

## **Consent for Counseling**

### **Part 1: General Information**

The DeKalb County Youth Service Bureau Inc. (YSB) provides individual and family counseling services to DeKalb County youth ages 8-18 and their families. Our mission at YSB is to assist DeKalb County youth to build healthy lives and responsible relationships with family, friends, and the community. Our goal is to provide caring and professional services for our clients.

YSB employs professionally trained counselors with graduate degrees in psychology, counseling, or marriage and family therapy. In addition, Master's level candidates completing their practical experience requirements are also on staff at YSB, and may be involved with, or serving as, your counselor. These interns are highly competent and will be working under the direct supervision of a clinical supervisor as well as a team of experienced youth and family counselors.

**Counseling** – YSB offers individual and family counseling that seeks to meet goals established by all persons involved, usually revolving around a specific presenting problem. Individuals may benefit a great deal during the counseling process by resolving specific concerns brought to counseling. In working to achieve any potential benefit, counseling will require that a firm effort be made to change and may involve the experience of discomfort. Seeking to resolve problems can similarly lead to relationship changes that may not have been originally intended.

**Groups** – YSB offers several specialized groups that seek to meet goals specific to the overall purpose of each group. Individuals may benefit a great deal during group process by resolving specific concerns brought to the group. In working to achieve any potential benefit, group activity will require that a firm effort be made to change and youth may experience discomfort. Seeking to resolve problems can similarly lead to discomfort as well as relationship changes that may not be originally intended.

**Court Ordered** - YSB offers services to youth who are court ordered for an assessment or for counseling. An assessment consists of 3 sessions to identify needs and recommendations. This is to be completed within 60 days of initial contact with YSB. Parental participation is required. A \$75 fee is required before the 3<sup>rd</sup> session is scheduled. For youth who are court ordered for ongoing counseling, the fees, frequency, and goals will be determined in conjunction with the therapist. You will be asked to sign an Authorization to Release Information which allows YSB to report compliance, progress, and recommendations to the referral source (ie: Juvenile Court Services). No confidential information will be disclosed.

### **Part 2: Your Rights as a Client**

1. **Confidentiality:** Within the limits of the law, information revealed by you will be kept strictly confidential and will not be revealed to any other person or agency unaffiliated with YSB without your written permission. We routinely staff our cases during clinical supervision and team consultation to assist counselors in improving skills and in planning for future sessions. These meetings will be kept strictly confidential.
2. Illinois law and ethical practice requires us to notify appropriate state agencies **without** your permission if **(a)** we suspect or know of a child or elder abuse/neglect situation, **(b)** you threaten bodily harm or death to another person or yourself, or **(c)** a judge issues a court order requesting relevant information. If you have concerns about any of the above stated conditions regarding confidentiality, please discuss them with your counselor.
3. You have the right to review your records in your file. If you wish to do so, please ask your counselor during a counseling session to set up a separate time to do this.
4. If you request it, any part of the records in your file can be released to any person or agency you designate. If you wish to do this, we are required by law to obtain a written release of information from you before we can release the designated records.
5. You have the right to end counseling at YSB at any time without any moral, legal, or financial obligations to YSB other than those already accrued. If you wish to terminate the relationship, we ask that you contact YSB by phone or in person to inform us of your decision.

**Part 3: Fees**

General Counseling Fees	Special Services	Fee
<ul style="list-style-type: none"> <li>• YSB offers services on a sliding fee basis. Our base rate is \$75 per session; however fees can be adjusted based on gross family income. Your counselor and you will determine the fee at the time of the first session. Please bring supportive documentation.</li> <li>• Fees can be adjusted to accommodate economic hardship.</li> <li>• Payment due at the time of service. Failure to make payment after 2 consecutive sessions will result in a hold on services until payment is received.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Counseling Assessment</b> (court-ordered) 3 sessions – Payment due before 3rd session.</li> <li>• <b>Drug &amp; Alcohol Intervention</b> Assessment &amp; 8 wk group or recommendations</li> <li>• <b>Anger/Emotion Management Group</b> Assessment &amp; 10 wk group or recommendations</li> <li>• <b>Girls Empowerment Group</b> Assessment &amp; 10 wk group or recommendations</li> <li>• <b>Tobacco Intervention</b> Assessment and 6 wk group or recommendations</li> <li>• <b>Active Parenting of Teens</b> Orientation, book, &amp; 6 week group</li> <li>• <b>Urine Screen</b></li> </ul>	<ul style="list-style-type: none"> <li>\$75</li> <li>\$50</li> <li>\$50</li> <li>\$50</li> <li>\$30</li> <li>\$50</li> <li>\$20</li> </ul>

**Part 4: Cancellation Policy**

1. Prior notice is required for cancellation of a scheduled session unless an emergency or sudden illness prevents prior cancellation.
2. If I need to cancel, I agree to call the YSB office at (815) 748-2010 before my appointment or by 5 PM if it is an evening appointment.
3. If I do not meet this requirement, I agree to pay the full session fee. For a missed counseling assessment appointment, I agree to pay an additional \$25.00 per session missed.

