



*Those who come to psychotherapy
are the wisest and most courageous among us.
Everyone has problems, but what they often do
is try to pretend that those problems don't exist,
or they run away from those problems,
or drink them down,
or ignore them in some other way.
It's only the wiser and braver among us
who are willing to submit themselves
to the difficult process of self-examination
that happens in a psychotherapist's office.
- M. Scott Peck, M.D.*



CLIENT INFORMATION

Name: _____ Date: _____

Street: _____ City, Zip _____

Best Phone Number: _____ OK to leave a message? Y N Birth Date: _____

Other Phone Number: _____ OK to call? _____ Employer: _____

Email Address: _____ OK to send you our email newsletter? Yes No

Please indicate how best to contact you: _____

Primary Care Physician: _____ Phone: _____

If you searched online, how did you find us? (Circle All) Bing Google Yahoo Facebook Twitter
 LinkedIn Psychology Today Denver Therapists Network YouTube CAGT DCAGT
 Other _____

If were you referred, by whom?: _____ Phone: _____

Address: _____

Reason for Referral : _____ May I send them a Thank-you note? Yes?

In Case of Emergency Contact:

Name: _____ Relationship: _____

Street, City, Zip: _____ Phone : _____

Person Responsible for the Bill:

Name: _____ Relationship: _____

Street, City, Zip: _____

Week Day Phone: _____ Week End/Night Phone: _____

You may release information necessary for billing to this person: _____

Please list all people living in your household:

Name	age	Relationship to you	Occupation/School grade
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Sharon M. Barnes, MSSW, LCSW

8089 S. Lincoln St. #203

Littleton, CO 80122

Parental Consent for Assessment and Treatment of a Minor

Thank you for choosing me as your child's therapist. I realize that starting therapy is a major decision and you may have many questions. Feel free to ask them in person, by phone or email. The information herein is in addition to the information contained in the Colorado Mandatory Disclosure Statement, Notice of Privacy Practices and my Practice Information and Policies document. I am legally and ethically responsible to provide you with information so that you can provide informed consent. If you have other questions or concerns, please ask, and I will try my best to give you all the information you need.

I provide counseling and psychotherapy to children and their families and adults in individual, couple and family sessions. I use a variety of treatment modalities. These include process work involving "talk therapy" and expressive therapy modalities such as art, writing and sand play. It is not unusual for more than one modality to be used in any given session.

When I work with children, it is my policy to provide parent(s) with general information about treatment status. I will also meet with parent(s) on a regular basis to consult about changes as well as to find out how our child is managing both at home and school. With your consent, I am happy to coordinate care with physicians, school counselors, and other relevant professionals. When parents are legally separated or divorced, both parents must give written consent to the therapy.

Confidentiality

Therapy is most effective when a trusting relationship exists between the therapist and the client. Privacy is important in securing and maintaining that trust. Specific details of the information children share with me in sessions are not shared with the parents unless the child gives me his/her consent, as to encourage children to be honest and forthcoming and to maintain an emotionally safe environment for them. As part of the therapeutic process, I encourage children to share information with their parents. I may also meet jointly with the child and parents to facilitate this sharing when it is important that the child share it rather than that I share it, and the child is unable to share it independently. However, there are specific exceptions to this confidentiality including the following:

- When there is a risk of imminent danger to your child or another person, I am required to take necessary steps to prevent such danger.
- When there is suspicion that your child is being sexually or physically abused or is at risk of abuse, I am mandated to take steps to protect your child, and to inform the proper authorities.

I will be photographing writing, sand trays and art work. The photos become a part of your child's treatment record. I also may use these photographs in a professional article, book or at a professional training. There will be no identifying information except for the age and gender of your child. It is my policy not to testify in custody battles. I do not allow treatment records to be read or reviewed by any person other than myself. My records are covered by confidentiality laws and are not to be revealed in a court process, as that jeopardizes the work the child is doing with me.

Consent for Treatment of Minors

I have read and understand the above. I give my consent for my child

_____ to be treated in psychotherapy by Sharon M. Barnes, MSSW, LCSW.

NOTE: BOTH PARENTS MUST SIGN AND DATE THIS IN ORDER FOR TREATMENT TO TAKE PLACE.

Signature of Parents or Legal Guardians of Minor Child:

_____ Date _____

_____ Date _____

Amen Clinics, Inc. Intake Questionnaire Used by permission

In order to be able to fully evaluate your child's needs, please fill out the following intake form and questionnaires to the best of your ability. We realize there is a lot of information and you may not remember or have access to all of it; please do the best you can. If there is any information that you do not want in your chart it is ok to refrain from putting in this information and we will discuss it. For questions not relevant to your situation, please write NA for "Not Applicable". Thank you!

