

Adolescent Questionnaire
Wise County Christian Counseling
1650 S FM 51 Suite 400
Decatur, Tx. 76234

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: _____
Address _____

Phone numbers:

Mother: _____

Father: _____

Step-Mother: (if applicable) _____

Step-Father: (if applicable): _____

Email address:

Please indicate if a message can be left at any of these numbers: _____

Child's Age: _____ Sex: _____ Male _____ Female _____

Date of Birth: _____

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:

Address of birth parent not living in home if applicable:

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?

How did you find out about us?

Current School & Grade/Teacher:

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 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:

Was there any trauma while child was in utero or during birth? If so, explain:

Mark any of the following which are presently causing the child difficulty:

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 _____

Mood-related Concerns _____

Disturbing memories _____

Difficulty going to sleep/staying asleep _____

Nightmares/night terrors _____

Suicidal ideation _____

Sadness _____

Feelings of guilt and shame _____

Excessive worrying _____

Anger/Irritable _____

Rule-Breaking/Behavior Problems _____

Aggression toward others _____

Drug/Alcohol use _____

Truancy _____

Running away _____

Stealing _____
Intentionally hurting animals _____
Fire-setting _____

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

Family-Relationship Concerns _____
Difficulty adjusting to family changes _____
Discipline concerns _____
Parent-child relationship problems _____
Sibling concerns _____
Divorce/Separation _____

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.)

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, or 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___ Sexually___

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___ Bedwetting___ Bone/joint/muscle___ Chest pain___

Chronic illness___ Developmental delay(s)___ Chronic Diarrhea___

Disability___ Dizziness___ Severe headaches___ Heart Palpitations___

Hospitalization___ Major accident___ Major illness___ Nervous Stomach___

Neurological problems/exam___ Severe PMS___ Serious overeating/undereating___

Shortness of breath without exercise___ Sleep problems___ Surgeries___

Other_____

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Consent to Counseling

Welcome to Wise County Christian Counseling! Thank you for choosing me for your counseling needs. This document is designed to inform you about my background and to ensure that you understand agency policies, procedures, and services.

I am a Texas State Licensed Professional Counselor specializing adolescents and adults. I hold a Bachelor of Science degree in Human Development and Family Studies from Abilene Christian University and a Master of Arts degree in Counseling from Amberton University.

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 will be contacted by one of my colleagues who will handle your records and care as needed.

I will keep confidential anything you say to me with the following exceptions: (a) you direct me to tell someone else; (b) I have reason to believe you are a danger to yourself or others; (c) I have reason to believe you intend to physically harm someone else; (d) you are abusing or have abused a child or an elderly person; or (e) I am ordered by a court to disclose information (f) If you disclose sexual contact with another health professional.

Supervision is a process within the counseling profession whereby cases are reviewed with objective, professional colleagues to ensure quality counseling. It is understood that this process may be utilized to provide the highest quality services.

I assure you that my services will be rendered in a professional manner consistent with accepted ethical standards. Please note that it is impossible to guarantee any specific results regarding your counseling goals. Together we will work to achieve the best possible results for you. 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 Hotline 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/or necessary. My lack of response does not indicate a lack of interest.

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

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.

Due to our high demand of calls, there is a \$50 charge for all no shows and cancellations made within the same day. A 24 hour notice of all cancellations is requested.

Mrs. Conway charges \$125/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 rebook 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) 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).

Your signature below indicates your understanding of and agreement to the terms and conditions stated on this form. If you have any questions, please feel free to ask for an explanation.

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

Name _____ Phone Number _____
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 Angela Conway 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 of parent(s)/couple/individual:

Client: _____ Guardian: _____ Date: _____

Counselor: _____ Date: _____

Wise County Christian Counseling
Patient Consent for Use and/or Disclosure of HIPAA Defined Protected Health
Information to Carry Out Treatment, Payment, and Healthcare Operations

I, _____, hereby state that by signing this consent, I
acknowledge and agree as follows:

The Provider's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Provider to provide treatment to me, and also necessary for the Provider to obtain payment for that treatment and to carry out its health care operations. The Provider explained to me that the Privacy Notice will be available to me in the future at my request. The Provider has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

The Provider reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

I understand that, and consent to, the following appointment reminders that may be used by the Provider: ___ Yes ___ No – A postcard mailed to me at the address provided by me.
___ Yes ___ No – Telephoning my home and leaving a message on my answering machine or with the individual answering the phone.
___ Yes ___ No – Telephoning my office and leaving a message on my phone mail or with the individual answering the phone.

The Provider may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Provider to treat me and obtain payment for the treatment, and as necessary for the Provider to conduct its specific health care operations.

I understand that I have a right to request that the Provider restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Provider is not required to agree to any restrictions that I have requested. If the Provider agrees to a requested restriction, then the restriction is binding on the Provider.

I understand that this Consent is valid for seven years and that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Provider has already taken action in reliance on this consent.

I understand that if I revoke this consent at any time, the Provider has the right to refuse to treat me.

I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Provider will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Name of Individual (Printed): _____

Signature of Legal Representative
(e.g., Attorney-In-Fact, Guardian, Parent if a minor)

Signature of Individual _____

Relationship to Client _____

Date signed _____ Witness: _____

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