe
LPC, MA, Counselor
303-880-5270

www.Poetryoflifecounseling.com

Client Name

Valerie Bye-Wolfe RN, MA, Psychotherapist

Colorado Secretary of State
Date and Time: 01/12/2009 05:15 PM
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Document number: 20091026136



Parent / Child Agreement Form

Valerie Bye-Wolfe

LPC, MA, Counselor
Brighton, Colorado 80601
303-880-5270

Poetry of Life Counseling Services

Counseling between the Child & Therapist should be kept confidential so that a relationship of trust can be established.

The Child or teenage client should be aware however, that if an issue of safety arises, it is the therapist's duty to inform the parent (s). If the child or teenager's safety has been compromised by an adult it also is the legal duty of the therapist to notify the proper authorities.

There will be sessions where I will meet with the parent (s) and Child /Teen, and possibly some sessions with the parent by themselves. This is done so the I can gain a better understanding of the relationships and will also help the parent (s) / child / teen better understand and appreciate each other.

Parent or Guardian

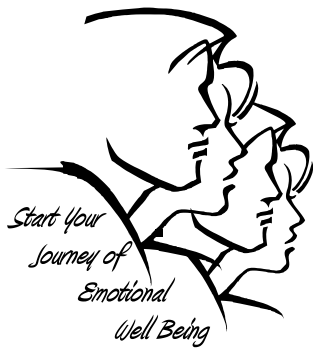
Date

Child / Teen

Date

Therapist

Date



New Client Form

Valerie Bye-Wolfe

LPC, MA, Counselor
Brighton, Colorado 80601
303-880-5270

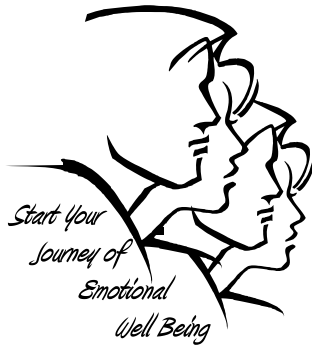
Poetry of Life Counseling Services

Welcome to my practice. I look forward to helping you reach your goals. This form requests information about your needs and informs you of my services and policies. Please take a few moments to complete this form. The questions on the following pages are designed to help me best meet your treatment needs. If the person seeking care is a child, the parent or guardian should complete this form. If you have any questions, I will be happy to answer them.

Client Name: _____ Birth date: _____
Address: _____ Age: _____
City, County, State, Zip: _____ Gender: Female Male
Client SSN _____ Relationship status: Single Married Domestic Partner
Separated Divorced Widowed
Mental Health Plan _____ Full Time Student: Yes No
Medical Health Plan _____ Occupation _____
Primary Care Physician _____ Phone: _____
Please list any medications you're currently taking: _____

Your Phone # _____ Work Phone: _____
Home OK to contact you there? Y N OK to contact you there? Y N
Emergency Contact: _____ Relationship _____
Home # _____ Cell # _____

Please list other persons living in your household and their relationships to you.



Client Intake Information

Poetry of Life Counseling Services

Valerie Bye-Wolfe

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- 1 Please describe your reason(s) for seeking treatment at this time. If there is a particular event which triggered your decision to seek treatment now, please list the event. _____

- 2 What result(s) do you expect from treatment? _____

- 3 Have you ever received mental health treatment before? If so, please list dates, provider name, and the issue for which treatment was sought: _____
- 4 Please indicate how the Issue(s) for which you are seeking treatment are affecting the following areas of your life.