CLIENT IDENTIFICATION

Name _____	First Appointment Date _____
Birth Date _____	Age _____ Gender _____
Religion _____	Best phone _____
Race _____	Other phone _____
Address _____	City _____
State/Province _____	Country _____

Who does your child currently living with? _____

MAIN PURPOSE OF THE CONSULTATION: (Please give a brief summary of the main problems)

WHY DID YOU SEEK THE CONSULTATION AT THIS TIME? What are your goals in being here?

PRIOR ATTEMPTS TO CORRECT THE PROBLEMS/MENTAL HEALTH HISTORY

(Please include contact with other professionals, medications, types of treatment, etc.)

Name: _____

MEDICAL HISTORY:

Current medical problems/medications: _____

Current supplements/herbs: _____

Past medical problems/medications: _____

Other medical/mental health professionals seen regularly: _____

Any history of head trauma? (describe) _____

Ever any seizures or seizure-like activity? _____

Prior hospitalizations (place, cause, date, outcome) _____

Prior abnormal lab tests, X-rays, EEG, etc: _____

Allergies/drug intolerances (describe) _____

Present Height _____ Present Weight _____ Any changes in weight: _____

CURRENT LIFE STRESSES (include anything that is currently stressful for your child; examples include relationships, job, school, finances, friends, etc.) _____

Prenatal and birth events: Your/ Spouse's attitude toward the pregnancy with this child: _____

Pregnancy complications (bleeding, excess vomiting, medication, infections, x-rays, smoking, alcohol/drug use, etc.) _____

Any birth problems, trauma, forceps or complications? _____

Sleep Behavior: sleepwalking, nightmares, recurrent dreams, current problems (getting up, going to bed, etc.) _____

School History: Last grade completed _____ Last school attended _____

Average grades received _____ Specific learning disabilities _____

Learning strengths _____

Any behavior problems in school? _____

What have teachers said about your child? _____

Please bring a copy of school report cards and any state, national or special testing that has been performed.

Employment History: (Summarize jobs your child/teen has had, list most favorite and least favorite)

Any work related problems? _____

What would your employers or supervisors say about your child/teen? _____

Name: _____

Military History? _____

Has your child ever had any legal problems? (If yes, please describe).

Child/Teen's Sexual History: (answer only as much as you feel comfortable)

Age at the time of first sexual experience: _____ Number of sexual partners: _____

Any history of sexually transmitted disease? _____ History of abortion? _____

History of sexual abuse, molestation or rape? _____

Current sexual problems? _____

Alcohol and Drug History (Please list age started and types of substances used through the years and any or current usage. Also, describe how each of these substances makes/made your child feel, what benefit your child get/got from them). These include alcohol, (hard liquor, beer, wine), marijuana, hash, prescription tranquilizers or sleeping pills, inhalants (glue, gasoline, cleaning fluids, etc.), cocaine or crack, amphetamines or crank or ice, steroids, opiates (heroin, codeine, morphine or other pain killers), barbiturates, hallucinating drugs (LSD, mescaline, mushrooms), PCP. _____

Have your child ever experienced withdrawal symptoms from alcohol or drugs? _____

Has anyone told you they thought your child had a problem with drugs or alcohol? _____

Have your child ever felt guilty about your drug or alcohol use? _____

Have your child ever used drugs or alcohol first thing in the morning? _ _____

What is your child's caffeine use per day? (Caffeine is in coffee, tea, sodas, chocolate) _____

What is your child's nicotine use per day? (Nicotine is in cigarettes, tobacco chew) _____

FAMILY HISTORY

Parent's Marital or Relationship Satisfaction _____

Child's Significant Developmental Events (Include marriages, separations, divorces, deaths, traumatic events, losses, abuse, etc.)

Parents' History of Past Marriages _____

Name: _____

Birth Mother History: age: _____ outside work: _____

School, highest grade completed _____

Learning problems: _____ Behavior Problems: _____

Marriages _____

Medical Problems: _____

Childhood atmosphere (family position, abuse, illnesses, etc) _____

Has mother ever had any psychiatric treatment? Yes _____ No _____ If yes, for what purpose? _____

Mother's alcohol/drug use history? _____

Have any of your mother's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (Specify) _____

Birth Father History: age: _____ outside work: _____

School, highest grade completed _____

Learning problems: _____ Behavior Problems: _____

Marriages _____

Medical Problems: _____

Childhood atmosphere (family position, abuse, illnesses, etc) _____

Has father ever had any psychiatric treatment? Yes _____ No _____ If yes, for what purpose? _____

Father's alcohol/drug use history? _____

Have any of your father's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (Specify) _____

Siblings (names, ages, problems, strengths, relationship to client) _____

Children (names, ages, problems, strengths, with whom they live) _____

Name: _____

Cultural/Ethnic Background _____

Describe your relationships with friends: _____

Describe Yourself _____

Describe your strengths _____

Name: _____

Please indicate HOW OFTEN the following statements are true **about your child** by circling the answer which is most correct. . If appropriate, please have the child answer these questions first, in different ink.

