Participant Name: Profiler ID:

Client Demographics

Personal Information

Full Name:

Address: Street: Apt: City: State: Zip Code:

County:

Telephone Number:

Date of Birth:

Preferred Name:

Pronoun:

Demographics

Country of Origin:

- ☐ USA
- ☐ Africa
  - ☐ East ☐ South ☐ West ☐ North
- ☐ China, Hong Kong
- ☐ Europe, Balkan Country
- ☐ Russia-Former USSR Country
- ☐ India
- ☐ Japan
- ☐ Korea
- ☐ South America
- ☐ Latin America
- ☐ Middle East
- ☐ Pacific Islands
- ☐ Philippines
- ☐ South East Asia
- ☐ Canada
- ☐ Mexico
- ☐ Iraq
- ☐ Iran
- ☐ Saudi Arabia
- ☐ Other
  - Specify _____

Citizenship:

- ☐ US Citizen
- ☐ Not US Citizen

Employment Status:

- ☐ Employed Full Time (35+ hours)
- ☐ Employed Part Time (20-34 hours)
- ☐ Employed Part Time (Less than 20 hours)
- ☐ Employed in a non-competitive job
- ☐ Not in Labor Force: Homemaker
- ☐ Not in Labor Force: Student
- ☐ Not in Labor Force: Retired
- ☐ Not in Labor Force: Disabled
- ☐ Not in Labor Force: Other reported classification (e.g. volunteer)
- ☐ Unemployed

Gender:

- ☐ Male
- ☐ Female
- ☐ Transgender
- ☐ Other Gender Not Listed
  - Specify: _____
- ☐ Non-binary

Veteran Status:

- ☐ Served in the U.S. military
- ☐ Has never served in the U.S. military

Veteran Family Status:

- ☐ Dependent child of a person who served in the U.S. military
- ☐ Spouse or domestic partner of a person who served in the U.S. military
- ☐ Neither the dependent child, nor the spouse or domestic partner of a person who served in the U.S. military

Smoking Status:

- ☐ Current Smoker
- ☐ Former Smoker
- ☐ Never Smoked

Relationship Status

- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Widowed
- ☐ Domestic Partner
- ☐ Divorced

Participant Name: Profiler ID:

Sexual Orientation
- ☐ Heterosexual
- ☐ Gay/Lesbian/Queer/Homosexual
- ☐ Bisexual
- ☐ Questioning
- ☐ Choosing not to disclose
- ☐ Other _____

Pregnant? ☐ No ☐ Yes ☐ N/A

Primary Language

☐ English	☐ Farsi	☐ Other Asian
☐ Korean	☐ Czech	☐ Other Language
☐ Vietnamese	☐ Mien (Laotian)	☐ Arabic
☐ Laotian	☐ Yakima/Native American	☐ Chinese
☐ Cambodian	☐ Puyallup/Native American	☐ Dutch
☐ Mandarin	☐ Thai	☐ Gujarati
☐ American Sign Language	☐ Portuguese	☐ Hindi
☐ Cantonese	☐ Hmong (Laotian)	☐ Lakota/Sioux
☐ Hungarian	☐ Samoan	☐ Limited English
☐ Russian	☐ Ilocano	☐ Malaysian
☐ Romanian	☐ Tagalog	☐ Marathi
☐ Polish	☐ French	☐ Norwegian
☐ Greek	☐ Japanese	☐ Spanish/Mexican
☐ Tigrigna	☐ German	☐ Ukrainian
☐ Amharic	☐ Native American Dialect	☐ Italian
☐ Finnish	☐ Other Filipino Dialect	

Interpreter Required? ☐ No – does not require an interpreter ☐ Yes – requires an interpreter

Education Status: ☐ Full-time education ☐ Part-time education ☐ Not in educational activities

Highest Degree Completed:
- ☐ None
  - Specify # of grades completed _____
- ☐ High School
- ☐ GED
- ☐ Associate
- ☐ Bachelors
- ☐ Masters
- ☐ PhD/Doctoral Level Degree
- ☐ Other: _____

Religion:

☐ Christian	☐ Jewish	☐ Native American	☐ Catholic
☐ Protestant	☐ Wicca/Pagan	☐ Pentecostal	☐ Buddhist
☐ Atheist/Agnostic	☐ Scientologist	☐ Hare Krishna	☐ Non-Denominational
☐ Muslim	☐ Lutheran	☐ Mormon	☐ Hindu
			☐ Other_____

Hispanic Origin:
- ☐ Cuban
- ☐ Mexican/Mexican American/Chicano
- ☐ Puerto Rican
- ☐ Other Spanish/Hispanic
- ☐ Not Spanish Hispanic
- ☐ Unknown

Participant Name: Profiler ID:

Ethnicity/Race:

- ☐ African
- ☐ Asian Indian
- ☐ Cambodian
- ☐ Eskimo/Alaskan
- ☐ Fijian
- ☐ Guamanian/Chamorro
- ☐ Hmong
- ☐ Iraqi
- ☐ Korean
- ☐ Lamet
- ☐ Laotian
- ☐ Middle Eastern
- ☐ Mixed Ethnic Identity
- ☐ North Vietnamese
- ☐ Other Pacific Islander
- ☐ Don't want to answer
- ☐ Samoan
- ☐ South Vietnamese
- ☐ Thai/Thai Dam
- ☐ Unknown
- ☐ Aleut
- ☐ Black/African American
- ☐ Chinese
- ☐ Ethiopian
- ☐ Filipino
- ☐ Hawaiian
- ☐ Iranian
- ☐ Japanese
- ☐ Lahu
- ☐ Laolue
- ☐ Mandarin
- ☐ Mien
- ☐ Native American
- ☐ Other Asian
- ☐ Other Ethnic Identity
- ☐ Russian
- ☐ Somali
- ☐ Spanish/Hispanic/Mexican
- ☐ Tibetan
- ☐ White/European American

What type of Residence Housing do You Currently Live In?

- ☐ Independent Housing (Lease/Rent)
- ☐ Personal Residence (Own Home)
- ☐ Adult Family Home
- ☐ Foster Care (Children)
- ☐ Long Term Adaptive Care
- ☐ Congregate Care Facility
- ☐ Group Home (Children)
- ☐ Long Term Rehab – LTR
- ☐ Jail/Prison
- ☐ Psychiatric Inpatient
- ☐ Homeless Shelter
- ☐ Drug-Free Shared/Transitional Housing
- ☐ Hospital/Other Institution
- ☐ No Stable Arrangement
- ☐ Not Collected
- ☐ On the Street
- ☐ Pre-Release Center
- ☐ Single Room Occupancy
- ☐ Student Residence
- ☐ Work Release Center
- ☐ Residential Alcohol/Drug Facility
- ☐ Controlled Environment
- ☐ Supported Housing

*If one of the residential facilities listed below:
Agape Outreach, Cascade Hall, Keystone, Summit Inn, Avondale House, Chartley House, Linden Lea Lodge, The Inn, Benson Heights, El Rey, Mercer Inn, Stillwater, Spring Manor, Highwest Residence, Northlake CCF, Transitional Resources.

