# NORTH DALLAS CHRISTIAN COUNSELING

1404 Gables Court #203
Plano, TX 75075

Phone 214.577.8334
www.NDCcounseling.com

**COUNSELEE INFORMATION** Today's Date: _____

Client Name _____ Spouse Name _____

Date of Birth: _____ Age: _____ Sex (please circle): M F

Highest level of education: _____ Degree(s): _____

Marital Status (please circle): Married (Years ____) Separated Divorced Widowed

Single Single in Relationship Single but Engagement

If Married, Children with Current Spouse (names/ages) : _____

_____

Previous Marriage(s): First (Duration ___) Second (Duration ___) Third (Duration ___) Fourth (Duration ____)

Children by Previous Marriage(s) (names/ages): _____

_____

Occupation _____ Employer _____

Home Address _____

City _____ State _____ Zip _____

Home Phone ( ) _____ Cell ( ) _____

Work Phone: ( ) _____

_____ (initial) **I grant permission for NDCC to leave voice mail messages on the phone number(s) above**

_____ (initial) **I grant permission to NDCC to send text appointment messages on the cell number above**

Primary email address _____

Secondary email address _____

Please check any of the following at which you prefer **NOT** to be contacted or receive written material:
___Work Phone ___Cell Phone ___Primary email ___Secondary email ___Home Address

**Emergency contact:** Name and phone # _____
Relationship to you _____

**_____ I grant permission to contact the above emergency contact should the counselor deem it necessary in regard to my mental and/or physical safety and care.**

**Physical Health** (please rate yourself):

Very good Good Average Poor Improving Declining

If not good or very good, please explain.

**Physical challenges**: List all illnesses, allergies, injuries or handicaps that presently affect you.

**Learning challenges**: Have you ever been diagnosed with a learning disability? Yes No If so, of what type?

**Sleep:** How many hours of quality sleep do you average each day?

**Exercise:** How much exercise do you get each week?

**Medications**: Please list any medications you are currently taking.

1. _____ Purpose: _____
2. _____ Purpose: _____
3. _____ Purpose: _____
4. _____ Purpose: _____
5. _____ Purpose: _____
6. _____ Purpose: _____

## MENTAL HEALTH

Are you currently under the care of another mental health or counseling professional? Yes No

If the answer is "yes," you will be asked by the North Dallas Christian Counseling counselor to sign a Consent to Disclose document, which allows for communication between counselors, in order to inform and consult with one another in the best interest of your treatment.

If yes, please indicate the name and contact information:

Name of professional _____

Address _____

Phone number _____

Reason(s) for provided care _____

## PRELIMINARY SELF-ASSESSMENT

1. Please indicate all the following that apply to you:

   Number according to the severity of your experience

   **1** = Constant/Major Problem **2** = Occasional/Moderate Problem

   **Leave Blank if never experienced, or not currently experiencing.**

| | |
|---|---|
| ___ I feel discouraged | ___ I feel anxious |
| ___ I feel insecure | ___ I feel inferior |
| ___ I feel hopeless | ___ I feel fearful |
| ___ I feel confused | ___ I feel lonely |
| ___ I feel angry | ___ I feel lustful |
| ___ I feel sad | ___ I think of suicide |
| ___ I feel inadequate | ___ I avoid or dislike touch |
| ___ I react to my feelings | ___ I suppress my feelings |
| ___ I am having panic attacks | ___ I avoid conflict or problems |
| ___ I have obsessive thoughts | ___ I have compulsive behaviors |

___ I struggle with jealousy (insecure about what I have)

___ I struggle with envy (wanting what others have)

| | |
|---|---|
| ___ I am judgmental | ___ I am controlling |
| ___ I feel guilty | ___ I feel shameful |
| ___ I distrust others | ___ I fear vulnerability |
| ___ I strive toward perfection | ___ I am lazy |
| ___ I dislike the way my body looks | ___ I have issues with food |