- | | | | |
|-------|-----------|-------|---|
| NEVER | SOMETIMES | OFTEN | I have an insatiable curiosity. |
| NEVER | SOMETIMES | OFTEN | I set very high standards for myself. |
| NEVER | SOMETIMES | OFTEN | I can be my own worst critic. |
| NEVER | SOMETIMES | OFTEN | I have a powerful need to know things. |
| NEVER | SOMETIMES | OFTEN | I am a seeker of ultimate truths. |
| NEVER | SOMETIMES | OFTEN | I have been criticized for being “too much” of everything. |
| NEVER | SOMETIMES | OFTEN | I feel deeply wounded by injustice and human suffering. |
| NEVER | SOMETIMES | OFTEN | I can see many sides to nearly every issue. |
| NEVER | SOMETIMES | OFTEN | I love a good debate. |
| NEVER | SOMETIMES | OFTEN | I have a lot of energy. |
| NEVER | SOMETIMES | OFTEN | I often feel driven by my own creativity. |
| NEVER | SOMETIMES | OFTEN | I love puzzles, mazes, paradoxes, complex ideas, and words. (If more than one, circle the ones which apply) |
| NEVER | SOMETIMES | OFTEN | I often feel responsible for problems that don’t belong to me. |
| NEVER | SOMETIMES | OFTEN | Many times I have felt ‘different’ from most other people. |
| NEVER | SOMETIMES | OFTEN | I often feel like a minority of one. |
| NEVER | SOMETIMES | OFTEN | I am a dyed-in-the-wool perfectionist. |
| NEVER | SOMETIMES | OFTEN | I have been criticized for not “sticking with one thing.” |
| NEVER | SOMETIMES | OFTEN | Honesty, integrity, and authenticity are very important to me. |
| NEVER | SOMETIMES | OFTEN | Frustration builds up in me when I don’t engage in activities that involve creative self-expression. |
| NEVER | SOMETIMES | OFTEN | I have a history of questioning rules and challenging authority. |
| NEVER | SOMETIMES | OFTEN | I have heightened senses: taste, touch, smell hearing, sight, and/or seem to be bothered by bright lights, aromas, or noises that others don’t even notice (If yes, circle the ones which apply). |
| NEVER | SOMETIMES | OFTEN | I have a well-developed sense of humor that is somewhat offbeat. |
| NEVER | SOMETIMES | OFTEN | I often have a childlike sense of playfulness and wonder. |
| NEVER | SOMETIMES | OFTEN | Stress seems to have more impact on me than it does on others. |

Please add up your score: NEVER _____ SOMETIMES _____ OFTEN _____

HIGH ACHIEVER, GIFTED LEARNER, CREATIVE THINKER – Which Kind(s) of Learner/Thinker are YOU?

Instructions: In each row, please circle ALL the answers which apply to you. If more than one applies, please mark the one which occurs most often or applies most strongly to you.

	A HIGH ACHIEVER	A GIFTED LEARNER	A CREATIVE THINKER
1	Remembers the answers	Poses unforeseen questions	Sees exceptions
2	Is interested	Is curious	Wonders
3	Is attentive	Is selectively mentally engaged	Daydreams; may seem off task
4	Generates advanced ideas	Generates complex, abstract ideas	Overflows with ideas, many of which will never be developed
5	Works hard to achieve	Knows without working hard	Plays with ideas and concepts
6	Answers the questions in detail	Ponders with depth and multiple perspectives	Injects new possibilities
7	Performs at the top of the group	Is beyond the group	Is in own group
8	Responds with interest and opinions	Exhibits feelings and opinions from multiple perspectives	Shares bizarre, sometimes conflicting opinions
9	Learns with ease	Already knows	Questions: What if ...
10	Needs 6-8 repetitions to master	Needs 1 to 3 repetitions to master	Questions the need for mastery
11	Comprehends at a high level	Comprehends in-depth, complex ideas	Comprehends in-depth, complex ideas
12	Enjoys the company of age peers	Prefers the company of intellectual peers	Prefers the company of creative peers, but often works alone
13	Understands complex, abstract humor	Creates complex, abstract humor	Relishes wild, off-the-wall humor
14	Grasps the meaning	Infers and connects concepts	Makes mental leaps, Aha!
15	Completes assignments on time	Initiates projects and extensions of assignments	Initiates more projects than will ever be completed
16	Is receptive	Is intense	Is independent and unconventional
17	Enjoys school often	Enjoys self-directed learning	Enjoys creating
18	Absorbs information	Manipulates information	Improvises
19	Is a technician with expertise in a field	Is an expert, abstracting beyond the field	Is an inventor and idea generator
20	Memorizes well	Guesses and infers well	Creates and brainstorms well
21	Is highly alert and observant	Anticipates and relates observations	Is intuitive
22	Is pleased with own learning	Is self-critical	Is never finished with possibilities
23	Gets A's	May not be motivated by grades	May not be motivated by grades
24	Is accurate and complete	Is original and continually developing	Is original and continually developing
25	Is able	Is intellectual	Is idiosyncratic

Adapted from *Differentiation: Simplified, Realistic, and Effective* by Bertie Kingore, 2004.

