North Texas Counseling Associates

8090 Precinct Line Road, Suite 103
Colleyville, TX 76034
(T) 817-281-6822 ; (F) 817-503-1996

What Information Should I Bring?

The following information needs to be provided at the first appointment in order for us to best select appropriate therapy/testing options for that first session. Releases are included in this packet to aid in gathering this information.

Required:

☐ Intake Forms

☐ HIPPA Notice – Signed

☐ Custody Records: If applicable we require a copy of any custody decree in order to document who has legal rights regarding the minor child.

If you wish us to contact other agencies or individuals:

☐ Release(s) of Mental Health Records

If your child is receiving Special Education Services:

☐ Current IEP Document

☐ Eligibility Report

☐ All Evaluation Reports

☐ Information regarding behavior and academic performance

Private Evaluations, including:

☐ Psychological – Psychiatric

☐ Neurological

☐ Therapy: Speech, Occupational, Physical, etc.

☐ Other Medical Records:

• Records of current & past medications (both prescription and over-the-counter plus “supplements” and “natural” substances)
• Records of illnesses, surgeries, accidents, and hospitalizations

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INFORMED CONSENT AND RELEASE OF LIABILITY

Our goal is to provide you with quality counseling. Some clients need only a few sessions to achieve these goals while others may require many more. As a client, you have the right to end our counseling relationship at any point.

1. I understand that my counselor is working under Texas laws, rules and statutes as a Licensed Psychologist, Licensed Professional Counselor (LPC), LPC-Intern or as a practicum student. LPC-Interns and practicum students are under the supervision of Dr. Jennie Fincher, LPC-S.

2. I understand that my counseling records are kept confidential, except where disclosure is required by law or the ethics of the counseling profession. Possible exceptions to confidentiality include but are not limited to the following situations:

- abuse of a child, elderly or disabled person
- potential harm or threat to self or others
- third party requests for payment
- child custody cases that go before a court of law
- information subpoenaed by a court of law

3. In consideration of the benefits to be derived from the counseling, the receipt whereof is hereby acknowledged, I hereby release, remise and forever discharge and covenant not to sue or hold legally liable North Texas Counseling Associates, PLLC, its employees or members from any and all claims, demands, actions, or causes of action of whatsoever kind and nature related to the counseling process. I also give permission for my counselor to converse with other counselors in the group practice to provide the best possible treatment.

4. The clinical records are the property of North Texas Counseling Associates, PLLC and are deemed records of confidential sessions between therapists and clients. I waive any right I may otherwise have to seek to use the clinical records of the counseling center as evidence in any judicial proceedings. I understand that if anyone from this office is subpoenaed or court ordered to testify in court as an expert witness, court fees are separate from the counselor's regular counseling rates. Court appearances, depositions, and attorney consultations are $150.00 per hour (including all time involved in preparation, research, parking fees, mileage, travel time to and from the court house and all other expenses incurred in relation to testifying). A retainer of $900.00 is to be paid prior to the court date. If the costs for the testifying process exceed the amount of the retainer then those fees will be billed to you and are due upon receipt of the invoice. The party issuing the subpoena is responsible for the testifying fees.

5. Counseling sessions last approximately forty-five (45) minutes. ***24-hour notice is required for all cancellations to avoid a $50.00 fee. If you fail to respond to communication for a late cancellation or missed appointment the card on file will be charged for the amount owed. Any client that has more than 3 no show fees, late cancellation fees, or combination of both on account, the individual forfeits future standing appointments.*** Fees are due at the beginning of each session. ***All accounts are required to have a credit card on file.***

☐ Credit Card Number: _____ Exp. Date:_____

Billing Zip Code: _____ Type of Card: ☐ DC ☐ VISA ☐ MC

6. If at any time you become extremely emotionally distressed or are in danger of hurting yourself or someone else, please call 911 for assistance. Our office will make every effort to return your call/email and schedule if necessary. We do not provide an on-call service at this time. You can also contact the National Suicide Prevention Lifeline at 1-800-273-8255 (TALK).

Privacy Practice Notice:
The Notice of Privacy Practices for NTCA is provided upon request. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) that will occur in my treatment, payment of my bills and the rights I have regarding my PHI.

