Wise County
CHRISTIAN COUNSELING

Client Information Questionnaire
Parent Form

Your cooperation in completing this questionnaire will be helpful in planning our services for you. Please answer each item carefully. Ask your therapist for clarification if you do not understand an item.

Child's name _____ Date _____
Completed by: _____ Relationship to child: _____
Address _____
_____
Phone numbers (List all that apply.): _____
Email address: _____
Please indicate if a message can be left at any of these numbers: _____

Child's Age _____ Sex: _____ Race _____ Date of Birth: _____
Grade: _____ School: _____

Caretaker's Occupation(s): _____
Household family income (including child support, unemployment, disability, etc.): _____
Religious preference: _____ Where do you attend? _____

Check all of the following which reflect the parent figures currently in your home:
_____Single parent _____Both birth parents _____Birth parent & Step-parent
_____Adoptive parents _____Foster parents _____Grandparents
_____Other relatives Other (Please explain): _____
Brief description of living arrangement: _____
_____

Child's Legal Guardian (Managing Conservator): _____
(If the child is not living with both biological parents, both adoptive parents, or only living parent, WCCC requires a photocopy of the legal document stating custody arrangements, consisting of the cover page, page specifying conservator(s), and signature page).

List the members of your family and all others that are currently living in your home.

Name(s)	Age/Grade	Relationship	Occupation

Briefly describe your reason(s) for seeking help: _____

_____

_____

_____

What do you hope to accomplish through counseling/play therapy? _____

_____

_____

_____

How did you find out about us? _____

Have you ever consulted a professional counselor? _____YES _____NO

If yes, name of agency: _____

How was counseling helpful then? _____

_____

Please list any medications that the child is taking at present: _____

_____

Has the child ever considered suicide? _____YES _____NO If so, when? _____

Has the child ever attempted suicide? _____YES _____NO If so, when? _____

Has this child ever attempted to harm themselves or others? _____YES _____NO If so, when? _____

Has the child experienced any trauma that has impacted his/her life (ex. Parents' divorce, abuse, death of a close relative/friend)? If so, please describe: _____

_____

_____

Mark any of the following which are presently causing the child difficulty (Put a * by the two most important items):

Problems Related to Abuse
Current or past physical abuse
Current or past sexual abuse
Current or past emotional abuse
Current or past neglect
History of abandonment
Suspected sexual abuse
History of family domestic violence

Academic/School Problems
Learning difficulties
Problems with peers
Problems with teachers
Speech problem

Mood-related Concerns
Disturbing memories
Difficulty going to sleep/staying asleep
Nightmares/night terrors
Suicidal ideation
Sadness
Feelings of guilt and shame

Family-Relationship Concerns
Difficulty adjusting to family changes
Discipline concerns
Parent-child relationship problems
Sibling concerns
Divorce/Separation
Excessive worrying Anger/Irritable

Rule-Breaking/Behavior Problems
Aggression toward others
Drug/Alcohol use
Truancy
Running away
Stealing
Intentionally hurting animals
Fire-setting

Other Behavioral Concerns
Sexual identity concerns
Inappropriate sexual behavior
Overeating/Refusal to eat
Hyperactive/Inattentive

Other Unusual Behaviors
(Please specify) _____

Please provide any additional information which you feel may be useful to your child's therapy. _____

_____

_____

_____

_____

Is there any history of mental illness in the family, including yourself? (anxiety, depression, OCD, schizophrenia, bipolar, addictions, etc.) Please list the condition and person affected. _____

_____

_____

_____

HISTORY OF TRAUMA/STRESSORS RELATED TO THE CHILD (For each of the following items that apply, write in your child's approximate age at the time it occurred):

Chronic illness of family member _____
Death of significant person _____
Domestic violence _____
Family member absent (explain) _____
Family member's disability/major accident/illness _____
Family member emotional problems (explain) _____
Family member suicide (explain) _____
Parent's divorced _____
Child separated from parent (how long and when) _____
Death of a pet____ Difficult medical treatments____ Natural disaster____
Sexual assault____ Victim of trauma (unusual, terrifying experience) _____
Other _____