Amen Brain System Checklist (Used by permission) Name _____

Please rate your child on each of the symptoms listed below using the following scale. If possible, to give us the most complete picture, have your child rate him or herself as well, and please have the child give her or his answers before you give yours.

0 **1** **2** **3** **4** **NA**
Never **Rarely** **Occasionally** **Frequently** **Very Frequently** **Not applicable/Not Known**

Parent Self Rating

- | | | | |
|-------|-------|-----|---|
| _____ | _____ | 1 | Fails to give close attention to details or makes careless mistakes |
| _____ | _____ | 2. | Trouble sustaining attention in routine situations (i.e., homework, chores, paperwork) |
| _____ | _____ | 3. | Trouble listening |
| _____ | _____ | 4. | Fails to finish things |
| _____ | _____ | 5. | Poor organization for time or space (such as backpack, room, desk, paperwork) |
| _____ | _____ | 6. | Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort. |
| _____ | _____ | 7. | Loses things |
| _____ | _____ | 8. | Easily distracted |
| _____ | _____ | 9. | Forgetful |
| _____ | _____ | 10. | Poor planning skills |
| _____ | _____ | 11. | Lack clear goals or forward thinking |
| _____ | _____ | 12. | Difficulty expressing feelings |
| _____ | _____ | 13. | Difficulty expressing empathy for others |
| _____ | _____ | 14. | Excessive daydreaming |
| _____ | _____ | 15. | Feeling bored |
| _____ | _____ | 16. | Feeling apathetic or unmotivated |
| _____ | _____ | 17. | Feeling tired, sluggish, or slow moving |
| _____ | _____ | 18. | Feeling spacey, or “in a fog” |
| _____ | _____ | 19. | Fidgety, restless or trouble sitting still |
| _____ | _____ | 20. | Difficulty remaining seated in situations where remaining seated is expected |
| _____ | _____ | 21. | Runs about or climbs excessively in situations in which it is appropriate (or wants to-restrains oneself) |
| _____ | _____ | 22. | Difficulty playing/working quietly |
| _____ | _____ | 23. | “On the go” or acts as if “driven by a motor” |
| _____ | _____ | 24. | Talks excessively |
| _____ | _____ | 25. | Blurts out answers before questions have been completed (or has to restrain oneself from doing so) |
| _____ | _____ | 26. | Difficulty waiting turn |
| _____ | _____ | 27. | Interrupts or intrudes on others (e.g., butts into conversations or games) |
| _____ | _____ | 28. | Impulsive (saying or doing things without thinking first) |
| _____ | _____ | 29. | Excessive or senseless worrying |
| _____ | _____ | 30. | Upset when things do not go your way |
| _____ | _____ | 31. | Upset when things are out of place |
| _____ | _____ | 32. | Tendency to be oppositional or argumentative |
| _____ | _____ | 33. | Tendency to have repetitive negative thoughts |
| _____ | _____ | 34. | Tendency toward compulsive behaviors |
| _____ | _____ | 35. | Intense dislike for change |
| _____ | _____ | 36. | Tendency to hold grudges |
| _____ | _____ | 37. | Trouble shifting attention from subject to subject |
| _____ | _____ | 38. | Trouble shifting behavior from task to task |
| _____ | _____ | 39. | Difficulties seeing options in situations |
| _____ | _____ | 40. | Tendency to hold on to own opinion and not listen to others |
| _____ | _____ | 41. | Tendency to get locked into a course of action, whether or not it is good |
| _____ | _____ | 42. | Needing to have things done a certain way or you become very upset |
| _____ | _____ | 43. | Others complain that you worry too much |
| _____ | _____ | 44. | Tend to say no without first thinking about question |
| _____ | _____ | 45. | Tendency to predict fear |
| _____ | _____ | 46. | Frequent feelings of sadness |
| _____ | _____ | 47. | Moodiness |