___ I worry
___ I am bitter
___ I struggle with identity
___ I do not feel or show empathy
___ I am having marital problems
___ I struggle as a parent
___ I abuse alcohol
___ I view pornography
___ I have been unfaithful to my spouse
___ I am a poor communicator
___ I do not attend church
___ I fear failure
___ I am or have been verbally abusive
___ I am or have been physically abusive
___ I am or have been sexually abusive

___ I have doubts
___ I feel worthless
___ I feel the need to please others
___ I lack discernment
___ I have issues with my family or in-laws
___ I abuse prescription drugs
___ I use illegal drugs
___ I struggle sexually
___ My spouse has been unfaithful to me
___ My spouse is a poor communicator
___ I do not read my Bible
___ I fear rejection
___ I am being or have been verbally abused
___ I am being or have been physically abused
___ I am being or have been sexually abused

2. Briefly describe why you have chosen to seek counseling at this time from this counselor.

3. What do you hope to achieve (goals) from the counseling process and what clear indicators will be present when counseling is complete? Please be specific.

4. Have you had counseling in the past? From whom? For what reasons? What were the outcomes?

5. If you ever been hospitalized for a mental health issue, please indicate when, where, and for what reasons.

# CLIENT RIGHTS AND RESPONSIBILITIES/INFORMED CONSENT

**PRACTICUM STUDENT COUNSELOR:**

Your counselor is Lindsey Smitham, a student working towards her graduate degree in counseling. As part of the requirements of her degree program, she must engage in face to face counseling. Your counseling is under the close supervision of a licensed professional, James S. Clay, LPC-S, and your counselor will be seeking guidance from him as it regards your case.

_____(initial) I understand my counselor's credentials and qualifications/limitations as stated above.

_____(initial) I understand that at any time I can terminate the counseling relationship. If I have a concern or complaint about my counselor, I am free to discuss those concerns with him/her or his/her supervisor.

**METHOD OF COUNSELING**

_____ (initial) I understand that my counselor provides counseling based on biblical truth and principles, that he or she is a Christian counselor who believes that Jesus Christ is the son of God, who offered life in His name on the basis of belief in His atoning death.

_____ (initial) I understand that my counselor may pray for me at any point during counseling sessions, and I do freely give my consent.

_____ (initial) I understand that, although I may not share the same faith, as my counselor helps me toward my intended goals he or she will work with me in a manner that is impacted by and consistent with his or her faith. A statement of the counselor's faith will be provided at my request. If I have any concerns about this, I will discuss them with my counselor. Should a conflict present itself, my counselor will provide referrals for continued treatment.

**GOALS, RISKS, AND BENEFITS**

_____(initial) I understand one of the goals of the counseling I will receive is to confront personal and interpersonal issues and painful emotions.

_____(initial) I understand the possibility that during the counseling process some emotional and interpersonal symptoms may worsen before they get better.

_____(initial) I understand that other resources will likely be suggested during the counseling process and that these are key to reaching my goals in a timely manner.

**LENGTH OF COUNSELING**

_____(initial) I understand that the length of counseling will be a joint effort on my part and that of my counselor, based on the unique strengths and weaknesses I bring to the counseling process, as well as the nature of the problem(s) to be addressed therein.

_____(initial) I understand that the goal of the counseling process is to thoroughly and adequately address my concerns, and to be done so in a timely manner, without unnecessary waste of time and money.

_____(initial) I understand that the length of the counseling process is significantly related to the effort and time I put into it.

**TERMINATION OF COUNSELING**

_____ (initial) I understand that counseling is normally complete when my counseling goals have been attained. This is usually, but not always, decided within a collaborative relationship between all those involved in the counseling relationship.

_____ (initial) I understand that it is prudent to stay in counseling until my goals have been reached and commit myself to the process that leads to the attainment of those goals.

_____ (initial) I understand that after six (6) months of non-contact or response ***from*** me, NDCC will consider the counseling relationship terminated and will close my file.

_____ (initial) I understand that my counselor may terminate counseling services at his or her discretion, examples of such are: lack of progress toward counseling goals, inconsistency of attended appointment times, excessive cancellations and/or failure to attend scheduled sessions without sufficient notice, failure to pay for services, or lapse of scheduled and attended appointments.

