**Velles Counseling Services LLC Intake Packet (Updated April 2025)**

**This top section is required, along with a copy of your insurance.**

Client name ­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_­­­ Sex \_\_\_\_\_\_\_\_\_\_\_ Gender \_\_\_\_\_\_\_\_ Marital Status\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary contact/scheduling email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact/scheduling phone 1 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Messages Y / N ?

Contact/scheduling phone 2 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Messages Y / N ?

Do you want email or phone reminders for appointments? Circle choice: Email / Phone

Is it ok for the provider to leave detailed messages with potentially sensitive information? Y/ N

If yes, please circle all contact points that may receive this information: Email / Phone 1 / Phone 2

Parents/Guardians (names; if under 18) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there an IEP/504 in place for the client? Y / N (If so, please provide a copy (will be returned))

If under 18, allowed to have treat/candy? **Y / N** Can provider give a reward for goals or progress? **Y / N**

If under 18 but over 13, ok to share information with parents/guardians (minor must consent)? **Y / N**

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

Race/Ethnicity \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Religion \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employed? **Y / N – FT/PT** Student? **Y / N – FT/PT** Interpreter/other services needed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you experiencing: Suicidal Thoughts? **Y / N** Ideation? **Y / N** Do you want to die/not exist? Y / N

Do you have a plan? **Y / N** Access to means? **Y / N** Any previous attempts? **Y / N**

Please provide any information (frequency, dates, plans, etc) regarding these thoughts and feelings. *Sharing this information does not require that you be “locked up” or forced to take medication.*

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Client Health Information

**Current diagnoses (of any kind)**

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Current Medications & Dosage:

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Caffeine \_\_\_ cups/day Alcohol \_\_\_/\_\_\_ drinks day/week Vaping \_\_\_\_\_\_ day Marijuana \_\_\_\_\_ day

Nicotine/Tobacco \_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Screen time per day (non-school) \_\_\_\_\_\_\_\_\_\_

Sleep: \_\_\_\_\_ Hours Exercise: Days per week \_\_\_\_/Min per day \_\_\_\_ Meals \_\_\_\_\_\_/day Healthy? **Y / N**

**For all clients, children especially – indicate if you have been evaluated for the following (circle if yes):**

Hearing problems Vision problems Sensory issues Dyslexia Dyscalculia Head Injuries

Food sensitivities Dye/fabric/other sensitivity Hormone Imbalances Autism Spectrum

ADHD disorders (inc. ODD) Learning Disorders Neurological Disorder

For women: Menstruation complications Postpartum complications

Please provide the name and contact information of any physicians below:

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Are you ok with Medically Necessary Information being shared with your providers? **Y / N**

**If so, which: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Family Psychiatric & Behavioral History

(Optional but preferred; use back of sheets if more room is necessary)

**History of Present Problem: symptoms, onset, duration, frequency, etc.**

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**Family history of any behavioral/psychological illnesses:**

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**Medical Conditions & History: current and past medical conditions, treatments, allergies, etc.**

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**Substance Use: history of substances used, prescription drugs other than as prescribed, present substance use, etc.**

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**Developmental History: developmental milestones, delays, etc.**

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**Educational/Vocational History: level of education, current/past employment, hobbies, leisure activities, etc.**

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**Legal History: arrest history, sentencing, DUI occurrences, incarceration, civil litigation, family court matters, etc.**

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**FINANCIAL AGREEMENT & CONSENT FOR SERVICES PROVIDED BY VELLES COUNSELING SERVICES LLC**

**Updated April 2025**

\_\_\_\_\_ (initial) I understand that I am responsible for the payment of this account regardless of insurance coverage; this may include a copayment and/or a deductible each session. I understand that I may be contacted by email or mail to have payment collected for services rendered. If I choose not to use my insurance, I will be responsible for the full fee.

\_\_\_\_\_ (initial) I agree that if I miss an appointment without notice I will be responsible for a fee of $150, which is not covered by insurance.

\_\_\_\_\_ (initial) I agree that if I give cancelation notice of less than 24 hours, I will be responsible or a fee of $100, which is not covered by insurance. (Some unforeseen circumstances, such as death in the family, may result in fee being waived.)