Name: _____

- _____ 48. Negativity
- _____ 49. Low energy
- _____ 50. Irritability
- _____ 51. Decreased interest in others
- _____ 52. Decreased interest in things that re usually fun or pleasurable
- _____ 53. Feelings of hopelessness about the future
- _____ 54. Feelings of helplessness or powerlessness
- _____ 55. Feeling dissatisfied or bored
- _____ 56. Excessive guilt
- _____ 57. Suicidal feelings
- _____ 58. Crying spells
- _____ 59. Lowered interest in things usually considered fun
- _____ 60. Sleep changes (too much or too little)
- _____ 61. Appetite changes (too much or too little)
- _____ 62. Chronic low self-esteem
- _____ 63. Negative sensitivity to smells/odors
- _____ 64. Frequent feelings of nervousness or anxiety
- _____ 65. Panic Attacks
- _____ 66. Symptoms of heightened muscle tension (headaches, sore muscles, hand tremor)
- _____ 67. Periods of heart pounding, rapid heart rate or chest pain
- _____ 68. Periods of trouble breathing or feeling smothered
- _____ 69. Periods of feeling dizzy, faint or unsteady on your feet
- _____ 70. Periods of nausea of abdominal upset
- _____ 71. Periods of sweating, hot or cold flashes
- _____ 72. Tendency to predict the worst
- _____ 73. Fear of dying or doing something crazy
- _____ 74. Avoiding places for fear of having an anxiety attack
- _____ 75. Conflict avoidance
- _____ 76. Excessive fear of being judged or scrutinized by others
- _____ 77. Persistent phobias
- _____ 78. Low motivation
- _____ 79. Excessive motivation
- _____ 80. Tics (motor or vocal)
- _____ 81. Poor handwriting
- _____ 82. Quick startle
- _____ 83. Tendency to 'freeze' in anxiety provoking situations
- _____ 84. Lacks confidence in their abilities
- _____ 85. Seems shy or timid
- _____ 86. Easily embarrassed
- _____ 87. Sensitive to criticism
- _____ 88. Bites fingernails or picks skin
- _____ 89. Short fuse or periods of extreme irritability
- _____ 90. Periods of rage with little provocation
- _____ 91. Often misinterprets comments as negative when they are not
- _____ 92. Irritability tends to build, then explodes, then recedes, often tired after a rage
- _____ 93. Periods of spaciness or confusion
- _____ 94. Periods of panic and/or fear for no specific reason
- _____ 95. Visual or auditory changes,, such as seeing shadows or hearing muffled sounds
- _____ 96. Frequent periods of déjà vu (feelings of being somewhere you have never actually been)
- _____ 97 Sensitivity or mild paranoia
- _____ 98. Headaches or abdominal pain of uncertain origin
- _____ 99. History of a head injury or family history of violence or explosiveness
- _____ 100. Dark thoughts, may involve suicidal or homicidal thoughts
- _____ 101. Periods of forgetfulness or memory problems

Name _____

Amen Clinic Learning Disability Screening Questionnaire

Provided by Sharon M. Barnes, MSSW, LCSW, Therapist For Sensitive And Gifted. Used by permission.

Please rate yourself on each of the symptoms listed below using the following scale. If possible, to give us the most complete picture, have another person (such as a spouse, partner or parent) rate you as well. List other person _____

0 1 2 3 4 NA
Never Rarely Occasionally Frequently Very Frequently Not applicable/Not Known

Other Self

Reading

- _____ 1. I am a poor reader
_____ 2. I do not like reading
_____ 3. I make mistakes when reading like skipping words or lines
_____ 4. I read the same line twice
_____ 5. I have problems remembering what I read even though I have read all the words
_____ 6. I reverse letters when I read (such as b/d, p/q)
_____ 7. I switch letters in words when reading (such as god and dog)
_____ 8. My eyes hurt or water when I read
_____ 9. Words tend to blur when I read
_____ 10. Words tend to move around the page when I read
_____ 11. When reading I have difficulty understanding the main idea or identifying important details.

Writing

- _____ 12. I have "messy" handwriting
_____ 13. My work tends to be messy
_____ 14. I prefer to print rather than writing in cursive
_____ 15. My letters run into each other or there is no space between words
_____ 16. I have trouble staying within lines
_____ 17. I have problems with grammar or punctuation
_____ 18. I am a poor speller
_____ 19. I have trouble copying off the board or from a page in a book
_____ 20. I have trouble getting thoughts from my brain to the paper
_____ 21. I can tell a story but cannot write it

Body Awareness/Spatial Relationships

- _____ 22. I have trouble with knowing my left from my right
_____ 23. I have trouble keeping things within columns or coloring within lines
_____ 24. I tend to be clumsy, uncoordinated
_____ 25. I have difficulty with eye hand coordination
_____ 26. I have difficulty with concepts such as up, down, over or under
_____ 27. I tend to bump into things when walking