**FEES and PAYMENT**

The fee structure for counseling services provided my counselor, Lindsey Smitham, is:

- **$50 for 50-minute sessions**

_____(initial) I understand that payment is due when services are rendered, payable to North Dallas Christian Counseling.

_____(initial) **I authorize NDCC, if credit card charges are disputed, questioned, or denied, to disclose to the credit card company used to pay for services, the identity of the person by which charges were made and the purpose for those charges.**

_____(initial) I understand that there will be a $25 charge for any returned or stopped checks used to pay for services rendered.

_____(initial) I understand NDCC has the right to withhold further counseling if I do not financially meet the obligation of payment as cited above.

**CANCELLATION POLICY**

_____(initial) I understand my appointment time is reserved exclusively for me and that I will be charged and expected to pay at the full session rate for any and all appointments for which I do not show up or for which I do not provide **48-hour** (business hours) notification of cancellation.

_____(initial) I understand that, if I have provided a credit card on file, my card will be charged the day after any missed appointments.

_____(initial) I understand that my failure to pay for no show or late cancellation appointments will result in cancellation of all future appointments until payment has been made.

**EMAIL AND PHONE CONSULTATIONS**

_____(initial) I understand that my counselor does not provide counseling via email and that all email correspondence should be kept to a minimum. The counselor will not give advice or counsel, nor will he or she address sensitive issues, in email.

_____(initial) I understand that if required, time spent by my counselor reading, sending or responding to emails or in phone conversations when exceeding more than 15 minutes will be billable for a minimum of one half hour, with payment due at the next counseling appointment, if not at the time of the correspondence.

**TELEHEALTH**

_____(initial) I understand that Telehealth is available to me under specific circumstances. My counselor will discuss with me the appropriateness of such services if needed or requested. I understand that an additional informed consent document accompanies Telehealth services. The fee structure for telehealth is the same as face-to-face, in-person counseling.

**CONFIDENTIALITY AND LIMITS OF CONFIDENTIALITY**

_____(initial)I understand that the counseling relationship and process will adhere to very strict confidentiality standards; that my information is managed using procedures designed to protect the privacy and security of personal data; that my counseling records are strictly confidential, except as noted below under section entitled Right to Privacy; that my ***written authorization is required if I desire that my information be shared by us to another person or agency***, except where stipulated below.

_____(initial)I understand that in couples counseling or family counseling, there will be limited confidentiality, ***meaning that confidentiality belongs to the relationship and not to the individual***; that when expedient the counselor will share with the counselee the intent to notify relatives or authorities before the above actions are taken.

_____(initial) I understand that because couples counseling involves two people, the identified "client" is the couple, not the individuals within the couple and that ***in order for counseling information to be released, both members of the couple must provide their written authorization.***

_____(initial) I understand that information discussed in couples or family counseling is for counseling purposes and is not intended for use in any legal proceedings involving the partners.

_____(initial) I understand that during the course of couples or family counseling, that both or all members of the relationship will be seen together and yet there will be times when I or my partner or family member in one or more one-on-one sessions. ***When seen as an individual, such sessions should be considered by the couple or family as a part of the couple's or family's therapy. Toward this end, I understand that anything I share in an individual session may be discussed in subsequent therapy sessions where your partner or family member is present***.

_____(initial) I understand that North Dallas Christian Counseling's policy of not keeping secrets when the identified client is a couple or family relationship is designed to help everyone feel safer in counseling, allowing my counselor to be completely honest, without having to be concerned about who told him or her what or when. If I have any questions about whether a topic is one that needs to be brought up in the joint or family session, I agree to ask my counselor ***before*** sharing any actual details of my particular situation.

_____(initial) I understand that this agreement of confidentiality applies to counseling sessions, phone calls, voice mail messages, texts, e-mail messages, or any and all forms of communication.

_____(initial) I understand that by initialing and signing this agreement, I am acknowledging that my counselor is free to discuss any information shared by me with the other person regularly attending counseling with me.

