



## Counselling Agreement - Informed Consent

*Any information written on these pages is only read/viewed by your counsellor*

### **Nature of Counselling**

As the client, I understand that the counselling process will involve learning to understand myself and assist in clarifying problems, goals and objectives. New Life Counselling & Training only counsel those whom they believe have the capacity to resolve their own challenges/situations/problems with the provided assistance.

The counselling process will follow a specific model, and although eclectic in nature, incorporates the concept of our assumptions and beliefs driving our self-talk, which in turn drives our emotions and then actions. Objectively examining the assumptions we have formed throughout life will allow clients to see whether these assumptions and beliefs are accurate or not. Changing negative thought patterns then impacts on every other area of our life.

The process of self-awareness, problem-solving and cognitive restructuring can, for certain clients, take some time to achieve. Some clients need only a couple of counselling sessions to achieve their goals, while others may require sessions over an extended period of time. *Most clients would need a minimum of 2-4 sessions to work through their issues/concerns.* As a client, you are in complete control and may end the counselling relationship at any point. New Life Counselling & Training will be supportive of your decision. If counselling is successful, you should feel that you are able to face life's challenges in the future without further support or intervention. New Life Counselling & Training believes that clients should feel change by at latest the third session. If not, we will happily refer you to another professional.

Although the sessions may be very emotionally and psychologically intimate it is important for you to realise that the counselling relationship is strictly professional in nature. You will be best served during counselling to remember this and concentrate exclusively on *your* issues, concerns, problems and circumstances. I understand that anything my counsellor says to me is to be taken as merely a suggestion, which I am free to accept or reject.

If at any time you are dissatisfied with the services of New Life Counselling & Training, please discuss it with your counsellor. Should you require a referral to another professional, your counsellor will discuss this with you. If you believe that any professional conduct is inappropriate, you may report your complaints to the Australian Counselling Association (ACA).

### **Data Collation**

The outcome of your counselling will be objectively monitored through the use of various questionnaires. These are completed prior to the first session, in the last session, and every second visit during your time of therapy. Information gathered from this questionnaire is only seen by your counsellor, and will be shared with you, to monitor the effectiveness of the counselling. Data gathered will be used in ongoing research, measuring the effectiveness of the counselling process/intervention. Please note, no personal or identifying information of any kind is divulged or included, only statistical data. Your confidentiality and anonymity is assured.

### **Fees and Cancellations**

In return for a fee of \$80 per session (payable on conclusion of each counselling session), New Life Counselling & Training agree to provide counselling services to you. You cannot have more than one session's payment outstanding. In the event that you are unable to keep an appointment, please provide 24 hours (Monday-Friday) advance notice (eg cancelling Monday would require notification Friday). If this is not done you will incur a cancellation fee of \$80. Counselling sessions are 60 minutes in duration.

Signed: \_\_\_\_\_ (client)  
\_\_\_\_\_  
\_\_\_\_\_ (counsellor)

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



**Background Information**

Date: \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

Title (eg Mr, Mrs): \_\_\_\_\_ First Name: \_\_\_\_\_ Surname: \_\_\_\_\_

Address: \_\_\_\_\_ Postcode: \_\_\_\_\_

Phone (w): \_\_\_\_\_ Phone (h): \_\_\_\_\_

Mobile: \_\_\_\_\_ Email: \_\_\_\_\_

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

- |   |                     |   |                |
|---|---------------------|---|----------------|
| Household income level: <input type="radio"/> | \$0 - \$10,000      | Highest Level of Education: <input type="radio"/> | High School    |
| <input type="checkbox"/>                      | \$10,001 - \$30,000 | <input type="checkbox"/>                          | Apprenticeship |
| <input type="checkbox"/>                      | \$30,001 - \$50,000 | <input type="checkbox"/>                          | TAFE           |
| <input type="checkbox"/>                      | \$50,001 - \$80,000 | <input type="checkbox"/>                          | Undergraduate  |
| <input type="checkbox"/>                      | \$80,001 +          | <input type="checkbox"/>                          | Postgraduate   |

Ethnicity of your family (eg German; Italian; Malaysian and English): \_\_\_\_\_

Brief description of issue that brought you to counselling:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

How long has this issue affected you/been occurring? \_\_\_\_\_

Previous Marital Status (circle): single, de facto, married, separated, divorced, widowed

Please provide detail: \_\_\_\_\_

Current Marital Status (circle): single, de facto, married, separated, divorced, widowed

Quality of Relationship: \_\_\_\_\_ Length: \_\_\_\_\_

Name of Partner: \_\_\_\_\_ Blended Family? \_\_\_\_\_

Please List Children (please also indicate whether step children/adopted etc):

- |       |            |
|-------|------------|
| _____ | Age: _____ |
| _____ | Age: _____ |
| _____ | Age: _____ |
| _____ | Age: _____ |
| _____ | Age: _____ |

Name of Your Parents: \_\_\_\_\_

Quality of Relationship with Your Parents: \_\_\_\_\_

Siblings: \_\_\_\_\_

Religious Affiliation: \_\_\_\_\_ Level of Commitment/Involvement: \_\_\_\_\_

Have you had previous counselling? \_\_\_\_\_ Please specify (eg psychologist, counsellor) \_\_\_\_\_

If yes, what for? \_\_\_\_\_

What are you hoping to achieve from counselling now? \_\_\_\_\_



## Confidentiality Agreement

Throughout the counselling process, confidentiality is maintained for clients. This standard procedure and practice is for all clients, regardless of age or background, except in the following circumstances:

- a) You instruct me to tell someone else and provide written permission of this
- b) I determine you are a danger to yourself (eg self-harm or suicide), to others or someone is a danger to you
- c) I am ordered by a court to disclose information
- d) The law is going to be, or has been, broken
- e) Abuse of children is a mandatory reporting offence which I am bound by law to report
- f) For supervision and education purposes (basic information only shared in this instance, not names or details that would in any way disclose or identify you, the client)

Where confidentiality cannot be maintained, as your counsellor I will take all steps possible to inform/discuss my intention with you.