	No effect	Little effect	Some effect	Much effect	Significant effect	Not Applicable
Marriage / Relationship	1	2	3	4	5	N/A
Family	1	2	3	4	5	N/A
Job / School	1	2	3	4	5	N/A
Friendships	1	2	3	4	5	N/A
Financial	1	2	3	4	5	N/A
Physical health	1	2	3	4	5	N/A
Anxiety levels / Nerves	1	2	3	4	5	N/A
Mood	1	2	3	4	5	N/A
Eating habits	1	2	3	4	5	N/A
Sleeping habits	1	2	3	4	5	N/A
Sexual functioning	1	2	3	4	5	N/A
Alcohol / Drug usage	1	2	3	4	5	N/A
Ability to concentrate	1	2	3	4	5	N/A
Ability to control your temper	1	2	3	4	5	N/A

5 Have you ever received mental health treatment before? If so, please list dates, provider name, and the issue for which treatment was sought: _____

6 Are you experiencing any suicidal thoughts, feeling, or actions. **Yes No** If yes please explain: _____

7 Have any friends or Family members attempted suicide? **Yes No** If yes please explain: _____

8 Are you experiencing any current homicidal or assaultive thoughts or feelings or anger-control problems? **Yes No** If yes, explain: _____

9 Do you have a plan to seek revenge or hurt someone else? **Yes No** If yes please explain: _____

10 Are there any traumatic losses going on in your life? (illness, divorce, custody, job loss, death of a loved one, etc.)? **Yes No** If yes please explain: _____

11 Do you have difficulty making decisions? **Yes No** If yes please explain: _____

12 Do you sometimes feel so sad that you have difficulty functioning, sleeping or concentrating? **Yes No** If yes please explain: _____

13 Do you sometimes feel that you have uncontrollable bursts of energy and that you have difficulty relaxing? **Yes No** If yes please explain: _____

14 Have you ever experienced racing thoughts when it became difficult to slow down your thinking? **Yes No** If yes please explain: _____



15 Have you ever experienced physical, sexual or emotional abuse? **Yes** **No** If yes please explain: _____

16 Briefly describe your most happiest childhood memory. _____

17 Briefly describe your most painful childhood memory. _____

18 Do you have any sexual practices or fantasies that you consider troubling? **Yes** **No** If yes please explain: _____

19 What have you already done to reach the goal(s) or solve the problems that has not worked? _____

20 When does the problem not occur? _____

21 When is the problem less severe or not an annoyance? _____

22 What would a day look like if the problem were no longer present? (do not use the words “great, wonderful, etc.) please tell us specifically what the course of the day would be like. _____

Client signature: _____

Therapist signature: _____



Statement of Confidentiality & Consent to Treat Poetry of Life Counseling Services

CONFIDENTIALITY

All information between provider and patient is held strictly confidential unless:

- 1 The client authorizes release of information with his/ her signature.
- 2 The client presents a physical danger to self
- 3 The client presents a danger to others.
- 4 Child/ Elder abuse/ neglect are suspected
- 5 Judge subpoenaed testimony in criminal court cases.

In the latter two cases, I am required by law to inform potential victims and authorities so that protective measures can be taken.

CANCELLED / MISSED APPOINTMENTS

Due to the nature of this practice the cancellation or missed-visit policy is strictly adhered to. Please notify your therapist 24 hours in advance if you plan to cancel an appointment. If you miss a visit without canceling 24 hours in advance, you will be charged the full amount of your session. Your insurance will not cover missed visits. Therefore, you will be responsible for the payment in full.

EMERGENCY PROCEDURES

If you need to contact me, leave a message according to the instructions on the phone service and your call will be returned. If an emergency situation arises, call or go to your closest emergency center or call 911. Please do this for true emergencies only. There may be a charge for lengthy telephone consultations.

RELEASE OF INFORMATION

I authorize the release of information regarding my care to my health plan for the payment of claims, certification/ case management decisions, and other purposes related to the administration of benefits for my health plan.

CONSENT OF TREATMENT

I further authorize and request that my treating provider carry out mental health examinations, treatments and /or Diagnostic procedures, which now or during the course of my care are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable.

I understand and agree to all of the above information.

