

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: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ 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? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

- Parenting groups     Co-parenting classes     Books  
 Individual therapy     Couples counseling

**Devon McCain, MA, LPC- Intern**  
**Supervised by Beverly Ross, MA, LPC-S**

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

**Informed 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.

**Qualifications:** I am a Texas State Licensed Professional Counselor Intern (TX 79607). I hold a Bachelor of Science degree in Deaf Education from Texas Woman's University and a Master of Arts in both School Counseling and Professional Counseling from Amberton University. I am supervised by Beverly Ross, MA, LPC-S.

**Counseling Relationship:** During our counseling relationship, we will direct our mutual efforts toward agreed upon goals determined on an individual basis. 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 the full hourly fee.

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 18<sup>th</sup> birthday. In the case of my incapacitation or death, you would be contacted by one of my colleagues 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 professional 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.

Devon McCain will not be able to participate in court appearances, depositions, and arbitrations, because of LPC- Intern status.

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:

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Name	Phone Number	Relationship
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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 Devon McCain 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: \_\_\_\_\_ Date: \_\_\_\_\_

Counselor: \_\_\_\_\_ Date: \_\_\_\_\_

**Wise County Christian Counseling  
Parental Consent for Counseling**

By signing this consent form, I am giving permission to Devon McCain to provide counseling services for my child. I recognize that the therapist listed above is a Licensed Professional Counselor Intern with WiseCCC. I understand that there is no guarantee that my child's problems will get better by seeing a therapist. I understand that my child's condition may even worsen if I remove my child 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'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 hereby state that I have managing conservatorship for \_\_\_\_\_ (child's name) and have the legal right to grant consent for mental health treatment. I give my permission for him/her to receive counseling services and will provide court documentation regarding conservatorship. \_\_\_\_\_ (Parent/Guardian initial)

\_\_\_\_\_ Parent/Guardian

\_\_\_\_\_ Date

\_\_\_\_\_ Parent/Guardian

\_\_\_\_\_ Child or Children's Name(s)



## HIPAA Notice of Privacy Practices

This notice 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:

\_\_\_\_\_  
Signature (parent or guardian if minor client) 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