Oral Expressive Language

- _____ 28. I have difficulty expressing myself in words
_____ 29. I have trouble finding the right word to say in conversations
_____ 30. I have trouble talking around a subject or getting to the point in a conversation

Name _____

Receptive language

- _____ 31. I have trouble keeping up or understanding what is being said in a conversation
 _____ 32. I tend to misunderstand people and give the wrong answers in conversations
 _____ 33. I have trouble understanding directions people tell me
 _____ 34. I have trouble telling the direction sound is coming from
 _____ 35. I have trouble filtering out background noises

Math

- _____ 36. I am poor at basic math skills for my age (adding, subtracting, multiplying and dividing)
 _____ 37. I make “careless mistakes” in math
 _____ 38. I tend to switch numbers around
 _____ 39. I have difficulty with word problems

Sequencing

- _____ 40. I have trouble getting everything in the right order when I speak
 _____ 41. I have trouble telling time
 _____ 42. I have trouble using the alphabet in order
 _____ 43. I have trouble saying the months of the year in order

Abstraction

- _____ 44. I have trouble understanding jokes people tell me
 _____ 45. I tend to take things too literally

Organization

- _____ 46. My notebook/paperwork is messy or disorganized
 _____ 47. My room is messy
 _____ 48. I tend to shove everything unto my backpack, desk or closet
 _____ 49. I have multiple piles around my room.
 _____ 50. I have trouble planning my time
 _____ 51. I am frequently late or in a hurry
 _____ 52. I often do not write down assignments or tasks and end up forgetting what to do

Memory

- _____ 53. I have trouble with my memory
 _____ 54. I remember things from long ago but not recent events
 _____ 55. It is hard for me to memorize things for work or school
 _____ 56. I know something one day but do not remember it to the next
 _____ 57. I forget what I am going to say right in the middle of saying it
 _____ 58. I have trouble following instructions that have more than one or two steps

Social Skills

- _____ 59. I have few or no friends
 _____ 60. I have trouble reading body language or facial expressions of others
 _____ 62. My feelings are often or easily hurt
 _____ 63. I feel uncomfortable around people I do not know well
 _____ 64. I am teased by others
 _____ 65. Friends do not call and ask me to do things with them
 _____ 66. I do not get together with others outside of school or work

Name _____

Scotopic Sensitivity

- _____ 67. I am light sensitive, bothered by glare, sunlight, headlights or streetlights
- _____ 68. I become tired, experience headaches, mood changes, feel restless or an inability to stay focused with bright or fluorescent lights
- _____ 69. I have trouble reading words that are on white, glossy paper
- _____ 70. When reading, words or letters shift, shake, blur, move, run together, disappear or become difficult to perceive
- _____ 71. I feel tense, tired, sleepy, or even get headaches with reading
- _____ 72. I have problems judging distance and have difficulty with such things as escalators, stairs, ball sports, or driving

Sensory Integration

- _____ 73. I seem to be more sensitive to the environment than do others
- _____ 74. I am more sensitive to noise than are others
- _____ 75. I am particularly sensitive to touch or very sensitive to certain clothing or tags on the clothing
- _____ 76. I have unusual sensitivity to certain smells
- _____ 77. I have unusual sensitivity to light
- _____ 78. I am sensitive to movement or crave spinning activities
- _____ 79. I tend to be clumsy or accident prone



8089 South Lincoln Street Suite 203, Littleton, CO 80122

Phone: (303) 987-0346 Fax: (303) 989-0099

Colorado Mandatory Disclosure Statement

DEGREES AND CREDENTIALS:

Bachelor of Science Degree; Major in Social Service: Loma Linda University, 1974

Master of Science in Social Work Degree: San Diego State University, 1976

Licensed Clinical Social Worker in California, #6986, initiated: 1979. No longer active.

Licensed Clinical Social Worker in Colorado, #991263, Active since 1994

The practice of both licensed and unlicensed psychotherapists is regulated by the Department of Regulatory Agencies under **12.43.214 (1) (C)**. Questions or complaints may be addressed to:

Colorado State Grievance Board

1560 Broadway, Suite 1340

Denver, Colorado 80202

(303) 894-7760

Under this statute, **12.43.214 (1)(d) CRS** you are entitled to receive information about the methods of therapy; the techniques used; the duration of therapy (if known) and the fee structure. You may seek a second opinion from another therapist or may terminate therapy at any time. In a professional relationship sexual intimacy is inappropriate and should be reported to the Grievance Board.

12.43.214 (1)(d) CRS: states that information provided by a client during therapy sessions is legally confidential in the case of licensed clinical social workers, except as provided in Section 12.43.218 and except for certain legal exceptions which will be identified by the licensee should any such situation arise during therapy.