I, the undersigned, consent to treatment and to North Texas Counseling Associates' Notice of Privacy Practices. My signature below indicates that I grant informed consent for North Texas Counseling Associates, PLLC to provide psychological services and counseling to myself and/or minor members of my family. I further understand that without 24-hour notice of cancellation, I will be charged $50.00.

Client/Guardian Signature:_____ Date:_____

North Texas Counseling Associates

Child/Adolescent Client Form

Today's Date:	
Referred by:	

CHILD/ADOLESCENT INFORMATION		
Name: ☐ M ☐ F	DOB:	Age:
Street Address:	Home Phone:	
City, State, Zip:	Cell Phone:	
Race: ☐ African-American ☐ Asian/Pacific Islander ☐ Caucasian/White ☐ Hispanic ☐ Native American ☐ Other:		

PARENT/GUARDIAN INFORMATION	
Mother Name:	Father Name:
Street Address (if different):	Street Address (if different):
City, State, Zip:	City, State, Zip:
Cell/Home Phone:	Cell/Home Phone:
Work Phone:	Work Phone:
Email:	Email:
Occupation:	Occupation:
Marital Status of Biological Parents: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed If divorced, how long have the biological parents been divorced? Has either biological parent remarried? ☐ Mother (Age of child at the time _____) ☐ Father (Age of child at the time _____) If divorced, who has legal custody? _____ ☐ Full custody ☐ Joint custody	
***Annual Household income:**	

EMERGENCY CONTACT	
Name:	Relationship:
Home Phone:	Cell Phone:

Name of child/adolescent's physician	
Name:	Phone Number:
Address:	Fax Number:

PRESENTING CONCERNS
Please describe the problems your child/adolescent is now having and what type of services you are seeking from us for these problems.
What do you hope your child/adolescent will gain or change by coming to us for services?

ACADEMIC HISTORY

What is your child/adolescent's current grade: Which, if any, grades did they repeat?
Child/Adolescent's School:

Has your child/adolescent ever been told they have special educational needs? ☐ Yes ☐ No **If yes,** what was done about it:
☐ 504 Plan ☐ Behavior Intervention Plan ☐ Psychological Evaluation ☐ I.E.P. ☐ Speech Evaluation ☐ Occupation Therapy Evaluation

Current Teachers:

Does your child/adolescent have problems in school with: ☐ Grades ☐ Behavior ☐ Detention ☐ Suspension ☐ Expulsion ☐ Bullying

EARLY PERSONAL HISTORY

What city and state was your child/adolescent born?

Who currently lives in the home with the child/adolescent?

Please list the child/adolescent's **siblings:**

Name age

___________________________________ _____________ ☐ Brother ☐ Sister ☐ Half-Brother ☐ Half-Sister ☐ Step-Brother ☐ Step-Sister
___________________________________ _____________ ☐ Brother ☐ Sister ☐ Half-Brother ☐ Half-Sister ☐ Step-Brother ☐ Step-Sister
___________________________________ _____________ ☐ Brother ☐ Sister ☐ Half-Brother ☐ Half-Sister ☐ Step-Brother ☐ Step-Sister
___________________________________ _____________ ☐ Brother ☐ Sister ☐ Half-Brother ☐ Half-Sister ☐ Step-Brother ☐ Step-Sister
___________________________________ _____________ ☐ Brother ☐ Sister ☐ Half-Brother ☐ Half-Sister ☐ Step-Brother ☐ Step-Sister

Where is your child/adolescent in the birth order (e.g., youngest, oldest)?

Please list any special needs or concerns regarding the other children living in your home:

Who is raising your child/adolescent? ☐ Both parents ☐ Mom ☐ Dad ☐ Grandparents ☐ Foster home ☐ Other ___________
Describe your child/adolescent's early home life:

Types of discipline used in the home (check all that apply): ☐ take away a privilege ☐ assign an additional chore ☐ send to room
☐ physical punishment ☐ reason with child ☐ yell at child ☐ ground child ☐ send to time-out ☐ other:

Has your child/adolescent ever been: ☐ Physically abused ☐ Sexually abused ☐ Emotionally abused
Who abused them and how? How old were they when this happened?

