Wise County
CHRISTIAN COUNSELING

1650 S. FM 51, Ste 400 Decatur, TX 76234 Phone: 940-627-1618 www.wiseccc.org

Client Information Questionnaire

One or both parents / guardians must complete intake paperwork for each child 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.

Child's name: ____ Date: ____________

Completed by: ____ Relationship: ___________

Address: ____

Phone numbers (List all that apply): ____

____

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

Age: _____ Sex: _____ Race / ethnicity: __________ Grade: _____ Birth date: ______

Parent(s)' Occupation(s): ____

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

Religious preference: _________________________ Where do you attend? ___________________

Has either parent served in the military? ____

____

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): ___________________________________

Brief description of living arrangement: ____

____

____

Child's Legal Guardian (Managing Conservator): ____

______ *Important: 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: ____

____

____

____

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

____

____

Please list all medications that your child is taking at present: ____________________________

____

____

What do you hope to accomplish through counseling? ______________________________________

____

____

____

How did you find out about us? ____

____

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

_____Asthma	_____Bedwetting	_____Bone/joint/muscle
_____ Chest pain	_____ Chronic illness	_____Dizziness
_____ Chronic Diarrhea	_____ Heart Palpitations	_____ Developmental delay(s)
_____ Disability	_____ Severe headaches	_____ Hospitalization
_____ Major accident	_____ Major illness	_____Nervous Stomach
_____ Sleep problems	_____Severe PMS	_____Serious overeating/undereating

____ Surgeries ____ Thyroid problems ____Shortness of breath without exercise

____ Neurological problems/exam:________________ ____ Other______________________

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
______ Mood related Concerns
______ Disturbing memories
______ Nightmares/night terrors
______ Difficulty going to sleep/staying asleep
______ 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
______ Bullying (victim or perpetrator)
______ Self-Harm
______ Change in self-care / grooming habits
______ Other Unusual Behaviors (Please specify) ____
____

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

Mental Health History

Have you ever consulted a professional counselor on behalf of this child? _____YES _____NO

If yes, name of agency: ____
____

How was counseling helpful then? ____
____

Please list any psychiatric medications, including antidepressants or antianxiety medications, that your child has been prescribed along with the date prescribed and place a star by any they are currently taking. ____
____
____
____

Please list any mental health diagnosis they have received along with the date diagnosed and the person who diagnosed them. ____
____
____
____

Has your child ever considered suicide? _____YES _____NO If so, when? ____________________

Has your child ever attempted suicide? _____YES _____NO If so, when? ____________________

Has your child ever struggled an addiction of any type? If so, please describe: _______________
____
____

Has your child ever received inpatient psychiatric treatment? If yes, please describe when and where. ____
____
____

Has your child experienced any trauma that has impacted their 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? ______________________________

____

____

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

______ Family member's disability/major accident/illness

______ Difficult medical treatments

______ Parent's divorced

______ Death of significant person

______ Death of a pet

______ Domestic violence

______ Natural disaster

______ Family member absent (explain) ______________________________________

______ Family member emotional problems (explain)________________________________

______ Family member suicide (explain) ______________________________________

______ Child separated from parent (how long and when) ____________________________

______ Sexual assault - Was assault reported to police? _____________________________

______ Victim of trauma (unusual, terrifying experience) ____________________________

______ Other (explain) ____

____

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 child been court mandated to receive therapy? 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____ Medically ____ School problems (check all that apply): Academic problems____ Discipline problems____ Social problems____ Other____ ____________________

Early language/Speech problems (explain): ____

Wise County Christian Counseling
1650 S. FM 51 Suite 400
Decatur, Texas 76234
(940) 627-1618

Parental Consent for Counseling

By signing this consent form, I am giving permission to Jana Bearden, LPC to evaluate and / or provide counseling services for my child.

I understand that there is no guarantee that my child or children's problems will get better by seeing a therapist. I understand that my child or children's condition may even worsen if I remove my child or children from counseling too soon or against the advice of my child's therapist.

I know that I also have the right to talk to my child or children's counselor about any aspect of counseling or how my child is responding to counseling. I also understand that my participation with my child in therapy could benefit him/her.

I understand that my child may be placed on a waitlist for counseling after the parent consultation. I agree to provide accurate information to the best of my ability so that my child can be matched with the best possible therapist for them. I also agree to contact Wise CCC if there are changes to my child's condition and to seek emergency medical care if my child becomes a danger to themselves or others. I understand that I may also receive parent education or other resources to help my family from Wise CCC and organizations that they may refer us to.

Parent ____ Date _____________________

Parent ____ Date _____________________

Child's Name ____

Client Signature____ Date _______________

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 Jana Bearden and I am a Texas State Licensed Professional Counselor. I hold a Bachelor degree from Baylor University and a Master of Science degree in Professional Counseling from Grand Canyon 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. Bearden 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.

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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