Please note, any data collected from the outcome measure questionnaires (for both monitoring and research purposes), has all identifying personal information removed.

Your signature on this document indicates that you have read and understood this statement, and any questions you have had about this statement have been answered to your satisfaction.

Name of Client: \_\_\_\_\_

Signature of Client: \_\_\_\_\_

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

Signature Counsellor (Ben Ramsey): \_\_\_\_\_

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



..... (Parent 11-17)

		No	Yes - minor difficulties	Yes - definite difficulties	Yes - severe difficulties
1.	Overall, do you think that your child has difficulties in one or more of the following areas:  emotions, concentration, behavior or being able to get on with other people?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	If you have answered "Yes", please answer the following questions about these difficulties:	Less than a month	1-5 months	6-12 months	Over a year
2.	How long have these difficulties been present?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Not at all	Only a little	Quite a lot	A great deal
3.	Do the difficulties upset or distress your child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Not at all	Only a little	Quite a lot	A great deal
4.	Do the difficulties interfere with your child's everyday life in the following areas?				
	Home Life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Friendships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Classroom Learning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Leisure Activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Not at all	Only a little	Quite a lot	A great deal
5.	Do the difficulties put a burden on you or the family as a whole?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Your Signature: \_\_\_\_\_ mother/father/other (please circle)

**Thank you very much for your help**

# Strengths and Difficulties Questionnaire (Self 11-17)

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of how things have been for you over the last six months.

Your name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Today's date: \_\_\_\_\_

	Not True	Somewhat True	Certainly True	ES	CP	Hyp	PP	PB
				<i>Don't Mark Below</i>				
1. I try to be nice to other people. I care about their feelings	0	1	2					<input type="checkbox"/>
2. I am restless, I cannot stay still for long	0	1	2			<input type="checkbox"/>		
3. I get a lot of headaches, stomach-aches or sickness	0	1	2	<input type="checkbox"/>				
4. I usually share with others, for example CD's, games, food	0	1	2					<input type="checkbox"/>
5. I get very angry and often lose my temper	0	1	2		<input type="checkbox"/>			
6. I would rather be alone than with people of my age	0	1	2				<input type="checkbox"/>	
7. I usually do as I am told	2	1	0		<input type="checkbox"/>			
8. I worry a lot	0	1	2	<input type="checkbox"/>				
9. I am helpful if someone is hurt, upset or feeling ill	0	1	2					<input type="checkbox"/>
10. I am constantly fidgeting or squirming	0	1	2			<input type="checkbox"/>		
11. I have one good friend or more	2	1	0				<input type="checkbox"/>	
12. I fight a lot. I can make other people do what I want	0	1	2		<input type="checkbox"/>			
13. I am often unhappy, depressed or tearful	0	1	2	<input type="checkbox"/>				
14. Other people my age generally like me	2	1	0				<input type="checkbox"/>	
15. I am easily distracted, I find it difficult to concentrate	0	1	2			<input type="checkbox"/>		
16. I am nervous in new situations. I easily lose confidence	0	1	2	<input type="checkbox"/>				
17. I am kind to younger children	0	1	2					<input type="checkbox"/>
18. I am often accused of lying or cheating	0	1	2		<input type="checkbox"/>			
19. Other children or young people pick on me or bully me	0	1	2				<input type="checkbox"/>	
20. I often volunteer to help others (parents, teachers, children)	0	1	2					<input type="checkbox"/>
21. I think before I do things	2	1	0			<input type="checkbox"/>		
22. I take things that are not mine from home, school or elsewhere	0	1	2		<input type="checkbox"/>			
23. I get along better with adults than with people my own age	0	1	2				<input type="checkbox"/>	
24. I have many fears, I am easily scared	0	1	2	<input type="checkbox"/>				
25. I finish the work I'm doing. My attention is good	2	1	0			<input type="checkbox"/>		

+ + + +

Total =

Do you have any other comments or concerns?

**Please turn over - there are a few more questions on the other side**

..... **(Self 11-17)**

		No	Yes - minor difficulties	Yes - definite difficulties	Yes - severe difficulties
1.	Overall, do you think that you have difficulties in one or more of the following areas:  emotions, concentration, behavior or being able to get on with other people?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	If you have answered "Yes", please answer the following questions about these difficulties:	Less than a month	1-5 months	6-12 months	Over a year
2.	How long have these difficulties been present?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Not at all	Only a little	Quite a lot	A great deal
3.	Do the difficulties upset or distress you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Not at all	Only a little	Quite a lot	A great deal
4.	Do the difficulties interfere with your everyday life in the following areas?				
	Home Life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Friendships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Classroom Learning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Leisure Activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Not at all	Only a little	Quite a lot	A great deal
5.	Do the difficulties make it harder for those around you (family, friends, teachers, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Your Signature: \_\_\_\_\_

**Thank you very much for your help**