History of your child having learning emotional, behavioral problems: Yes No
(If yes, please explain) _____
History of your child having alcohol/drug/substance abuse: Yes No
(If yes, please explain) _____
History of family violence: Yes No
(If yes, please explain)_____
History of criminal activity in the family: Yes No
(If yes, please explain) _____
Has your child been abused (check all that apply): Physically____ Emotionally____ Sexually____
Has your child been neglected (check all that apply): Physically____ Emotionally____
School problems (check all that apply):
Academic problems____ Discipline problems____ Social problems____ Other _____
Early language/Speech problems (explain): _____

History of health/physical problems includes (check all that apply):

Asthma____	Disability____	Nervous Stomach____
Bedwetting____	Dizziness____	Neurological problems/exam____
Bone/joint/muscle____	Severe headaches____	Severe PMS____
Chest pain____	Heart Palpitations____	Serious overeating/undereating____
Chronic illness____	Hospitalization____	Developmental delay____
Major accident____	Sleep problems____	Chronic Diarrhea____
Major illness____	Surgeries____	
Shortness of breath without exercise____		Other_____

Parenting Style

(If more than one parent is attending the intake, each adult should complete a separate form.)

How would you describe yourself as a parent? _____

_____

_____

Where did you learn to parent like you do? _____

_____

_____

When do you feel most connected to your child? _____

_____

_____

How do you reward your child when they succeed? _____

_____

_____

How do you typically discipline your child? _____

_____

_____

What are your strengths as a parent? _____

_____

_____

What are your challenges as a parent? _____

_____

_____

What are your favorite things about your child? _____

_____

_____

What are your goals for your child in therapy? _____

_____

_____

Please check any additional resources you would be interested in learning about.

_____ Parenting groups _____ Co-parenting classes _____ Books

_____ Individual therapy _____ Couples counseling

Informed Consent to Counseling

Welcome to Wise County Christian Counseling. Thank you for choosing me for your counseling needs. Starting counseling is a major decision and you may have many questions. This document is designed to inform you about agency policies and procedures as well as your rights, so that you can consent to treatment. If you have other questions or concerns, do not hesitate to ask me about them.

My name is LeAnne Shepard and I am a Texas State Licensed Professional Counselor Intern, I hold a Bachelor of Science degree and a Master of Arts degree in Counseling Psychology from Texas Woman's University. I am supervised by Beverly Ross, LPC-S.

Sessions will last approximately 45-50 minutes. Although sessions may be very personal, the relationship between you and I, and your child, is a professional one, rather than a social one. If I see you in public, I will protect your confidentiality by acknowledging you only if you approach me first.

Services are by appointment only and you are responsible for keeping your appointments and arriving on time. In the event that you cannot keep an appointment, it is your responsibility to call the office at least 24 hours in advance to cancel or reschedule. Cancellations made within the 24 hours prior to the session or no- showed, will be billed $50.

You have the responsibility to notify me of any other ongoing mental health relationship. If you are seeing another mental health professional, then permission must first be granted by the first therapist to proceed with a secondary counseling relationship. During the course of this relationship, if you choose to seek counseling elsewhere, you have the responsibility to terminate this counseling relationship before being seen by another mental health professional.

Other options for counseling include talking with other professionals, your clergy person, or choosing to let the situation remain the same. If you have any complaints, please discuss them with me. If you are not satisfied with the resolution of the problem, you have the right to call the Consumer Complaint Hot Line at 1-800-942-5540.

We may utilize email or text as a means of communication, but it is important to understand the parameters of this medium. I will not engage in therapy over the Internet or through text. There may also be times where I receive, but do not respond to your email or text. I will respond if I believe it is appropriate and/or necessary. My lack of response does not indicate a lack of interest.