Who Do You Live With?

- ☐ Alone
- ☐ With parents, or with children
- ☐ With Roommates
- ☐ With children/alone
- ☐ With other family members
- ☐ With spouse/partner with children
- ☐ With friends
- ☐ With spouse/partner no children
- ☐ Foster parents/group home

Family Size: _____

DOB of Youngest Child in the Home: _____

Current Legal Status:

- ☐ None
- ☐ Awaiting Charges
- ☐ Awaiting Trial
- ☐ Child Custody Issue
- ☐ Convicted, Awaiting Sentence
- ☐ CPS Court Involved
- ☐ Diversion
- ☐ Drug Court-Adult
- ☐ Drug Court-Juvenile
- ☐ In other Supervised Program
- ☐ Incarcerated-Post Conviction
- ☐ Incarcerated-Pre Trial
- ☐ On Probation/Parole
- ☐ On Trial
- ☐ DUI Deferred Prosecution
- ☐ Least Restrictive Order
- ☐ Juvenile Detention
- ☐ Other _____

Participant Name: Profiler ID:

HIPAA CONSENT TO LEAVE MESSAGE

Patient Name		Profiler ID	

Telephone/Cellular Phone

I hereby give my consent for Therapeutic Health Services to call me by phone at the number(s) provided below and to leave HIPAA compliant voice messages on the number(s) below. These messages may be a reminder for upcoming appointment date(s) and time, notification of need to schedule an appointment, or other message regarding care provided to me by Therapeutic Health Services.

I have requested that Therapeutic Health Services communicate with me via the method listed above. I acknowledge THS does not have any obligation to provide any messages or updates to me via the communication methods listed above or by any other means in connection with appointment reminders or any other information.

Approved Numbers to Leave Voice Messages

Type of Contact	Number	Priority	Type of Message
Cell:		☐ Call First ☐ Call Last	☐ Name & Number ☐ Detailed Message
Home:		☐ Call First ☐ Call Second	☐ Name & Number ☐ Detailed Message
Emergency Contact:	Name: Number:	☐ ROI on File ☐ Emergency Contact Only	☐ Name & Number ☐ Detailed Message

Approved 3rd Parties

In addition to the above, THS may communicate with the following persons regarding my mental health treatment

Name/Relationship	Number	Type of Communication	Type of Message	ROI on File
		☐ Written ☐ Phone	☐ Name & Number ☐ Detailed Message	☐ Yes ☐ No
		☐ Written ☐ Phone	☐ Name & Number ☐ Detailed Message	☐ Yes ☐ No
		☐ Written ☐ Phone	☐ Name & Number ☐ Detailed Message	☐ Yes ☐ No
		☐ Written ☐ Phone	☐ Name & Number ☐ Detailed Message	☐ Yes ☐ No

ALL participants have the right to change their minds and have these services stopped. If you no longer wish to receive these messages as set forth above, please notify you assigned counselor in writing. If you change your cellular number or home number provided above, please inform us so we can update our records.

Participant Signature:	
Clinician Signature:	
Date:	

Participant Name: Profiler ID:

Consent to Treatment

I request and consent to services from Therapeutic Health Services (THS):
THS is required to provide information to clients about their rights, the services they receive, and their health records at THS.
I have read or had explained to me in a language most familiar to me and received a copy of THS Client Rights. As a THS client, I understand that I have some rights with respect to my health information that is kept by THS.
I understand that:

- With this consent, health information may be used and disclosed to specifically carry out treatments payment or health care operations.
- THS will not otherwise disclose health information to others unless you allow us to do so or as the law authorizes or requires us to do so.
- I have the right to request that THS restrict how my health information is used or disclosed and that THS is not required to agree to requested restrictions.
- I have the right to revoke or take back my consent and I must do so in writing.
- I have received a copy of the THS and the King County, "Notice of Privacy Practices," which provides a more complete description of my health information rights.
- I have been provided information about Advance Directives.
- I have been given Disclosure Statements about my THS providers. My THS provider will be:

For the best results in treatment, cooperation is required between clients and providers. I agree to comply with the following code of conduct. I understand my noncompliance may result in the discontinuation of THS services.

- Any potential weapons are not permitted on the premises.
- Disruptive, dangerous, threatening, harassing, and/or any behaviors that are counter-effective to treatment are unacceptable.
- Alcohol and unauthorized drugs are not permitted on the premises

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ADVANCE DIRECTIVE FOR PSYCHIATRIC CARE (participants 18 and over)

No one likes to think that something bad will happen to them, but it's better to plan for the worst. The "Advance Directive" is a new idea in the mental health field to plan for times when mental health issues make it hard for individuals to make decisions about their care. One type of Advance Directive is a "Durable Power of Attorney" which allows you to designate someone to make decisions for you (like a friend or relative) when you are in crisis. You can also develop a written plan called "An Instructional Directive for Psychiatric Care", which will inform caregivers about your wishes for treatment during an emergency. If you are interested in getting more information about advance directives and/or writing one or both, please ask your counselor for help.

Printed Name (Client):	Signature:	Date:
Printed Name (Guardian):	Signature:	Date:
Printed Name (Witness):	Signature:	Date:

MINORS (at least age 13) as a minor, I acknowledge that I have discussed with my counselor and have been encouraged to inform my parent(s)/guardian about my request for services. My initials here indicate that I have chosen not to involve and inform my parent(s)/guardians at this time. _____ Initials

Please List any Special Conditions:

Participant Name: Profiler ID:

STATEMENT OF CLIENT CLINICAL – INDIVIDUAL RIGHTS

Washington State Law provides certain rights to clients, prospective clients and legally responsible others seeking services from a certified behavioral health treatment facility. You have the right to:

(a) Receive services without regard to race, creed, national origin, religion, gender, sexual orientation, age or disability;

(b) Practice the religion of choice as long as the practice does not infringe on the rights and treatment of others or the treatment service. Individual participants have the right to refuse participation in any religious practice;

(c) Be reasonably accommodated in case of sensory or physical disability, limited ability to communicate, limited English proficiency, and cultural differences;

(d) Be treated with respect, dignity and privacy, except that staff may conduct reasonable searches to detect and prevent possession or use of contraband on the premises;

(e) Be free of any sexual harassment;

(f) Be free of exploitation, including physical and financial exploitation;

(g) Have all clinical and personal information treated in accord with state and federal confidentiality regulations;

(h) Review your clinical record in the presence of the administrator or designee and be given an opportunity to request amendments or corrections;

(i) Receive a copy of agency grievance system procedures upon request and to file a grievance with the agency, or behavioral health organization (BHO), if applicable, if you believe your rights have been violated; and

(j) Lodge a complaint with the department when you feel the agency has violated a WAC requirement regulating behavior health agencies.