**Part 5: Miscellaneous**

1. Supervision of youth engaging in services at YSB is my sole responsibility.
2. If I elect to leave my youth unsupervised during services at YSB, I am advised to be present to pick up my youth prior to the end of session and or group.
3. In the event that my youth chooses to leave the premises of YSB prior to the end of session or group and have elected to leave the premises as well, I will be contacted by YSB as soon as possible to be informed of the departure.
4. I will in no way hold YSB and/or any of their staff responsible for any damages that my youth may incur or for leaving the premises prior to the end of session or group.

I certify that I have read this form or had it read to me, including the statement on the limits of confidentiality and the fee agreement, and that I understand its contents. If I have any questions or concerns now or in the future, I understand that I should consult with my counselor or the Executive Director of YSB (748-2010). I certify that I have legal authority to give consent for the treatment of all minor children that are included in counseling.

Signed:

\_\_\_\_\_

Parent/Guardian

\_\_\_\_\_

Date

\_\_\_\_\_

Child (age 12 and above)

\_\_\_\_\_

Date

\_\_\_\_\_

Witness

\_\_\_\_\_

Date



# ACKNOWLEDGEMENT OF TRAINING STATUS AND SUPERVISION CONSENT/DISCLOSURE

Dear Client[s]:

The Youth Service Bureau serves as a training facility for Graduate Level Intern Therapists completing their final stages of their Master’s Degree at Northern Illinois University. Graduate Level Student-Intern Therapists have completed courses of study related to working with individuals, families, and groups. This internship’s purpose is to give the student intern an opportunity to get first-hand experience working in a family social services environment.

At the Youth Service Bureau, we strive to give the Student-Interns as much clinical experience as possible while serving their internship. Student interns provide full levels of clinical treatment and are supervised by a Licensed Marriage and Family Therapist as a means of guidance and training for him/her. Student interns are aware that confidentiality must be strictly maintained.

By signing below, you affirm that you understand that the student intern you may be working with is in a training status. Your signature also provides consent for the student-therapist to discuss various aspects of your case with clinical faculty and MFT student-therapists from the NIU Program. If you have any questions, please contact:

Jason Nicol, M.S., LMFT  
 AAMFT Approved Supervisor Candidate  
 330 Grove Street  
 DeKalb, IL 60115  
 815.748.2010  
 jnicol@dcysb.com

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Client Signature (12 & older)	Date
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Parent Signature	Relationship	Date
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Other Signature	Relationship	Date
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Therapist/Witness	Student Intern	Date
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## About Student-Interns...

*The therapist you may be working with is currently in a training status. She/he is in their second year of study in a Commission on Accreditation in Marriage and Family Therapy Education (COAMFTE) approved graduate program in Marriage and Family Therapy at Northern Illinois University in DeKalb, IL. The student-intern is currently completing a clinical internship at YSB. She/he has completed courses of study involving the treatment of mental and emotional disorders associated with individuals, couples, families, and groups.*

*While she/he has been trained to deliver these services, she/he is also receiving supervision from a direct supervisor at YSB as well as the MFT Program at NIU. Supervision provides guidance, training, and meets accreditation requirements. At times your case may be discussed with a clinical faculty member and/or other MFT student therapists from the NIU program for educational and training purposes. However, confidentiality will be strictly maintained at all times. Your identity will be concealed to further assure anonymity and confidentiality.*

# Confidential History and Family Information Database

## **Verification**

Person Completing this Database: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Date Completed: \_\_\_\_\_

## **Information About Child**

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Race: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_

## **Information About Natural Mother:**

Name: \_\_\_\_\_

Age: \_\_\_\_\_ (D for deceased) Cause of Death: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Race: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone - Home: \_\_\_\_\_ Work: \_\_\_\_\_

Occupation: \_\_\_\_\_

Employed by: \_\_\_\_\_ Hours: \_\_\_\_\_

## **Information About Natural Father:**

Name: \_\_\_\_\_

Age: \_\_\_\_\_ (D for deceased) Cause of Death: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Race: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone - Home: \_\_\_\_\_ Work: \_\_\_\_\_

