

Colorado state professional disclosure for: Lloyd Davis, MA, LPC, CEAP

- License, certificate, and degree held
- Licensed professional counselor Colorado state license #194
- Masters of arts in counseling from Adams State College
- ThD in counseling from Christian Bible College and Seminary
- Certified employee assistance professional
- Substance abuse professional

State law requires disclosure of much of this material, but I hope it will also help you to be an educated consumer of counseling services, or those of any other mental health professional.

The practice of psychotherapy is regulated in Colorado whether the provider is licensed or unlicensed. The Colorado Department of Regulatory Agencies has this responsibility and they offer the services of a state grievance board. You may visit or contact them at 1560 Broadway, Suite 1340, Denver, Colorado 80202, (303) 894-7766.

You are entitled to know what you are getting in counseling. Ask anything you wish about my training and qualification, what methods I may use, how long I think it may take to reach the goals we agree upon, and what the fees are. Please do not hesitate to question or challenge me. Your honesty will only help me do my job better. You may seek a second opinion; you may fire me at any time. I also may suggest that you get a second opinion, and I too have the right to terminate the relationship if I believe my services are not benefiting you.

Sexual intimacy between a mental health provider and a client (regardless of age) is unethical and illegal, and should be reported to the grievance board.

The information you or your family members provide to me during our sessions is legally confidential, which means I am not free to disclose it to anyone else without your permission. Often children or teenagers ask, "What are you going to tell my parents?" or parents ask, "What did my child say?" My policy is never to promise full confidentiality to young people, but rather to use careful judgment in passing information back and forth and to be as clear as possible in explaining to the child what I wish to share with the parents. Please let me know if you have concerns about what you are hearing or not hearing from me.

There are exceptions to the confidentiality rule, which include giving warning about:  
a client who presents a danger to self or others,  
suspected child abuse, or  
a client who files suit against me.

I will alert you if any legal exceptions to confidentiality arise in our sessions. Most often, keeping this confidential from those outside our professional relationship is not a problem.

Please feel free to clarify any questions you may have concerning this information.

I look forward to working with you.

Signature acknowledges client received a copy.

Client: \_\_\_\_\_

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

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# Outpatient Counseling

## Questionnaire for Counseling Services Adult Kit

The following information will help us serve you better and to evaluate the effectiveness of the outpatient counseling program. All information will remain strictly confidential as prescribed by law and the policy of the hospital.

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

Home Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_ M \_\_\_\_\_ F

SS#: \_\_\_\_\_

Telephone Numbers:

Home: \_\_\_\_\_  okay to call/leave message

Work: \_\_\_\_\_  okay to call/leave message

Cell: \_\_\_\_\_  okay to call/leave message

Other: \_\_\_\_\_  okay to call/leave message

E-mail Address: \_\_\_\_\_

Marital Status:

Married  Divorced

Partnered  Separated

Single  Widowed

May we contact you by mail for anonymous follow-up surveys.  Yes  No

How were you referred to the outpatient counseling program? Please circle as appropriate:

Co-worker  Physician or health service

Global e-mail  Human resources

Pastoral care  Poster

Employee health  Brochure

Family member  Friend

Orientation  Supervisor

Self  Other: \_\_\_\_\_

Counselor

Please provide the following employee information:

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

Employer: \_\_\_\_\_

Shift:

Full Time  
 Part Time  
 PRN/Casual

Job title: \_\_\_\_\_

Relation to employee:

Self  
 Spouse  
 Dependent

# Outpatient Counseling

## Questionnaire for Counseling Services Adult Kit

Reason for today's appointment: (Please mark in order #1 #2 #3 etc.)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Depression          | <input type="checkbox"/> Panic attacks             | <input type="checkbox"/> Substance use/abuse     |
| <input type="checkbox"/> Personal issues     | <input type="checkbox"/> Addictions                | <input type="checkbox"/> Anger                   |
| <input type="checkbox"/> Bereavement         | <input type="checkbox"/> Depression                | <input type="checkbox"/> Disability              |
| <input type="checkbox"/> School              | <input type="checkbox"/> Sexuality                 | <input type="checkbox"/> Stress                  |
| <input type="checkbox"/> Suicidal            | <input type="checkbox"/> Work related issues       | <input type="checkbox"/> Management issues       |
| <input type="checkbox"/> Stress              | <input type="checkbox"/> Work injury               | <input type="checkbox"/> Trauma                  |
| <input type="checkbox"/> Family issues       | <input type="checkbox"/> Parent-Child difficulties | <input type="checkbox"/> Pre-Marriage counseling |
| <input type="checkbox"/> Relationship issues | <input type="checkbox"/> Medical/Dental issues     | <input type="checkbox"/> Financial issues        |
| <input type="checkbox"/> Custody issues      | <input type="checkbox"/> Other: _____              |  |

Name of primary care physician: \_\_\_\_\_

List all medications you are currently taking:

_____	_____
_____	_____
_____	_____

Please describe any physical/health problems or concerns:

_____	_____
_____	_____
_____	_____

How would you rate the general state of your health?