MENTAL HEALTH HISTORY

Has your child/adolescent ever seen a psychologist, psychiatrist, or counselor? ☐Yes ☐No

List all mental health or substance abuse diagnoses your child/adolescent has had: ☐ None

Has your child/adolescent ever been suicidal? Please explain.

Do any family members have mental health problems?

Is there any family history of the following?
☐ Autism Spectrum Disorders ☐ Learning Problems/Disabilities ☐ ADHD ☐ Depression ☐ Anxiety Disorders ☐ Psychosis/Schizophrenia

☐ Substance Abuse/Dependence ☐ Intellectual Disability ☐ Other Mental Health Concern

MEDICAL HISTORY

Were there any complications with the pregnancy ☐Yes ☐No (If yes, please provide details of complications on the back of this page)

Was birth a full term? ☐Yes ☐No Type of Delivery: ☐Spontaneous ☐Induced ☐Vaginal ☐C-Section

Has your child/adolescent ever had a head injury or been hit in the head? ☐Yes ☐No Did they lose consciousness? ☐Yes ☐No

Has your child/adolescent ever had a fever above 104°? ☐Yes ☐No If yes, please explain:

Has your child/adolescent ever had a seizure? ☐Yes ☐No If yes, please explain:

List any medical problems.

Mental Health/Substance Abuse Hospitalizations (Inpatient, PHP, IOP - Use back page if necessary.)

Date	Reason for Treatment	Hospital	Duration of Treatment	Treatment Response (helpfulness)

Counseling/Therapy (Individual, Family, Group, Play Therapy - Use back page if necessary.)

Date	Reason for Treatment	Treatment Provider	Duration of Treatment	Treatment Response (helpfulness)

Current Medications (List any prescription medications your child/adolescent is currently taking. Use back if necessary)

Name of Drug	Reason for Taking It	Date Started	Frequency Taken	Strength	Has it been helpful?
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No

Describe any side effects that they find troublesome from any of the medications they are currently taking.

Does your child/adolescent generally take their medications as prescribed? ☐ Yes ☐ Take too much ☐ Don't always take

What other psychiatric medications have they taken in the past?

Substance Use

List any substance use problems your child/teen has experienced (marijuana, alcohol, etc.)

When did this problem first begin?

ACTIVITIES OF DAILY LIVING / SOCIAL FUNCTIONING

(Use the back of pages as necessary to answer completely)

What time does your child/adolescent: get up in the morning? go to bed at night?

What does your child/adolescent do with their time? How do they spend their day?

List your child/adolescent's **close** friends and how long they have known them:

Child/Adolescent's extracurricular activities, including sports, clubs, hobbies, lessons, etc:

☐ Football ☐ Baseball ☐ Cheerleading ☐ Basketball ☐ Soccer ☐ Karate ☐ Music Lessons ☐ Scouts ☐ Dance ☐ Choir ☐ Gymnastics ☐ Other

RELIGIOUS HISTORY

Is your child/adolescent religious/spiritual?

What role does religion/spirituality play in your child/adolescent's life?

How regularly does your child/adolescent attend religious/spiritual services?

LEGAL HISTORY

How many **juvenile arrests** has your child/adolescent had? When and what were they for?

How many times has your child/adolescent been: in jail? _____ convicted? _____ on probation? _____ violated probation? _____

CURRENT STATUS

Please check any of the following that apply to your child/adolescent presently or in the recent past:

☐ Abuse, Physical
☐ Abuse, Sexual
☐ Abuse, Verbal
☐ Aggressive
☐ Alcohol/Drug Use
☐ Anger
☐ Anxiety
☐ Bad Dreams
☐ Change in Appetite
☐ Communication
☐ Concentration
☐ Cutting/Self harm
☐ Difficulty Breathing
☐ Eating Problems
☐ Friends
☐ Grief
☐ Headaches
☐ Hearing Noises/Voices
☐ Hopelessness
☐ Impulsive
☐ Loneliness
☐ Nervousness
☐ Making Decisions
☐ Pain
☐ Panic
☐ Problems sleeping
☐ Rapid Heart Rate
☐ Racing Thoughts
☐ Seeing Thing
☐ Self-Control
☐ Shyness
☐ Stress
☐ Stomach Trouble
☐ Terminal Illness
☐ Trauma
☐ Trouble Relaxing
☐ Unhappiness
☐ Other_____