Client (or Parent / Guardian) Name -- Printed

Date

Client (or Parent / Guardian) Name -- Signature

Date

Therapist Signature



Statement of Disclosure Poetry of Life Counseling Services

Valerie Bye-Wolfe

LPC, MA, Counselor
Brighton, Colorado 80601
303-880-5270

Your Rights as a Client

The practice of both licensed and unlicensed persons in the field of psychotherapy is regulated by the State of Colorado. Any questions, concerns or complaints regarding the practice of mental health may be directed to: Department of Regulatory Agencies Division of Registrations Mental Health Section, 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800. You are entitled to receive information about method of therapy, techniques used, duration of therapy, if known, and fee structure. You are also to be informed of the therapist's degree, credentials and licenses. You may seek a second opinion from another therapist or terminate therapy at any time. I am legally required to terminate, refer or consult if your psychotherapy issues are beyond my level of competence or scope of practice. You should know that in a professional relationship such as ours, sexual intimacy is never appropriate and should be reported to the Department of Regulatory Agencies mental health section.

Method(s) of Therapy

Valerie Bye-Wolfe LPC,MA , uses a variety of techniques in her practice. At any time she may integrate the following techniques: Cognitive /Behavioural, Person Centered, Solution Focused, Psychoanalysis, Existential and Child Play Therapy. Her style is also known as an eclectic counseling style. These techniques will be utilized to fit the individual needs of the client(s). If the client wishes, scripture and prayer may be used to support the client's faith with in Christian context.

Counselor's Credentials

Valerie Bye-Wolfe MA, RN, is a National Board Certified Counselor and is a member of the NCC. She received her Degree of Master of Arts in Counseling at Denver Seminary and has a Bachelor of Science in Organizational Management from Colorado Christian University. She is a member of the American Counseling Association. She is of the Christian faith and believes that one's spiritual beliefs can help a great deal in the journey of ones emotional well being. Valerie also is a Registered Nurse and has been in this profession for 22 years. The majority of her experience has been in hospice care; she has dealt with issues in the area of death and dying, and the grieving that occurs after the loss of a loved one.

Confidentiality

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- 3 The client presents a danger to others.
- 4 Child/ Elder abuse/ neglect are suspected
- 5 Judge subpoenaed testimony in criminal court cases.

If circumstances three and four occur, I am required by law to inform potential victims and authorities so that protective measures can be taken. In addition, I consult with and am supervised by, Jane Johnson LPC,CPT at 333 west Drake. Office 141 Fort Collins 970-481-6905 All information shared with Jane Johnson is kept confidential. From time to time, I also may consult with other colleagues. Your signature constitutes your giving permission for such consultations and supervision. -----

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Fees and Payment

The charge of psychotherapy is _____ per session (55 minutes) for the first _____ months paid with check, money order, or cash. Make checks payable to Valerie Bye -Wolfe.

Since I have reserved our appointment time for you, it is my policy to charge for cancellations received with less than 24 hours notice. Appointments or cancellations may *not* be made via E-Mail, fax, or the internet.

Availability and Answering Service

If you have a major emergency or a life-threatening situation you will need to seek help at the closest mental health, or emergency center near you, or dial 911 immediately.





Questionnaire for Teenage Clients

Valerie Bye-Wolfe

LPC, MA, Counselor
Brighton, Colorado 80601
303-880-5270

Poetry of Life Counseling Services

Client Name: _____ Birth date: _____

Address: _____ Age: _____

City, County, State, Zip: _____ Gender: Female Male

Full Time Student: Yes No

Medical Health Plan _____ Occupation _____

Primary Care Physician _____ Phone: _____

Please list any medications you're currently taking: _____

Your Phone # _____ Work Phone: _____

Home OK to contact you there? Y N OK to contact you there? Y N

Emergency Contact: _____ Relationship _____

Home # _____ Cell # _____

Please list other persons living in your household and their relationships to you.

Do you feel like harming yourself? NO ____ YES ____

If yes please explain.