(2) THS ensures the applicable individual participant rights described in subsection (1) of this section are:

(a) Provided in writing to each individual on or before admission;

(b) Available in alternative formats for individuals who are blind;

(c) Translated to the most commonly used languages in the agency's service area;

(d) Posted in public areas; and

(e) Available to any participant upon request.

(3) All research concerning an individual whose cost of care is publicly funded is done in accordance with CH. 388-04 WAC, protection of human research subjects, and other applicable state and federal rules and laws.

(4) In addition to the requirements in this section, THS, as an agency providing services to Medicaid recipients ensures an individual seeking or participating in behavioral health treatment services, or the person legally responsible for the individual is informed of their Medicaid rights at time of admission and in a manner that is understandable to the individual or legally responsible person.

(5) The grievance system rules in WAC 388-877-0654 through WAC 388-877-0675 apply to an individual who receives behavioral health services funded through a federal Medicaid program or sources other than a federal Medicaid program.

Please ask your behavioral health provider if you would like more information about your/your child's rights. You have the right to request policies and procedures of the behavioral health organization (BHO) and community behavioral health agencies as they pertain to your rights.

Therapeutic Health Services (THS) must legally inform appropriate authorities where there are serious threats of suicide, serious threats of harm to others, all instances of suspected child abuse, incest, neglect and abuse to dependent and vulnerable adults.

Participant Signature:	Date:

Participant Name: Profiler ID:

Receipt of Participant Handbook

Participant will mark each of the below items to indicate they were informed of the contents during the intake appointment:

_____Participant Rights

_____Participant Medicaid Rights

_____Confidentiality

_____Notice of Privacy Practices (HIPAA)

_____THS Code of Ethical Conduct (Staff)

_____Standards of Ethical Conduct (Patients)

_____THS Policy on Grievances

_____National Consensus Statement on Mental Health Recovery

_____Discharge & Transition Criteria

_____Services at THS

_____THS Health and Safety Information

_____After Hours Crisis Services

_____HIV/AIDS Risk Intervention Education Information

_____BHO Resources

_____List of Authorized Providers

_____Advance Directive

Signing below signifies that I have read or had explained to me the contents of the patient handbook.

_____ _____

Client Signature Date

_____ _____

Parent/Guardian Signature: (participants age 12 & under):

_____ _____

Clinician Signature and Credentials Date

Participant Name: Profiler ID:

STATEMENT OF INDIVIDUAL MEDICAID RIGHTS

(1) Medicaid recipients have general individual rights and Medicaid-specific rights when applying for, eligible for, or receiving behavioral health services authorized by a behavioral health organization (BHO).

(a) General rights that apply to all individuals, regardless of whether an individual is or is not a Medicaid recipient, include:

(i) All applicable statutory and constitutional rights;

(ii) The participant rights provided under WAC 388-877-0600; and

(iii) Applicable necessary supplemental accommodation services in chapter 388-472 WAC.

(b) Medicaid-specific rights that apply specifically to Medicaid recipients include the following. You have the right to:

(i) Receive medically necessary behavioral health services, consistent with access to care standards adopted by the department in its managed care waiver with the federal government. Access to care standards provide minimum standards and eligibility criteria for behavioral health services and are available on the behavioral health administration's (BHA) division of behavioral health and recovery (DBHR) website.

(ii) Receive the name, address, telephone number, and any languages offered other than English, of behavioral health providers in your BHO.

(iii) Receive information about the structure and operation of the BHO.

(iv) Receive emergency or urgent care or crisis services.

(v) Receive post-stabilization services after you receive emergency or urgent care or crisis services that result in admission to a hospital.

(vi) Receive age and culturally appropriate services.

(vii) Be provided a certified interpreter and translated material at no cost to you.

(viii) Receive information you request and help in the language or format of your choice.

(ix) Have available treatment options and alternatives explained to you.

(x) Refuse any proposed treatment.

(xi) Receive care that does not discriminate against you.

(xii) Be free of any sexual exploitation or harassment.

(xiii) Receive an explanation of all medications prescribed and possible side effects.

(xiv) Make a mental health advance directive that states your choices and preferences for mental health care.

(xv) Receive information about medical advance directives.

(xvi) Choose a behavioral health care provider for yourself and your child, if your child is under thirteen years of age.

(xvii) Change behavioral health care providers at any time for any reason.

(xviii) Request and receive a copy of your medical or behavioral health services records, and be told the cost for copying.

(xix) Be free from retaliation.

(xx) Request and receive policies and procedures of the BHO and behavioral health agency as they relate to your rights.

(xxi) Receive the amount and duration of services you need.

(xxii) Receive services in a barrier-free (accessible) location.

(xxiii) Medically necessary services in accordance with the early periodic screen, diagnosis and treatment (EPSDT) under WAC 182-534-0100, if you are twenty years of age or younger.

(xxiv) Receive enrollment notices, informational materials, materials related to grievances, appeals, and administrative hearings, and instructional materials relating to services provided by the BHO, in an easily understood format and non-English language that you prefer.

STATEMENT OF INDIVIDUAL MEDICAID RIGHTS - CONTINUED

(xxv) Be treated with dignity, privacy and respect, and to receive treatment options and alternatives in a manner that is appropriate to your condition.

(xxvi) Participate in treatment decisions, including the right to refuse treatment.

(xxvii) Be free from seclusion or restraint used as a means of coercion, discipline, convenience or retaliation.

(xxviii) A second opinion from a qualified professional within your BHO area at no cost, or to have one arranged outside the network at no cost to you, as provided in 42 C.F.R. § 438.206(3).

(xxix) Receive medically necessary behavioral health services outside of the BHO if those services cannot be provided adequately and timely within the BHO.

(xxx) File a grievance with the BHO if you are not satisfied with a service.

(xxxi) Receive a notice of action so that you may appeal any decision by the BHO that denies or limits authorization of a requested service, that reduces, suspends, or terminates a previously authorized service, or that denies payment for a service, in whole or in part.

(xxxii) File an appeal if the BHO fails to provide services in a timely manner as defined by the state, or act within the timeframes provided in 42 CFR § 438.408(b).

(xxxiii) Request an administrative (fair) hearing if your grievance or appeal is not resolved in your favor.

(xxxiv) Services by the behavioral health Ombuds office to help you in filing a grievance or appeal, or to request an administrative hearing.

(2) A behavioral health agency licensed by the division of behavioral health and recovery (DBHR) and certified by DBHR to provide mental health and/or substance use disorder services must ensure the Medicaid rights described in subsection (1)(b) of this section are:

(a) Provided in writing to each Medicaid recipient, and if appropriate, the recipient's legal representative, on or before admission;

(b) Upon request, given to the Medicaid recipient in an alternative format or language appropriate to the recipient and, if appropriate, the recipient's legal representative;

(c) Translated to the most commonly used languages in the agency's service area; and

(d) Posted in public areas.