\_\_\_\_\_ (initial) I understand and have read, or have had explained to me, any documents that require my signature/initials/consent. I understand that I may receive a copy of any such document upon request. These may include the following:

* This Financial Agreement & Consent for Services
* My therapist’s disclosure statement
* My therapist’s fee scheduled
* Any others that apply to me and that I have signed

I, the undersigned, agree to receive, and compensate for, services through Velles Counseling Services LLC, as noted above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Patient Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Guardian (if patient is under 18) Signature Date

**Patient Health Questionnaire**

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

***In the last 2 weeks, how often have you been bothered by the following problems? Circle Answer*.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***PHQ-9*** | **Not at all** | **Several days** | **More than half the days** | **Nearly every day** |
| 1. Little interest or pleasure in doing things. | 0 | 1 | 2 | 3 |
| 2. Feeling down, depressed, or hopeless. | 0 | 1 | 2 | 3 |
| 3. Trouble falling or staying asleep, or sleeping too much. | 0 | 1 | 2 | 3 |
| 4. Feeling tired or having little energy. | 0 | 1 | 2 | 3 |
| 5. Poor appetite or overeating. | 0 | 1 | 2 | 3 |
| 6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down. | 0 | 1 | 2 | 3 |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television. | 0 | 1 | 2 | 3 |
| 8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual. | 0 | 1 | 2 | 3 |
| 9. Thoughts that you would be better off dead, or of hurting yourself in some way. | 0 | 1 | 2 | 3 |
| ***Add the score for each column*** |  |  |  |  |

**Total Score (add your column scores): \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

**Not difficult at all Somewhat difficult Very Difficult Extremely Difficult**

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***Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers*.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***GAD-7*** | **Not at all sure** | **Several days** | **Over half the days** | **Nearly every day** |
| 1. Feeling nervous, anxious, or on edge. | 0 | 1 | 2 | 3 |
| 2. Not being able to stop or control worrying. | 0 | 1 | 2 | 3 |
| 3. Worrying too much about different things. | 0 | 1 | 2 | 3 |
| 4. Trouble relaxing. | 0 | 1 | 2 | 3 |
| 5. Being so restless that it’s hard to sit still. | 0 | 1 | 2 | 3 |
| 6. Becoming easily annoyed or irritable. | 0 | 1 | 2 | 3 |
| 7. Feeling afraid as if something awful might happen. | 0 | 1 | 2 | 3 |
| ***Add the score for each column*** |  |  |  |  |

**Total Score (add your column scores): \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

**Not difficult at all Somewhat difficult Very Difficult Extremely Difficult**

**Authorization For Disclosure of Mental Health Treatment Information**

**Updated April 2025**

**Fill out if necessary/requested**

**I hereby­­ authorize Velles Counseling Services LLC. to disclose to and/or obtain from**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [Name of person or organization]

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [Phone number(s) / email(s)]

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [Phone number(s) / email(s)]

**the following information (Client should check each item that may be disclosed):**

\_\_\_ Current Treatment Update \_\_\_ Treatment Plan or Summary \_\_\_ Diagnosis \_\_\_ Medication Management

\_\_\_ Continuing Care Plan \_\_\_ Discharge/Transfer Summary \_\_\_ Educational Information

\_\_\_ Psychosocial Evaluation \_\_\_ Psychological Evaluation \_\_\_ Psychiatric Evaluation

\_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This disclosure is valid until treatment is ended or when the client requests termination of this agreement, when such request is received by Velles Counseling Services LLC/Dr. Christopher D. Elliott.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client Date

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Signature of Parent, Guardian, or Personal Representative Date

Check here if patient/client refuses to sign authorization \_\_\_\_\_\_\_

**Dr. Christopher D. Elliott**

Licensed Mental Health Counselor

Certified Peer Counselor

Mental Health Professional

Child Mental Health Specialist

**What is a Licensed Mental Health Counselor?**

A Licensed Mental Health Counselor has a Master’s degree in a psychology-related field, a minimum of two years of supervised post-graduate experience, and has passed a national licensure examination. LMHCs are trained and licensed in the practice of psychotherapy.

**What are my rights and responsibilities?**

You have the right to be treated with respect and courtesy at all times. You have the right to express your thoughts and feelings about your therapy issues, your therapist, therapy approach, to change therapists, or to discontinue therapy whenever you choose. It is your responsibility to raise any questions or concerns you may have.

Counselors practicing counseling for a fee must be registered or certified (licensed) with the Department of Health for the protection of public health and safety. Registration of an individual with the department does not include recognition of any practice standards, nor necessarily imply the effectiveness of any treatment. The purpose of the counselor Credentialing Act is to (A) provide protection for the public health and safety; and (B) to empower citizens of this state with a complaint process against acts of unprofessional conduct.

**What is Christopher’s training and experience?**

PhD in Forensic Psychology (August 2022).

Master’s degree in Psychological Counseling (January 2011).

Bachelor’s degree in Cognitive Psychology (August 2008).

Certified Peer Counselor, Mental Health Professional, Child Mental Health Specialist (in WA).

Licensed Mental Health Counselor in Washington State & Massachusetts.

The majority of Christopher’s experience is with severe mental and behavioral health disorders, which are often accompanied by disorders such as anxiety or depression. Christopher has over 12 years’ experience working with families and parents and has almost as much experience in working with trauma. Additionally, Christopher has training and volunteer experience with multicultural populations.

Areas of special interest include trauma, severe mental illness, multicultural counseling, and gender identity and expression (primarily male).