Any type of audio/visual recording is prohibited in counseling sessions.

Referrals: Should you or I believe that a referral is needed, I will provide some alternatives including programs and/or people who may be available to assist you. A verbal exploration of alternatives to counseling will also be made available upon request. You will be responsible for contacting and evaluating those referrals.

In the event that you have a mental health emergency, you may wish to call 911 or University Behavioral Health at (940) 320-8100.

Records and Confidentiality: All of our communication becomes part of the clinical record. Adult records are disposed of six years after the file is closed. Minor client records are disposed of six years after the client's 18th birthday. In the case of my incapacitation or death, you would be contacted by one of my colleagues at Wise CCC, who would handle your records and care, as needed.

I will keep confidential anything you say to me with the following exceptions:

(a) If you direct me to release your records
(b) I have reason to believe you are a danger to yourself or others
(c) In the case of billing or collection of fees
(d) In the cases of abuse, neglect, or exploitation of a child or elderly adult (e) I am ordered/subpoenaed by a court to disclose information
(f) I am otherwise required by law to disclose information
(g) If you disclose sexual contact with another health professional

Supervision is a process within the counseling profession wherby cases are reviewed with professional, objective colleagues to ensure quality counseling. It is understood that this process may be utilized within the professionals at Wise CCC, in order to provide the highest quality services.

Fees: I am dedicated to providing counseling services to my clients knowing certain financial limitations exist. Being a non-profit organization, I can set my fees at a lower rate. No family will be turned away because of lack of funds. This agency asks our clients to determine their fees by using a sliding scale. For every $10,000 your household brings home per year, please consider paying $10 per session, up to $120. (Example: if your family brings home $50,000 per year, please pay $50 per session.) Checks or cash will be accepted. Checks will be made payable to Wise County Christian Counseling.
Mrs. Shepard charges $125 per hour for court appearances, depositions, and arbitrations, including related travel and preparation. If I am subpoenaed to court because of your case, then I will block out a 4 hour portion (unless I am notified that I will be required to stay longer) of my work day. If your hearing is rescheduled, it is your responsibility to notify me at least 48 business hours in advance, so that I may re-book those appointments. If you fail to notify me within the appropriate time frame, you will be billed for that block of time and your minimum court fee will not be refunded. I require the minimum court fee ($500.00) 48 business hours in advance of the hearing, and any additional fees will be billed, and are expected to be paid, within 48 hours of the court appearance. You are responsible for any legal fees I incur as related to your case (litigation issues, lack of payment, etc.).

Please provide at least one emergency contact with whom you give permission for me to contact in case of intended harm or threat to self or others:

Name: _____ Phone: _____ Relationship_____

Name: _____ Phone: _____ Relationship_____

By signing this consent form, we give our permission for any or all of our family members including minors to enter into a counseling relationship with LeAnne Shepard at Wise County Christian Counseling. We do this of our own free will. We recognize there is no guarantee expressed or implied that our problems will be alleviated in coming to counseling, and that in some cases our situation/problems may initially worsen before they improve. We recognize that we can terminate counseling at any time that we choose. Signature(s) of parents(s)/couple/individual:

Client: _____ Date: _____

Client: _____ Date: _____

Counselor: _____ Date: _____

HIPAA Notice of Privacy Practices

This notices describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and this is related to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your therapist and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the therapist's practice as necessary, and any other use required by law.

Treatment: We will use and disclose your protected health information as necessary to provide, coordinate, or manage your health care and any related services. This includes the coordination of management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you; or your protected health information may be provided to a physician to whom you have referred to insure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay or a higher level of treatment may require that your relevant protected health information be disclosed to the health plan to obtain approval for admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information to support the business activities of your therapist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of therapists associated with this practice, licensing, marketing and fund raising activities, and conducting or arranging for other business activities. For example, we may call you by name in the waiting room when the therapist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization: communicable diseases, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, and if you present a threat to yourself and others.