Please ask your behavioral health provider if you would like more information about your/your child's rights. You have the right to request policies and procedures of the behavioral health organization (BHO) and community behavioral health agencies as they pertain to your rights.

Please be aware that Therapeutic Health Services (THS) must legally inform appropriate authorities where there are serious threats of suicide, serious threats of harm to others, all instances of suspected child abuse, incest, neglect and abuse to dependent and vulnerable adults.

Participant Signature:	Date:
Parent/Guardian Signature: (participants age 12 & under):	Date:

Participant Name: Profiler ID:

GAINS-SS

GAIN-SS (Self-Report) Completed by Consumer
By answering the questions in this checklist, you will help your treatment provider understand what treatment you may need. This information will help you and your treatment provider develop the best possible plan of treatment for you. Your answers will also help to improve the mental health care in your community. Completing the checklist is optional. If you are willing to answer the questions, please tell your treatment provider and give the checklist back to you treatment provider.

Global Appraisal of Individual Needs-Short Screener (GAINS-SS)		
The following questions are about common psychological, behavioral or personal problems. These problems are considered significant when you have them for two or more weeks, when they keep coming back, when they keep you from meeting you responsibilities, or when they make you feel like you can't go on. Please answer the question Yes or No.		
During the past 12 months, have you had significant problems		
a. With feeling very trapped, lonely, sad, blue, depressed or hopeless about the future	☐ Yes	☐ No
b. With sleep trouble, such as bad dreams, sleeping restlessly, or falling asleep during the day	☐ Yes	☐ No
c. With feeling very anxious, nervous, tense, scared, panicked, or like something bad was going to happen?	☐ Yes	☐ No
d. When something reminded you of the past, you became very distressed or upset	☐ Yes	☐ No
With thinking about ending your life or committing suicide	☐ Yes	☐ No
IDS Sub-scale Score (0-5) _____		
During the past 12 months, did you do any of the following things two or more times		
a. Lie or con to get things you wanted or to avoid having to do something	☐ Yes	☐ No
b. Have a hard time paying attention at school, work or home	☐ Yes	☐ No
c. Have a hard time listening to instructions at school, work or home	☐ Yes	☐ No
d. Been a bully or threatened other people	☐ Yes	☐ No
e. Start fights with other people	☐ Yes	☐ No
EDS Sub-scale Score (0-5) _____		
During the past 12 months, did you		
a. You use alcohol or drugs weekly	☐ Yes	☐ No
b. You spend a lot of time either getting alcohol or drugs, using alcohol or drugs, or feeling the effects of alcohol or drugs (high, sick)	☐ Yes	☐ No
c. You keep using alcohol or drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people	☐ Yes	☐ No
d. Your use of alcohol or drugs cause you to give up, reduce or have problems at important activities at work, school, home or social events	☐ Yes	☐ No
e. You have withdrawal problems from alcohol or drugs like shaking hands, throwing up, having trouble sleeping or sitting still, or use alcohol or drugs to stop being sick or avoid withdrawal problems	☐ Yes	☐ No
SDS Sub-scale Score (0-5) _____		

Signature:	Date:

Participant Name: Profiler ID:

Nicotine Dependence Assessment

☐ I do not use any nicotine products (Stop here)
☐ I do use nicotine products (Please complete the assessment below)

Question	Please Select Your Answer	Points
1. How soon after you wake up do you smoke your first cigarette?	☐ Within 5 minutes ☐ 6-30 minutes ☐ 31-60 minutes ☐ After 60 minutes	3 2 1 0
2. Do you find it difficult to refrain from smoking in places where it is forbidden (e.g. church, library, in cinema, etc.)?	☐ Yes ☐ No	1 0
3. Which cigarette would you hate most to give up?	☐ The first one in the morning ☐ All others	1 0
4. How many cigarettes per day do you smoke?	☐ 10 or less ☐ 11-20 ☐ 21-30 ☐ 31 or more	0 1 2 3
5. Do you smoke more frequently during the first hours after waking than during the rest of the day?	☐ Yes ☐ No	1 0
6. Do you smoke if you are so ill that you are in bed most of the day?	☐ Yes ☐ No	1 0
	Total Score:	
Signature:	Date:	

Participant Name: Profiler ID:

Gambling Screener

☐ I do not gamble **(Stop here)**
☐ I do gamble **(Please complete the assessment below)**

DSM-V Pathological Gambling Diagnostic Form		
In the past year . . .		
1. Have you often found yourself thinking about gambling (e.g., reliving past gambling experiences, planning the next time you will play or thinking of ways to get money to gamble)?	☐ Yes	☐ No
2. Have you needed to gamble with more and more money to get the same amount of excitement you are looking for?	☐ Yes	☐ No
3. Have you become restless or irritable when trying to cut down or stop gambling?	☐ Yes	☐ No
4. Have you gambled to escape from problems or when you are feeling depressed, anxious or bad about yourself?	☐ Yes	☐ No
5. After losing money gambling, have you returned another day in order to get even?	☐ Yes	☐ No
6. Have you lied to your family or others to hide the extent of your gambling?	☐ Yes	☐ No
7. Have you made repeated unsuccessful attempts to control, cut back or stop gambling?	☐ Yes	☐ No
8. Have you risked or lost significant relationship, job, educational or career opportunity because of gambling?	☐ Yes	☐ No
9. Have you sought help from others to provide money to relieve a desperate financial situation cause by gambling?	☐ Yes	☐ No
Add Columns		
Signature:	Date:	

Adapted from the American Psychiatric Association Diagnostic Criteria from the DSM V 2013

Participant Name: Profiler ID:

Anxiety Screener

For Children ages 8-18 years (To be filled out by child)

For children ages 8 to 11, it is recommended that the clinician explain all questions, or have the child answer the questionnaire sitting with an adult in case they have any questions.