Do you have a plan? NO ____ YES ____

If yes please explain.



Please finish the sentences

These are some things I enjoy ...

School is...

I have a boyfriend / girlfriend, he / she is ...

I wish that I could ...



My Mom

is... _____

My Dad

is... _____

What I like about myself

is... _____

What I would like to change about myself

is... _____

A perfect day for me would look

like... _____



Here are some questions to answer.

I am sexually active NO _____ YES _____

I would like to talk more about being sexually active NO _____ YES _____

Are you depressed? NO _____ YES _____

If yes, Explain to me what **you** think is making you depressed.

Do you throw up after you eat a meal? NO _____ YES _____

If yes please tell me a little about this

What goals do you have for the future?

What would you like to accomplish while getting counseling?



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Colorado Secretary of State

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Limited Liability Corporation

CASE NOTES

Name _____ Date _____ Start _____

AXIS I: _____ AXIS II: _____
Axis III: _____ Axis IV _____
AXIS V: _____ GAP: _____

Session Goals/ Objectives _____

DATA
Homework from past session (s): _____

Functional Impairment (emotional, social, occupational, legal, behavioral, include degree and frequency): _____

Current Issues/ Topics/ Stressors: _____

Interventions: _____

Observations: _____

Other: _____

ASSESSMENT (progress/ Impairment/ effectiveness of intervention) _____

PLAN (homework, objectives for next session, changes, testing) _____

End ____ : ____ A.M. / P.M. Duration ____ Next Appointment ____ / ____ / ____ @ ____ A.M / P.M.

○ ○

CASE NOTES

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Interventions: _____

Observations: _____

Other: _____

ASSESSMENT (progress/ Impairment/ effectiveness of intervention) _____

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○ ○

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Observations: _____

Other: _____

ASSESSMENT (progress/ Impairment/ effectiveness of intervention) _____

PLAN (homework, objectives for next session, changes, testing) _____

End ____ : ____ A.M. / P.M. Duration ____ Next Appointment ____ / ____ / ____ @ ____ A.M / P.M.

○ ○

CASE NOTES

Name _____ Date _____ Start _____

AXIS I: _____ AXIS II: _____

Axis III: _____ Axis IV _____

AXIS V: _____ GAP: _____

Session Goals/ Objectives _____

DATA

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Current Issues/ Topics/ Stressors: _____

Interventions: _____

Observations: _____

Other: _____

ASSESSMENT (progress/ Impairment/ effectiveness of intervention) _____

PLAN (homework, objectives for next session, changes, testing) _____

End ____: ____ A.M. / P.M. Duration ____ Next Appointment ____/____/____@ ____ A.M / P.M.

○ ○

CONFIDENTIAL EXCHANGE OF INFORMATION FORM

I _____ give _____
permission to share confidential information with _____
regarding my progress of treatment. The information shared will be specifically for the needs
of the practitioner and or physician to collaborate the best treatment plan possible for you as a
client.

Client Signature: _____

Therapist Signature: _____

Physician / Therapist Signature: _____

○ ○

Permission to Video or Audio Tape Therapy Sessions

I/We _____
consent to the video or audio taping of therapy sessions with _____.
I/We are aware of the presence of the video and/or audio equipment and permit the use of all or
part of the video and/or audiotape for the purpose of: (initial below the type of use you are permit-
ting)

_____ (initial) Our therapist and our review of our case to assist in our
therapy.

_____ (initial) Our therapist's consultation with a clinical supervisor(s).

_____ (initial) Our therapist's consultation with his/her supervision group.

In no way will the refusal to grant permission for this video taping effect my/our receiving assis-
tance for myself/ourselves. If at any time during the treatment process, we wish to stop the taping
we may do so and still continue treatment.

Print Name

Signature/Date

Print Name

Signature/Date

Therapist's Printed Name

Therapist's Signature/Date