**CLIENT RECORDS AND RELEASE OF INFORMATION**

Intake forms and session notes become part of the client's clinical record. North Dallas Christian Counseling is responsible for the maintaining and safekeeping of these records. In accordance with legal requirements, adult client records may be disposed of seven (7) years after the file is closed or five (5) years after the client reaches the age of majority, whichever is greater. A client may request a copy of his or her file through a written request. Payment of fee for copying the file ***will need to be provided in advance***. In the case of marriage, couples, or family counseling, there is limited confidentiality, ***meaning that confidentiality belongs to the relationship and not to the individual***. Therefore, the clinical record belongs to the relationship, not to the individual, requiring a written release form from all members of the clinical relationship (those who attended counseling).

_____ (initial) I understand that in the case of marriage, couples, or family counseling, there is limited confidentiality, *meaning that confidentiality belongs to the relationship and not to me as an individual*, and that release of the full clinical record requires written notification from all members of the clinical relationship.

_____ (initial) I understand that in order to receive a copy of my records, I will need to pay in advance the

associated fee before being provided a copy of my records.

While most communication between a client and counselor is confidential, the following limitations and expectations do exist:

**With Written Consent**

A client may request that specific information be sent to another individual. Prior to a disclosure, the client must sign an "Authorization to Disclose Protected Healthcare Information" form. Information will not be released for reasons unrelated to treatment.

*In the event that the client is a relationship, rather than an individual, written consent must be obtained by all parties in the relationship prior to release of information.*

**Without Written Consent**

Client information may be released without consent in the following situations:

- Case records may be utilized for purposes of consultation with other health care professional(s), supervision, professional development, and research. In such cases, to preserve confidentiality, clients are identified by first name only.
- The counselor determines if the client is a danger to himself or someone else.
- The client discloses abuse, neglect, or exploitation of a child, the elderly, or a disabled person.
- The client discloses sexual contact with another mental health professional.
- The counselor is ordered by a court to disclose information.
- The counselor is otherwise required by law to disclose information.
- Your insurance company requests information, in order to process your claim for reimbursement.

**SUPERVISION**

The staff of North Dallas Christian Counseling operates as a team to improve the quality of counseling we offer. Your counseling may be discussed with your counselor's clinical supervisor and other counselors at North Dallas Christian Counseling (during group supervision). ***Such discussions will remain confidential***. Names will only be shared with the director or clinical supervisor on an as needed basis. Tape or video recording may be made of your counseling sessions for professional training purposes. ***This recording will be done only with your knowledge and only with your written permission.*** Your counselor will discuss this with you.

_____(initial) I understand that my case will be discussed in clinical supervision with the intent of providing better care in my behalf, and that any video or audio recordings *would be done so only with my written consent.*

**REFERRALS**

_____(initial) I understand that should a referral be deemed necessary or requested, my counselor or her supervisor will provide such referral in accordance with his or her professional judgment.

_____(initial) I understand that should my counselor provide a referral to me, it is my responsibility to evaluate and contact those referral alternatives.

**EMERGENCIES**

North Dallas Christian Counseling is not a crisis response center. Emergencies should be directed to appropriate agencies that provide emergencies services. In the event of what appears to the client as an emergency, he or

she should contact a physician, a local emergency room, or the local police department when necessary and appropriate (dialing 911). It is the client's responsibility to seek the appropriate resources in emergency situations.

_____(initial) I understand that NDCC does not provide 24-hour emergency crisis counseling. Should I experience an emergency requiring immediate mental health attention, I will immediately access help via a 911 emergency call or go to the emergency room at a local hospital.

**SIGNATURES**

By your signature below, you indicate that you have read and understood this statement, and any questions about this statement were answered to your satisfaction. A copy of this completed form will be provided to you at your request. Your counselor, by indication of his or her signature, verifies the accuracy of this statement and acknowledges his/her commitment to conform to its specifications. Your signature also acknowledges that you have received a copy of NDCC Privacy Practices and Informed Consent.

**Client**
Signature: _____ Printed Name: _____

Date: _____

**Practicum Counselor**
Signature: _____ Printed Name: _____

Date: _____