Screen for Child Anxiety Related Disorders (SCARED) Youth Version				
Directions: Below is a list of sentences that describe how people feel. Read each phrase and decide if it is "Not True or Hardly Ever True", or "Somewhat True or Sometimes True", or "Very True or Very Often True" for you. Then, for each sentence, write the number that corresponds to the response that seems to describe you ***for the last 3 months.***	**0 = Not True or Hardly Ever True**	**1= Somewhat True or Sometimes True**	**2= Very True or Often True**	
1. When I feel frightened, it is hard for me to breathe.	0	1	2	PN
2. I get headaches when I am at school.	0	1	2	SH
3. I don't like to be with people I don't know well.	0	1	2	SC
4. I get scared if I sleep away from home.	0	1	2	SP
5. I worry about other people liking me.	0	1	2	GD
6. When I get frightened, I feel like passing out.	0	1	2	PN
7. I am nervous.	0	1	2	GD
8. I follow my mother or father wherever they go.	0	1	2	SP
9. People tell me that I look nervous.	0	1	2	PN
10. I feel nervous with people I don't know well.	0	1	2	SC
11. I get stomachaches at school.	0	1	2	SH
12. When I get frightened, I feel like I am going crazy.	0	1	2	PN
13. I worry about sleeping alone.	0	1	2	SP

14. I worry about being as good as the other kids.	0	1	2	GD
15. When I get frightened, I feel like things are not real.	0	1	2	PN
16. I have nightmares about something bad happening to my parents.	0	1	2	SP
17.I worry about going to school.	0	1	2	SH
18. When I get frightened, my heart beats fast.	0	1	2	PN
19.I get shaky.	0	1	2	PN
20. I have nightmares about something bad happening to me.	0	1	2	SP
21. I worry about things working out for me.	0	1	2	GD
22. When I get frightened, I sweat a lot.	0	1	2	PN
23. I am worrier.	0	1	2	GD
24.I get really frightening for no reason at all.	0	1	2	PN
25. I am afraid to be alone in the house.	0	1	2	SP
26.It is hard for me to talk with people I don't know well.	0	1	2	SC
27. When I get frightened, I feel like I'm choking.	0	1	2	PN
28. People tell me that I worry too much.	0	1	2	GD
29. I don't like to be away from my family.	0	1	2	SP
30. I am afraid of having anxiety (or panic) attacks.	0	1	2	PN
31. I worry that something bad might happen to my parents.	0	1	2	SP
32. I feel shy with people I don't know well.	0	1	2	SC

Participant Name: Profiler ID:

33. I worry about what is going to happen in the future.	0	1	2	GD
34. When I get frightened, I feel like throwing up.	0	1	2	PM
35. I worry about how well I do things.	0	1	2	GD
36. I am scared to go to school.	0	1	2	SH
37. I worry about things that have already happened.	0	1	2	GD
38. When I get frightened, I feel dizzy.	0	1	2	PN
39. I feel nervous when I am with other children or adults and I have to do something while they watch me (for example: read aloud, speak, play a game, play a sport.	0	1	2	SC
40. I feel nervous when I am going to parties, dances, or any place where there will be people that I don't know well.	0	1	2	SC
41. I am shy	0	1	2	SC
Add Columns	0	1		
			Total Score	

If you checked off any problems, how difficult have these problems mae it for you to do your work, take care of things at home, or get aong with other people?	Not Difficult at all _____ Somewhat Difficult _____ Very Difficult _____ Extremely Difficult _____	

Signature:	Date:

Developed by Boris Birmaher, M.D., Suneeta Khetarpal, M.D., Marlane Cully, M.Ed., David Brent, M.D., and Sandra McKenzie, Ph.D., Western Psychiatric Institute and Clinic, University of Pittsburgh (October, 1995). Email: [redacted]

See: Birmaher, N., D. A., Chiapetta, L., Bridge, J., Monga, S., # Baugher, M. (1999). Psychometric properties of the Screen for Child Anxiety Related Emotional Disorders (SCARED): a replication study. Journal of the American Academy of Child and Adolescent Psychiatry, 37 (10), 1230-6.

Participant Name: Profiler ID:

Anxiety Screener

For Parents/Guardians with Children ages 8-18 years (To be filled out by Parent/Guardian)

Screen for Child Anxiety Related Disorders (SCARED) Youth Version				
Directions: Below is a list of sentences that describe how people feel. Read each phrase and decide if it is "Not True or Hardly Ever True", or "Somewhat True or Sometimes True", or "Very True or Very Often True" for your child. Then, for each sentence, write the number that corresponds to the response that seems to describe your child ***for the last 3 months.***	**0 = Not True or Hardly Ever True**	**1= Somewhat True or Sometimes True**	**2= Very True or Often True**	
1. When my child feels frightened, it is hard for him/her to breathe.	0	1	2	PN
2. My child get headaches when he/she is at school.	0	1	2	SH
3. My child doesn't like to be with people he/she doesn't know well.	0	1	2	SC
4. My child gets scared if he/she sleeps away from home.	0	1	2	SP
5. My child worries about other people liking him/her.	0	1	2	GD
6. When my child gets frightened, he/she feels like passing out.	0	1	2	PN
7. My child is nervous.	0	1	2	GD
8. My child follows me wherever I go.	0	1	2	SP
9. People tell me that my child looks nervous.	0	1	2	PN
10. My child feels nervous with people he/she I doesn't know well.	0	1	2	SC
11. My child gets stomachaches at school.	0	1	2	SH
12. When my child gets frightened, he/she feels like he/she is going crazy.	0	1	2	PN

Participant Name: Profiler ID:

13. My child worries about sleeping alone.	0	1	2	SP
14. My child worries about being as good as other kids.	0	1	2	GD
15. When he/she gets frightened, he/she feel like things are not real.	0	1	2	PN
16. My child has nightmares about something bad happening to his/her parents.	0	1	2	SP
17. My child worries about going to school.	0	1	2	SH
18. When my child gets frightened, his/her heart beats fast.	0	1	2	PN
19. He/she gets shaky.	0	1	2	PN
20. My child has nightmares about something bad happening to him/her.	0	1	2	SP
21. My child worries about things working out for him/her.	0	1	2	GD
22. When my child gets frightened, he/she sweats a lot.	0	1	2	PN
23. My child is a worrier.	0	1	2	GD
24. My child gets really frightened for no reason at all.	0	1	2	PN
25. My child is afraid to be alone in the house.	0	1	2	SP
26. It is hard for my child to talk with people he/she doesn't know well.	0	1	2	SC
27. When my child gets frightened, he/she feel like he/she is choking.	0	1	2	PN
28. People tell me that my child worries too much.	0	1	2	GD
29. My child doesn't like to be away from his/her family.	0	1	2	SP

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Participant Name: Profiler ID:

30. My child is afraid of having anxiety (or panic) attacks.	0	1	2	PN
31. My child worries that something bad might happen to his/her parents.	0	1	2	SP
32. My child feels shy with people he/she doesn't know well.	0	1	2	SC
33. My child worries about what is going to happen in the future.	0	1	2	GD
34. When my child gets frightened, he/she feels like throwing up.	0	1	2	PM
35. My child worries about how well he/she does things.	0	1	2	GD
36. My child is scared to go to school.	0	1	2	SH
37. My child worries about things that have already happened.	0	1	2	GD
38. When my child gets frightened, he/she feels dizzy.	0	1	2	PN
39. My child feels nervous when he/she is with other children or adults and he/she has to do something while they watch him/ her (for example: read aloud, speak, play a game, play a sport.)	0	1	2	SC
40. My child feels nervous when he/she is going to parties, dances, or any place where there will be people that he/ she doesn't know well.	0	1	2	SC
41. My child is shy.	0	1	2	SC
Add Columns		1		
			Total Score	