Occupation: \_\_\_\_\_

Employed by: \_\_\_\_\_ Hours: \_\_\_\_\_

## **Information About Natural Parents:** Check all that apply

The Child's Natural Parents Are:

married (date - \_\_\_\_\_)

separated (date - \_\_\_\_\_)

divorced (date - \_\_\_\_\_)

never married

**Information About Child's Stepmother or Guardian:**

Name: \_\_\_\_\_ Stepmother or Guardian? \_\_\_\_\_  
If guardian, relationship to child: \_\_\_\_\_  
Age: \_\_\_\_\_ (D for deceased) Cause of Death: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Race: \_\_\_\_\_  
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Same as Natural Father:  
Telephone \_ Home: \_\_\_\_\_ Work: \_\_\_\_\_  
Occupation: \_\_\_\_\_  
Employed by: \_\_\_\_\_ Hours: \_\_\_\_\_

**Information About Child's Stepfather or Guardian:**

Name: \_\_\_\_\_ Stepfather or Guardian? \_\_\_\_\_  
If guardian, relationship to child: \_\_\_\_\_  
Age: \_\_\_\_\_ (D for deceased) Cause of Death: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Race: \_\_\_\_\_  
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Same as Natural Mother:  
Telephone – Home: \_\_\_\_\_ Work: \_\_\_\_\_  
Occupation: \_\_\_\_\_  
Employed by: \_\_\_\_\_ Hours: \_\_\_\_\_

**Information About Other Children in the Family:**

Name:	Age:	Full/Step/1/2	School	Grade	Living With
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

**Information About Family Alcohol & Drug Use:**

Item	Type(s)	By Whom
Alcohol	_____	_____
Drugs	_____	_____
Prescription Drugs	_____	_____
Tobacco Products	_____	_____
Others	_____	_____

Has alcohol use caused a problem on either side of the family?  No  Yes

Has drug use caused a problem on either side of the family?  No  Yes

Have you or any family member ever overdosed on alcohol/drugs?  
 No  Yes Which Member: \_\_\_\_\_

Has anyone in the family attended Alcoholics Anonymous (AA), Alateen, or any group dealing with alcohol or drug concerns?  
 No  Yes Who: \_\_\_\_\_ Which group: \_\_\_\_\_

**Information About Living Situation:**

Are there other adults living in the household?: \_\_\_\_\_

How many times has the child changed residences since Kindergarten? \_\_\_\_\_

How many times has the child changed residences in past 12 months? \_\_\_\_\_

Do you attend religious services:            Yes                            No

Does this child attend:                        Yes                            No

How often:                                        Weekly                        Monthly                        Yearly

For what problem(s) are you seeking counseling? \_\_\_\_\_

What is your opinion of the cause of the problem? \_\_\_\_\_

*For Statistical Purposes Only:*

**Estimated Annual Income:**

<b>Below \$15,000</b>	<b>\$25-34,999</b>	<b>\$45-54,999</b>	<b>\$65-74,999</b>
<b>\$15-24,999</b>	<b>\$35-44,999</b>	<b>\$55-64,999</b>	<b>\$75,000 or above</b>

**Total Number of People in Home:** \_\_\_\_\_

**Health Insurance:**                        None                        Public Aid                        Private: \_\_\_\_\_

**Information About Child's Legal History:**

List any contacts this child has had with the law:

<b>Charge</b>	<b>Date</b>	<b>What Happened</b>	<b>Consequences</b>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Has this child ever run away?**     No                             Yes,    **When** \_\_\_\_\_



**Information About Child's Health:**

Is child physically healthy:                      Yes                      No                      Don't Know

If no, explain: \_\_\_\_\_

Is child emotionally healthy:                      Yes                      No                      Don't Know

If no, explain: \_\_\_\_\_

Has there ever been a child abuse report filed or DCFS investigation?      Yes                      No

Have you ever gone to anyone for help for this child?                      Yes                      No

If yes, list agencies, persons, or hospitals consulted:

<b>Date</b>	<b>Place</b>	<b>Purpose</b>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name of child's physician: \_\_\_\_\_

Date of last physical: \_\_\_\_\_

Is child currently taking prescription medication?                      Yes                      No

If yes, what: \_\_\_\_\_ Prescribed by: \_\_\_\_\_

**Check any of the following conditions this child has experienced:**

(Circle any for which this child was hospitalized.)

- |                                             |                              |
|---------------------------------------------|------------------------------|
| Cuts, bruises, & burns                      | Nose bleeds                  |
| Frequent accidents                          | Kidney problems              |
| Recent changes in appetite                  | Heart problems               |
| Recent weight changes                       | Chest pains                  |
| Frequent irritation of mouth/throat         | Pneumonia                    |
| Nausea                                      | Skin/Eyes have yellow color  |
| Vomiting or dry heaves                      | Diabetes                     |
| Stomach ulcers or stomach problems          | Frequent headaches           |
| Abdominal pain or cramps                    | Migraine headaches           |
| Bleeding from bowels                        | Allergies                    |
| Diarrhea or constipation                    | Special diet                 |
| History of head injuries                    | <b><u>For Daughters:</u></b> |
| Liver problems                              | Abortion                     |
| Tremors or shakes                           | Miscarriage                  |
| Seizures or convulsions                     | Irregular periods            |
| Tingling, Pain, numbness in hands/feet      | No periods                   |
| Muscle pain in arms/legs                    | Premenstrual Syndrome (PMS)  |
| Do not feel rested after full night's sleep | Severe cramps                |