- Excellent       Good       Fair       Poor

Are you under the care of a mental health provider?       Yes       No

If yes, please provide name(s): \_\_\_\_\_

Reason: \_\_\_\_\_

Have you seen other professionals for today's problem?       Yes       No

If yes, please provide name(s): \_\_\_\_\_

Do you have any history of traumatic life experience or emotional trauma such as physical/sexual abuse, neglect, domestic violence, etc.?       Yes       No

If yes, please list:

_____
_____

**Outpatient Counseling**  
Questionnaire for Counseling Services  
Adult Kit

Do you have any children?     Yes     No

If yes, please provide name(s) and age(s):

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Are there any family concerns that you have – childhood through present?     Yes     No

How would you rate the following:

Your exercise program:	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
Your diet and nutritional habits:	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
Your social relationships:	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor

Are you concerned about possible violence at work?     Yes     No

Are you concerned about possible violence in your personal life?     Yes     No

Are there any drug or alcohol issues we should be aware of?     Yes     No

History of alcohol or drug abuse in your immediate family?     Yes     No

History of alcohol or drug abuse in your family of origin?     Yes     No

History of depression/suicide in your family?     Yes     No

History of depression/suicide in your family of origin?     Yes     No

If EAP services were not available, would you have sought assistance through your health insurance benefit?

Yes     No

Religious preference: \_\_\_\_\_

Name of church: \_\_\_\_\_

Is there anyone you would like me to talk to regarding your treatment or to gain further information?

Yes     No

If yes, please provide name(s): \_\_\_\_\_

# Outpatient Counseling

## Questionnaire for Counseling Services Adult Kit

Please check all that apply to you:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Depression<br><input type="checkbox"/> Low energy<br><input type="checkbox"/> Low self-esteem<br><input type="checkbox"/> Chills/hot flashes<br><input type="checkbox"/> Tingling/numbness<br><input type="checkbox"/> Pain<br><input type="checkbox"/> Fear of dying<br><input type="checkbox"/> Fear of going "crazy"<br><input type="checkbox"/> Nausea<br><input type="checkbox"/> Fears of Phobias<br><input type="checkbox"/> Obsessions or compulsions<br><input type="checkbox"/> Thoughts racing<br><input type="checkbox"/> Disorganization<br><input type="checkbox"/> Procrastination<br><input type="checkbox"/> Can't hold on to an idea<br><input type="checkbox"/> Anger or frustration<br><br><input type="checkbox"/> Suspiciousness or mistrustfulness<br><input type="checkbox"/> Problems trusting others<br><input type="checkbox"/> Easily irritated or annoyed<br><input type="checkbox"/> Aggressiveness<br><input type="checkbox"/> Perfectionist behavior<br><input type="checkbox"/> Lying<br><input type="checkbox"/> Bothered by recurring thoughts<br><input type="checkbox"/> Family problems<br><input type="checkbox"/> Parent-child problems<br><input type="checkbox"/> Blackouts<br><input type="checkbox"/> Partner abuse<br><input type="checkbox"/> Unpleasant thoughts that won't go away | <input type="checkbox"/> Panic attacks<br><input type="checkbox"/> Heart racing<br><input type="checkbox"/> Chest pain or heaviness<br><input type="checkbox"/> Excessive behaviors<br><input type="checkbox"/> Delusions or hallucinations<br><input type="checkbox"/> Sexual problems or behaviors<br><input type="checkbox"/> Self injurious behaviors<br><input type="checkbox"/> Shyness<br><input type="checkbox"/> Lack of Social skills<br><input type="checkbox"/> Lack of Social support<br><input type="checkbox"/> Stealing<br><input type="checkbox"/> Strange, weird, or peculiar behavior<br><input type="checkbox"/> Confusion or can't think clearly<br><input type="checkbox"/> Feeling "not real"<br><input type="checkbox"/> Feeling detached from yourself<br><input type="checkbox"/> Feeling "hyper"<br><br><input type="checkbox"/> Financial problems<br><input type="checkbox"/> Grief/bereavement<br><input type="checkbox"/> Health problems<br><input type="checkbox"/> Problems impact others<br><input type="checkbox"/> Losing track of time<br><input type="checkbox"/> School or educational problems<br><input type="checkbox"/> Property destruction<br><input type="checkbox"/> Marital problems<br><input type="checkbox"/> Use of alcohol<br><input type="checkbox"/> Physical abuse<br><input type="checkbox"/> Parent abuse | <input type="checkbox"/> Performing unusual rituals of habits<br><input type="checkbox"/> Impulsiveness<br><input type="checkbox"/> Poor concentration<br><input type="checkbox"/> Lack of interest or enjoyment<br><input type="checkbox"/> Feeling hopeless<br><input type="checkbox"/> Feeling worthless<br><input type="checkbox"/> Feeling guilty or shameful<br><input type="checkbox"/> Sleep changes<br><input type="checkbox"/> Loneliness<br><input type="checkbox"/> Bad dreams or nightmares<br><input type="checkbox"/> Feeling ignored or abandoned<br><input type="checkbox"/> Appetite changes<br><input type="checkbox"/> Mood swings<br><input type="checkbox"/> Thoughts of hurting self<br><input type="checkbox"/> Thoughts of hurting others<br><input type="checkbox"/> Isolation from others or social withdrawal<br><input type="checkbox"/> Feelings of sadness or loss<br><input type="checkbox"/> Weight problems<br><input type="checkbox"/> Stress<br><input type="checkbox"/> Anxiety, tension or worry<br><input type="checkbox"/> Arguing with others<br><input type="checkbox"/> Making or keeping friends<br><input type="checkbox"/> Self-criticism<br><input type="checkbox"/> Relationship problems<br><input type="checkbox"/> Use of drugs<br><input type="checkbox"/> Sexual abuse<br><input type="checkbox"/> Trouble with the law<br><input type="checkbox"/> Other: |
|---|--|---|

I, \_\_\_\_\_ consent to the following EAP services

(check all that apply):

- Clinical Interview/Evaluation
- Counseling/Psychotherapy/Referral
- Other

Signature of person giving consent: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of witness/EAP representative: \_\_\_\_\_ Date: \_\_\_\_\_