If you checked off any problems, how difficult have these problems mae it for you to do your work, take care of things at home, or get aong with other people?	Not Difficult at all _____ Somewhat Difficult _____ Very Difficult _____ Extremely Difficult _____	
Signature:	Date:	

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ths

Participant Name: Profiler ID:

Depression Screener

Ages 11–17* *PHQ-9 modified for Adolescents (PHQ-A)—Adapted

Instructions: How often have you been bothered by each of the following symptoms during the past 7 days?	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. Little interest or pleasure in doing things?	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much?	0	1	2	3
4. Poor appetite, weight loss, or overeating?	0	1	2	3
5. Feeling tired, or having little energy?	0	1	2	3
6. Feeling bad about yourself—or feeling that you are a failure, or that you have let yourself or your family down?	0	1	2	3
7. Trouble concentrating on things like school work, reading, or watching TV?	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 were 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
			Total Score	

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not Difficult at all _____ Somewhat Difficult _____ Very Difficult _____ Extremely Difficult _____
In the past year have you felt depressed or sad most days, even if you sometimes felt ok?	Yes_____ No_____
Has there been a time in the past month when you have had serious thoughts about ending your life?	Yes_____ No_____
Have you **EVER** in your whole life tried to kill yourself or made a suicide attempt?	Yes_____ No_____
Signature:	Date:

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display, or distribute

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Participant Name: Profiler ID:

Trauma Screening

Age 3-17

Child and Adolescent Trauma Screen (CATS) Youth Report (continued)		
Stressful or scary events happen to many people. Below is a list of stressful and scary events that sometimes happen. Mark YES if it happened to you. Mark No if it didn't happen to you.		
1. Serious natural disaster like a flood, tornado, hurricane, earthquake, or fire.	☐ Yes	☐ No
2. Serious accident or injury like a car/bike crash, dog bite, sports injury.	☐ Yes	☐ No
3. Robbed by threat, force or weapon.	☐ Yes	☐ No
4. Slapped, punched, or beat up in your family.	☐ Yes	☐ No
5. Seeing someone in your family get slapped, punched or beat up.	☐ Yes	☐ No
6. Seeing someone in the community get slapped, punched or beat up.	☐ Yes	☐ No
7. Seeing someone in the community get slapped, punched or beat up.	☐ Yes	☐ No
8. Someone older touching your private parts when they shouldn't.	☐ Yes	☐ No
9. Someone forcing or pressuring sex, or when you couldn't say no.	☐ Yes	☐ No
10. Someone close to you dying suddenly or violently.	☐ Yes	☐ No
11. Attacked, stabbed, shot at or hurt badly.	☐ Yes	☐ No
12. Seeing someone attacked, stabbed, shot at, hurt badly or killed.	☐ Yes	☐ No
13. Stressful or scary medical procedure.	☐ Yes	☐ No
14. Being around war.	☐ Yes	☐ No
15. Other stressful or scary event?	☐ Yes	☐ No
Describe: _____		

Which one is bothering you the most now? _____

If you marked "YES" to any stressful or scary events, then turn the page and answer the next questions.

Participant Name: Profiler ID:

Child and Adolescent Trauma Screen (CATS) Youth Report (continued)				
Directions: Mark 0, 1, 2 or 3 for how often the following things have bothered you in the last two weeks:	0 = Never	1 = Once in a while	2 = Half the time	3 = Almost always
1. Upsetting thoughts or pictures about what happened that pop into your head.	0	1	2	3
2. Bad dreams reminding you of what happened.	0	1	2	3
3. Feeling as if what happened is happening all over again.	0	1	2	3
4. Feeling very upset when you are reminded of what happened.	0	1	2	3
5. Strong feelings in your body when you are reminded of what happened (sweating, heart beating fast, upset stomach).	0	1	2	3
6. Trying not to think about or talk about what happened. Or to not have feelings about it.	0	1	2	3
7. Staying away from people, places, things, or situations that remind you of what happened.	0	1	2	3
8. Not being able to remember part of what happened.	0	1	2	3
9. Negative thoughts about yourself or others. Thoughts like "I won't have a good life, no one can be trusted, the whole world is unsafe."	0	1	2	3
10. Blaming yourself for what happened, or blaming someone else when it isn't their fault.	0	1	2	3
11. Bad feelings (afraid, angry, guilty, ashamed) a lot of the time.	0	1	2	3
12. Not wanting to do things you used to do.	0	1	2	3
13. Not feeling close to people	0	1	2	3
14. Not being able to have good or happy feelings.	0	1	2	3
15. Feeling mad. Having fits of anger and taking it out on others.	0	1	2	3
16. Doing unsafe things.	0	1	2	3

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Participant Name: Profiler ID:

	0 = Never	1 = Once in a while	2 = Half the time	3 = Almost always
17. Being overly careful or on guard (checking to see who is around you)	0	1	2	3
18. Being jumpy.	0	1	2	3
19. Problems paying attention.	0	1	2	3
20. Trouble falling or staying asleep.	0	1	2	3

Please mark "YES" or "NO" if the problems you marked interfered with:		
1. Getting along with others	☐ Yes	☐ No
2. Hobbies/Fun		
3. School or work	☐ Yes	☐ No
4. Family relationships	☐ Yes	☐ No
5. General happiness	☐ Yes	☐ No
Signature:	Date:	

Participant Name: Profiler ID:

Psychosocial Screener

Age 4-18 To be filled out by Caregiver Guardian

Pediatric Symptom Checklist-17 (PSC-17)						
Instructions: Emotional and physical health go together in children. Because caregivers are often the first to notice a problem with their child's behavior, emotions or learning, you may help your child get the best care possible by answering these questions. Please mark under the best care possible by answering these questions. Please mark under the heading that best fits your child.	Never	Sometimes	Often	For Office Use		
				I	A	E
1. Feel sad.						
2. Feel hopeless.						
3. Feel down on him/herself.						
4. Worry a lot.						
5. Seem to be having less fun.						
6. Fidget, is unable to sit still.						
7. Daydream too much.						
8. Distract easily.						
9. Have trouble concentrating						
10. Act as if driven by a motor.						
11. Fight with other children.						
12. Not listen to rules.						
13. Not understand other people's feelings.						
14. Tease others.						
15. Blame others for his/her troubles.						
16. Refuse to Share.						
17. Take things that do not belong to him her.						
			Total Score			
Signature:	Date:					

Participant Name: Profiler ID:

Developmental Assessment (Parent of Child 6-12)

Please answer the following questions as completely as possible. Your answers will allow us to find the most helpful avenue of treatment. If you have questions, feel free to ask your clinician and they will be happy to help.

Physical Development	Always	Sometimes	Never
Physically, is your child's body developing like you expect it to?			
Does your child have a healthy diet and regular exercise?			
Does your child have any physical limitations? Please specify below.			
If yes, do you feel that he/she copes well with these?			