**What is Christopher’s therapeutic orientation?**

Christopher utilizes Cognitive-Behavioral Therapy (CBT), Motivational Interviewing (MI), and Gestalt/Existential therapies and techniques to help you identify and address your thoughts and emotions, and their interactions with your behaviors. This also includes utilizing your self-knowledge and previous successes to work through your current challenges, while recognizing and respecting your beliefs and values.

**About Services Provided by Velles Counseling Services LLC.**

Updated April 2025

**Duty To Warn & Protect & Mandated Reporting**

Velles Counseling Services LLC. (VCS) is legally and ethically obligated to report when someone makes a threat to harm another and/or when someone threatens to harm themselves. These threats do not need to be explicit but can be the result of the totality of someone's behaviors and actions. Similarly, VCS is legally and ethically obligated to report when a person is being abused by another person. The abuse can be emotional, physical, psychological, financial, some other type, or any combination thereof.

**Confidentiality and Your Health Record**

All issues discussed in the course of therapy are strictly confidential, including the fact that you are seeing a therapist. We will not disclose any information to others unless you tell us to do so, or unless compelled to do so by law.

**For WA clients: For children under 13**, we do not need the child's permission to talk with you about their sessions, however, please understand that sometimes children may need to express their thoughts and feelings without about having everything available to you. **Teens 13 years and older have the same confidentiality rights as adults have under Washington State Law.** The teen must give their permission to us to communicate with outside parties, including the parent/guardian, unless there is an imminent risk to self or others. We do make every effort to keep parents informed of what is happening in their teen’s counseling, whenever possible, and most teens agree with us giving at least a progress report.

**In summary**, information about your medical treatment may be released to other persons under the following circumstances only:

* When a release of information is signed by you; or if under age 13 by a parent/ legal guardian.
* To a parent or legal guardian, when the patient is under the age of 13.
* When abuse or neglect must be reported by law.
* When you are a danger to yourself or someone else, or are gravely disabled.
* When your behavioral health provider deems it necessary or appropriate to disclose information to another physician or health provider.
* When your behavioral health provider deems it in accordance with good professional practice to disclose information to a family member, unless you specifically instruct the provider in writing not to do so.
* When it is necessary to provide information in a legal proceeding/disciplinary action.
* When your insurance company requests your record in order to process your insurance claim. L&I patient records are accessed by many; please see the separate handout *Industrial Injury Program.*
* When your spouse, family member, or significant other attends a therapy session with you we make every effort to maintain privacy, but their communication is not privileged or protected by law and can be released without their permission.
* We may resist releasing info to others or to you if we believe that the release would cause imminent harm.

**Emergencies**

In an immediate life or death situation call 911. If you are having a less severe psychiatric emergency involving feeling suicidal, at risk of hospitalization, or other serious symptoms please call 911 or your local hospital, police station, fire department, or other emergency service.

**Custody and Parental/Guardian Fitness**

VCS LLC does not mediate custody disputes, evaluate parental fitness, or provide custody evaluations, or otherwise get involved in legal disputes between parents. Custody evaluations are a forensic procedure requiring specialized training, and they are not covered by health insurance. Secondly, children may feel uncomfortable sharing feelings with a counselor if they worry that what they say will be used against one of the parents.

**Other Services Not Provided**

At this time, VCS LLC does not provider Group Therapy, Substance Abuse/Use Treatment, treatment for Eating Disorders, Psychological/Psychiatric assessments or prescription of any kind, Autism evaluations, neurological/-cognitive evaluations, sleep evaluations, or other similar specialized treatment or assessment unless specifically listed. Court-ordered therapy/evaluations not provided.

**Cancelled and Missed Appointments**

Your appointment is held exclusively for you. If for some reason you can’t keep your appointment, please give us as much notice as possible so we can make your appointment available to someone else. If you don't give us at least 4 hours’ notice (except in case of an emergency), you may be charged a fee that is not covered by insurance. Do not hesitate to call, there is no need to worry!

**Missed (No Call/No Show) Appointments - $125/75**

Why do we have this policy? Even if you cancel with a 8-hour notice, someone else cannot always use that time. If missed appointments begin to happen regularly, you may be denied services with VCS and given information for another provider.

**Outcome Questionnaires**

You may be asked to fill out a brief questionnaire to help you and your provider see your progress and to improve our services.

**Do You Have a Concern?**

If you have a concern about your treatment, medical record, or any of our office functions, please talk first to your provider. When the provider is aware of an issue, often something can be changed or worked out..

**Benefit Exclusions**

Marriage or family counseling and other conditions may be specifically excluded on your certificate of coverage. It is your responsibility to call your insurance company to see what is covered and what services you are responsible for. Similarly, Employee Assistance Program referrals are not always covered by insurance - please allow VCS time to check coverage before trying to make appointments.