

CHRISTIAN COUNSELING



1650 S. FM 51, Ste 400 Decatur, TX 76234

Phone: 940-627-1618

Client Information Questionnaire

Each client must complete their own intake paperwork and sign all release forms before meeting with their therapist. 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.

Full name \_\_\_\_\_ Date \_\_\_\_\_

Spouse Full Name: \_\_\_\_\_

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

Phone numbers (List all that apply): \_\_\_\_\_

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

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

Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Race / ethnicity: \_\_\_\_\_ Relationship status: \_\_\_\_\_

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

Household family income (including child support, unemployment, disability, etc.): \_\_\_\_\_

Religious preference: \_\_\_\_\_ Where do you attend? \_\_\_\_\_

Have you or a family member served in the military? \_\_\_\_\_

Please described any previous or ongoing medical issues that may impact your mental health (ex. chronic pain, cancer, hypothyroidism, etc.) \_\_\_\_\_

Please list all medications that you are taking at present: \_\_\_\_\_

If applicable, briefly describe your marital history (divorce, # of marriages, etc): \_\_\_\_\_

Check all of the following which reflect the parent figures currently in your home:

\_\_\_\_ Both birth parents      \_\_\_\_ Single parent      \_\_\_\_ Birth parent & Step-parent

\_\_\_\_ Foster parents      \_\_\_\_ Adoptive parents      \_\_\_\_ Grandparents

\_\_\_\_ Other relatives      Other (Please explain): \_\_\_\_\_



Mental Health History

Have you ever consulted a professional counselor? \_\_\_\_ YES \_\_\_\_ NO

If yes, name of agency: \_\_\_\_\_

How was counseling helpful then? \_\_\_\_\_

Please list any psychiatric medications, including antidepressants or anti-anxiety medications, that you have been prescribed along with the date prescribed and place a star by any you are currently taking. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list any mental health diagnosis you have received along with the date diagnosed and the person who diagnosed you. \_\_\_\_\_

\_\_\_\_\_

Have you ever considered suicide? \_\_\_\_ YES \_\_\_\_ NO If so, when? \_\_\_\_\_

Have you ever attempted suicide? \_\_\_\_ YES \_\_\_\_ NO If so, when? \_\_\_\_\_

Have you ever struggled with an addiction of any type? If so, please describe: \_\_\_\_\_

\_\_\_\_\_

Have you ever received inpatient psychiatric treatment? If yes, please describe when and where. \_\_\_\_\_

\_\_\_\_\_

Have you experienced any trauma that has impacted your life (ex. Parents' divorce, abuse, death of a close relative/friend)? If so, please describe: \_\_\_\_\_

\_\_\_\_\_

Is there any history of mental illness in your family? (anxiety, depression, OCD, schizophrenia, bipolar, addictions, etc.) \_\_\_\_\_

\_\_\_\_\_

What symptoms are you hoping to improve with therapy? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

- |               |                   |                 |                 |             |
|---------------|-------------------|-----------------|-----------------|-------------|
| Abuse         | Depression        | Insomnia        | Religion        | Alcohol use |
| Divorce       | Legal Matters     | Sadness         | Allergies       | Drug use    |
| Loneliness    | Self-Concept      | Anxiety         | Education       | Marriage    |
| Self-control  | Appetite          | Energy          | Memory          | Separation  |
| Assertiveness | Fears             | Mood swings     | Sexual problems | Asthma      |
| Finances      | Motivation        | Shyness         | Bed-wetting     | Food        |
| My past       | Sleep             | Bowels          | Friends         | My thoughts |
| Stress        | Career            | Choices         | Guilt           | Nervousness |
| Temper        | Suicidal thoughts | Children        | Headaches       | Nightmares  |
| Parenting     | Health problems   | Concentration   | Tiredness       | Confusion   |
| Inferiority   | Parents           | Ulcers          | Dating          | Infidelity  |
| Premarital    | Unhappiness       | Decision-making | In-laws         | Relaxation  |
| Work          | Other: _____      |                 |                 |             |

Please provide any additional information which you feel may be useful to your therapy. \_\_\_\_\_

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## DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: \_\_\_\_\_ Age: \_\_\_\_ Sex:  Male  Female Date: \_\_\_\_\_

If this questionnaire is completed by an informant, what is your relationship with the individual? \_\_\_\_\_

In a typical week, approximately how much time do you spend with the individual? \_\_\_\_\_ hours/week

**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 been bothered by the following problems?	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
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

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## **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. I hold a Bachelor of Science degree and a Master of Arts degree in Counseling Psychology from Texas Woman's University.

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 whereby 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. Because Wise CCC is 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, credit cards 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: \_\_\_\_\_

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

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.