I understand that, and consent to, the following appointment reminders that may be used by the Provider:

____Yes ____No – A text message sent to the cell phone number provided.

____Yes ____No – Telephoning my home or cell and leaving a message on my answering machine or with the individual answering the phone.

____Yes ____No – An email sent to the email address provided.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization and opportunity to object unless required by law. You may revoke this authorization at any time, in writing, except to the extent that your therapist or therapist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

I acknowledge that I have received and understand the HIPAA Notice of Privacy Practices for this office:

_____ _____

Client Signature (parent or guardian if minor client) Date

_____ _____

Client Signature (parent or guardian if minor client) Date

You have the right to request restrictions of uses and disclosures of your health information; however, this office is not required to agree to a requested restriction. You have the right to revoke this consent in writing, except to the extent that this office has previously taken action in reliance to this consent. Your treatment by this office is conditional on your signing this consent.

Wise County

CHRISTIAN COUNSELING

Due to the length of our waiting list and our deep desire to help people, beginning January 1, 2017, there will be a $50 charge for all appointments not kept or broken without 24 hour notice.

Signature(s) of couple/individual

X_____ _____

Client signature Date

X_____ _____

Client signature Date

X_____ _____

Counselor signature Date

DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

Child's Name: _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**_____

Relationship with the child: _____

Instructions *(to the parent or guardian of child):* The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during the **past TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS,** how much (or how often) has your child…	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1.	Complained of stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Said he/she was worried about his/her health or about getting sick?	0	1	2	3	4	
II.	3.	Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4	
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than he/she used to?	0	1	2	3	4	
	6.	Seemed sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Seemed angry or lost his/her temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or did more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual for him/her, but still had lots of energy?	0	1	2	3	4	
VIII.	11.	Said he/she felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	0	1	2	3	4	
IX.	14.	Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?	0	1	2	3	4	
	15.	Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	0	1	2	3	4	
	17.	Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS,** has your child …						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes	☐ No	☐ Don't Know			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes	☐ No	☐ Don't Know			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes	☐ No	☐ Don't Know			
	23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes	☐ No	☐ Don't Know			
XII.	24.	In the past **TWO (2) WEEKS,** has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	☐ Yes	☐ No	☐ Don't Know			
	25.	Has he/she EVER tried to kill himself/herself?	☐ Yes	☐ No	☐ Don't Know			

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 11–17

Name: _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**_____

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS,** how much (or how often) have you…	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1.	Been bothered by stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Worried about your health or about getting sick?	0	1	2	3	4	
II.	3.	Been bothered by not being able to fall asleep or stay asleep, or by waking up too early?	0	1	2	3	4	
III.	4.	Been bothered by not being able to pay attention when you were in class or doing homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than you used to?	0	1	2	3	4	
	6.	Felt sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Felt more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Felt angry or lost your temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or done more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual but still had a lot of energy?	0	1	2	3	4	
VIII.	11.	Felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Not been able to do things you wanted to or should have done, because they made you feel nervous?	0	1	2	3	4	
IX.	14.	Heard voices—when there was no one there—speaking about you or telling you what to do or saying bad things to you?	0	1	2	3	4	
	15.	Had visions when you were completely awake—that is, seen something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Had thoughts that kept coming into your mind that you would do something bad or that something bad would happen to you or to someone else?	0	1	2	3	4	
	17.	Felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Worried a lot about things you touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Felt you had to do things in a certain way, like counting or saying special things, to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS,** have you…						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes		☐ No			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes		☐ No			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like Ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes		☐ No			
	23.	Used any medicine without a doctor's prescription to get high or change the way you feel (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes		☐ No			
XII.	24.	In the last 2 weeks, have you thought about killing yourself or committing suicide?	☐ Yes		☐ No			
	25.	Have you EVER tried to kill yourself?	☐ Yes		☐ No			