Practice Information: Sharon M. Barnes, MSSW, LCSW is incorporated in the state of Colorado as Sharon M. Barnes, LCSW, PLLC and is in independent practice. She is not in partnership with any other professional or therapist who uses the same office suite.

I have been informed of my therapist's degrees, credentials and licenses.

I have also read the preceding information and understand my rights as a client.

Client Signature

Date

Therapist Signature

Date

Fee Schedule and Agreement

Sharon Barnes' fee per 50 minute session is \$150.00.

* ____ The amount I agree to pay for counseling services is \$150.00 per 50/minute session.

* ____ I understand that any time under or over 50 minutes will be pro-rated accordingly.

INSURANCE BILLING: I understand that the fee for each counseling session is due and payable at the time of service. I also understand I am responsible for finding out what my insurance will cover (if anything) and for filing my own insurance claims. At my request, Sharon Barnes will provide me with a statement containing all the information necessary for me to file a claim with my insurance carrier so that I may receive insurance reimbursement. I understand that there will be a fee for this.

* ____ **APPOINTMENT CANCELLATION POLICY:** I understand that I am responsible to keep my therapy appointments, and that I am to notify the office at least 24 hours in advance of any appointments which cannot be kept. If I provide less than 24 hours' notice, I agree that I will be charged the regular rate for my usual appointment.

* ____ **CREDIT CARD AUTHORIZATION:** I hereby authorize Sharon M. Barnes, LCSW, PLLC to charge my credit card for missed sessions, as agreed. I understand that Sharon Barnes will keep my Credit Card Information confidential, with my client record. I understand that my credit card statements will show charges as coming from "Sharon M. Barnes, MSSW, PLLC".

Name as it appears on the Card: _____	Type of Card: _____
Card Number / _____ / _____ / _____ / _____ /	Authorization Code: _____
Exp Date: _____	Address: _____
City _____	State ____ Zip _____ Home Phone: _____
Daytime Phone: _____	Email Address _____

*Please read each section & get clarification on any questions you may have before initialing each one.

Client Signature _____ Date _____

Therapist Signature _____ Date _____

Sharon M. Barnes, LCSW, PLLC Business Practices Descriptions and Disclosures

Welcome to my counseling and psychotherapy practice. I look forward to working with you. I see women, men, teens and some children. I use individual, group, couple, and family sessions and a combination of these. The problems I most frequently work with include coping & thriving as a creative, highly sensitive, and/or gifted person, parenting creative, highly sensitive, and/or gifted children; coping & thriving with ADD or AD/HD; relationship concerns, self-esteem issues, grief issues, coping with chronic or life-threatening illness, parenting concerns; personal and spiritual growth, life passages and transitions, creativity recovery and development, trauma recovery and resolution, and adoption issues.

My gentle, supportive approach focuses on guiding people through the Wilderness of Inner Territory to Destinations of Delight. The healing, change and growth that people seek when they come to work with me takes place within the context of our therapeutic relationship. This enables people to find their way through anxieties, depression, fears, confusion, abuse, loss, relationship and life changes. I help people learn how to discover their own pathways to healing, joy and fulfillment. In this inner journey, many discover metaphorical personal treasure which had been hidden in life's deep dark woods. It is my privilege to accompany many people on this inner quest, and to help them create better self-esteem; be centered and find their voice; be empowered to understand themselves better and form more fulfilling relationships; as well as to be more able to know who they are, what they want in life, and how to craft a life they love to live.

Most clients come on a regular basis, weekly or every other week, and often for six months to a year or more. Sessions usually last 50 minutes, but may be extended to 75 minutes for couples, families, or whenever indicated. Fees are adjusted according to the length of the session. See my Fee Agreement for more details on my fee structure.

FOLLOWING IS IMPORTANT INFORMATION ABOUT MY POLICIES AND PROCEDURES. PLEASE READ IT CAREFULLY AND CLARIFY ANY QUESTIONS YOU HAVE ABOUT IT. THANK YOU.

Confidentiality

The information you discuss during a psychotherapy is protected as confidential under law (CRS 12,43,214 (1)(d)), with certain limitations.

- In most situations, your written consent is required before any information can be released. However, there are specific situations in which I am legally required to release information without your consent.
- It is my legal responsibility and my policy to report suspected child abuse without an investigation to the proper authorities who may then investigate.
- I may take some action without your consent if I assess you to be a serious harm to yourself or another. Any action I take without your consent will be discussed with you.
- If I am unable to collect my agreed upon fee, I may send your name and address to a collection agency.
- If you file a complaint or a lawsuit against me, according to Colorado law, your right to confidentiality will be waived.
- If you choose to use your health benefit plan, you will have given your insurance or managed care company consent to obtain required confidential information for the purpose of determining eligibility for reimbursement. This normally requires diagnosis and procedure code information.
- If I seek consultation from another mental health professional, your privacy will be protected by that professional, and I will reveal only the necessary private information for the purpose of the consultation.
- If another mental health professional is involved in your mental health treatment and I determine that it is important for your treatment, I may collaborate in order to coordinate care. Your authorization may not be obtained, but you will be advised of this situation.
- Clerical and/or billing persons contracted by me may have access to limited confidential information, for example, your name, address, diagnosis, dates and procedure codes. This information is protected from further disclosure and is used solely for administrative purposes.
- When I am away from my office for a few days, we will discuss how to handle any emergent need which may arise. If we decide to ask another licensed therapist to cover emergencies for me, I will disclose to this therapist only what he or she needs to know to assist you in an emergency.

