# NORTH DALLAS CHRISTIAN COUNSELING

1404 Gables Court #203
Plano, TX 75075

Phone 214.577.8334
www.NDCcounseling.com

# CHILD INTAKE

***Form to be completed by parent or guardian***

**PARENT/GUARDIAN INFORMATION** Date: ________________

Parent/Guardian Name: ______________________________________ DOB: ______________

Relationship to Child: _____________________

Home Address: _______________________________________________________________
Street City State, Zip

Home Phone: ________________ Cell Phone: ________________ Work: __________________

Email Address: __________________________________

*May we call you and leave messages at home?* Yes No Cell? Yes No

May we call you at work? Yes No

*May we send email to you at this email address?* Yes No

May we send you texts reminders for your child's appointments? Yes No

Marital Status: S M D W Date of Current Marriage/Separation: _____________

Number of Marriages: _____

Children's Names:

Date of Birth: M F Date of Birth: M F Date of Birth: M F Date of Birth: M F

Occupation: __________________________ Highest Level of Education:_____________

Name of other custodial parent: _____________________________ Phone :________________

*Do you have consent from the other custodial parent for treatment of said child?* Yes No

**Important Note:** NDCC must have a copy of the divorce decree and a signed custodial parental consent before the intake session can begin.

How much contact per month does the child have with his biological mother/father?

______________________________________________________________________________

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## EMERGENCY CONTACT

Name:

Relationship to child:____________________

Home phone: _________________________ Work phone:__________________________

Address: _____________________________________________________

City, State, Zip _________________________________________________

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***Complete all remaining information according to the child coming for treatment.***

## GENERAL INFORMATION

Child Name: _____________________________________________Date of Birth: __________________

The child is currently living with: _________________________________________________________

School: __________________________________________Grade: _____________

Extracurricular activities/interests: _______________________________________________________

Screen time per day: ________ hours

## MEDICAL HISTORY

How would you rate your child's current physical health? Excellent Good Fair Poor

Is the child currently complaining of any physical problems (e.g. headaches, stomach aches)? Yes No

If yes, please explain:

Previous hospitalizations for medical or mental health reasons

Date: __________________ Reason: _____________________________________________

Date: __________________ Reason: _____________________________________________

Please list any medical conditions or disabilities:_______________________________________

Please list any learning disabilities: __________________________________________________

| MEDICATION(S) Over-the-counter or prescription | DOSAGE |
| --- | --- |

| | |
|---|---|
| | |
| | |
| | |

## COUNSELING AND PSYCHIATRIC HISTORY

Is the child currently under the care of another mental health professional? Yes No

If so, please give the name and contact information for this professional.

Name of professional ________________________________

Address and phone number

____________________________________________________________________

Has the child had any previous counseling? Yes No

For what reason? ____________________________________________________________

If yes, when?______________________ For how long? _____________

Name and location of counselor: ___________________________________________________

Has the child ever been diagnosed with or treated for any type of mental illness? Yes No

If yes, which type? ____________________________________________________________

Has anyone in the child's family ever been diagnosed with or treated for any type of mental illness?

Yes No If yes, which type? ____________________________________________

| PSYCHIATRIC MEDICATION(S) | DOSAGE |
|---|---|
| | |
| | |
| | |

## REASONS FOR SEEKING HELP

What concerns about the child have brought you to counseling today?

Where are these concerns causing the most problems for YOU?

Please check all that apply: Home Work Marriage Other: _____________

Where are these concerns causing the most problems for the CHILD?

Please check all that apply: Home School Friends Other: _____________

When did the present concerns begin to be a problem for the child?

What concerns about the child have been identified by others?

From the following circle areas that are currently problems for the child:

| | |
|---|---|
| Crying spells | Hyperactivity |
| Excessive fears or anxieties | Bullying/picking fights |
| Separation from specific family members | Refusal to respond to authority |
| Hearing voices | Getting into trouble at school/play |
| Nightmares | Obsessions/compulsion with specific activities |
| Temper tantrums | Lack of motivation |
| Decreased/increased appetite | Difficulty falling asleep/inability to sleep at night |
| Lack of self-confidence | Difficulty making or keeping friends |
| Loss of interest in usual activities | Other: _________________________ |

What do you hope to gain from counseling?

How did you hear about North Dallas Christian Counseling?

# 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.

_______(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 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 may 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/Guardian**
Signature: ____________________________________ Printed Name: ___________________________________

Date: ___________________________________

**Practicum Counselor**
Signature: ___________________________________ Printed Name: __________________________________

Date: ___________________________________