How has your child developed on par physically up to this point?
Do you have any concerns in this area?

Cognitive Development	Always	Sometimes	Never
Is your child able to follow the rules and expectations at school?			
Does your child enjoy school and learning?			
Is your child able to find answers to his/her own problems?			

How has your child developed mentally on par up to this point?
Do you have any concerns in this area?

Emotional Development	Always	Sometimes	Never
Does your child stay calm when stressed about school or friendships?			
How often does your child need parent support in calming down when upset about something?			

Does your child have the skills to resolve conflicts/stress?			

What are your child's strengths in regards to handling his/her/their emotions?
Do you have any concerns in this area?

Moral Development	Always	Sometimes	Never
Does your child's understanding of right and wrong meet your expectations?			
Does your child's knowledge of right and wrong match his/her behavior?			
Do you feel you are a good role model to your child about right and wrong?			

What are important values or principals to your child?
Do you have any concerns in this area?

Sense of Self/ Identity Formation	Always	Sometimes	Never
Does your child express what he/she wants to be when grown up?			
Does your child act independently when appropriate?			
Does your child feel he/she has control over things that happen in life?			
Does your child engage in creative play?			
Does your child feel good about him/herself?			

How does your child view him/herself?
Do you have any concerns in this area?

Participant Name: Profiler ID:

Social Identity Development	Always	Sometimes	Never
Does your child develop and maintain friendships with peers?			
Does your child get along with adults and seek mentoring and support from adults around them?			
Does your child "fit in" during social situations (able to follow social rules and cues)?			
Is your child able to make safe choices and say no to wrong or dangerous people or things?			

What are your child's strengths in this area?
Do you have any concerns with your child's ability to relate to others?

Family Relationships	Always	Sometimes	Never
Does your child handle separation from his/her family?			
Does your child have responsibilities at home (i.e. chores, expectations)?			
Does he or she carry out these responsibilities?			
Is your child happy with his/her family, community, culture?			

Describe your child's relationship with his/her family.
Do you have any concerns with how your child interacts with family members?

Name of Person Completing Assessment:	
Relationship to child:	
Date:	

Participant Name: Profiler ID:

Developmental Assessment (Youth 13-16)

Please answer the following questions as completely as possible. Your answers will allow us to find the most helpful avenue of treatment. If you have questions, feel free to ask your clinician and they will be happy to help.

Physical Development	Always	Sometimes	Never
Physically, is your body developing like you expect it to?			
Do you have a healthy diet and regular exercise?			
Do you have any physical limitations? Please specify:			
If yes, do you think you cope well with these limitations?			

What do you like about your body?
What would you change about your body?

Cognitive Development	Always	Sometimes	Never
Do you handle challenges and difficult situations without showing frustration in negative ways?			
Are you progressing in school, and being challenged by your work?			
Are you interested in school/academics?			

How do you handle it when you don't understand what is being taught in school?
What do you like about school and/or learning?
What is hard for you in school?

Emotional Development	Always	Sometimes	Never
Do you share happy moments with others?			

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Participant Name: Profiler ID:

Do you share stressful moments with others?			

How do you handle excitement? How do you handle disappointment?
What do you do when you have strong emotions like anger, jealousy, or fear?
Do you have any concerns in your ability to regulate your emotions?

Moral Development	Always	Sometimes	Never
Does your idea of what is right and wrong match others around you?			
Are you able to stand up for what you believe in even if others disagree with you?			
Do you act according to what you believe is right and wrong?			

What are your values and moral principals in life?
Do you have any concerns regarding what you believe to be right or wrong?
Pretend you see a kid being bullied at school. How do you react?

Sense of Self/ Identity Formation	Always	Sometimes	Never
Do you have goals for your future?			
Do you seek out more responsibility from your parents or teachers?			
Do you feel like you have control over your choices in life?			
Do you have positive feelings about yourself?			

Participant Name: Profiler ID:

How would you describe yourself? What makes you different from others?

Do you have any concerns how you feel or think about yourself or who you are?

Social Identity Development	Always	Sometimes	Never
Do you have friends that you trust?			
Do you make friends easily?			
Do you have adults in your life that you trust?			
Do you stay away from people who are likely to get you in trouble?			
Are you able to say no to dangerous things or in situations where you don't want to do what your peers are doing?			
Are you happy with your home, school, where you live?			

Describe your social network? How do they react if you disagree with them?

Do you have any concerns with your ability to interact or relate socially?

Sexual Identity Development	Always	Sometimes	Never
Are you comfortable with your sexuality?			
Do you struggle with how your individual sexuality fits in with your peers or society?			
Have you begun to have more meaningful romantic relationships?			

Describe what you think is a healthy romantic relationship?

Do you have any concerns with your sexual identity or orientation?

Participant Name: Profiler ID:

Family Relationships	Always	Sometimes	Never
Do you talk with your parents when you need support or mentoring?			
Do you feel respected by your family even when you have disagreements?			
Do you feel you have as much independence in your family as your peers?			

What do you like about your family?
Do you have concerns with your family relationships?

Name of Person Completing Assessment:	
Date:	

2018

Participant Name: Profiler ID:

Developmental Assessment (Young Adults 17-21)

Please answer the following questions as completely as possible. Your answers will allow us to find the most helpful avenue of treatment. If you have questions, feel free to ask your clinician and they will be happy to help.

Physical Development	Always	Sometimes	Never
Physically, do you feel comfortable with your body?			
Do you have a healthy diet and regular exercise?			
Do you have any physical limitations? Please specify:			
If yes, do you think you cope well with these limitations?			

How do you think about your body?

If anything, what would you change about your body?

Cognitive Development	Always	Sometimes	Never
When you have a problem, can you find alternative solutions?			
Is it hard for you to learn or understand new concepts?			
Are you interested in school/academics?			

How do you handle it when you don't understand what is being taught or expected of you?

What do you like about school, learning, or working?

What is hard for you in school and/or work?

Emotional Development	Always	Sometimes	Never
Do you share happy moments with others?			
Do you share stressful moments with others?			

Are you able to make decisions according to your values when you are upset?			

How do you handle excitement? How do you handle disappointment?

What do you do when you have strong negative emotions like anger, jealousy, or fear?

Do you have any concerns in your ability to regulate your emotions?

Moral Development	Always	Sometimes	Never
Does your idea of what is right and wrong keep you from getting in trouble?			
Does your idea of right and wrong match those around you?			
Are you able to stand up for what you believe in even if others disagree with you?			
Do your friends have a good idea of what your values and beliefs are?			

What are your values and moral principals in life?

Do you have any concerns regarding what you believe to be right or wrong?

Give an example of when you stood up for what you believed in.

Sense of Self/ Identity Formation	Always	Sometimes	Never
Do you have goals and dreams for your future?			
Do you seek out more responsibility in your roles in life?			