Availability

I answer my phone directly when I am able. At other times, it is forwarded to my confidential voicemail. I am notified of every message that is left for me. You may leave a voicemail message 24 hours a day at 303-987-0346, and I or a designated backup therapist will attempt to return your call within 24 hours during the weekdays or on the first working day following a weekend or holiday. **I do not provide routine 24 hour emergency coverage. In the event of a psychiatric emergency, you will need to call 9-1-1 or go to your nearest emergency room.** When, in our work together, we are able to anticipate the potential of such emergencies, we will make plans together for how to handle the emergency.

Health Care Benefits

_____ As stated in the Fee Agreement, with the exception of regular Medicare, I do not accept insurance benefits. In the event that you choose to use your health care benefits, and my services are reimbursable under your insurance plan, you are responsible to file your own insurance claims. You will also need to give me written authorization to release any required information. Confidential information required by your insurance company may range from identifying information, diagnosis, dates and types of sessions and charges to a written assessment with treatment goals and progress reports, when your benefits come under managed care. My policy is to provide the least amount of information necessary for the purpose of authorizing benefits. However, I can no longer be in control of the storage or access to your confidential information when it is given to a third party. The insurance company will determine benefit coverage and the kind of service for which they will reimburse. I charge for report writing time at the same rate as therapy time.

Records

_____ Records may include identifying information, dates and types of sessions, an assessment and diagnosis, a treatment plan, progress notes, and any reports, consultations or collateral contacts made, and informed consent disclosures. My private psychotherapy notes are kept separate, and are not a part of the record. These psychotherapy notes are further protected from subpoena and unauthorized access by HIPAA. Your records will be stored safely with attention to your privacy for at least 7 years as required by Colorado Statute. In the event that I am no longer able to secure and monitor access to your record, another mental health professional will act as my professional representative. That professional representative will contact you regarding the location of your record. Your records are protected by Colorado Statute, HIPAA regulations, and Professional Ethics. Records can only be released with your written permission and direction. It is my policy not to release an entire record, even with your authorization. Instead, I will summarize the content related to the request. Colorado Statute, CRS 25-1-803, limits release to a summary after termination. If you were seen in couple or family sessions, all adults present would have to sign the release. You will be granted reasonable access to your record, but no copy of the record. If you choose to read your record, it is my policy to be present in order to respond to any questions or confusion you have about the recordings. You may request, in writing, an amendment or addition to your record. My time in dealing with any request for records is reimbursable at the rate agreed upon in the fee agreement.

Termination

_____ Termination will usually be agreed upon mutually, but you are free to terminate at any time. Ending treatment by reviewing our work together and summarize what you are taking with you is much more helpful to you than ending treatment without the benefit of this wrap-up review. Even though planned endings and spoken goodbyes can be difficult, they are well worth the effort and I highly recommend it, especially in our work together. In a few rare and special instances I may decide to stop working with you even though you wish to continue. The reason for this may include a need for special services outside of the area of my competency, a failure to meet the terms of our fee agreement, or and/or prolonged failure to make progress in our work together. Should any of these occur, I will discuss the reason for termination with you, and you will be helped to make different plans for yourself, including a referral to a more appropriate resource.

CLIENT AGREEMENT

_____ **I consent to becoming a client of Sharon M. Barnes, LCSW, PLLC. I have been informed of her degrees, credentials and licenses. I have read the above information. I have clarified all areas about which I have had questions. I understand and agree to my rights and responsibilities as a psychotherapy or consultation client.**

Parent or Guardian of Minor Child Signature

Date

Therapist Signature

Date



Acknowledgement of Receipt of Notice of Privacy Rights

I, _____, acknowledge that I have received access to a copy
Please Print Client Name

of the Notice of Privacy Practices for *Sharon M. Barnes, LCSW, PLLC*.

I acknowledge that these Privacy Practices are posted on her website and available to me at my convenience in this location: <http://therapistforsensitiveandgifted.com/counseling/notice-privacy-practices/>

Signature of Parent or Guardian of Minor Child

Date

Signature of Parent or Guardian of Minor Child

Date