# PARENT ASSESSMENT OF YOUTH

Parent's Name \_\_\_\_\_ Youth's Name \_\_\_\_\_ Date \_\_\_\_\_

Please circle any of the following that you believe apply to your child - (Indicate whether underlined item occurred *previously* **(P)** **(have not occurred in the last 6 months)** or *now* **(N)** by writing the letter **P** or **N** next to the condition. Use both letters if the symptom is reoccurring.

- |                                          |                                               |
|------------------------------------------|-----------------------------------------------|
| Nightmares                               | Recent move                                   |
| Feel panicky                             | Recent job change                             |
| Bowel disturbances                       | Overworked                                    |
| No appetite                              | Feel tense                                    |
| Insomnia                                 | Depressed mood                                |
| Sleep too much                           | Over-ambitious                                |
| Other sleep disturbances                 | Jealousy                                      |
| Dizziness                                | Racing thoughts                               |
| Stomach trouble                          | Irritable/angry                               |
| Physical handicap                        | Hopelessness                                  |
| Physical limitations                     | Guilt                                         |
| P.M.S.                                   | Feeling time pressures                        |
| Miscarriage                              | Unable to enjoy life                          |
| Abortion                                 | Feeling lonely                                |
| Fatigue                                  | Inferiority feelings                          |
| Tremors                                  | Temper outbursts                              |
| Recent weight gain                       | Compulsive overeating                         |
| Recent weight loss                       | Bulimia                                       |
| Fainting spells                          | Anorexia                                      |
| Learning disabilities                    | Suicidal thoughts                             |
| Heart condition                          | Suicidal attempt                              |
| High blood pressure                      | Cut, burned, harmed self                      |
| Allergies                                | Sexually abused                               |
| Low energy                               | Emotionally abused                            |
| Anxiousness                              | Physically abused                             |
| Elevated mood                            | Abandoned                                     |
| Headaches                                | Marital problems between the youth's parents  |
| Palpitations                             | Co-parenting problems with the youth's        |
| Unable to relax                          | divorce/separated parents                     |
| Shy with people                          | Relationship problems (i.e., peers, siblings) |
| Can't make decisions                     | Problems related to drugs or alcohol          |
| Lot of stress and/or arguing in the home | Disorganized                                  |
| between family members                   | Impulsivity                                   |
| Recent relationship ended                | Difficulty concentrating                      |
| Reading difficulties                     | Impatient                                     |
| Recent death                             | Obsessive thoughts                            |
| Sexually active                          | Compulsions                                   |
| Can't make friends                       | Oppositional/defiant                          |
| Can't keep job                           | Other: _____                                  |
| Financial problems                       |                                               |

# YOUTH SELF-ASSESSMENT

Name \_\_\_\_\_ Date \_\_\_\_\_

Please **underline** any of the following that you are **currently** experiencing in the past **6 months**. Write **P** for Previously next to any conditions that haven't occurred in the last 6 months but you have experienced in your life.

Nightmares  
Feel panicky  
No appetite  
Can't fall asleep  
Sleep too much  
Other sleep problems  
Dizziness  
Stomach trouble  
Physical handicap  
Physical limitations  
P.M.S.  
Fatigue  
Tremors  
Recent weight gain  
Recent weight loss  
Fainting spells  
Learning disabilities  
Heart condition  
High blood pressure  
Allergies  
Low energy  
Anxiousness  
Elevated mood  
Headaches  
Palpitations  
Unable to relax  
Shy with people  
Can't make decisions  
Home conditions bad  
Recent relationship ended  
Reading difficulties  
Recent death  
Can't make friends  
Can't keep job  
Financial problems

Recent move  
Recent job change  
Overworked  
Feel tense  
Depressed mood  
Over-ambitious  
Jealousy  
Racing thoughts  
Irritable/angry  
Hopelessness  
Guilt  
Feeling time pressures  
Unable to enjoy life  
Feeling lonely  
Inferiority feelings  
Temper outbursts  
Compulsive overeating  
Bulimia  
Anorexia  
Suicidal thoughts  
Suicidal attempt  
Cut, burns, harms self  
Sexually abused  
Emotionally abused  
Physically abused  
Abandoned  
Relationship problems  
Problems related to drugs or alcohol  
Disorganized  
Impulsivity  
Difficulty concentrating  
Impatient  
Other: \_\_\_\_\_  
Other: \_\_\_\_\_