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Do you feel like you have control over your choices in life?			
Do you have positive feelings about yourself?			
Are the choices you make based on what you think is best for you as opposed to what others think?			
Do you have a good sense of who you are and what you value?			

How would you describe yourself? What makes you different from others?
Do you have any concerns how you feel or think about yourself or who you are?

Social Identity Development	Always	Sometimes	Never
Do you have friends that you trust?			
Do you make friends easily?			
Do you have adults in your life that you trust?			
Are you able to say no in situations where you don't want to do what your peers are doing?			

Describe your social network? What is your role in your peer group?
Give an example of how your views on a topic may be different from a teachers', parents', or peers' view.
Do you have any concerns with your ability to interact socially?

Sexual Identity Development	Always	Sometimes	Never
Are you comfortable experimenting with your sexuality?			
Do you struggle with how your individual sexuality and/or orientation fits in with your peers or society?			

Have you begun to have more meaningful romantic relationships?			

Describe what you think is a healthy romantic relationship?

Do you have any concerns with your sexual identity, orientation, or your ability to have relationships?

Family Relationships	Always	Sometimes	Never
Are you comfortable going to your family for support?			
Do you feel respected by your family even when you have disagreements?			
Do you feel you are equal with older family members?			

What does your family do well?

What concerns do you have with your family relationships?

Name of Person Completing Assessment:	
Date:	

Participant Name: Profiler ID:

Release of Information Forms

Complete Release of Information Forms for all of the following that apply:

- ☐ School
- ☐ Parent/guardian (if 13 or older)
- ☐ Emergency Contact
- ☐ Primary Care Doctor
- ☐ DSHS
- ☐ Former Mental Health Providers
- ☐ WRAP services
- ☐ Hospital records
- ☐ Drug Court
- ☐ Probation
- ☐ Lawyer
- ☐ Other: _____

CENTRAL YOUTH AND FAMILY SERVICES
1901 Martin Luther King Jr. Way South · Seattle, WA 98144 · (206) 322-7676

Individual and Family Counseling/Mental Health Program
Disclosure Statement

The Individual and Family Counseling/Mental Health Program at THS-Central Youth and Family Services provides individual, group and family counseling services, as well as case management, referral and advocacy to clients and their families. Counselors begin by conducting a multi-dimensional assessment looking at presenting issues, as well as areas of strength and identified needs. From this assessment a treatment plan is developed to address each client and family's unique issues and goals, incorporating strengths to be used in the treatment process. THS-YFS staff members are committed to providing all services in a culturally sensitive manner in order to assist children, youth and families to build upon existing strengths and overcome barriers that keep them from experiencing personal growth and success. The goal of this program is to empower clients/families to take control of their own lives.

Counselor Disclosure:

Jessalyn Jackson, MA, LMHCA
Credential #: MC60950291
National Provider Identifier: 1952959843

Counselor Education/Training:

Northwest University, Clinical & Counseling Psychology, MA, 2019
Northwest University, Communications, BA, 2012

Counselor Experience/Approach:

My experience in counseling began during my graduate program throughout the last two years. During that time I worked with diverse populations in the South Seattle and Edmonds area. Under the supervision of psychologist, Dr. Jeff Baird, I was trained primarily in Cognitive Behavioral Therapy (CBT), and Dialectical Behavioral Therapy (DBT). However, I was supported in attending more specific trainings outside of my internship, such as Acceptance and Commitment Therapy (ACT) and Internal Family Systems therapy (IFS).

I use elements of these modalities to inform my practice, however, each individual is unique and treatment is planned collaboratively to fit each person's specific needs. It takes a great deal of courage to begin a healing process and through a person-centered, strengths-based approach, I help the individual pull strengths from their story to encourage positive change his or her life.

ALL COUNSELING IS CONFIDENTIAL WITH THE EXCEPTIONS REQUIRED BY THE LAWS OF THIS STATE (AS EXPLAINED IN THE CONSENT FOR TREATMENT).

Emergency: If your counselor is unavailable, please call the Crisis Clinic at 461-3222 or contact your local Emergency Center for information, support or other emergency care.

Services provided through this program can be covered through a Medicaid benefit, billed to private insurance (where applicable) or assessed on a fee for service basis according to a sliding fee schedule.

I have been provided with a copy of required disclosure information, including counselor credentials, training and experience, what course of treatment and services I can expect to receive and what services will cost. I have also been made aware of the Counselor Credentialing Act (see back of page) and what behavior constitutes unprofessional conduct). I have read and understand the information cited above:

Client's Name: _____ **Client's Profile Number:** _____

Client Signature: _____ **Date:** _____

Parent/Guardian Signature*: _____ **Date:** _____

Counselor Signature: _____ **Date:** _____

* Required for clients age 12 and under.

IMPORTANT INFORMATION REGARDING THE COUNSELOR CREDENTIALING ACT

The Counselor Credentialing Act provides protection for any person seeking counseling services. The purpose of the law relating to counselors is to:

- Provide protection for public health and safety; and
- Empower clients by providing a complaint process against counselors who commit acts of unprofessional conduct.

Counselors are subject to discipline by the Department of Health. Cause for disciplinary action for unprofessional conduct (RCW 18.130.180) are described below:

- False, fraudulent or misleading advertising;
- The commission of any act involving moral turpitude, dishonesty or corruption relating to the practice of counseling;
- Incompetence, negligence or malpractice resulting in injury or unreasonable risk of harm to the client;
- Possession, use, prescription for use or distribution of controlled substances or legend drugs in any way except for legitimate therapeutic purposes;
- Violation of any federal or state law or rules and rules of any health agency.
- Aiding or abetting an unregistered or uncertified person to engage in the practice of counseling, exempt by law;
- Misrepresentation or fraud in any aspect of counseling;
- Counseling involving contact with the public while suffering from a contagious or infectious disease;
- Promotion for personal gain of any unnecessary or useless drug, device, treatment, procedure or service;
- Conviction of any gross misdemeanor or felony relating to the practice of counseling;
- Procuring, aiding or abetting in procuring a criminal abortion;
- Offering or undertaking or agreeing to cure by secret method, procedure or treatment;
- Willful betrayal of counselor/client privilege as recognized by law;
- Violation of the rebating laws which includes payment for referral of clients;
- Use of threats or harassment against clients or witnesses to prevent them from providing evidence in a disciplinary proceeding or legal action;
- Drunkenness or habitual intemperance in the use of alcohol or addiction to alcohol;
- Abuse of a client or sexual contact with a client.

If you feel one of the above described incidents has occurred during your treatment, the following resources can be helpful in addressing the situation:

- ***CYFS Counseling/Mental Health Supervisor at (206) 322-7676, ext. 223***
- ***King County Mental Health Ombudsman Service at (206) 205-5329.***
- ***WA State Department of Health at (360) 753-1761.***